STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

October 31, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jorge Perez, M.D.
213 14th Street
Palisades Park, New Jersey 07650

T. Lawrence Tabak, Esq.
Tabak & Stimpfl
190 EAB Plaza
East Tower-15th Floor
Uniondale, New York 11556-0190

Daniel Guenzburger, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

RE: In the Matter of Jorge Perez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-302) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien/nm

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER
OF
JORGE PEREZ, M.D.

DETERMINATION
AND
ORDER
BPMC-03-302

GERALD M. BRODY, M.D., Chairperson, **JERRY WAISMAN, M.D.**, and **GARRY SCHWALL, R.P.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) and (12) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges charges the Respondent with professional misconduct by practicing the profession of medicine with negligence on more than one occasion (one specification) and with incompetence on more than one occasion (one specification), by practicing the profession of medicine with gross negligence on a particular occasion (four specifications) and with gross incompetence (one specification).

The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing and Statement of Charges Dated:	April 21, 2003 and April 17, 2003 respectively
Date of Service of Commissioner's Order and Notice of Hearing and Statement of Charges:	April 21, 2003[1]
Answer to Charges Dated:	April 22, 2003
Amended Statement of Charges Dated:	April 28, 2003
Prehearing Conference Date:	April 28, 2003
Hearing Dates:	May 2, 2003 May 23, 2003 May 30, 2003 June 9, 2003 June 16, 2003
Hearing Committee's Recommendation and Commissioner's Interim Order Dated:	June 16, 2003 and June 26, 2003 respectively
Deliberation Date:	July 23, 2003
Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	Daniel Guenzburger, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Tabak & Stimpfl 190 EAB Plaza East Tower – 15th Floor Uniondale, N.Y. 11556-0190 By: T. Lawrence Tabak, Esq.

[1] See stipulation appearing on page 10 of the transcript of the Prehearing Conference conducted on April 28, 2003.

WITNESSES

For the Petitioner:	Mark S. Silberman, M.D. Harvey Stern, M.D. Fernando Jara, M.D. Frank B. Fromowitz, M.D.
For the Respondent:	Jorge Perez, M.D. Patrick M. Davis, M.D. Hedva Shamir, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Jorge Perez, M.D. ["the Respondent"] was authorized to practice medicine in New York State on or about October 26, 1990 by the issuance of license number 184454 by the New York State Education Department (Ex. 2; Answer, ¶ 1).

2. The Respondent received his medical education in San Juan, Puerto Rico. He attended the San Bautista School of Medicine from August 1982 to June 1984 and the University of Puerto Rico School of Medicine from August 1984 to June 1986, where he received his M.D. Degree. (Tr. 567-568; Ex. C).

3. After graduating medical school the Respondent received postgraduate medical training in different disciplines, including a year in family practice at Mountainside Family Practice Associates in Verona, N.J. (July 1987-June 1988); a year and a half of anesthesia training at Monmouth Medical Center in Long Branch, N.J. (July 1988-February 1990); and, two years of residency training in internal medicine at Bronx-Lebanon Hospital Center in Bronx, N.Y. ["Bronx-Lebanon"] (July 1993-June 1995). (Tr. 570-572; Ex. C).

4. The Respondent has never been board certified in any medical specialty and he failed the certifying examination in emergency medicine twice and the examination in internal medicine three times (Tr. 581-582).

5. The Respondent has extensive experience as an Emergency Room physician, having worked as a full-time emergency physician from July 1995 through December 2002 as well as a part-time emergency physician from August 1990 through June 1993 (Tr. 575; Ex. C).

6. Since August 1990 the Respondent has worked in the Bronx-Lebanon system full-time and he is familiar with the facilities, service, procedures and support at the complex (Ex. C).

SPECIFIC FINDINGS AS TO EACH PATIENT

Patient A

7. On August 11, 2001 at about 6:00 P.M., Patient A, a 38 year old male, presented to the Emergency Room of Wyckoff Heights Medical Center in Brooklyn, N.Y. ["Wyckoff"], with a chief complaint of abdominal pain since the night before (Tr. 53-55; Ex. 3).

8. At about 6:50 P.M. Patient A was evaluated by Dr. Eichenstein who found that the patient had "diffuse" abdominal pain and abdominal distention. Dr. Eichenstein ordered laboratory work (CBC, Chem 7, Amylase) and an abdominal x-ray. (Tr. 54-56; Ex. 3, pp. 1 and 3).

9. At approximately 7:00 P.M. the Respondent assumed responsibility for the care of Patient A and, shortly thereafter, the Respondent received the results of the laboratory work that had been previously ordered by Dr. Eichenstein. (Tr. 56-58 and 64-65; Ex. 3, pp. 3, 6 and 7-11; Ex. 3B). The most significant laboratory finding was an elevated white blood count ["WBC"] of 16,400. Once the Respondent became aware of the elevated WBC, he needed to reassess the patient in light of the abnormal laboratory finding. The elevated WBC raised the possibility of an abdominal infection and brought into the differential diagnosis such conditions as appendicitis, cholecystitis, and diverticulitis. (Tr. 57-60).

10. The Respondent reevaluated Patient A on two separate occasions as documented in the nursing notes, but he failed to document his reevaluations (Tr. 60-61; Ex. 3, pp. 3 and 6).

11. The Respondent inappropriately ordered the administration of Toradol. At approximately 11:35 P.M. the Respondent ordered Toradol 60 mg., to be administered intramuscularly ["IM"]. Toradol is a non-steroidal anti-inflammatory medication that may alter the

results of a physical examination by masking symptoms. Since repetition of the physical examination would have been critical to the process of diagnosing the cause of Patient A's abdominal pain, the Respondent compromised further evaluation by inappropriately administering Toradol. (Tr. 62-63; Ex. 3, p. 3).

12. The Respondent's evaluation of Patient A was inadequate since he failed to order a reexamination of the patient's vital signs, especially temperature. In a patient with a significantly elevated WBC, the prudent physician would want to know if the patient developed a fever. Patient A's vital signs were never repeated during the seven and one-half hours that the patient was in the Emergency Room. The failure to check the patient's vital signs prior to discharge was a deviation from medically accepted standards. (Tr. 60-61, 128-129 and 1008-1011; Ex. 3).

13. The Respondent's evaluation of Patient A was inadequate since he failed to order either an abdominal Cat Scan and/or ultrasound examination. Patient A's abnormally high WBC, coupled with the continuing complaint of abdominal pain, raised appendicitis as a possible diagnosis. Further imaging studies would have helped resolve whether the patient had significant localized intra-abdominal infection. (Tr. 61-62 and 1034-1037; Ex. 3).

14. The Respondent inappropriately diagnosed urinary tract infection based upon a mistaken analysis of the history and laboratory findings. First, the patient did not complain of any urinary symptoms. A diagnosis of urinary tract infection is most often associated with clinical findings such as dysuria and frequency. Second, a diagnosis of urinary tract infection is an extremely rare diagnosis in a 38 year old male who does not have co-morbid conditions. (Tr. 63-64 and 104-106; Ex. 3, pp. 1 and 4).

15. Patient A had a WBC of 16,400, which represents a marked elevation of the WBC (Tr. 57-58 and 1022). The Respondent incorrectly characterized this elevated WBC as a "moderately elevated white count" (Tr. 721).

16. A WBC of 16,400 is not consistent with a lower urinary tract infection in the absence of specific signs and symptoms (Tr. 64-64, 106, 1006-1007 and 1029-1030).

17. The Respondent inappropriately interpreted Patient A's urinalysis as positive, when, in fact, the patient had a normal urinalysis. Although the laboratory reported that the microscopic evaluation showed three to four white blood cells per higher power field, this was a normal result since the reference range for normal was zero to five white blood cells per higher power field. (Tr. 58-59; Ex. 3, pp. 3 and 7).

18. The Respondent placed undue significance on the presence of a few bacteria in the urine. The presence of a few bacteria in the urine is not diagnostic of a urinary tract infection, especially in the absence of clinical symptoms. (Tr. 95-96).

19. The Respondent failed to order either a Cat Scan or a surgical consultation. Based on Patient A's high WBC and continuing complaint of abdominal pain, the Respondent should have ordered either a Cat Scan or a surgical consultation to evaluate for the possibility of appendicitis or other condition that would have required surgical intervention. (Tr. 61-62).

20. The Respondent inappropriately discharged Patient A at 2:40 A.M on August 12, 2001 with a diagnosis of urinary tract infection. The Respondent should not have discharged the patient because his diagnosis was not consistent with the findings in the patient, which suggested a life threatening condition. (Tr. 60-65; Ex. 3, p. 3).

21. On August 12, 2001 at about 3:40 P.M., approximately thirteen hours after Patient A was discharged by the Respondent, Patient A returned to the Wyckoff Emergency Room with a complaint of ongoing abdominal pain. Patient A underwent an exploratory laparotomy and was diagnosed with acute appendicitis. The operative findings were a "ruptured" and "gangrenous" appendix and "purulence in the abdominal cavity". (Tr. 68-69; Ex. 3A, pp. 3, 5, 7, 9, 10 and 11-12).

Patient B

22. On February 7, 2001 at about 2:25 P.M., Patient B, a 31 year old female, presented by ambulance to the Emergency Room of the Fulton Division ["Fulton"] of Bronx-Lebanon. The patient reported that she had "felt dizzy and fainted". She had a past medical history of end stage renal disease, hemodialysis, HIV infection, asthma and the recent excision of a cyst from her back. (Tr. 132-134; Ex. 4, pp. 1, 2 and 3).

23. At about 2:30 P.M. Patient B was examined by the Respondent. At the time the Respondent initially examined Patient B the Respondent failed to take an adequate history. He inappropriately failed to elicit and note symptoms associated with syncope, including whether the patient experienced chest pain or whether the fainting episode was associated with a seizure. (Tr. 134-135; Ex. 4, p.4).

24. In addition, the Respondent failed to elicit the date when Patient B last had dialysis. Such information would have helped determine whether Patient B's syncope related to an issue of electrolyte imbalance, including hyperkalemia, an. excessive level of potassium in the blood. (Tr. 134-135; Ex. 4, p. 4).

25. The Respondent failed to order an EKG at the time of the initial evaluation. The performance of a 12 lead EKG is an expeditious test to determine whether Patient B was suffering from hyperkalemia. (Tr. 174-175 and 973-974; Ex. 4, p. 1).

26. The Respondent failed to order cardiac monitoring at the time he initially examined Patient B, which would demonstrate the cardiac rhythm. Such information is critical in the case of patient who has recently fainted. (Tr. 135-137). The Respondent is responsible to ensure that a patient with a history of syncope is placed on a cardiac monitor (Tr. 149).

27. At about 2:45 P.M. Patient B went into cardiac arrest. The Respondent intubated the patient and began cardio-pulmonary resuscitation. The patient was pronounced dead at 3:25 P.M.. (Tr. 137 and 141; Ex. 4, pp. 10 and 16).

28. The Respondent failed to administer sodium bi-carbonate, calcium and other anti-hyperkalemic medication. Hyperkalemia can be reversed within minutes of the administration of these medications. (Tr. 170-171 and 819-821). The Respondent did not order anti-hyperkalemic treatment because he was waiting for laboratory test confirmation of hyperkalemia. (Tr. 821 and 853-854). The accepted medical standard is to immediately initiate anti-hyperkalemic treatment when a patient with a history of renal failure is in cardiac arrest. The potential benefit to the patient far outweighs the risk of delay in treatment. (Tr. 170 and 1085).

29. The Respondent ordered the laboratory profile stat. The test results were not available until some time after the patient had already died. The test results provide laboratory confirmation that the patient had hyperkalemia. (Tr. 1055; Ex. 4; Ex. 4B).

30. The Respondent failed to comply with Advanced Cardiac Life Support ["ACLS"] protocols, which require treatment for hyperkalemia in this patient's circumstances (Tr. 138-140).

31. In addition, the Respondent failed to comply with ACLS protocols because the patient should have been manually ventilated with an ambu bag rather than mechanically ventilated. The Respondent placed the patient on a mechanical ventilator with a tidal volume of 600 ml., a respiratory rate of 16 per minute, and oxygen concentration of one hundred per cent. There is no documentation of manual ventilation. (Tr. 141-144; Ex. 4, p. 10).

32. The Respondent pronounced the patient dead at 3:25 P.M.. Although the Respondent diagnosed myocardial infarction as the cause of death of this 31 year old female, this patient did, in fact, die from untreated hyperkalemia. (Ex. 4, p. 16; Ex. 4B, p. 2).

Patient C

33. On February 8, 1999, Patient C, a 46 year old male, was brought to the Fulton Emergency Room by ambulance. The presumptive diagnosis of the EMS crew was asthma secondary to pneumonia. While in the ambulance the patient received Albuterol nebulizer treatment. (Tr. 179-180; Ex. 5, p. 9).

34. The Respondent evaluated the patient and documented that the patient had been sick for one week, had been found by EMS sitting in his room with shortness of breath, and had fever and a cough productive of greenish sputum. The Respondent noted a past medical history of pneumocystis pneumonia, HIV positive and a psychiatric history. He found that the patient was well developed, well nourished and in acute distress secondary to shortness of breath. (Tr. 181-182; Ex. 5, p. 1).

35. At about 1:30 P.M., Patient C became diaphoretic and unresponsive. The Respondent intubated the patient and placed him on a ventilator. The Respondent ordered one hundred per cent oxygen at a rate of 16 and a tidal volume of 600. (Tr. 182; Ex. 5, p. 2).

36. The Respondent failed to administer appropriate treatment for asthma, which was indicated in this patient (Tr. 182-183).

37. Anti-asthma treatments, including beta-agonist medication and steroids, should have been administered after the patient went into arrest. Such treatments could have been administered through the endotracheal tube as well as parenteraly (while the patient still had a pulse). (Tr. 187-190 and 1124-1125).

38. Although intravenous fluids were administered, the Respondent failed to appropriately treat Patient C's hypotension. Commencing at about 1:40 P.M., when the patient's blood pressure fell below 90 systolic, the Respondent should have initiated treatment for hypotension. The Respondent should have checked to see that there was no mechanical problem to explain the patient's precipitous drop in blood pressure. (Tr. 183-187; Ex. 5, p. 2).

39. The Respondent did not comply with Basic and Advanced Cardiac Life Support protocols since he failed to assess the adequacy of oxygenation. The Respondent should have reassessed proper placement of the endotracheal tube by any of a variety of means, including listening for breath sounds and pulse oximetry. (Tr. 142-143 and 182-183; Ex. 5, p. 2).

40. Furthermore, when Patient C's hypotension became more severe, at about 1:45 P.M., the Respondent should have administered epinephrine or other cardiac pressors (Tr. 185-186; Ex. 5, p. 2).

41. The Respondent failed to appropriately treat Patient C's bradycardia. Patient C suffered from bradycardia, which started at about 1:35 P.M., when his pulse was 55. Patient C's progressive bradycardia suggested a problem with his oxygenation, which Respondent should have addressed by administering asthma medication, checking proper placement of the endotracheal tube, and administering epinephrine. (Tr. 187-188; Ex. 5, p. 2).

42. The Respondent deviated from medically accepted standards by failing to order the administration of Atropine. Atropine is not listed on the cardio-pulmonary resuscitation flow sheet as a medication administered to the patient. (Tr. 190 and 1120-1121; Ex. 5, p. 7).

43. The Respondent inappropriately ventilated the patient through a mechanical rather than manual means of ventilation, as documented in the cardiopulmonary resuscitation flow sheet as well as separate nursing progress notes. (Tr. 191-192; Ex. 5, pp. 5 and 7).

44. The Respondent inappropriately defibrillated the patient. The Respondent defibrillated Patient C five times at five-minute intervals starting at 1:35 P.M.. The patient had a bradycardic pulse up until 1:55 P.M.. Defibrillation of a patient with bradycardic pulse is inappropriate. (Tr. 192-193 and 1134-1136; Ex. 5, pp. 2 and 7).

Patient D

45. On September 28, 1999 at approximately 2:00 P.M., Patient D, a 50 year old male, presented to the Fulton Emergency Room. The patient reported that he had abdominal pain for four months and vomiting for three months. The triage nurse examined the patient and found abdominal tenderness. The nurse classified Patient D's case as urgent. (Tr. 358-360; Ex. 6, p. 1).

46. At approximately 3:00 P.M. Patient D was examined by the Respondent. While the triage nurse noted a history of vomiting for three months and found abdominal tenderness, the Respondent specifically noted no vomiting and that the patient's abdomen was soft and without tenderness. (Tr. 359-365 and 429-431; Ex. 6, pp. 1 and 2).

47. The Respondent inappropriately discharged Patient D with a diagnosis of constipation. (Tr. 331-334, 373-376, 407-411, 417-418, 435-437, 475, 479-480 and 671-672; Ex. 6, pp. 1 and 2; Ex. 7).

48. On September 29, 1999 at about 12:40 P.M., approximately twenty-two hours after the Respondent had examined Patient D and sixteen hours after the patient had been discharged from the Fulton Emergency Room, Patient D died at Parkview Home for Adults, the adult home where he lived (Tr. 376-378; Ex. 7, pp. 11 and 12).

49. Patient D died from peritonitis secondary to a perforated gastric ulcer (Tr. 378 and 472; Ex. 7, p. 12).

50. The New York City Medical Examiner's Office performed an autopsy on Patient D and obtained samples from the perforated gastric ulcer. Microscopic evaluation of the samples showed that the gastric ulcer had perforated a minimum of three days before death, and probably a week or more. It also demonstrated peritonitis with granulation tissue in the serosa, consistent with peritonitis developing before the patient's visit to the Fulton Emergency Room. (Tr. 473-475, 494-496 and 509; Ex. 7, p. 2; Exs. 14 and 14A).

51. The Respondent failed to perform an adequate physical examination, which, in this case, should have included a brief head to toe examination, a thorough examination of the abdomen, and a rectal examination. The abdominal examination should have also included auscultation, listening for bowel sounds, observing for signs of distention,

palpating the abdomen to look for signs of tenderness, rigidity, guarding and rebound tenderness. (Tr. 363-36365, 375, 418-421, 427-429, 1155, 1158 and 1162-1163).

52. The Respondent's abdominal findings, "soft and without tenderness", are inconsistent with physical findings associated with the peritonitis known to be present in the patient. (Tr. 379-380, 508-509 and 1142-1144; Ex. 6, p. 1).

53. The Respondent failed to order appropriate laboratory studies, especially a CBC and basic chemistry testing, which would yield a significant amount of information, including information relating to an underlying infectious process. Laboratory testing is particularly critical when dealing with a patient, like Patient D, who may not be able to provide a clear history. (Tr. 365-366).

54. The Respondent failed to obtain an adequate history, including such basic questions as follows: Did the nature of the abdominal pain change at any point? What was the precipitating event that led this patient to decide to go to the Emergency Room? Whether the pain had exacerbating or relieving features? (Tr. 361-362, 375 and 411; Ex. 6, pp. 1 and 2).

55. The Respondent inappropriately ordered Toradol. He ordered Toradol after his initial evaluation at about 2:30 P.M., when he did not have a clear explanation of the cause of the patient's four months of abdominal pain. Since the effects of Toradol could jeopardize further evaluation by masking symptoms, the Respondent inappropriately ordered the medication. (Tr. 371-372 and 416-417; Ex. 6, p. 2).

56. The Respondent inappropriately interpreted the abdominal x-ray as no obstruction when, in fact, it showed the presence of "free air" under the right hemidiaphragm, which is consistent with perforation of a gastric ulcer. (Tr. 306-308, 331-333 and 366-367; Ex. 6, p. 2).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C and D, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did practice medicine with incompetence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C and D.

The Respondent did practice medicine with gross negligence on a particular occasion. The Petitioner has proved by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients B, C and D, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did practice medicine with gross incompetence. The Petitioner has proved by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients B and C.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily on the medical testimony of Mark S. Silberman, M.D., and Frank B. Fromowitz, M.D., and the factual testimony of Harvey Stern, M.D., and Fernando Jara, M.D., in its efforts to establish its case against the Respondent. While Dr. Silberman testified

with regard to the Respondent's medical care and treatment of the various patients listed in the Statement of Charges, the testimony of Dr. Fromowitz was limited to the pathological findings relating to the death of Patient D. Drs. Stern and Jara also testified about Patient D. However, their testimony concerned a missing x-ray and the authenticity of an x-ray report interpreting the missing x-ray (Ex. 10).

As its first witness the Petitioner presented Mark S. Silberman, M.D., as an expert in the field of emergency medicine. Dr. Silberman received his medical training at Northwestern University Medical School in Chicago, Illinois (1980-1984). After graduating medical school he did an internship and residency in internal medicine (1984-1987) and a fellowship in Pulmonary and Critical Care Medicine (1987-1990) at The Presbyterian Hospital, Columbia University College of Physicians & Surgeons in New York, New York ["Columbia-Presbyterian"]. He also served as an Instructor in Clinical Medicine (1987-1990) and currently serves as an Assistant Professor of Clinical Medicine (1990-present) at Columbia-Presbyterian.

Dr. Silberman is affiliated with New York Presbyterian Hospital in New York, New York, where he served as Associate Director of Emergency Medicine (1997-2000) and currently serves as an Attending Emergency Physician (1990-present). He is also affiliated with Community Hospital at Dobbs Ferry in Dobbs Ferry, New York, where he serves as an Emergency Physician (1989-present), Director of Emergency Medicine (1990-present), and Hospital Medical Director (1997-present).

In addition, Dr. Silberman is board-certified in four separate disciplines of medicine – Emergency Medicine (1996), Critical Care Medicine (1991), Pulmonary Medicine (1990), and Internal Medicine (1987). Furthermore, he is a Certified Provider, Instructor and Course Director of Advanced Cardiac Life Support; a Certified Provider and Instructor of Advanced

Trauma Life Support; and, a Certified Provider of Pediatric Advanced Life Support. (Tr. 24-28; Ex. 9).

The Hearing Committee found Dr. Silberman to be a very convincing and highly credible witness. He was straightforward, non-evasive, extremely knowledgeable and his testimony was balanced and unbiased. His credentials are quite impressive and he demonstrated a far-reaching command of the field of emergency medicine as well as a thoughtful and well-reasoned analysis of the issues involved in this matter. Furthermore, he was well prepared, thoroughly familiar with the cases that were the subject of his testimony, and highly articulate.

Following the testimony of Dr. Silberman, the Petitioner presented Harvey Stern, M.D., the current Director of the Radiology Department at Bronx-Lebanon. Dr. Stern received his medical education at the Albert Einstein College of Medicine, interned at Montefiore Medical Center, and did a residency in radiology at Jacobi Bronx Municipal Hospital, all of which are in Bronx, New York. He served as a Staff Radiologist at Beth Israel Medical Center for about a year and was affiliated with the Radiology Department at Maimonides Medical Center in Brooklyn, New York, from 1976 to 1988, where he served as an Associate Director for approximately ten years. From 1989 until 1999 he served as an Associate Director of the Radiology Department at Bronx-Lebanon and has been serving as the Director of the Radiology Department at Bronx-Lebanon since 1999. (Tr. 238-239).

The Hearing Committee found Dr. Stern to be a credible witness. His testimony was limited to Patient D's missing x-ray, the authenticity of the x-ray report interpreting the missing x-ray (Ex. 10), and the procedure utilized to attempt to locate the missing x-ray (Tr. 240-251). The Hearing Committee believes that a diligent search was conducted at Bronx-Lebanon to find the missing x-ray. Unfortunately, the search was unsuccessful.

The Petitioner's third witness was Fernando Jara, M.D., the former Director of the Department of Emergency Medicine at Bronx-Lebanon. Dr. Jara attended the Albert Einstein College of Medicine (1980-1984) and did a one year surgical internship at Montefiore Medical Center. Following his internship Dr. Jara went to California and practiced as a general practitioner for one year with migrant farm workers. He then continued with his formal medical education and went to Boston, Massachusetts, where he completed a residency training program in emergency medicine (1986-1989). After completing his residency Dr. Jara worked at various hospitals, including Framingham Union Hospital in Boston, Massachusetts; St. Luke's-Roosevelt Hospital in New York, New York (1990-1995); and, Wood Hull Hospital in Brooklyn, New York, where he served as the Director of the Emergency Department. In 1998 Dr. Jara went to Bronx-Lebanon and served as the Director of the Department of Emergency Medicine until 2002. Dr. Jara is board-certified in Emergency Medicine. (Tr. 299-301).

The Hearing Committee found Dr. Jara to be a credible witness. The Hearing Committee noted that he has held several positions with supervisory responsibility in two hospitals in the New York City metropolitan area; that he was responsible for the quality assurance program for the Emergency Department at Bronx-Lebanon; and, that he has demonstrated a strong commitment to the medical care of indigent populations. Furthermore, there has been no convincing evidence that Dr. Jara was biased against the Respondent. Finally, his testimony that he observed the presence of free air under the right hemidiaphragm in Patient D's missing x-ray, is consistent with Patient D's Autopsy Report and the testimony of Drs. Silberman and Fromowitz (Tr. 308, 366-367 and 535; Ex. 7).

The Petitioner's final witness, Frank B. Fromowitz, M.D., was presented as an expert in the field of anatomic pathology. Dr. Fromowitz attended Jefferson Medical College in Philadelphia, Pennsylvania, and received his M.D. degree in 1973. Following medical school he did a residency in anatomic pathology at Yale-New Haven Hospital in New Haven, Connecticut (1973-1977), and at New York University Medical Center in New York, New York (1977-1978). He has held various academic appointments including Assistant Professor of Pathology at Albert Einstein College of Medicine (1978-1982); Assistant Professor of Pathology at the School of Medicine, Health Sciences Center, State University of New York at Stony Brook (1982-1988); Associate Professor of Pathology at the School of Medicine, Health Sciences Center, State University of New York at Stony Brook (1988-1995); and, Professor of Pathology and Laboratory Medicine at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School in Newark, New Jersey (1996-2002). In addition, he has served as an Assistant Attending Pathologist at Montefiore Hospital and Medical Center (1978-1982) and he currently serves as a staff Pathologist at St. Luke's Hospital in Bethlehem, Pennsylvania (2002-present). Finally, Dr. Fromowitz holds a certification in Anatomic Pathology from the American Board of Pathology (1978); belongs to various professional organizations; and, has an impressive list of professional publications to his credit. (Tr. 457-458; Ex. 12).

The Hearing Committee found Dr. Fromowitz to be a highly credible witness with impressive qualifications and expertise. He was straightforward, non-evasive and extremely knowledgeable. He appeared objective and his statements were backed up by persuasive reasoning. The Hearing Committee noted that no credible evidence has been presented contradicting his testimony.

The Respondent's case relies primarily on the medical testimony of Patrick M. Davis, M.D., the factual testimony of Hedva Shamir, M.D., and the medical and factual testimony of the Respondent. While Dr. Davis and the Respondent testified with regard to the Respondent's medical care and treatment of the various patients listed in the Statement of Charges, Dr. Shamir testified about various interviews that she conducted with the Respondent, Dr. Jara and Dr. Stern relating to Patient D. Her testimony was specifically limited to statements made by each of the three doctors to her concerning the interpretation of Patient D's x-ray.

Patrick M. Davis, M.D., was presented as an expert in the field of emergency medicine. Dr. Davis attended the College of Medicine, Health Science Center of Brooklyn, State University of New York in Brooklyn, New York, where he received his M.D. degree (1994-1998). After graduating medical school he did a residency in emergency medicine at St. Luke's-Roosevelt Hospital Center in New York, New York (1998-2001).

Prior to attending medical school Dr. Davis had worked as an Emergency Medical Technician-Paramedic at St. Clare's Hospital in New York, New York (1980-1981); Cabrini Medical Center in New York, New York (1981-1982); St. Vincent's Hospital and Medical Center in New York, New York (1982-1992); and, Staten Island University Hospital in Staten Island, New York (1992-1998). He was also a Paramedic Instructor, Emergency Training Coordinator/Administrator at the Emergency Care Institute at St. Vincent's Hospital and Medical Center of New York (1989-1992).

After completing his residency Dr. Davis has been working as an Assistant Attending Emergency Physician at Robert Wood Johnson University Hospital, Division of Emergency Services, in New Brunswick, New Jersey (2001-present) and as a Junior Assistant Attending Physician at St. Luke's-Roosevelt Hospital Center, Department of Emergency Medicine, in New

York, New York (2001-present). Dr. Davis is board-certified in Emergency Medicine. (Tr. 983-985; Ex. D).

Although Dr. Davis has had considerable experience as an Emergency Medical Technician-Paramedic, he is relatively inexperienced as an emergency medicine physician. Nevertheless, the Hearing Committee found Dr. Davis to be honest and forthright. He was credible and objective during most of his testimony, although at times he became vague and evasive. However, when pressed he did provide objective testimony, even when such testimony did not support the Respondent's position. The following examples illustrate this observation: when questioned about the treatment of Patient B, Dr. Davis supported the treatment of the patient's hyperkalemia without the specific confirmatory laboratory results (Tr. 1076-1079 and 1088); when questioned about the treatment of Patient A, he suggested that given the Respondent's findings on repeat physical examination, the use of other diagnostic tests should have been considered (Tr. 1039-1041); when questioned about the adequacy of the history the Respondent took regarding Patient B, Dr. Davis acknowledged that it was important to know the date of the patient's last dialysis (Tr. 1087); and, when questioned about the management of Patients B and C while in cardiac arrest, he acknowledged that the Respondent's treatment was not in accordance with ACLS guidelines (Tr. 1072-1076, 1088-1089 and 1134-1136).

Hedva Shamir, M.D., was presented by the Respondent for the primary purpose of discrediting Dr. Jara's testimony that he actually read Patient D's x-ray and he observed "free air" in the x-ray. Dr. Shamir works as a Medical Coordinator for the Office of Professional Medical Conduct of the New York State Department of Health ["OPMC"] (Tr. 1201-1202). In connection with the OPMC investigation that gave rise to the current charges against the Respondent, Dr. Shamir interviewed the Respondent as well as Drs. Jara and Stern. During these

interviews: the Respondent told her that the x-ray was negative and showed no evidence of obstruction (Tr. 1203-1204); Dr. Jara told her that there was "free air" in the x-ray (Tr. 1208 and 1215-1216); and, Dr. Stern told her that he had no recollection of the event (Tr. 1211-1213). However, Dr. Shamir acknowledged that she did not note that Dr. Jara told her that he had personally read Patient D's x-ray until her second interview with him (Tr. 1204-1210). She also admitted that when she first interviewed Dr. Jara, she didn't specifically ask whether he had personally read the x-ray (Tr. 1219-1220).

Although the Hearing Committee found Dr. Shamir to be honest, straightforward and credible, her testimony shed minimal light on the precise charges which are the subject of this hearing and was of limited value to the resolution of the issues relating to Patient D's x-ray.

The most important witness to testify in support of the Respondent's case, was the Respondent himself. The Respondent has extensive experience as an Emergency Room physician and has worked full-time at Bronx-Lebanon since 1990. The Respondent has also received training in family practice, anesthesia and internal medicine. However he has never been board certified in any medical specialty. Furthermore, despite completing an approved residency in internal medicine and achieving board eligibility in emergency medicine, the Respondent has failed the certifying examination in emergency medicine twice and the examination in internal medicine three times. Thus, the Respondent has been unable to demonstrate minimal competency in either field. (See findings 1 through 6, *supra*).

The Respondent testified at length in his own behalf. The Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. His testimony was frequently self-serving, inconsistent and contradicted by other independent evidence. For example, while discussing the specific indications for the treatment of

hyperkalemia with respect to Patient B, the Respondent first stated that he wouldn't start treatment for hyperkalemia until he received laboratory confirmation that the patient's potassium level was elevated (Tr. 955). However, he subsequently changed his testimony when he admitted that he would commence such treatment on the basis of an EKG consistent with hyperkalemia (971-974). Furthermore, the Respondent's testimony regarding the physical examination that he performed on Patient D, during which he noted "abdomen soft no tenderness" (Tr. 616-618; Ex. 6, p. 1), serves as an example of testimony that is inconsistent with and contradicted by other independent evidence. More specifically, the Respondent's testimony that the patient's abdomen was soft and without tenderness is inconsistent with and contradicted by the post mortem pathological examination, the physical findings of the triage nurse, and the testimony of both Dr. Silberman and Dr. Davis. (Tr. 379-380, 493-496, 504 and 1142-1144; Ex. 6, p. 1; Ex. 7; See findings 46, 49, 50 and 52, *supra*).

Finally, the Hearing Committee noted that the Respondent demonstrated a reluctance to accept responsibility for his actions. He didn't seem to fully appreciate or accept responsibility for his failure to adhere to acceptable medical standards. He also had difficulty recognizing his own shortcomings. For example, while being questioned about his efforts to revive Patient B from cardiac arrest, it appeared that the Respondent did not know that a patient could have a cardiac rhythm and no pulse. At first he attempted to defend his use of mechanical ventilation by asserting that the patient actually had a pulse, which is contrary to the notations appearing in the Cardiopulmonary Resuscitation Flowsheet (T.831-832; Ex. 4, p. 10). In support of this assertion he stated that the monitoring strips show that there was a cardiac rhythm, and therefore, "if there's a

rhythm, there has to be a pulse." (Tr. 855-857; Ex. 4, p. 13). However, when questioned about "pulseless electrical activity", he conceded that the mere fact that the patient had a rhythm does not establish that the patient had a pulse (Tr. 857-858).

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients. An evaluation of the factual testimony concerning the Respondent's treatment of each of the particular patients was also required.

The Respondent deviated from acceptable medical standards in connection with the care and treatment that he provided to Patients A, B, C and D. Consequently, the Hearing Committee found the Respondent negligent in connection with the medical care and treatment that he provided to each of the four patients. In addition, the Hearing Committee found that the Respondent's negligence regarding Patients B, C and D, was, in certain instances, egregious and conspicuously bad, and thereby constituted gross negligence.

More specifically, the Hearing Committee believes that the following conduct of the Respondent constitutes a significant deviation from acceptable medical standards that is egregious and conspicuously bad: the failure to treat Patient B for hyperkalemia; the failure to treat Patient C for asthma; inappropriately defibrilating Patient C and failing to order beta-agonist medication, which constitutes a failure to comply with Basic and Advanced Life Support protocols; and, the failure to perform an abdominal examination[2] and a rectal examination of Patient D.

[2] Based upon the pathological evidence, the Hearing Committee believes that the Respondent did not perform an abdominal examination of Patient D, despite his testimony to the contrary.

While the Hearing Committee found the Respondent negligent in connection with the medical care that he provided to Patient A, the Hearing Committee does not believe that any of the proven allegations relating to Patient A rises to the level of gross negligence.

In addition, the Respondent lacked the requisite skill or knowledge to practice medicine in connection with the care and treatment that he provided to Patients A, B, C and D. Consequently, the Hearing Committee found the Respondent incompetent in connection with the medical care and treatment that he provided to each of the four patients. Furthermore, the Hearing Committee found that the Respondent's incompetence regarding Patients B and C, involved, in certain instances, a total and flagrant lack of necessary knowledge or ability to practice medicine, and thereby constituted gross incompetence.

More specifically, the Hearing Committee believes that the following conduct of the Respondent involves a total and flagrant lack of necessary knowledge or ability to practice medicine: the failure to treat Patient B for hyperkalemia; and, inappropriately defibrilating Patient C, which constitutes a failure to comply with Basic and Advanced Life Support protocols.

Finally, although the Hearing Committee found the Respondent incompetent in connection with the medical care that he provided to Patients A and D, the Hearing Committee does not believe that any of the proven allegations relating to Patients A and D rises to the level of gross incompetence.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

Sustained: A, A1, A1a, A1c,[3] A2, A3, A4,[4] and A5

Not Sustained: A1b

Factual Allegations relating to the treatment of Patient B

Sustained: B, B1a, B1b, B1c, B2 and B3

Factual Allegations relating to the treatment of Patient C

Sustained: C, C1, C2, C3, C3a, C3b, C3d, C3e, C3f (i), C3f(iii), C3f(iv) and C3f(v)

Not Sustained: C3c

Withdrawn: C3f (ii)

Factual Allegations relating to the treatment of Patient D

Sustained: D, D1, D2, D3, D4, D5 and D6

Specifications

Negligence on More than One Occasion

1st Specification — Sustained

Sustained Factual Allegations in Support of the 1st Specification:

Treatment of Patient A: A, A1, A1a, A1c, A2, A3, A4 and A5

Treatment of Patient B: B, B1a, B1b, B1c, B2 and B3

[3] Failure to order either a Cat Scan or a surgical consultation constitutes a deviation from medically accepted standards.

Treatment of Patient C: C, C1, C2, C3, C3a, C3b, C3d, C3e, C3f (i), C3f(iii), C3f(iv) and C3f(v)

Treatment of Patient D: D, D1, D2, D3, D4, D5 and D6

Incompetence on More than One Occasion

2nd Specification Sustained

Sustained Factual Allegations in Support of the 2nd Specification:

Treatment of Patient A: A, A1, A1c, A3, A4 and A5

Treatment of Patient B: B and B2

Treatment of Patient C: C, C1, C3, C3e, C3f(i), C3f(iii) and C3f(iv)

Treatment of Patient D: D, D3, D5 and D6

Gross Negligence

3rd Specification (Treatment of Patient A) Not Sustained

4th Specification (Treatment of Patient B) Sustained

Sustained Factual Allegations in Support of the 4th Specification: B and B2

5th Specification (Treatment of Patient C) Sustained

Sustained Factual Allegations in Support of the 5th Specification: C, C1, C3, C3e and C3f(i)

6th Specification (Treatment of Patient D) Sustained

Sustained Factual Allegations in Support of the 6th Specification: D and D2

Gross Incompetence

7th Specification Sustained

Sustained Factual Allegations in Support of the 7th Specification:

Treatment of Patient B: B and B2

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[4] See note 3, *supra*.

Treatment of Patient C: C, C3 and C3e

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be revoked.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee believes that the Respondent does not fully appreciate the seriousness of his failure to respond appropriately to the particular patient problems that were presented during the course of this hearing. The Hearing Committee noted that despite extensive and diverse training in internal medicine, anesthesiology and family practice, suggesting excellent preparation for a career in emergency medicine, the Respondent repeatedly demonstrated: 1) an inability to obtain relevant history and perform an adequate physical examination in an Emergency Room setting; and 2) a lack of the requisite knowledge to identify and treat common crisis in the Emergency Room. The Respondent further demonstrated: 1) a lack of insight into his deficiencies; 2) an inability to learn from his mistakes; and 3) a reluctance

to take responsibility for his actions.

During the course of the hearing a consistent, long-term, pattern of negligence and incompetence, emerged from the evidence presented. The Hearing Committee believes that the Respondent presents a danger to the public because of his adherence to this pattern and he practices medicine in a substandard fashion. The Hearing Committee also believes that the Respondent is not a good candidate for retraining or practicing under supervision. Since the Respondent does not appear to believe that he is practicing outside the scope of acceptable medical standards, there is no reason to assume that his behavior will change.

The Hearing Committee unanimously concluded that the Respondent's conduct was unacceptable and that public safety requires that it not be permitted to continue. In view of the Respondent's long-term, repeated and egregious failure to care for his patients within acceptable medical standards, together with his failure to fully appreciate the seriousness of his misconduct and to genuinely accept the responsibility for his actions, the Hearing Committee finds that the only appropriate and acceptable penalty is revocation.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The 1st, 2nd, 4th, 5th, 6th and 7th Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The 3rd Specification of professional misconduct contained within the Amended Statement of Charges (Appendix I) is **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: **New York, New York**
October 30, **2003**

GERALD M. BRODY, M.D.
Chairperson

JERRY WAISMAN, M.D.
GARRY SCHWALL, R.P.A.,

TO: **JORGE PEREZ, M.D.**
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APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
JORGE PEREZ, M.D.

AMENDED
STATEMENT
OF
CHARGES

JORGE PEREZ, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 26, 1990, by the issuance of license number 184454 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about August 11, 2001, 6:00 P.M., Patient A, a 38 year old male, presented to the Emergency Room of Wyckoff Heights Medical Center, Brooklyn, New York, ("Wyckoff ER") with a chief complaint of diffuse abdominal pain and nausea from the night before. The Patient's abdomen was distended and he had a significantly elevated white blood count of 16, 400. Respondent assumed responsibility for the care of Patient A around 7:00 P.M, approximately an hour after admission to the Wyckoff ER. On or about August 12, 2:40 A.M. the Respondent discharged Patient A with a diagnosis of abdominal pain, food intolerance and urinary tract infection. He prescribed Cipro and ordered follow up with the Patient's primary care physician.

(Patient A and the other patients are identified in the annexed appendix.)

Respondent deviated from medically accepted standards in that he:

1. Failed to adequately evaluate Patient A, including but not limited to failing to:

   a. Order a reexamination of the Patient 's vital signs.

   b. Perform a repeat physical examination.

   c. Order further imaging studies, including an abdominal Cat Scan and/or ultrasound examination.

2. Inappropriately ordered the administration of Toradol.

3. Inappropriately diagnosed urinary tract infection.

4. Failed to order a surgical consult

5. Inappropriately discharged Patient A.

B. On or about February 7, 2001, 2:25 P.M., Patient B, a 31 year old female, presented to the Bronx Lebanon Hospital Emergency Room by ambulance after a fainting episode. The Patient's history included end-stage renal disease for which she was maintained on dialysis, HIV infection, hypertension and asthma. At approximately 2:45 P.M. the patient went into cardiac arrest. She was pronounced dead at 3:25 P.M. Respondent deviated from medically accepted standards in that:

1. At the time Respondent initially examined the patient, he:

   a. Failed to take an adequate history, including failing to ascertain and/or note the last date of renal dialysis.

   b. Failed to order an EKG.

   c. Failed to order continuous cardiac monitoring.

2. Respondent failed to administer sodium bicarbonate, calcium and/or other anti-hyperkalemic medication.

3. Failed to comply with Advanced Cardiac Life Support protocols, including but not limited to inappropriately ventilating the Patient through a mechanical rather than manual means of ventilation.

C. On or about February 8, 1999, Patient C, a 46 year old male, presented to the Bronx Lebanon ER by ambulance with a complaint of shortness of breath for one week. Patient C had a history of AIDS and asthma. The Respondent concluded that the patient was in acute distress secondary to shortness of breath. He ordered mechanical ventilation and intravenous saline at 125 ml/hour. Patient C developed progressive bradycardia and hypotension and went into full cardiac arrest. Respondent deviated from medically accepted standards in that he:

1. Failed to administer appropriate medical treatment for asthma.

2. Failed to appropriately treat the Patient's hypotension and bradycardia..

3. Failed to comply with Basic and Advanced Cardiac Life Support protocols, including but not limited to:

   a. Failing to appropriately assess the adequacy of oxygenation.

   b. Failing to appropriately confirm the proper placement of the endotracheal tube.

   c. Inappropriately administering intravenous fluids.

   d. Inappropriately ventilating the Patient through a mechanical rather than manual means of ventilation

   e. Inappropriately defibrilating the Patient.

   f. Failing to order:

      i. Beta-agonist medication.

      ii. Sodium bicarbonate

      iii. Atropine.

      iv. Epinephrine.

      v. Intravenous steroids.

D. On or about September 28, 1999 Patient D, a 50 year old male, presented to

the Bronx Lebanon ER with a complaint of abdominal pain for four months. Respondent performed a physical examination and ordered an abdominal x-ray. Respondent deviated from medically accepted standards in that he:

1. Failed to take an adequate history.
2. Failed to perform an adequate physical examination, including failing to perform a rectal exam.
3. Failed to order appropriate laboratory studies.
4. Inappropriately ordered Toradol.
5. Inappropriately interpreted the abdominal x-ray.
6. Inappropriately discharged the patient with a primary diagnosis of constipation.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. A, A1, A1(a), A1(b), A1(c) A2, A3, A4, A5, B, B1, B1(a), B1(b),

B1(c), B2, B3, C, C1, C2, C3, C3(a), C3(b), C3(c), C3(d), C3(e), C3(f), C3(f)(i), C3(f)(ii), C3(f)(iii), C3(f)(iv), C3(f)(v), D, D1, D2, D3, D4, D5 and/or D6.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. A, A1, A1(a), A1(b), A1(c) A2, A3, A4, A5, B, B1, B1(a), B1(b), B1(c), B2, B3, C, C1, C2, C3, C3(a), C3(b), C3(c), C3(d), C3(e), C3(f), C3(f)(i), C3(f)(ii), C3(f)(iii), C3(f)(iv), C3(f)(v), D, D1, D2, D3, D4, D5 and/or D6.

THIRD THROUHGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross

negligence on a particular occasion as alleged in the facts of the following:

3. A, A1, A1(a), A1(b), A1(c), A2, A3, A4, and/or A5.

4. B, B1, B1(a), B1(b), B1(c), B2, and/or B3.

5. C, C1, C2, C3, C3(a), C3(b), C3(c), C3(d), C3(e), C3(f), C3(f)(i), C3(f)(ii), C3(f)iii), C3(f)(iv), and/or C3(f)(v).

6. D, D1, D2, D3, D4, D5 and/or D6.

SEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. A, A1, A1(a), A1(b), A1(c) A2, A3, A4, A5, B, B1, B1(a), B1(b), B1(c), B2, B3, C, C1, C2, C3, C3(a), C3(b), C3(c), C3(d), C3(e), C3(f), C3(f)(i), C3(f)(ii), C3(f)(iii), C3(f)(iv), C3(f)(v), D, D1, D2, D3, D4, D5 and/or D6.

DATED: April 28, 2003
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct