NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

August 20, 2020

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
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Denny Pacheco, D.O.
[redacted]

RE: In the Matter of Denny Pacheco, DO

Dear Parties:

Enclosed please find the Determination and Order (No. 20-221) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:nm
Enclosure

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

IN THE MATTER

OF

DENNY PACHECO, D.O.

COPY

DETERMINATION

AND

ORDER

BPMC-20-221

A Notice of Hearing and Statement of Charges, both dated September 13, 2018, were served upon **DENNY PACHECO, D.O.** ("Respondent"). Pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("PHL"), **DIANE M. SIXSMITH, M.D.**, Chairperson, **FRANK E. IAQUINTA, M.D.** and **JOAN MARTINEZ McNICHOLAS**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **MATTHEW C. HALL**, Administrative Law Judge, served as the administrative officer.

The Department of Health, Bureau of Professional Medical Conduct ("Department") appeared by RICHARD J. ZAHNLEUTER, then General Counsel, by **TIMOTHY J. MAHAR, Deputy Counsel**, and **NATHANIEL WHITE, Associate Counsel**. The Respondent was represented by **ANTHONY Z. SCHER, ESQ.** Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Pre-Hearing Conference:	October 25, 2018
Hearing Dates:	November 5, 2018 January 30, 2019 March 20, 2019 June 6, 2019 June 13, 2019 August 18, 2019 September 17, 2019
Witnesses for Petitioner:	Sachin Shah, M.D. Jason Friedman, M.D.
Witnesses for Respondent:	Kevin O'Connor, M.D. Virgil Smaltz, M.D. Denny Pacheco, D.O.
Written Submissions Received:	October 31, 2019
Deliberations Held:	April 9, 2020

The record closed April 9, 2020.

STATEMENT OF CASE

The Department charged the Respondent with twenty-one specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York ("Educ. Law"). The Respondent denied the Factual Allegations and Specification of Charges set forth in the Statement of Charges.

The Department recommends that the Respondent's license to practice medicine be revoked. The Respondent asks that the Hearing Committee conclude that he did not commit professional misconduct either

clinically or by fraudulently filing false applications for hospital privileges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Numbers below in parentheses refer to exhibits (Ex.) or transcript page numbers (T.). The Hearing Committee hereby makes the following findings of fact:

1. The Respondent, Denny Pacheco, D.O., was authorized to practice medicine in New York State on September 9, 2010, by the issuance of license number 258600 by the New York State Education Department. (Dept. Ex. 1.)

2. The Respondent graduated from the University of Medicine and Dentistry of New Jersey in 2002. Following medical school, he entered the United States Navy (Navy) and spent a year as a general medical officer. (T. 520.)

3. After a year in the Navy, the "Navy decided to let [the Respondent] go because [he] couldn't pass step two of the boards within [the Navy's] time frame." (T. 546-548.)

4. From about September 2012 to December 2016, the Respondent practiced medicine as a physician in the emergency department (ED) of Vassar Brothers Medical Center (VBMC) and Arnot Ogden Medical Center (Arnot Ogden). (Dept. Ex. 1.)

5. At VBMC and Arnot Ogden, the Respondent evaluated and treated Patients A through E for a variety of complaints. (Dept. Ex. 1.)

6. During this same period, the Respondent submitted applications for staff and hospital privileges at Arnot Ogden and Ellis Medicine. (Dept. Ex. 1.)

Patient A

7. On Sunday, March 17, 2013 at around 9:46 p.m., Patient A, an eight-month-old female, was brought to VBMC emergency department by her parents. (Dept. Ex 3.)

8. Patient A's primary complaint was shortness of breath. Her medical history included a week-long illness, cough, congestion, not eating well and diapers that were less wet than usual. (Dept. Ex 3.)

9. Patient A had been treated by her pediatrician the previous Friday and Saturday and was diagnosed with Respiratory Syncytial Virus (RSV). (T. 41.)

10. RSV has a range of degrees of severity, from symptoms similar to a common cold to "extreme difficulty breathing, high fever, dehydration, severe congestion and wheezing." (T. 44.)

11. RSV and other conditions can lead to bronchiolitis, which is the inflammation of the smaller airways of the lungs. A patient with RSV, who also has bronchiolitis, would be on the severe end of the degrees of RSV severity. (T. 45.)

12. Prior to bringing Patient A to the hospital, her parents had been administering nebulizer treatments to her every three hours as instructed by her pediatrician. Her most recent treatment was given approximately one hour prior to being brought to the hospital. (Dept. Ex. 3; T. 47-48.)

13. Patient A's vital signs in the ED included an oxygen saturation rate of 91%, indicating that the patient was hypoxic and not attaining sufficient oxygen in her blood, resulting in respiratory difficulty. (T. 52-53.)

14. Patient A's pulse and respiration rates were elevated. This, combined with her shortness of breath and low saturation rate, "fit the picture of a child that's having some respiratory distress." (T. 54.)

15. The emergency room nurse's respiratory assessment of Patient A documented "labored respirations," which refers to respiratory effort, and "decreased air exchange." (Ex. 3; T. 54.)

16. In addition to these findings, the Respondent also found that Patient A had congestion, rhinorrhea, and an increased respiratory rate, or tachypnea. (Dept. Ex. 3; T. 58-59.)

17. Respondent's documented physical exam findings consisted of "wheezing" on the respiratory exam. (Ex. 3; T. 62.)

18. Wheezing on the respiratory exam indicates inflammation of the patient's smaller airways in the lower lungs. (T. 63.)

19. Respondent's initial assessment of Patient A was time stamped in the medical record at 10:45 p.m. He reassessed the patient

approximately 42 minutes later at 11:27 p.m. as per the time stamp. (T. 68.)

20. An Albuterol treatment was completed at 11:20 p.m., around 7 minutes prior to Respondent's reassessment. (Ex. 3; T. 67-68.)

21. When the Respondent reevaluated Patient A, he found her to be "improved." Oxygen saturation levels had improved with nose suctioning and nebulizer treatment. Also, the Respondent noted that Patient A's lung exam was "benign." (Ex. 3; T. 70.)

22. Respondent ordered Patient A to be discharged at 11:30 p.m., 10 minutes after the documented completion of the Albuterol treatment. (Ex. 3; T. 10.)

23. Upon discharge, Patient A was still wheezing, potentially dehydrated, and uncomfortable in the ED. Prior to discharge, Respondent did not confirm that Patient A's parents were correctly administering the out-patient nebulizer treatments. (T. 71-72.)

24. Respondent did not conduct a visual examination for the presence of retractions around the clavicle or between the ribs, and abdominal breathing. Retractions and abdominal breathing would indicate that Patient A was using accessory muscles in addition to her diaphragm in order to help her breath. (T. 74.)

25. There is no documentation that shows that Respondent evaluated Patient A for the presence of retractions or abdominal breathing. (T. 75.)

26. Patient A presented to the ED with a temperature of 101.8F, and her temperature at discharge was 100.7F. (T. 90-91.)

27. Respondent did not order any treatment for Patient A's fever, including Tylenol or Motrin, given either orally or by suppository. (T. 91.)

28. Following Respondent's care and upon his discharging her, Patient A left the ED at 12:21 a.m. on March 18, 2013. (Ex. 3; T. 93.)

29. Patient A returned to the VBMC ED approximately six hours later at 6:26 a.m. (Ex. 4.)

30. At the time of her return visit, the parents reported increased work of breathing despite nebulizer treatments at home, that the patient was not eating or drinking, and that she had dryer diapers. Triage described the patient as "ill-appearing." (Ex. 4; T. 94.)

31. Patient A's vital signs demonstrated tachycardia with a heart rate of 157, and her respiratory rate was significantly increased at 58. Her oxygen saturation rate had decreased to 91 percent, and her fever had spiked to 101.8F. (Ex. 4; T. 95.)

32. ED physician, Jason Friedman, documented fever, tachycardia, hypoxia, tachypnea, as well as mild retractions and nasal flaring. No significant wheezing was noted. (Ex. 4; T. 97.)

33. Dr. Friedman ordered laboratory studies, chest x-rays, IV fluids and a consult with a pediatric hospitalist, who then examined Patient A. (Ex. 4; T. 97-98.)

34. Patient A's chest X-ray had findings of increased bilateral interstitial markings. The documented impression was of bilateral perihilar interstitial infiltrates. (Ex. 4; T. 99.)

35. Patient A was admitted to the hospital for three days. She was hypoxic after admission and required oxygen, which she was slow to be weaned from. She was given albuterol treatments and slowly weaned from them as well. (Ex. 4; T. 100-101.)

36. The diagnosis at discharge was viral bronchiolitis. (Ex. 4; T. 113.)

Patient B

37. Patient B was a 25-year-old male who presented to Arnot Ogden on July 14, 2016 with complaints of headache, lethargy and vomiting which had started three days prior. The patient was on no medications. (Ex. 6; T 146-147.)

38. Patient B had a low-grade fever of 103F and a heart rate of 110 beats per minute. He rated his head pain as 10 on the scale of 1 to 10. He described his pain as "aching." (Ex. 5; T. 147-148.)

39. The nursing documentation indicated that Patient B was unsteady, but with no mental status changes. (Ex. 5.)

40. The nursing documentation indicated no findings regarding Patient B's ears, nose and throat. The same documentation indicated that the patient was "lethargic," and that he had a headache and

weakness. It also indicated that he had not been eating or drinking for the previous few days. (Ex. 5.)

41. The Respondent's documentation for his treatment of Patient B indicated complaints of headache, fever, lethargy and nausea/vomiting for the previous three days. (Ex. 5; T. 152.)

42. Respondent diagnosed Patient B with dehydration and sinusitis, which signifies inflammation or infection of the sinuses. (Ex. 5; T. 154.)

43. On Respondent's physical examination of Patient B's eyes, ears, nose and throat, Respondent documented pharyngeal erythema, or redness in the back of the throat commonly associated with viral or bacterial infections. Sinus tenderness was also documented. (Ex. 5; T. 156.)

44. There was no documentation by the Respondent of nasal congestion or sinus drainage for his physical exam, or in the nursing documentation. (T. Ex. 5; T. 157.)

45. Patient B's white blood count was documented at 18.3. (Ex. 5; T. 158.)

46. The patient had a CT scan of his head while in the ED. There were no acute findings from the scan, and the radiologist indicated that neither the paranasal sinuses nor the mastoid cells were opacified. (Ex. 5; T. 159-160.)

47. Bacterial meningitis is inflammation of the layer that surrounds and protects the brain. Some forms of bacterial meningitis can be fatal. (T. 159-160.)

48. A lumbar puncture would assist in determining if a patient had either meningitis or encephalitis. (T. 168-171.)

49. Respondent did not perform a lumbar puncture on Patient B on July 14, 2016 to evaluate for meningitis or encephalitis. (T. 172.)

50. Respondent documented that Patient B was "improved" after receiving hydration and medications in the ED for his nausea and headache. (T. 173.)

51. Patient B received Augmentin, an antibiotic, in the ED and was discharged by the Respondent on that medication. (T. 174.)

52. Patient B returned to Arnot Ogden on July 15, 2016, approximately eleven hours after being discharged by the Respondent. Again, he complained of vomiting, head pain, lethargy, not being able to answer questions, difficulty walking and weakness. His white blood count was then 19.5. He also had pain when he flexed his neck, and he was noted to be disoriented to place and time. (Ex. 5; T. 176-178.)

53. A lumbar puncture performed during this ED visit determined that Patient B did not have meningitis. (Ex. 5; T. 179-180.)

54. Patient B's condition worsened, and he required intubation. (T. 182.)

55. An MRI of the head showed diffuse white matter abnormality within the cerebrum, which is concerning for a demyelinating disease

which effects the central nervous system and the ability to function properly. The MRI findings were consistent with acute demyelinating encephalomyelitis, a condition which causes inflammation and disease of the brain tissue. (T. 184.)

56. Patient B was transferred from Arnot Ogden to Strong Memorial Hospital in Rochester, New York, a facility where he could receive a higher level of neurology and infectious disease care. (T. 185.)

57. Patient B was admitted to Strong Memorial Hospital for approximately 50 days where his demyelinating encephalomyelitis was treated. (Ex. 7; T. 186-187.)

Patient C

58. On January 8, 2016, Patient C, a 61-year-old female, was injured in a motor vehicle collision and was transported from the accident scene to Arnot Ogden, where she was treated and released from the ED by Respondent. (Ex. 9; T. 218-219.)

59. Nursing triage documents indicate that approximately 45 minutes prior to presenting at the ED, Patient C's vehicle T-boned another vehicle, with Patient C's vehicle sustaining significant damage. (Ex. 9.)

60. In the ED, Patient C's vital signs were normal or only slightly elevated. Her pain, however, was documented as an 8 on the scale from 1 to 10, which the record characterized as "very severe." (Ex. 9; T. 220.)

61. The record documented Patient C's Body Mass Index (BMI) as 33.8, and that she was an everyday smoker of tobacco and presented as "unsteady." (Ex. 9; t. 222.)

62. Patient C's prior medical history included myocardial infarction, hypertension, Chronic Obstructive Pulmonary Disease (COPD), asthma, thyroid disease and depression. (Ex. 9; T. 222.)

63. COPD significantly diminishes the patient's lung function. (T. 223.)

64. Both the Respondent's and nursing evaluation's documentation showed pain and bruising to the abdomen and chest as well as both of her knees. Patient C also had a laceration to the right knee which was repaired by sutures in the ED. A nursing entry indicated that Patient C was not ambulatory following the accident. (Ex. 9, T. 237.)

65. A CT scan was performed, and the radiologist's report indicated that Patient C had sustained four consecutive, non-displaced rib fractures on the right side of her chest. (Ex. 9; T. 245.)

66. Patient C's history also included shortness of breath when walking prior to the accident. (Ex. 9.)

67. Prior to the accident, Patient C's outpatient pain medications included Lyrica, Trazodone, Hydrocodone Acetaminophen (Vicodin), Ibuprofen, Opana, Valium, Tylenol and Soma. (Ex. 9; T. 251-253.)

68. Respondent did not prescribe any additional medications to Patient C when he discharged her from the ED on January 8, 2016. (Ex. 9; T. 255-256.)

69. A radiologist's interpretation of x-rays of Patient C's knees was that there was a patella fracture of the left knee with joint effusion. With the fracture of the kneecap and the fluid build-up, it would be very difficult for Patient C to walk on that leg. (Ex. 9; T. 263.)

70. The radiologist's reading was available to the Respondent. The Respondent did not document the patella fracture. (Ex. 9; T. 264-266.)

71. Patient C returned to the Arnot Ogden ED on January 10, 2016 at 2:27 p.m. Her chief complaints at that time were shortness of breath and confusion. Her oxygen saturation rate was measured at 80 % and she was in severe pain. The oxygen saturation rate value of 80% signifies hypoxia, or an abnormal oxygen level in the blood. Patient C's son noted that Patient C was confused, saying things that did not make sense, and was repeatedly dozing off prior to returning to the hospital. (Ex. 9; T. 256-267.)

72. Patient C was transferred to the ICU where she was evaluated for possible respiratory arrest, as she was unable to adequately ventilate and oxygenate herself. (Ex. 9; T. 269.)

73. Upon her initial release from the ED on January 8, 2016, Patient C did not stop smoking, did not use oxygen, did not use the

incentive spirometer as she was instructed, and did not use the CPAP all the time. When she returned to the ED, she complained of increased chest congestion. (Ex. 9; T. 269-270.)

74. A repeat CT of the chest showed a small, right side pneumothorax (collapsed lung). Two of the four rib fractures were now displaced, and a sternal fracture was observed. (Ex. 9; T. 132-133.)

75. A subsequent CT of the chest showed findings likely representing pneumonia. Patient C was given a course of antibiotics during the admission to treat the pneumonia. (Ex. 9.)

76. Patient C was initially put on a BiPAP in the ICU for ventilatory support and was assessed as having pneumonia secondary to not being able to take deep respiratory air due to lung contusion and multiple rib fractures. (Ex. 9; T. 273.)

77. During the January 10, 2016 admission, Patient C's activity tolerance required the use of a roller walker and the assistance of one person. The Respondent did not document an assessment of Patient C's ability to ambulate at the time of her discharge on January 8, 2016.

78. At the time of Patient C's discharge on January 16, 2016, following a six-day admission, Percocet was added to her out-patient drug regimen for her rib fractures. (Ex. 9; T. 273-274.)

Patient D

79. Patient D, a 22-year-old female, presented on Monday, September 3, 2012, Labor Day, with a chief complaint of abdominal pain,

specifically right upper quadrant abdominal pain. Her pain level was documented as 10 out of 10. (Ex. 11; T. 406-409.)

80. Patient D was taken to a bed at 12:51 a.m. and assigned to the care of Respondent at 1:02 a.m. (Ex. 11; T. 410.)

81. The Respondent ordered a CT scan of Patient D's abdomen and pelvis at 1:03 a.m. (Ex. 11; T. 410-411.)

82. The Respondent ordered lipase and amylase studies at 1:03 a.m., and the results were within normal limits. (Ex. 11; T. 4011.)

83. The Respondent ordered a complete blood count study at 1:03 a.m. The results returned at 1:51 a.m., and showed Patient D had an elevated white blood count which could be a result of inflammation, infection, or pain. (Ex. 11; T. 412.)

84. At 1:50 a.m., Respondent ordered Morphine 5 mg injection and Zofran 4 mg injection. The Morphine order was documented as completed at 1:52 a.m. and the Zofran order was documented as completed at 1:58 a.m. (Ex. 11; T. 413-414.)

85. The effects of Morphine work quickly and last approximately two hours. (T. 447.)

86. Patient D was assessed by nurse "J.P." at 1:51 a.m. and was noted to have abdominal pain with bowel sounds. (Ex. 11; T. 415.)

87. Approximately 40 minutes later at 2:31 a.m., Patient D was again assessed by nurse J.P. and found to be in "no acute distress," and that Patient D was "medicated as ordered." (Ex. 11; T. 416.)

88. Nurse J.P.'s assessment was approximately 40 minutes after the orders for Morphine and Zofran were documented as "completed." (Ex. 11; T. 416.)

89. The Respondent's assessment of Patient D stated the "time of physician's visit" was 3:01 a.m., although the Respondent believes he saw the patient at 1:02 a.m. (Ex. 11; T. 417, 473, 772.)

90. The Respondent documented in his assessment that Patient D was a twenty-two-year old female with right upper quadrant pain with nausea and a history of known gallbladder stones. The pain level recorded was 10 out of 10. The physical exam revealed tenderness in the right upper quadrant. (Ex. 11; T. 417.)

91. The Respondent documented that Patient D had, in the past, been told to see a surgeon and that the Respondent would reassess for any changes. (Ex. 11; T. 445.)

92. The Respondent's differential diagnosis included Cholecystitis, but he documented that Patient D's condition was "most likely gallstones." (Ex. 11; T. 418.)

93. The Respondent's "actual diagnosis" was Biliary Colic. (T. 780, 803.)

94. Biliary Colic is a condition where stones in the gallbladder get stuck in the gallbladder neck causing distension. The patient is at risk of a stone becoming stuck in the gallbladder and blocking secretion of bile which can cause the gallbladder to swell, distend and become inflamed. (T. 421.)

95. If Biliary Colic persists, the condition can progress to Cholecystitis, which is inflammation of the gallbladder and the gallbladder wall which can lead to an infection. (T. 419-20.)

96. Right upper quadrant pain is not a common symptom of gallstones as many people have gallstones and remain asymptomatic. It is, however, a symptom of Biliary Colic and Cholecystitis. Nausea and vomiting are also symptoms of Biliary Colic and Cholecystitis. (T. 420-422.)

97. With Cholecystitis, a patient is at risk of the gallbladder inflammation leading to infection which, if untreated, can spread into the bloodstream and the abdomen leading to sepsis. Cholecystitis can also lead to gangrene of the gallbladder or death of gallbladder tissue. The patient is at risk of becoming very ill or dying. (T. 422.)

98. Ultrasound imaging is commonly available in EDs and can be used to evaluate the gallbladder. A CT scan can evaluate for gallbladder disease but is not as effective. The Ultrasound is more focused and can identify more subtle findings such as thickness of the gallbladder wall, biliary sludge, the size of the gallstones, or any dilation of the common bile duct. (T. 423-425.)

99. The CT scan ordered by the Respondent was performed at 3:38 a.m. and the report was available at approximately 10:00 a.m. (Ex. 11; T. 426.)

100. The CT scan report found that Patient D's gallbladder was significantly distended, measuring 4.5 cm in diameter. The CT scan did

not find wall thickening, pericholecystic fluid or duct dilation. (Ex. 11; T. 14-15.)

101. The impression in the CT scan report was that Patient D's gallbladder was "significantly distended," similar to the findings of a March 2012 Ultrasound study. (Ex. 11; T. 428-429.)

102. There was clinical suspicion of Cholecystitis in Patient D because she had right upper quadrant pain, nausea, vomiting, and an elevated white count and a history of gallstones. (T. 431.)

103. Ultrasound is the preferred test for evaluating the gallbladder and was available at VBMC ED at the time of Patient D's treatment. (Ex. 13B; T. 435-36.)

104. The CT scan ordered by Respondent could not confirm or rule out the cause of Patient D's right upper quadrant pain. (T. 431.)

105. The Respondent ordered Patient D's discharge at 4:06 a.m. and the patient left the hospital at 4:16 a.m. (Ex. 11; T. 433.)

106. Patient D's medical record indicated that at the time of discharge, her condition was "improved." (Ex. 11.)

107. The Respondent did not reexamine Patient D prior to discharge. (T. 449.)

108. Respondent did not order a food and drink challenge for Patient D prior to her discharge. (T. 449.)

109. Patient D was diagnosed by the Respondent with "abdominal pain, right upper quadrant," and referred to a surgeon. (T. 433.)

110. The Respondent instructed the patient to see the surgeon because of a gallbladder attack, otherwise known as transient Biliary Colic. (T. 434.)

111. The Respondent did not conduct a "complete workup" prior to arriving at a diagnosis for Patient D. (T. 435.)

112. The Respondent did not perform a reevaluation prior to discharge on September 3, 2012. (T. 436-437.)

113. At 4:16 a.m., approximately thirty-eight minutes after the CT scan was performed and following the Respondent's order for discharge, Patient D's level of pain was recorded as "five out of ten." (Ex. 11; T. 446.)

114. The Respondent did not order an abdominal Ultrasound to further evaluate Patient D's gallbladder on September 3, 2012 despite her ongoing symptoms. (T. 436.)

115. About twenty hours after her discharge, Patient D returned to the ED at VBMC on September 4, 2012. She complained of right upper quadrant abdominal pain which she described as "ten out of ten." (Ex. 12; T. 451.)

116. The Respondent treated Patient D at VBMC on September 4, 2012. (Ex. 12; T. 451.)

117. The Respondent ordered Zofran and Dilaudid around 1:23 a.m. and ordered an abdominal Ultrasound around 2:18 a.m. (Ex. 12; T. 453-454.)

118. There was no documented history, physical or other assessment of Patient D by the Respondent for the date she returned to VBMC, September 4, 2012. (T. 454.)

119. The Respondent did not have an independent recollection of obtaining a history and physical for Patient D on her September 4, 2012 visit. (T. 807-808.)

120. The Ultrasound study showed that Patient D had sludge and calculi in the gallbladder and a positive Murphy sign was noted. (Ex. 12; T. 456.)

121. The Radiologist at VBMC documented an impression that Patient D had Cholelithiasis, otherwise known as gallstones. (Ex. 12; T. 458-459.)

122. At 4:03 a.m., Respondent placed an order to call surgery, and he admitted Patient D at 4:14 a.m. (Ex. 12; T. 459.)

123. A surgical history and physical for Patient D were documented at 4:47 a.m. (Ex. 12; T. 459-460.)

124. A HIDA scan was ordered by the surgical physician assistant which showed poor functioning of the gallbladder. (Ex. 12.)

125. The surgeon performed a laparoscopic cholecystectomy for Patient D and found a moderately distended gallbladder with evidence of inflammation. (Ex. 12; T. 462-464.)

126. The inflammation found in Patient D's gallbladder showed that she had Cholecystitis. (Ex. 12; T. 464.)

127. The pathology of the gallbladder concluded that Patient D had acute Cholecystitis, superimposed chronic Cholecystitis, Cholelithiasis, Cholesterolosis and Cholesterol Polyp. (Ex. 12; T. 464.)

Patient E

128. Patient E, then a 50 year-old-male, was treated in the ED of VBMC on June 2, 2014. Patient E was seen in triage at 12:33 a.m. (Ex. 15; T. 307.)

129. Patient E's chief complaint was that he had an asthma attack at home, his left arm went numb, and he had chest pressure, nausea and vomiting, and shortness of breath. (T. 308.)

130. An asthma attack causes breathing difficulty due to airways in the lungs becoming tight. Patient E used a rescue inhaler and a nebulizer at home. (T. 308-309.)

131. Patient E's respiration rate was elevated at 22 when measured in the ED. His oxygen saturation level was at 92 % on room air. (T. 310.)

132. Patient E had COPD. (Ex. 15.)

133. It was documented by nursing that Patient E had a pain level of 7 out of 10, and that the pain was in his chest. (Ex. 15.)

134. With an asthma attack, patients describe chest pressure or tightness, and shortness of breath. They do not typically, however, describe pain going down the left arm, and nausea and vomiting. (T. 311-312.)

135. Pain going down the left arm, and nausea and vomiting are typical symptoms of a cardiac event. (T. 312.)

136. Patient E was a current, everyday smoker, a risk for cardiac disease. He had been taking a statin drug for cholesterol control. (Ex. 15.)

137. Patient E's complaints of chest pressure following an asthma attack which radiated down his left arm with nausea and vomiting in addition to his multiple cardiac risk factors placed him at high risk for a cardiac event. (T. 315-316.)

138. The findings on the EKG taken of Patient E at 12:43 a.m. on June 2, 2014 included "ST wave depressions in leads I, II and AVF, as well as in V5 and V." The presence of ST depressions is concerning for cardiac ischemia, an indication that the heart is not receiving enough blood flow or oxygen. This can be a precursor to a heart attack. (Ex. 14; T. 316-317.)

139. In addition to the ST depressions shown on Patient E's EKG, a computer-generated interpretation of the EKG would also have been available to the Respondent, including an interpretation of the ST depressions. (Ex. 14; T. 322-323.)

140. The Respondent's own documentation of the EKG included that it showed "ST depression." (Ex. 15; T. 325-326.)

141. Patient E's asthma and/or COPD with hypoxia were stress factors which possibly caused an increase demand on the heart. If the

heart was unable to keep up with an increased demand, the ST depressions could have been the result. (T. 327.)

142. Respondent's recorded medical history for Patient E included that the chest pain or pressure was exacerbated on movement and exertion. Such pain is an indication that when the patient's heart is called upon for more blood flow and oxygen to the body, it is unable to do so without pain and ischemia. (Ex. 14; T. 330-331.)

143. Patient E's history, as documented by the Respondent's evaluation, was that approximately 90 minutes before he was seen in the ED triage, he had a bad asthma attack, vomited, and felt generalized tightness, specifically in the left side of his chest that radiated down his left arm. (T. 333.)

144. The patient used his rescue inhaler and nebulizer, after which all chest tightness and left arm numbness subsided. (T. 333.)

145. There was no documented history stating whether Patient E had experienced radiating pain to the arm during prior asthma and COPD episodes. (T. 334.)

146. There was no documentation describing the presence or absence of a family history for Patient E of coronary artery disease. (T. 335.)

147. Other than a statin medication, Patient E was not taking any cardiac medications. (T. 336.)

148. On Respondent's physical examination of Patient E, the respiratory exam noted that the respirations were non-labored, breath

sounds were equal, bilateral base diminished and wheezes present. This examination occurred 25 minutes after treatment had started. (T. 339.)

149. Respondent ordered a troponin level for Patient E which was drawn at 12:50 a.m. A troponin level assesses for myocardial damage or cell death. (Ex. 15; T. 340.)

150. The troponin was drawn approximately two hours after the onset of chest pain at 1:00 p.m. The troponin was reported back as negative. A troponin level will not rise until four hours after onset of pain. (Ex. 14; T. 342-343, 379-380.)

151. Patient E received a duo nebulizer treatment ordered at 12:51 a.m., an albuterol treatment ordered at 12:56 a.m., and a steroid, Prednisone, for his asthma and COPD, ordered at 12:51 a.m. by the Respondent. (Ex. 15; T. 49-50, 343-344.)

152. Respondent re-examined Patient E at 1:46 a.m. and documented that the patient was improved, stated that he was feeling better with treatment, and that the patient's lungs revealed clear sounds. The patient's pulse oxygenation was documented at 92 %. (Ex. 15; T. 345.)

153. According to documentation in the medical record at 12:40 a.m., Respondent again examined Patient E, and noted that the patient was improved with interventions, and that "this is a COPD exacerbation." Clear lung sounds with improved oxygen saturation levels were documented. A Prednisone prescription was to be given, and it was documented that the patient has a rescue inhaler and albuterol. (Ex. 15; T. 346.)

154. A chronology of Patient E's vital signs in the ED shows that at the time of triage (12:35 a.m.), the pulse ox level was 92 %. Between 1:00 a.m. and 2:30 a.m., while the patient was on a high flow nebulizer, his pulse ox levels improved to the mid to high 90s. It was during that same period that the Respondent had documented at 2:40 a.m., that the Respondent was improved with treatment. Typically, a high flow nebulizer is given with the oxygen. Patient E's improved pulse ox levels were measured while he was receiving supplemental oxygen. At 3:20 a.m., Patient E again had a low pulse ox level at 91 %. (Ex. 15; T. 347-348.)

155. At the time of triage at 12:35 a.m., Patient E's heart rate was 86 bpm and respiratory rate was 22 rpm. At 2:40 a.m., the heart rate was 104 bpm and the respiration rate was 28 rpm. At 3:09 a.m., the heart rate was 119 bpm with a respiration rate of 35 rpm. At 3:20 a.m., the patient's heart rate was 136 bpm. (Ex. 15; T. 349.)

156. Despite his high heart rate and respiration rate, the Respondent was preparing Patient E for discharge at 3:20 a.m. The patient's vital signs were consistent with a patient at risk for an asthma attack, hypoxia and cardiac ischemia, given the tachycardia. (T. 350.)

157. The Respondent documented a discharge diagnosis of asthma with COPD and documented a prescription for Prednisone and patient education materials for COPD. (Ex. 15.)

158. Despite Patient E's EKG findings of significant ST depressions, after the patient had complained of chest pressure radiating down the left arm with nausea and vomiting, the Respondent did not document in Patient E's hospital record, a differential diagnosis including: a coronary event, acute coronary syndrome or unstable angina. (T. 354.)

159. The standard of care to evaluate Patient E for acute coronary syndrome would be hospitalization, obtaining serial troponin levels, serial EKGs, and obtaining a cardiology consult. (T. 355.)

160. The Respondent did not order serial troponins or serial EKGs for Patient E. (T. 355.)

161. The Respondent went off shift at 3:00 a.m. on June 2, 2014, and the patient had not been dispositioned to remain in the hospital by Respondent. The Respondent did not communicate to the oncoming physician, either verbally or in writing, a plan for the patient to be admitted to the hospital for further cardiac assessment. (T. 358.)

162. At 2:40 a.m., Respondent ordered that Patient E be ambulated. (Ex. 15.)

163. At 3:20 a.m., nursing documentation showed that Patient E had ambulated through the department and that his pulse ox was 91 % on room air. (Ex. 15; T. 361-362.)

164. At 3:41 a.m., nursing documentation showed that the patient's wife was screaming, and that the patient was found slumped in a chair, unresponsive, without a pulse, and not breathing. Dr. Jason

Friedman responded to the patient in the ED, and attempted resuscitation. (Ex. 15; T. 483-485.)

165. At 4:23 a.m., Patient E was unresponsive in ventricular fibrillation and was subsequently pronounced dead. Ventricular fibrillation is an abnormal heart rhythm which can potentially result in circumstances in which cardiac ischemia progresses to myocardial infarction. Ventricular fibrillation can be fatal. (Ex. 15; T. 364-365.)

166. Patient E failed the ambulatory test. Patient E's collapse 10 minutes following ambulation was consistent with the condition of ischemia. (T. 387-388.)

167. Troponin assays should be measured at the time of the patient's admission and then serially at regular intervals to determine rise and fall, as troponin may not appear in the blood within the first hours following myocardial infarction. (Ex. 22; T. 391-392.)

168. With Patient E's presentation and findings in the ED, had a troponin been negative at four hours following onset of pain, it would not have ruled out cardiac ischemia given the EKG findings and the patient's symptoms. Patients can have an ischemic event without a rise in the troponin level. With Patient E's presentation and EKG findings, the admission of anti-platelet agents, such as aspirin, were indicated. (T. 393-394.)

Arnot Ogden Medical Center Application for Staff Privileges

169. Respondent practiced emergency medicine at VBMC during the period from October 2010 to December 31, 2014. (T. 658-659.)

170. Respondent submitted an application for staff privileges to Arnot Ogden Medical Center (Arnot Ogden) dated January 15, 2015. (Ex. 16.)

171. Respondent answered the following question "No" on the Arnot Ogden applications:

> Has your employment, medical staff appointment, practice or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, discontinued, denied, relinquished, terminated, reduced, refused or limited in any hospital or health care facility or have proceedings towards any of those ends eve been instituted or recommended by any official, committee or governing body of any health care facility? (Ex. 16.)

172. Respondent signed the following oath as to the truth of the information he provided on the Arnot Ogden application, dated January 15, 2015:

> Denny J. Pacheco being duly sworn deposes and says that I, as the applicant, who makes the foregoing application and know the contents thereof, and the same is true to the best of my knowledge and information. (Ex. 16.)

173. By letter dated October 3, 2014, approximately three months prior to the Respondent's application to Arnot Ogden for staff privileges, Respondent was notified in writing by Robert Friedberg, President of VBMC, that the Medical Executive Committee of VBMC had recommended that Respondent's medical staff privileges be suspended following an investigation by a Special Committee at VBMC which found

that his care of three patients failed to meet the standard of care. Respondent was further advised by Mr. Friedberg that it was recommended that Respondent complete a minimum of six months of "full time hands on emergency medicine training under the direction and supervision of a qualified clinical proctor" and at the completion of the emergency medicine training program, the clinical proctor must state in writing that Respondent has been assessed as qualified to provide emergency medicine care without restriction; following completion of the training program, Respondent would submit to a focused professional evaluation of at least 30 charts; and as required by VBMC Staff Bylaws, Respondent would be required to obtain Board Certification in Emergency Medicine by the end of 2015. (Ex. 17a.)

174. Mr. Friedberg's letter to Respondent notifying him of the suspension of his privileges closes by stating, "In light of the adverse recommendation, you are entitled to exercise your right to a hearing in accordance with Article 13 of the Medical Staff Bylaws." (Ex. 17a.)

175. In correspondence from Respondent to Mr. Friedberg dated October 23, 2014, Respondent, among other things, acknowledged receipt of Mr. Friedberg's October 3, 2014 letter to him concerning the findings of the Medical Executive Committee and Respondent's clinical privileges at VBMC. In the same correspondence, Respondent requested a hearing on the issues raised in Mr. Friedberg's correspondence. (Ex. 17a.)

176. In correspondence from Mr. Friedberg to Respondent dated November 13, 2014, VBMC acknowledged the receipt of Respondent's request of October 23, 2014 for a hearing, among other things. (Ex. 17c.)

177. Respondent's response of "NO" to the above question on the Arnot Ogden Application was false, as was his oath that the contents of the application were true.

178. At the time Respondent submitted the Arnot Ogden application, he had within the prior three months received written notification from the President of VBMC that the hospital's Medical Executive Committee had recommended the suspension of his clinical privileges for substandard clinical care and of his right to request a hearing to review that matter. Respondent had exercised this right by requesting a hearing regarding the recommendation that Respondent's staff privileges be suspended.

179. The subject question on the Arnot Ogden application inquires in relevant part the following:

> Ha(ve) your…clinical privileges ever been voluntarily or involuntarily suspended…in any hospital…or have proceedings towards any of these ends ever been…recommended by…a governing body of any health care entity. (Ex. 16.)

180. Respondent was required to answer "yes" to this question.

181. As the question asks the applicant to disclose if a hospital governing body had "ever" recommended proceedings concerning the suspension of clinical privileges, the fact that Respondent's hearing was never held is irrelevant to that part of the question which inquires

as to whether such a proceeding was ever "recommended." Respondent was free, if he chose, to explain to Arnot Ogden why the hearing was not held, but he was nevertheless obligated to answer "Yes" to the subject question.

182. Respondent testified that CompHealth, a locum tenens agency which he engaged, completed the Arnot Ogden application form which he provided. Respondent further testified that he corrected certain responses CompHealth made on the application, an indication that he reviewed the information provided. Further, above his signature at page 9 of the application is an oath or affirmation that states in effect that the Respondent is aware of the information provided in the application and that information is true "to the best of my knowledge and information." (Ex. 16.)

183. Regardless of the involvement of CompHealth in completing the application, Respondent was responsible for the false response he gave both by the fact that he had reviewed and corrected the application, and by the oath that he swore that he knew what information was being provided and that the information was true to the best of his knowledge.

Ellis Medicine Application

184. Respondent submitted two applications for clinical privileges to Ellis Medicine, Schenectady, New York (Ellis). On or about December 1, 2016, Respondent applied for hospital privileges at Ellis as locum

tenens. On or about December 20, 2016, Respondent applied to Ellis for staff member privileges. (Ex. 18.)

185. On each application to Ellis, the following questions are asked in which, in every instance, Respondent answered "No.":

a. Have any disciplinary actions or investigation by any state licensing or disciplinary or regulatory board been initiated against you?
b. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare, Medicaid, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child sex abuse or sexual offense or sexual misconduct?
c. Have you ever received sanctions from or are you currently the subject of [sic] investigation by any regulatory agencies? (Ex. 18.)

186. On or about December 1, 2016, Respondent signed the following attestation to the application for temporary privileges as locum tenens, which provides in part:

> All information submitted by me in this application is true and complete to the best of my knowledge and belief. I fully understand that any relevant misstatement in or omission from this application may constitute cause for a denial of appointment to the Medical-Dental Staff of Ellis Medicine, or the annulment or limitation of any appointment made upon the information contained in this application. Any misstatement or omission may also subject me to other disciplinary proceedings by the hospital. (Ex. 18.)

187. On or about December 28, 2016, Respondent electronically signed the following attestation to the Ellis application:

> I attest that all information in the Application is true and complete to the best of my knowledge and belief. I will notify the Organizations and/or their agents within 10 days of any material change to the information I have provided in my application or authorized to be released pursuant to credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by the Organizations, and must be submitted on-line or in writing, and must be dated and signed by me. (Ex. 18.)

188. By correspondence dated August 16, 2016, approximately four months prior to his submission of these applications to Ellis, Respondent was notified by an investigator for the Office of Professional Medical Conduct (OPMC) that he was under investigation regarding his evaluation, care, and treatment of patients in the ED of VBMC, including Patients A, D and E in the instant hearing. Respondent was further advised that under the Public Health Law he had an opportunity to be interviewed by OPMC to explain the issues under investigation. (Ex. 19a.)

189. On October 31, 2016, Respondent, in the presence of his attorney, interviewed with an Investigator and Medical Coordinator with OPMC regarding, among other things, his care and treatment of Patient E whose care by Respondent was part of the then current OPMC investigation. Among other things, the process of an OPMC investigation was discussed with Respondent at that time. (Ex. 19b.)

190. As the interview was not completed on October 31, 2016, another letter was sent by the OPMC Investigator to Respondent, dated November 1, 2016, again advising him of the aspects of the OPMC

investigation and the opportunity to continue the interview on November 17, 2016. (Ex. 19c.)

191. On November 17, Respondent, in the presence of his attorney, continued the interview with the OPMC Investigator and Medical Coordinator. Respondent offered explanations of his care of Patients A and D. (Ex. 19d.)

192. Respondent's answer, "No," to questions (Paragraph 15 a, b, and c in Finding # 186 above) on both locum tenens and staff membership application to Ellis was false.

193. In each instance, Respondent failed to disclose the existence of the OPMC investigation in response to a direct question as to whether he is, or had ever been, the subject of an investigation by a state disciplinary board, a state health program, or "any" regulatory agency.

194. Respondent's false statements to Ellis on the two applications constitutes filing a false report.

CONCLUSIONS OF LAW

Respondent is charged with professional misconduct as defined in § 6530 of the Educ. Law, as follows:

- § 6530(3) - Practicing the profession of medicine with negligence.
- § 6530(4) - Practicing the profession of medicine with gross negligence.

- § 6530(5) - Practicing medicine with incompetence on more than one occasion or with a lack of knowledge necessary to practice the profession.
- § 6530(6) - Practicing the profession of medicine with gross incompetence.
- § 6530(32) - Failing to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient.
- § 6530(2)- Practicing the profession of medicine fraudulently.
- § 6530(21)- Willfully making or filing a false report.

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (*See* Prince, Richardson on Evidence § 3-206). The Hearing Committee made these conclusions of law pursuant to the factual findings and definitions listed above, and all conclusions resulted from a unanimous vote.

The Department called Sachin Shah, M.D. as an expert witness. Dr. Shah, the Department's primary witness, is licensed to practice medicine in New York and has been since 2000. He is board certified in emergency medicine by the American Board of Emergency Medicine. In addition to his primary practice location of St. Luke's Newburgh in Newburgh, New York, Dr. Shah also practices in Hudson Valley Hospital in Peekskill,

New York and Montefiore New Rochelle Hospital, Montefiore Nyack Hospital and Westchester Medical Center. At St. Luke's Newburgh, Dr. Shah primarily oversees the physicians, nurse practitioners and physician assistants that staff the emergency department.

The Department also called Dr. Jason Friedman as a fact witness. Dr. Friedman practiced in the emergency department at VBMC and provided follow-up care after Respondent's care to Patient A and Patient E.

The committee finds that Dr. Shah's testimony was thoughtful, clear and comprehensive. He readily acknowledged instances when care rendered by the Respondent was within the appropriate standard of care and when the Respondent's actions did not pose a risk to a patient. The committee further found Dr. Shah to be well-credentialed, his testimony to be very credible, and his opinions on deviations in standards of care to be rendered on the appropriate standards at the time care was provided.

The Respondent called Dr. Kevin O'Connor and Dr. Virgil Smaltz, both practicing, board certified, emergency department physicians. Dr. O'Connor worked with the Respondent for five years at Arnot Ogden and was the Respondent's supervisor at the time the Respondent was hired at Arnot Ogden. Dr. Smaltz also worked in the emergency department with the Respondent at Arnot Ogden. (T. 983.)

The Department's First through Fifth Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross

negligence in his care of Patients A through E. Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates a risk of potentially grave consequences. Post v. State of New York Department of Health, 245 A.D.2d 985 (3d Dept. 1997).. There is no need to prove that a physician was conscious of the impending dangerous consequences of his conduct. Minielly v. Commissioner of Health, 222 A.D.2d 750 (3d Dept. 1995).

The Respondent provided medical care to Patient A, then a 7-month-old female, in the emergency department at VBMC on March 17, 2014, for respiratory syncytial virus, and fever, among other conditions. Patient A returned to VBMC emergency department, approximately 6 hours following her discharge by Respondent from the emergency department with increased respiratory difficulty, fever, and retractions, among other conditions.

Both the Department's expert, Dr. Shah, and Respondent's expert, Dr. O'Connor, recognized that at the time of Respondent's care, and despite nebulizer treatments by both parents and her pediatrician in the prior seventy-two hours, Patient A was not progressing on outpatient treatment. She was hypoxic, tachypneic, and wheezing. Respondent's treatment plan was to add nasal suctioning with the ongoing nebulizer treatments. There was no documented history that the parents had been instructed on suctioning and had not already been suctioning the patient.

Dr. Shah testified that extending the period of monitoring in the ED for a ninety-minute to 2-hour period following the nebulizer ordered

by the Respondent was indicated prior to Patient A's discharge. This would have allowed the Respondent to determine if the patient could maintain her oxygen saturation level, tolerate oral intake, and that she would not desaturate while sleeping. The Respondent treated Patient A to the point where her vital signs had improved due to the administration of Albuterol. However, Respondent discharged Patient A only ten minutes after administering albuterol to her and giving her a nebulizer treatment. He also instructed her parents to suction the child's nose often. (Ex. 3; T. 752.)

Respondent documented at his reassessment that the parents were "comfortable" with taking the patient home and giving nebulizer treatments. The Department asserts that the parents' assent to the discharge plan did not in any way excuse or diminish the Respondent's responsibility to care for the patient and that the Respondent cannot shift his responsibilities for the appropriate care and treatment of his patient. (T. 751-752.)

Dr. O'Connor testified that the discharge was not inappropriate and did not constitute a deviation from standard, accepted practice and stated that, "based on the information contained in the medical record, he too would have discharged the patient." (T. 897.)

The hearing committee found that the Respondent failed to adequately evaluate Patient A's respiratory status. One would expect a child to improve after treatment, as Patient A did. However, a reasonable emergency room physician would realize that a patient such

as Patient A would tend then to deteriorate again once the medication wears off. An emergency room physician should realize that a child such as Patient A, who had been sick for 72 hours prior to her admission to the ED with a fairly diligent effort by the parents to get her treated, was in a serious medical condition. The committee agreed that the Respondent needed to continue to observe Patient A and not discharge her shortly after treatment. Patient A was hypoxic. A physician should not let a patient this sick go home after the treatment she received. His job was to anticipate that Patient A would remain sick.

Respondent's care of Patient A departed from the accepted standards of care in discharging her from the ED without an adequate period of monitoring for sustained improvement following treatment. The Departments charge of Gross Negligence regarding Patient A is sustained.

The Respondent also provided medical care to Patient B, then a 25-year-old male, in the emergency department of Arnot Ogden on July 14, 2016, for a three-day history of nausea, vomiting, headache and lethargy, among other things. Patient B was discharged from the emergency department with a diagnosis of sinusitis and a prescription for Augmentin after having been treated in the emergency department with IV fluids, Zofran and Toradol, among other things. Patient B returned to Arnot Ogden ED approximately 17 hours following discharge with complaints of vomiting, lethargy and confusion. A lumbar puncture was performed, and Patient B was admitted for presumptive meningitis.

In his care of Patient B, Respondent adopted a diagnosis of sinusitis, which was not supported in the absence of common clinical findings such as nasal drainage, and despite a CT scan not showing sinus abnormalities. A diagnosis of sinusitis would necessarily ignore or leave unexplained a three-day history of nausea and vomiting. Respondent failed to rule out meningitis and encephalitis, despite the severity of the patient's symptoms.

Regarding Respondent's diagnosis of sinusitis, Respondent admitted to the Hearing Committee that Patient B's white blood count was 18,000, he had been nauseous for three days, and had a 10 out of 10 headache. He also complained of "lethargy." The Respondent admitted that this is not a common presentation for sinusitis. The Respondent's expert, Dr. O'Connor testified that it is likely, given this set of circumstances, that he would have performed a lumbar puncture for Patient B, in order to diagnose either meningitis or encephalitis as early as possible. (T. 573-574.)

The Respondent's failure to perform a lumbar puncture and his diagnosis of sinusitis without medical indications were severe deviations from the standards of care and placed Patient B at severe risk. The Department's charge of Gross Negligence regarding Patient B is also sustained.

The Respondent also provided medical care to Patient C, a 61-year old female, in the Arnot Ogden ED on January 8, 2016 for injuries Patient C sustained in a motor vehicle accident approximately 35 minutes

earlier, including four, consecutive, right-sided rib fractures, a fractured sternum, and a fractured patella. Patient C's medical history included, among other things, COPD and continued tobacco use. Following evaluation and treatment, Respondent discharged Patient C with an incentive spirometer, among other things. Patient C returned to Arnot Ogden on January 10, 2016 and was treated for hypoxia and confusion. Her medical history on January 10, 2016 included her non-compliance with the spirometer. Patient C was admitted to Arnot Ogden for six days.

Patient C required hospital admission with four consecutive rib fractures and a left patella fracture in circumstances of a compromised respiratory system from COPD, her continued tobacco use, her obesity and her opiate tolerance which would complicate pain control. Respondent's former colleague and expert, Dr. Virgil Smaltz, testified that Patient C's discharge from the hospital would have been acceptable if her pain was under control, and if the patient was able to ambulate. Neither of these conditions had been met on January 8, 2016, but the Respondent discharged her anyway.

The Hearing Committee found it very concerning that the Respondent discharged Patient C despite significant injuries to both knees, including a fractured patella with fluid build-up on her left knee. Indeed, the Respondent never documented Patient C's fractured patella at all, indicating that he was not aware that her kneecap was broken despite clear evidence of this available to him in her chart. The

Hearing Committee was further concerned that the Respondent did not adequately address the patient's pain level before discharging her. Patient C had four consecutive rib fractures which would certainly have caused her significant pain, as evidenced by her "very severe: pain level of 8 on a scale from 1 to 10. Such severe pain in the patient's ribs would make it very difficult to take a deep breath. While the patient was instructed upon discharge to use an incentive spirometer to exercise her lungs, both experts and the Respondent recognized that four consecutive rib fractures would cause significant pain, and if the pain is not adequately controlled, the patient is less likely to use the incentive spirometer to perform deep breathing exercises. The Respondent, however, discharged Patient C despite the patient having 8 out of 10 pain at discharge, without further treating her pain.

The Respondent testified that he did not prescribe any pain medications to Patient C at discharge because she had pain medications at home, and in the Respondent's words, "she knew how to manage her pain." (T. 590.)

Respondent discharged Patient C despite no adequate pain control provided by him other than instructing her to manage her pain with the medications she already had. He also sent her away with a fractured, untreated patella. Respondent severely deviated from accepted standards of care in inappropriately discharging Patient C from the ED, an in not diagnosing her patella fracture. The Department's charge of Gross Negligence regarding Patient C is sustained.

The Respondent also provided medical care to Patient D, a 22-year old female, in the emergency department at VBMC on September 3, 2012 for right upper quadrant abdominal pain and vomiting, among other conditions. Respondent discharged Patient D with a diagnosis of upper right quadrant pain and with a referral to a surgeon. Patient D returned to the emergency department approximately 21 hours later at which time she was evaluated by Respondent for intense pain. A surgical consult was requested. Patient D was admitted and subsequently underwent a cholecystectomy.

Patient D arrived at the ED at VBMC after midnight on Labor Day. Patient D's presentation suggested that she was having an issue in her gallbladder. Biliary Colic and Cholecystitis were appropriately considered as possible diagnoses.

The Respondent ordered labs and a CT Scan of the abdomen which the Department's expert, Dr. Shah, credited as a reasonable approach for evaluating the patient's complaints. The Respondent treated Patient D with Zofran for her nausea and Morphine for her pain. The CT Scan report found that Patient D's gallbladder was significantly distended with no wall thickening or pericholecystic fluid noted. Her white blood count came back as elevated at 12.2. Dr. Shah testified that the Respondent's workup at this point was appropriate, but incomplete. Dr. Shah testified that a diagnostic study such as an Ultrasound or HIDA scan could be used to better evaluate the gallbladder. The CT Scan obtained by the Respondent recommended an Ultrasound if the patient

exhibited clinical signs of Cholecystitis, which she did. Despite the recommendation of the radiologist, the Respondent discharged Patient D without an Ultrasound, and without further reassessing her symptoms.

The Respondent's expert, Dr. Smaltz, testified that it was reasonable for the Respondent to discharge Patient D because there were no acute findings on the CT Scan, no evidence in her bloodwork, and the patient's pain was not controlled. Dr. Shah opined, however, that because the patient had pain at the time of discharge, which occurred after she was given Morphine, her pain was returning and was not under control. Nevertheless, the Respondent ordered the discharge and instructed her to follow up with a surgeon but did not facilitate a consultation between Patient D and a surgeon.

Patient D returned to VBMC approximately 21 hours later with essentially the same symptoms as the night before and was again seen by the Respondent. This time, Patient D was admitted, a surgical consult was requested, and the patient underwent a cholecystectomy.

While Respondent deviated from accepted standards of care in his treatment of Patient D by discharging her without administering an Ultrasound, the Hearing Committee found that he did not severely deviate from the standards of care. The Hearing Committee finds that the Respondent was negligent in his care of Patient D, but not grossly negligent, and the Department's charge of Gross Negligence regarding Patient D is not sustained.

The Respondent also provided medical care to Patient E, then a 50-year old male, with a history of COPD, diabetes, Body Mass Index of 29kg/m2, and continued tobacco use, in the VBMC ED on June 2, 2014 for complaints of shortness of breath and bilateral chest pain radiating to the left arm. An electrocardiogram performed in the ED showed ST segment depressions. The Respondent entered a discharge diagnosis of COPD exacerbation with discharge instructions and outpatient prescriptions for COPD exacerbation in the patient's medical record, and then went off shift. Patient E suffered a cardiac arrest in the ED and subsequently died.

Respondent's own expert, Dr. Smaltz, agreed that Respondent departed from accepted standards by not repeating the troponin value for Patient E. He also recognized that in circumstances of EKG findings consistent with cardiac ischemia like there were here, and with the patient's complaints of pain, a single troponin value does not rule out myocardial ischemia. In Dr. Smaltz's opinion, the Respondent did not appropriately diagnose Patient E with regard to cardiac pathology.

Respondent suggested several times during his testimony that Patient E had convinced him that this COPD/asthma attack was similar to previous ones, and that this steered the Respondent's diagnosis of respiratory illness. In failing to adequately evaluate Patient E given his presentation and abnormal EKG, in failing to obtain an adequate cardiac history, and in not transferring his care to the oncoming ED provider, Respondent deviated from the standards of care to a severe

degree. Indeed, regarding Patient E, Respondent concedes that he erred in his diagnosis by not correctly interpreting Patient E's EKG in the context of Patient E's presenting symptoms and by relying on a single troponin level. The Respondent also concedes that he should not have allowed himself to rely on Patient E's assurances that his symptoms were simply those of an asthma/COPD attack. (T. 830.)

The Department's charge of Gross Negligence regarding Patient E is sustained.

The Department's Sixth through Tenth Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence in his care of Patients A through E. Incompetence is defined as the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board of Professional Medical Conduct, 224 A.D.2d 609 (3rd Dept. 1996). Gross incompetence is a lack of requisite skill to practice medicine safely that can be characterized as serious or significant, carrying potentially grave consequences. Dhabuwala, 225 A.D.2d 609; Post; 245 A.D.2d 985.

As discussed above, the Respondent failed to adequately evaluate Patient A's respiratory status and did not recognize that a patient in her condition would tend to deteriorate after the medicine administered by the Respondent wore off. Patient A was hypoxic, and a physician should not let a patient this sick go home. For these and the other

reasons discussed above, the Hearing Committee found that the Department's charge of Gross Incompetence regarding Patient A is sustained.

The Committee found that the Respondent also failed to adequately diagnose Patient B. Respondent adopted a diagnosis of sinusitis, which was not supported in the absence of common clinical findings such as nasal drainage, and despite a CT scan not showing sinus abnormalities. A diagnosis of sinusitis would necessarily ignore or leave unexplained a three-day history of nausea and vomiting. Respondent failed to rule out meningitis and encephalitis, despite the severity of Patient B's symptoms.

The Committee concludes that the Respondent's failure to perform a lumbar puncture and his diagnosis of sinusitis without medical indications were severe deviations from the standards of care, revealed lack of knowledge and skill to practice safely and placed Patient B at severe risk. The Department's charge of Gross Incompetence regarding Patient B is sustained.

The Respondent also failed to adequately diagnose Patient C. As discussed above, the Hearing Committee found it very concerning that the Respondent discharged Patient C despite significant injuries to both knees, including a fractured patella with fluid build-up on her left knee. Indeed, the Respondent never documented Patient C's fractured patella at all, indicating that he was not aware that her kneecap was broken, despite clear evidence of this available to him in

her chart. The Hearing Committee was further concerned that the Respondent did not adequately address the patient's pain level before discharging her. Patient C had four consecutive rib fractures which would certainly have caused her significant pain. The Department's charge of Gross Incompetence regarding Patient C is sustained.

The Respondent also failed to adequately diagnose Patient D. Similar to the Hearing Committee's determination regarding Gross Negligence of Patient D, the Hearing Committed has determined that the Respondent's care of Patient D, while incompetent, did not rise to the level of Gross Incompetence. Therefore, the Department's charge of Gross Incompetence regarding Patient D is not sustained.

Finally, the Respondent also failed to adequately diagnose Patient E, and as described above, the Respondent's care of Patient E was not only clearly Grossly Negligent, but also clearly Grossly Incompetent. His actions placed the patient at serious risk of harm or even death. Further, the Respondent conceded that his care of Patient E was unacceptable and certainly severely beneath the standard of care. Accordingly, the Department's charge of Gross Incompetence regarding Patient E is sustained.

The Department's Eleventh Specification charged the Respondent 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 in his care of Patients A through E. Negligence

is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. Bogdan v. State Board for Professional Medical Conduct, 195 A.D.2d 86 (3d Dept. 1993).

As discussed above, the Hearing Committee has determined that Respondent was grossly negligent in his treatment of Patients A, B, C and E. Although they did not find that Respondent was grossly negligent regarding Patient D, they did find that his care of Patient D was negligent. In that the Respondent's care of Patients A, B, C and E was deemed by the Hearing Committee to be grossly negligent, his treatment of these patients is necessarily deemed to be negligent. As such, the Department's charge of negligence on more than one occasion is sustained.

The Department's Twelfth Specification charged the Respondent 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 in his care of Patient's A through E. Incompetence is defined as the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board of Professional Medical Conduct, 224 A.D.2d 609 (3rd Dept. 1996).

As discussed above, the Hearing Committee has determined that Respondent was grossly incompetent in his treatment of Patients A, B,

C and E. Although they did not find that Respondent was grossly incompetent regarding Patient D, they did find that his care of Patient D was incompetent. In that the Respondent's care of Patients A, B, C and E was deemed by the Hearing Committee to be grossly incompetent, his treatment of these patients is necessarily deemed to be incompetent. As such, the Department's charge of incompetence on more than one occasion is sustained.

The Department's Thirteenth through Seventeenth Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) in that the Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient. A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v. New York State Dept. of Health, 9 A.D.2d 522 (3d Dept. 2004). Regarding Patient A, the Respondent failed to adequately document the medical record for either the presence of retractions or abdominal breathing. For Patient B, the Respondent failed to document an adequate medical history regarding the patient's complaints of lethargy and a severe headache. Regarding Patient C, the Respondent failed to document that the Patient had a broken patella, and also failed to document any assessment of her ability to ambulate prior to discharge. For Patient D, the Hearing Committee did not determine that the Respondent failed to keep accurate records.

Regarding Patient E, however, the Respondent's medical record lacked appropriate documentation as to prior asthma attacks, specifically regarding radiating pain to the arm, and also lacked adequate documentation of the treatment plan at the time of the shift change. Accordingly, the Department's charge of failure to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient, is sustained as it applies to Patients A, B, C and E.

The Department's Eighteenth and Nineteenth Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) in that the Respondent practiced the profession fraudulently. Fraud is defined as making a false representation that one knows was false and was made with the intent to mislead. Adler v. Bureau of Prof'l. Med. Conduct, 211 A.D.2d 990, 992 (3rd Dept. 1995). Further, with respect to professional misconduct of fraud in the practice of medicine, the Department of Health's former General Counsel's Memorandum regarding fraud states:

> The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, and with intent to deceive, constitutes fraudulent practice of medicine. To sustain a charge that a licensee has engaged in the fraudulent practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to lead through false representation. The licensee's knowledge and intent may properly be inferred from the facts found by the hearing committee, but the committee must specifically state the inferences it is drawing

regarding knowledge and intent. Fraudulent intent may be inferred from evidence that the licensee was aware of the true state of facts at the time the responses were given. (T. 4-5.)

In the Arnot Ogden application, the Respondent was asked whether a committee or governing body had "ever" recommended proceedings regarding the suspension of his hospital privileges. Three months prior to the submission of this application, the Medical Executive Committee (MEC) at VBMC had done precisely that, *i.e.*, notified the Respondent of the MEC's recommendation for the suspension of his privileges. Respondent clearly was aware of this correspondence, as he later referenced that correspondence in his reply to VBMC requesting a hearing. (Ex. 17b.) Respondent's answer of "No" to this question was false, and the Respondent knew it was false. His intent to deceive is inferred by the Hearing Committee in that the Respondent clearly knew his answer was false. His intent was to deceive so that he would obtain the privileges he was seeking.

Similarly, in his application for clinical privileges at Ellis, the Respondent was fraudulent in his application. When asked if he had ever had any "disciplinary actions or investigations by any state licensing or disciplinary or regulatory board, the Respondent answered "No." This response was given despite having received two letters from OPMC notifying him that his care of patients, including Patient's A, D, and E in the instant hearing was being investigated. Again, the Hearing Committee infers the Respondent's intent to deceive Ellis by not

disclosing the ongoing OPMC investigation as disclosing the ongoing OPMC investigation would likely diminish the chances of his application being approved.

Accordingly, the Department's charge that the Respondent committed professional misconduct by practicing the profession fraudulently, is sustained.

The Department's Twentieth and Twenty-First Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) in that the Respondent willfully made or filed a false report.

As discussed above, the Respondent submitted applications for medical privileges to both VBMC and Ellis. In both situations, the Respondent answered "no," to questions that he clearly knew the appropriate answer was "yes." Regarding the Arnot Ogden application, Respondent testified that the locum tenens company, Comphealth, completed the application. However, Respondent testified that he nevertheless made corrections to some of the information entered by Comphealth on that application. Therefore, having reviewed the Arnot Ogden application to make corrections, Respondent was responsible for correcting the false response to the application question at issue. Moreover, the attestation clause on the Arnot Ogden application signed by Respondent provides that the Respondent "knows" the contents of the

application and further knows those contents to be "true to the best of my knowledge and information." (Ex. 16.)

Respondent represented by this oath that he knew of the information provided in the application and that he was affirming that the information was true to the best of his knowledge. This representation by the Respondent was also false. Accordingly, the Department's charge of committing professional misconduct by willfully making or filing a false report, is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee considered the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension, probation, censure, and the imposition of civil penalties.

The Hearing Committee is mindful that the Respondent held a very serious and stressful position and that he successfully treated the majority of his patients while employed as an emergency room physician. The Hearing Committee also appreciates that the Respondent took full responsibility without excuses for the unfortunate occurrences regarding his care of Patient E. The Hearing Committee also finds that the Respondent's care of Patient D, while not within the standard of care, did not rise to the level of a severe departure from the accepted standard of care for emergency department physicians. In addition to Patient E, the Hearing Committee did find that the Respondent's

treatment of Patients A, B and C severely departed from the standard of care for these patients.

Further, the Hearing Committee had concerns regarding the Respondent's credibility. While under oath, the Respondent attempted to conceal his academic standing following his medical internship in the US Navy. Respondent's sworn testimony implied that he successfully completed the Naval internship. Under cross-examination, the Respondent continued to suggest that he completed the Naval internship but decided of his own accord to transfer to Frankfort Hospital. Only when asked point blank if he had successfully completed the Naval internship did he acknowledge that he was dismissed from the program after failing Step II of the USMLE. Such questionable veracity supported the Hearing Committee's finding that the Respondent's explanations for his inaccurate filing of applications for medical privileges were highly questionable, and indeed were fraudulent.

Physicians must comply with among the highest of ethical standards, which become of utmost importance when dealing with the rigors of a hospital emergency room. In addition to doubting the Respondent's veracity, the Hearing Committee concludes that the Respondent's treatment of Patients A, B, C and E demonstrate that he is a danger to potential new patients should he be reinstated as an emergency room physician. Accordingly, the Hearing Committee concurs with the Department's Recommendation that the Respondent's license be revoked.

ORDER

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

1. The First, Second, Third, Fifth, Sixth, Seventh, Eighth, Tenth, Eleventh, Twelfth, Thirteenth, Fourteenth, Fifteenth, Sixteenth, Seventeenth, Eighteenth, Nineteenth, Twentieth and Twenty-First Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED**; and

2. The Forth and Ninth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED**; and

3. Pursuant to PHL § 230-a(4), the Respondent's license to practice medicine in the State of New York is **revoked**; and

4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail or upon the Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
July , 2020

NYS DEPT OF HEALTH

AUG 19 2020

Division of Legal Affairs
Bureau of Adjudication

[redacted]

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Denny Pacheco, D.O.
[redacted]

APPENDIX I

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

IN THE MATTER OF DENNY PACHECO, D.O.

STATEMENT

OF

CHARGES

DENNY PACHECO, D.O., the Respondent, was authorized to practice medicine in New York State on or about September 9, 2010, by the issuance of license number 258600 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, then a 7-month old female, (Patients are identified by name in Appendix A hereto) in the emergency department at Vassar Brothers Medical Center (VBMC) in Poughkeepsie, New York on March 17, 2013 for respiratory syncytial virus, and fever, among other conditions. Patient A returned to VBMC emergency department, approximately 6 hours following her discharge by Respondent from the emergency department with increased respiratory difficulty, fever, and retractions, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient A's respiratory system on one or more occasions.
2. Respondent failed to adequately treat Patient A's fever.
3. Respondent failed to adequately evaluate Patient A prior to discharge.
4. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B, then a 25-year old male, in the emergency department of Arnot Ogden Medical Center in Elmira, New York on July 14, 2016, for a three-day history of nausea, vomiting, headache and lethargy, among other things. Patient B was discharged from the emergency department with a diagnosis of sinusitis and a prescription for Augmentin after having been treated in the emergency department with IV fluids, Zofran and Toradol, among other things. Patient B returned to the Arnot Ogden Medical Center emergency department approximately 17 hours following discharge with complaints of vomiting, lethargy and confusion, among other things. A lumbar puncture was performed and Patient B was admitted for presumptive meningitis. Patient B was transferred from Arnot Ogden Medical Center to Strong Memorial Hospital in Rochester, New York to continue treatment during the period from July 20, 2016 through September 8, 2016. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient B during the July 14, 2016 emergency department visit for possible meningitis and/or encephalitis, including but not limited to, the failure to perform and/or order a lumbar puncture.
2. Respondent diagnosed Patient B with sinusitis, among other conditions, during the July 14, 2016 emergency department visit, without adequate medical indication.
3. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C, then a 61-year old female, in the emergency department of Arnot Ogden Medical Center on January 8, 2016 for injuries Patient C sustained in a motor vehicle accident approximately 35 minutes earlier, including four, consecutive, right-sided rib fractures, a fractured sternum, and a fractured patella. Patient C's medical history included, among other things, chronic obstructive pulmonary disease (COPD) and continued tobacco use. Following

evaluation and treatment, Respondent discharged Patient C with an incentive spirometer, among other things. Patient C returned to Arnot Ogden Medical Center on January 10, 2016 and was treated for hypoxia and confusion, among other things. Her medical history on January 10, 2016 included her non-compliance with the spirometer. Patient C was admitted to Arnot Ogden Medical Center for six days. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent inappropriately discharged Patient C from the emergency department and/or failed to seek the admission of Patient C to the hospital on January 8, 2016.
2. Respondent failed to adequately and/or timely diagnose Patient C's patella fracture, and/or failed to adequately manage and/or treat the patella fracture.
3. Respondent discharged Patient C from the emergency department on January 8, 2016 without adequate pulmonary treatment and/or without adequate follow-up medical care of her pulmonary condition.
4. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided medical care to Patient D, then a 22-year old female, in the emergency department at VBMC on September 3, 2012 for right upper quadrant abdominal pain and vomiting, among other conditions. Respondent discharged Patient D with a diagnosis of upper right quadrant pain and with a referral to a surgeon. Patient D returned to the emergency department approximately 21 hours later at which time she was evaluated by Respondent for intense pain. A surgical consult was requested. Patient D was admitted and subsequently underwent a cholecystectomy. Respondent's medical care of Patient D deviated from accepted standards as follows:

1. Respondent failed to adequately evaluate Patient D's gallbladder on September 3, 2012.
2. Respondent failed to adequately re-evaluate Patient D prior to discharge from the emergency department on September 3, 2012.

3. Respondent, in discharging Patient D on September 3, 2012, failed to adequately manage her medical condition.
4. Respondent failed to document an adequate medical history and/or the performance of an adequate physical examination at the time of Patient D 's September 4, 2012 evaluation.
5. Respondent failed to maintain an adequate medical record for Patient D on September 3, 2012 and/or September 4, 2012.

E. Respondent provided medical care to Patient E, then a 50-year old male, with a history of COPD, diabetes, Body Mass Index of 29 kg/m2, and continued tobacco use among other conditions, in the emergency department at VBMC on June 2, 2014 for complaints of shortness of breath, and bilateral chest pain radiating to the left arm, among other conditions. An electrocardiogram performed in the emergency department showed, among other things, ST segment depressions. Approximately one hour after Respondent had entered a discharge diagnosis of COPD exacerbation with discharge instructions and outpatient prescriptions for COPD exacerbation in the patient's medical record, and then went off shift, Patient E suffered cardiac arrest in the emergency department and subsequently died. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent failed to obtain an adequate cardiac history for Patient E.
2. Respondent failed to adequately interpret Patient E's EKG, and/or failed to adequately manage, evaluate and/or treat Patient E given the abnormal EKG findings.
3. Respondent failed to adequately monitor and/or evaluate Patient E's cardiac status, including, but not limited to, repeating cardiac enzyme and/or EKG testing.

4. Respondent failed to adequately diagnose and/or reassess Patient E prior to entering a discharge diagnosis, discharge instructions and outpatient treatment for COPD exacerbation in the medical record.
5. Respondent failed to adequately transfer the care of Patient E to the oncoming emergency room provider.
6. Respondent failed to maintain an adequate medical record for Patient E.

F. In an application for staff privileges which Respondent submitted to Arnot Ogden Hospital, Elmira, New York, on or about January 15, 2015 (Arnot Ogden Application), Respondent answered the following question "No":

> Has your employment, medical staff appointment, practice or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, discontinued, denied, relinquished, terminated, reduced, refused or limited in any hospital or health care facility or have proceedings toward any of those ends ever been instituted or recommended by an official, committee or governing body of any health care entity?

On or about January 15, 2015, Respondent signed the following attestation to the Arnot Ogden Hospital application:

> Denny J. Pacheco being duly sworn deposes and says that I, as the applicant, who makes the forgoing application, that I have read the foregoing application and know the contents thereof, and the same is true to the best of my knowledge and information.

Respondent's Arnot Ogden Application for staff privileges deviated from accepted standards of care as follows:

1. Respondent knew that his negative answer to the application question was false in that an official, committee or governing body of a hospital at which Respondent previously had hospital privileges had, on or about September 2, 2014 (and as accepted by that hospital's Board of Trustees on or about September 18, 2014), instituted or recommended proceedings to take one or more of the actions described in the Arnot Ogden Application question against Respondent's employment, medical staff appointment, practice or clinical privileges at that hospital. On or about October 23, 2014 Respondent requested a hearing pursuant to the provisions of the medical staff by laws to contest the actions which had been recommended against his employment, medical staff appointment or privileges. Respondent made the false answer on the application in an attempt to conceal from Arnot Ogden Hospital actions taken by another hospital against his practice at that hospital.

2. Respondent knew that his signed attestation of January 15, 2015 that "...I have read the foregoing application and know the contents thereof, and the same are true to the best of my knowledge and information." was false. Respondent made the false attestation on the application in an attempt to conceal from Arnot Ogden Hospital actions taken at another hospital against his practice at that hospitals.

G. In an application for temporary hospital privileges as a *locum tenens* which Respondent submitted to Ellis Medicine in Schenectady, New York, on or about December 1, 2016, and/or in a credentialing application for staff member privileges which Respondent submitted to Ellis Medicine (Ellis Hospital Application) on or about December 28, 2016 Respondent and/or Respondent's agent answered "No" to the following questions:

5. Have any disciplinary actions or investigations by any state licensing or disciplinary or regulatory board been initiated against you?

15. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare, Medicaid or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct?

17. Have you ever received sanctions from or are currently the subject or [sic] investigation by any regulatory agencies (e.g., CLIA, OSHA, etc...)?

On or about December 1, 2016, Respondent signed the following attestation to the application for temporary privileges as a *locum tenens*, which provides in part:

> All information submitted by me in this application is true and complete to the best of my knowledge and belief. I fully understand that any relevant misstatement in or omission from this application may constitute cause or a denial of appointment to the Medical-Dental Staff of Ellis Medicine, or for the annulment or limitation of any appointment made upon the information contained in this application. Any misstatement or omission may also subject me to other disciplinary proceedings by the hospital.

On or about December 28, 2016, Respondent or his agent electronically signed the following attestation to the Ellis Medicine Application:

> I attest that all information in the Application is true and complete to the best of my knowledge and belief. I will notify the Organizations and/or their agents within 10 days of any material change to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by the Organizations, and must be submitted on-line or in writing, and must be dated and signed by me.

Respondent's application for temporary privileges as a *locum tenens* and/or the Ellis Medicine Application deviated from accepted standards of care as follows:

1. Respondent knew that the negative answer to question #5 above on the Ellis Hospital Application and/or his negative answer to question #5 above on the application for temporary privileges as a *locum tenens* were false in that an investigation of Respondent by a state disciplinary or regulatory board had been initiated prior to December 1, 2016. Respondent, or his agent, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

2. Respondent knew that the negative answer to question #15 above on the Ellis Hospital Application and/or his negative answer to question #15 above in the application for temporary privileges as a *locum tenens* were false in that Respondent was currently the subject of an investigation by a state health program during the period including December 1, 2016 through December 28, 2016. Respondent, or his agent, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

3. Respondent knew that the negative answer to question #17 above, on the Ellis Hospital Application and/or the negative answer to question #17 on the application for temporary privileges as a *locum tenens* were false in that Respondent was currently the subject of an investigation by a regulatory agency during the period including December 1, 2016 through December 28, 2016. Respondent, or his agents, gave the false answer or answers described above to conceal from Ellis Medicine a state investigation of his medical practice.

4. Respondent knew that his signed attestation of December 1, 2016 to the application for temporary privileges as a *locum tenens* that "All of the

information submitted by me in this application is true and complete to the best of my knowledge and belief," was false. Respondent, or his agent, made the false attestation to the supporting documents in an attempt to conceal from Ellis Medicine a state investigation of Respondent's medical practice.

5. Respondent knew that the signed attestation of December 28, 2016 to the Ellis Hospital Application that "I attest that all information provided in this Application is true and complete to the best of my knowledge and belief" was false. Respondent, or his agent, made the false attestation to the Ellis Hospital Application to conceal from Ellis Medicine a state investigation of Respondent's medical practice.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH 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:

1. The facts as alleged in paragraphs A and A.1 and/or A and A.3.
2. The facts as alleged in paragraphs B and B.1.
3. The facts as alleged in paragraphs C and C.1.
4. The facts as alleged in paragraphs D and D.1.
5. The facts as alleged in paragraphs E and E.2 and/or E and E.3.

SIXTH THROUGH TENTH SPECIFICATIONS

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:

6. The facts as alleged in paragraphs A and A.1 and/or A and A.3.

7. The facts as alleged in paragraphs B and B.1.

8. The facts as alleged in paragraphs C and C.1.

9. The facts as alleged in paragraphs D and D.1.

10. The facts as alleged in paragraphs E and E.2 and/or E and E.3.

ELEVENTH 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 two or more of the following:

11. The facts as alleged in two or more of the following paragraphs: A and A.1, and/or A and A.2, and/or A and A.3, and/or A and A.4, and/or B and B.1, and/or B and B.2, and/or B and B.3, and/or C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4, and/or D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5, and/or E and E.1, and/or E and E.2, and/or E and E.3, and/or E and F.4, and/or E and E.5, and/or E and E.6.

TWELFTH 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 two or more of the following:

12. The facts as alleged in two or more of the following paragraphs: A and A.1, and/or A and A.2, and/or A and A.3, and/or A and A.4, and/or B and B.1, and/or B and B.2, and/or B and B.3, and/or C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4, and/or D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5, and/or E and E.1, and/or E and E.2, and/or E and E.3, and/or E and E.4, and/or E and E.5, and/or E and E.6.

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATIONS

RECORD KEEPING

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) in that Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient as alleged in the following:

13. The facts as alleged in paragraphs A and A.4.

14. The facts as alleged in paragraphs B and B.3.

15. The facts as alleged in paragraphs C and C.4.

16. The facts as alleged in paragraphs D and D.4 and/or D and D.5.

17. The facts as alleged in paragraphs E and E.6.

EIGHTEENTH THROUGH NINETEENTH SPECIFICATIONS

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession fraudulently as alleged in the following:

18. The facts as alleged in paragraphs F and F.1, and/or F and F.2.

19. The facts as alleged in paragraphs G and G.1, and/or G and G.2, and/or G and G.3, and/or G and G.4, and/or G and G.5.

TWENTIETH THROUGH TWENTY-FIRST SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report as alleged in the following:

20. The facts as alleged in paragraphs F and F.1, and/or F and F.2, and/or F and F.3.

21. The facts as alleged in paragraphs G and G.1, and/or G and G.2, and/or G and G.3, and/or G and G.4, and/or G and G.5.

DATE: September 13, 2018
Albany, New York

[redacted]
MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct