Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

December 4, 2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Roger Gorman, M.D.

Ian H. Silverman, Esq.
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Roger Gorman, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 23-247) 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.

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 Respondent or the Department may seek a review of a committee determination.

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:

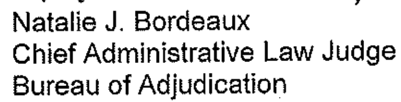
Jean T. Carney, Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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 Judge Carney 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,



Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

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

COPY

IN THE MATTER OF ROGER GORMAN, M.D.	DETERMINATION AND ORDER
	BPMC-23-247

A Notice of Referral Proceeding and Statement of Charges dated October 6, 2023, were duly served upon Roger Gorman, M.D. (Respondent) pursuant to Public Health Law (PHL) § 230(10)(d)(i). (Exhibits 1, 2.) A hearing was held on November 29, 2023, via WebEx videoconference. Pursuant to PHL § 230(10)(e), **CASSANDRA E. HENDERSON, M.D., M.Sc., CDCES**, Chairperson, **PROSPERE REMY, M.D.**, and **MYRA M. NATHAN, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee. **NATALIE BORDEAUX** served as the administrative officer.

The Department appeared by Ian H. Silverman, Esq. The Respondent appeared and represented himself. The Hearing Committee received and examined documents from the Department (Exhibits 1-4) and from the Respondent (Exhibit A). A transcript of the proceeding was made. After consideration of the entire hearing record, the Hearing Committee hereby issues this Determination and Order, sustaining the charge and imposing the penalty of censure and reprimand on the Respondent's medical license. All findings, conclusions, and determinations are unanimous.

BACKGROUND

The Department brought the case pursuant to PHL § 230(10)(p), which provides for a hearing when a licensee is charged solely with a violation of Education Law § 6530(9). The Respondent is charged with professional misconduct pursuant to Education Law § 6530(9)(d), having disciplinary

action taken against his medical license in Florida after a disciplinary action was instituted by a duly authorized professional agency of that state, where the conduct resulting in the disciplinary action would, if committed in New York state, constitute professional misconduct under the laws of New York. Under PHL § 230(10), the Department had the burden of proving its case by a preponderance of the evidence.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York on November 3, 1986, under license number 168488. (Exhibit 3.)

2. By Final Order dated August 22, 2022, the Florida Board of Medicine (Florida Board) adopted a Counter Settlement Agreement entered into between the Respondent and the Florida Department of Health to resolve charges that, while acting as the anesthesiologist for a 62-year-old male patient, he acted negligently in administering anesthetic agents and failed to adequately treat the patient's hypotension. The Respondent was also charged with failing to document anesthesia administered, urine output and fluids contemporaneously, and documented the patient's end CO2 levels once every 30 minutes instead of every 15 minutes. The Florida Board issued a reprimand against the Respondent's license, imposed an administrative fine of $10,000, and ordered the reimbursement of costs of $6,836.68 incurred for investigating and prosecuting the case. The Respondent was ordered to complete the following Continuing Medical Education (CME) courses: three hours in medical recordkeeping; ten hours in managing hypotension during surgical procedures; ten hours in anesthesiology; and five hours in risk management. Within nine months of the entry of the Final Order, the Respondent was required to undergo an evaluation by Florida CARES (Comprehensive Assessment and Remedial Education Services) Program, Center for Personalized Education for Professionals (CPEP), the UC San Diego PACE Program, or another equivalent program

preapproved by the Florida Board and personally appear before the Florida Board with the evaluation and the evaluator's recommendation. The Respondent was placed on probation until he underwent the evaluation, presented the evaluation to the probation committee, and made his required appearance before the probation committee. During his probation, the Respondent was required to practice under the direct supervision of a Board-certified anesthesiologist. (Exhibit 4.)

DISCUSSION

The Florida Board's Final Order dated August 22, 2022 incorporated a Settlement Agreement, slightly modified by a Counter Settlement Agreement, whereby the Respondent was subjected to professional discipline and agreed not to dispute charges that, while acting as a patient's anesthesiologist during an outpatient facelift procedure, he administered three separate anesthetic agents, sevoflurane, precedex, and propofol, without documenting justification for administering three separate anesthetic agents and without documenting the dosages of propofol and precedex he administered to the patient. Each anesthetic agent administered individually or in combination with the others could lead to hypotension. When the patient became hypotensive, the Respondent failed to adequately treat the patient's condition with vasopressors, did not document the patient's urine output and fluids contemporaneously, and documented the patient's end tidal CO2 levels once every 30 minutes instead of once every 15 minutes. The Respondent administered atropine, glycopyrrolate and Neo-Synephrine to treat the patient's hypotension, but administered an inappropriate dosage of Neo-Synephrine. He did not use fluid resuscitation to treat the patient's hypotension. When the Respondent was unable to resuscitate the patient, he called 911 for the patient's emergency transport to a hospital and did not treat the patient's hypotension while awaiting emergency services. After the facelift and hypotensive incident, the patient suffered from ischemic injuries related to prolonged intraoperative

hypotension including severe anoxic encephalopathy, type 2 myocardial infarction, lactic acidosis, and acute renal failure. (Exhibit 4.)

The Hearing Committee agreed that the Respondent's conduct resulting in the Florida Board's disciplinary action would, if committed in New York, constitute misconduct pursuant to Education Law § 6530(3), practicing the profession with negligence on more than one occasion; and Education Law § 6530(32), failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. The Hearing Committee thus determined that the Respondent violated Education Law § 6530(9)(d).

After determining to sustain the charge, the Hearing Committee considered all possible penalties authorized by PHL § 230-a. The Department recommended a censure and reprimand, combined with a three-year period of probation, during which time the Respondent would be required to practice under the direct supervision of a Board-certified anesthesiologist. The Hearing Committee agreed that a censure and reprimand was sufficient to address the issues raised by the Final Order but declined to impose additional penalties.

The Respondent complied with the terms of the Final Order and is no longer subject to any restrictions in his practice of medicine in Florida. (Exhibit A.) The removal of those restrictions signifies that the Respondent was deemed competent to practice after an evaluation, and that the Respondent has also the completed the required CME courses.

The Respondent explained to the Hearing Committee that, despite due diligence by the plastic surgery practice with which he worked and where he encountered patient [redacted] the patient and his wife both failed to disclose, despite being asked on multiple occasions, that the patient was taking a body-building steroid, a substance that is contraindicated for the administration of any anesthetic agent. The Respondent also explained that he administered three anesthetic agents, each at 1/3 the dose, thus

offering patients the benefits of all three anesthetics without the side effects. Finally, the Respondent explained that he called 911 for the patient's transport to the hospital in order to offer expert assistance to the patient rather than attempt to triage the situation in the outpatient setting (plastic surgeon's office) where the patient experienced his medical complications.

The Hearing Committee found the Respondent's testimony compelling and credible. The Respondent has already met competency standards by virtue of his successful completion of an evaluation and removal of restrictions on his Florida license. The Hearing Committee determined the Respondent to be qualified and suitable for practice, without posing safety concerns to the public. While the Hearing Committee certainly did not condone the allegations in the Administrative Complaint which ultimately prompted the Final Order, the Respondent's testimony offered context to the situation. The Respondent recognized the danger of errors such as that which occurred with patient [redacted] even when, such as in this case, they are difficult to avoid. The Hearing Committee found the Respondent suitable for the practice of medicine. The Respondent accepted responsibility for administering the anesthetics to patient [redacted] and displayed competence and recognition of the need for careful attention to anesthesia administered. For these reasons, the Hearing Committee determined that the appropriate penalty in this case was a censure and reprimand on the Respondent's license.

ORDER

IT IS HEREBY ORDERED THAT:

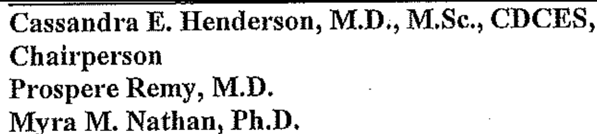
1. The charge of professional misconduct, as set forth in the Statement of Charges, is sustained.

2. A censure and reprimand is imposed on the Respondent's license pursuant to PHL § 230-a(1).

3. This Order shall be effective upon service on the Respondent in accordance with the requirements of PHL § 230(10)(h).

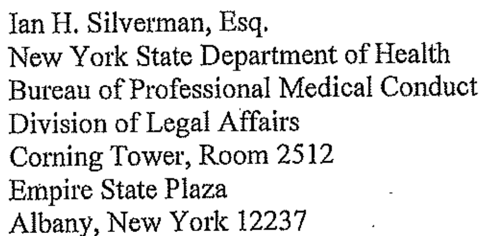
DATED: November 30, 2023

New York, New York



Cassandra E. Henderson, M.D., M.Sc., CDCES, Chairperson
Prospere Remy, M.D.
Myra M. Nathan, Ph.D.

To: Roger Gorman, M.D.



Ian H. Silverman, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Division of Legal Affairs
Corning Tower, Room 2512
Empire State Plaza
Albany, New York 12237

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

IN THE MATTER OF ROGER GORMAN, M.D.	STATEMENT OF CHARGES

ROGER GORMAN, M.D. the Respondent, was authorized to practice medicine in New York State on or about November 3, 1986, by the issuance of license number 168488 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about August 22, 2022, the Florida Board of Medicine (Florida Board) issued a Final Order accepting and approving a Settlement Agreement entered into between the Florida Board and the Respondent. The Settlement Agreement placed Respondent on probation until he undergo an evaluation by Florida Cares, Center for Personalized Education for Professionals (CPEP), the UC San Diego PACE program or other equivalent program pre-approved by the Board and personally appear before the Probation Committee with said evaluation and the evaluator's recommendation. If the evaluator recommends that Respondent undergo further evaluation for an impairment issue, such evaluation must be done under the auspices of the Professional Resource Network. Upon review of the evaluation, the Probation Committee shall set forth terms of remediation and may impose additional terms and conditions on Respondent's practice that may include, but are not limited to, a period of probation with said terms and conditions to be set at such time. Respondent shall not practice except under the direct supervision of a Board-Certified Anesthesiologist who has been approved by the Probation Committee. Respondent was required to document completion of CME courses within one year from the date the Final Order. Respondent was required to pay a $10,000 fine and $6,836.68 in reimbursement costs. The Florida Board's Final Order was based on Respondent's care and treatment of Patient [redacted] who presented for an outpatient facelift procedure. Respondent failed to titrate the proper anesthetic agents and dosages

required for Patient [redacted] during the procedure and/or failing to account for the possibility of hypotension in Patient [redacted] Respondent failed to adequately treat Patient [redacted]'s hypotension with appropriate vasopressors and/or fluid resuscitation. Respondent also failed to maintain legible medical records justifying the course of treatment of Patient [redacted] by failing to document justification for the use of three separate anesthetic agents. Respondent failed to document the anesthetic dosages for the Propofol and Precedex given to Patient [redacted] and/or failed to document Patient [redacted]'s urine output and fluids during the procedure. Respondent also failed to document Patient [redacted]'s end tidal CO2 levels at appropriate intervals.

B. Respondent's conduct as described above would, if committed in New York State, constitute professional misconduct under the laws of the State of New York as follows:

1. New York Education Law §6530 (3) (practicing the profession with negligence on more than one occasion) and/or
2. New York Education Law §6530 (32) (failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient).

SPECIFICATION OF CHARGES

HAVING HAD DISCIPLINARY ACTION TAKEN

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(9)(d) by having his or her license to practice medicine revoked, suspended or having other disciplinary action taken, or having his or her application for a license refused, revoked or suspended or having voluntarily or otherwise surrendered his or her license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or refusal, revocation or suspension of an application for a license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state (namely N.Y. Educ. Law § 6530 (24) as alleged in the facts of the following:

1.The facts in Paragraph A and B.

DATE: October 6 ,2023
Albany, New York

Jeffrey J. Conklin
Deputy Director
Bureau of Professional Medical Conduct