STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

May 1, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee Davis, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

Thomas Gerrowe, M.D.
226-4 Meadow Farm North
North Chili, New York 14514

RE: In the Matter of Thomas Gerrowe, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-129) 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER

OF

THOMAS GERROWE, M.D.

COPY

DECISION

AND

ORDER

BPMC-00-129

GEORGE C. SIMMONS, ED.D., Chairperson, **SHARON KURITZSKY, M.D.** and **JAMES O. ROBERSON, M.D.**, duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law.

TIMOTHY J. TROST, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After Consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	December 23, 1999
Pre-Hearing Conference:	February 4, 2000
Hearing Date:	February 4, 2000
Place:	Four Point Sheraton 120 East Main Street Rochester, New York

Date of Deliberation: February 4, 2000

Petitioner appeared by: Lee Davis, Esq.

Respondent did not appear in person or by counsel.

WITNESS

Eric Richard, M.D.

STATEMENT OF CHARGES

The Statement of Charges alleges that the Respondent is a physician without a license whose care and treatment of Patient A did not meet an acceptable standard in that he lied to the chief resident and the residency director in denying that he wrote a prescription for that patient; that in regard to Patient B, Respondent used inappropriate and unprofessional language; and as regards Patient C, Respondent failed to obtain or record an adequate medical history and improperly touched the patient's breast during an exam.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified. All exhibits with numbers are Petitioner exhibits. All exhibits with letters are Respondent's.

GENERAL FINDINGS OF FACT

AS TO THE RESPONDENT

1. Thomas Gerrowe, M.D., was authorized to practice medicine in New York State without a license from July 1, 1997 through June 30, 1998 pursuant to New York Education Law §6526.

2. Petitioner caused the Notice of Hearing, Statement of Charges and Department of Health Rules to be served by certified mail, pursuant to Public Health Law (PHL) §230(10)(d) (Ex. 3-a).

3. Pursuant to 10NYCRR §51.7, service of the Notice of Hearing, Statement of Charges and Summary of Department of Health Hearing Rules was effective on January 15, 2000, three days after mailing.

4. Personal service of the Notice of Hearing, Statement of Charges and Summary of Department of Health Hearing Rules could not be accomplished despite due diligent efforts, because of Respondent's intentional evasion of personal service (Ex. 2). On three separate occasions, Respondent refused to communicate with the process server, although the server was able to see Respondent look through the security "peep hole" of the apartment door (Ex. 2).

5. Petitioner effected four additional means of alternative service, including the affixing of the Notice of Hearing, Statement of Charges and Summary of Department of Health Hearing Rules upon the door of Respondent's residence after the process server identified himself, and stated his purpose for being at Respondent's residence (Exs. 3b-3e).

6. Respondent failed to appear for the hearing. Respondent failed to file an answer to the Statement of Charges.

PATIENT A – FINDINGS OF FACT

7. On September 18, 1997, at approximately 4:45 p.m., Respondent prescribed 50mg of Imitrex (Sumatriptan) for Patient A. (Ex. 5, p. 432) Imitrex was contraindicated for Patient A at the time Respondent prescribed said medication, for one such as Patient A who was suffering from a subarachnoid bleed (T-16). Martin Pfitzner, M.D., Chief Medical Resident at St. Mary's Hospital in September, 1997, learned of this physician's order from Patient A's attending physician (T-16). The Chief Medical Resident discussed the matter with Respondent, and informed him that Imitrex was contraindicated (T-20-21). Respondent told Dr. Pfitzner that someone else had told him to write the order, but he did not recall who (T-20-21).

8. After this conversation, Respondent approached Dr. Pfitzner indicating that he wanted to clarify the incident with Patient A (Ex. 10). Respondent gave Dr. Pfitzner a page from the physician's order sheet for Patient A. He told Dr. Pfitzner that after reviewing this document he recalled that the Imitrex was prescribed by a "Dr." Theoplidos (Ex. 10).

9. Dr. Pfitzner and Respondent proceeded to the floor to jointly review the medical record of Patient A (T-21, Ex. 10). Dr. Pfitzner then showed Respondent the order sheet containing Respondent's signature for the Imitrex order at 50mg, po (orally) x1, ordered at 16:45 (T-21; 37 Ex. 5, pg. 432; Ex. 10). The order shown to Dr. Pfitzner by Respondent containing the name of Theoplidos was written at 5:00 p.m. and was ordered 6mg, SQ x1 now, or 15 minutes after the order of Respondent (Ex. 5, pg. 436; Ex. 10). The order from Theoplidos at 5:00 p.m. was a verbal request to change the method by which the Imitrex

was to be administered to Patient A, because the pharmacy did not have the medication in the oral form, as ordered by Respondent (T-23-25). After reviewing the physician's order sheets in the presence of Dr. Pfitzner, Respondent acknowledged to Dr. Pfitzner that he had in fact written the order for Imitrex (T-21; 37 Ex. 10).

10. Respondent lied when he informed Dr. Pfitzner that someone told him to write the order. Respondent lied when he informed Dr. Pfitzner that "Dr." Theoplidos had prescribed the Imitrex for Patient A.

11. Eric Richard, M.D., Resident Program Director, spoke with Respondent regarding Respondent's prescribing of Imitrex to Patient A. This conversation took place approximately 2 to 3 weeks following the conversations between Respondent and Dr. Pfitzner (T-18, Ex. 9). Respondent told Dr. Richard that he did not order the Imitrex for Patient A and that his name had been forged on the Physician Order sheet (T-20, Ex.9). Dr. Richard then spoke with Dr. Pfitzner, who informed Dr. Richard that Respondent made similar denials to Dr. Pfitzner when first confronted about the Imitrex order (T-20-21, Ex.9)

12. Dr. Richard spoke with Respondent again, this time with the two order sheets, one possessing the signature of Respondent the other with the name of Theoplidos (T-25, Ex. 9). Respondent told Dr. Richard he did not know how his name got on the order sheet and that it was not his signature. When Dr. Richard replied it appeared to be Respondent's signature and that he had made similar denials to Dr. Pfitzner, Respondent stated words to the effect "if you told me that I wrote the order then I wrote the order" (T-25-26, Ex. 9). Dr. Richard testified that he recognized Respondent's signature, and that the signature on the order was Respondent's (T-23-24).

13. Dr. Richard explained that "Dr." Theoplidos was in fact a pharmacist at St. Mary's. It was the practice at the hospital at that time for the pharmacy to call the doctor who writes the order if the pharmacy did not have the medication in the form that was ordered, and

request permission to change the form to one that was available. That is what occurred in the different orders for Imitrex, initially ordered by Respondent at 4:45, and the oral order of Theoplidos at 5:00 (Ex. pp. 432, 436; T-24-25).

14. Respondent lied when he told Dr. Richard that he was not aware how his name got on the physician order sheet and that it must be forged. Respondent lied when he again stated that he did not know how his name got on the order sheet when shown a copy of the sheet.

PATIENT B

15. Respondent treated Patient B at St. Mary's Hospital on October 2 and/or 3, 1997 (Ex.16). While treating Patient B, Respondent spoke with the daughter and son-in-law of Patient B. Respondent failed to identify himself as an intern upon meeting the daughter of Patient B, leaving her with the impression that he was the attending physician of Patient B (T-31, Ex. 7). During the course of this conversation between Respondent and the daughter and son-in-law of Patient B, Respondent referred to himself on at least two occasions as a "representative of God" or words to that effect (T-31, Exs. 7 & 8).

16. Dr. Richard learned of the complaint of Patient B's daughter about Respondent from a member of the hospital administrative staff (T-29). Dr. Richard was at a conference the day the complaint was received, so R. Reddy, M.D., Chief Medical Resident, spoke with the family of Patient B (T-29). Dr. Reddy's conversation with Patient B's daughter confirmed the information the hospital staff had received (T-30, Ex. 8). In addition, the daughter of Patient B stated that she did not want Respondent to provide any further care for her mother based upon her interaction with Respondent (Ex. 9).

17. Patient B was hospitalized for approximately three (3) weeks at St. Mary's Hospital in October 1997 (Ex. 16). Patient B's daughter was with her mother virtually every day, for many hours each day. This allowed Patient B's daughter to interact with virtually every

person providing care to her mother. She never expressed any concern or complaint of any other care provider other than those against Respondent (T-50). The lack of complaints against any of the other care givers supports the credibility of Patient B's daughter regarding her complaints against Respondent (T-48-50).

PATIENT C

18. On October 22, 1997, Respondent treated Patient C at St. Mary's Hospital, Rochester, New York (T-38, Exs. 12 & 13). Respondent performed a history and physical examination of Patient C on October 22, 1997 (T-38, Exs. 11-13, 15).

19. The history and physical examination performed by Respondent on Patient C was part of Respondent's compulsory Clinical Evaluation Exercise (T-38, Ex. 13). A Clinical Evaluation Exercise is a history and physical examination performed by a resident under the supervision of an attending Internist, consistent with the standards established by the American Board of Internal Medicine. The Clinical Evaluation Exercise of Respondent was supervised and evaluated by Barbara Weber, M.D. (T-38, Exs. 11, 13, 15).

20. Respondent spent approximately 45 minutes attempting to elicit the patient's history. Despite this amount of time, he recorded very little useful information: approximately 5 lines in the chart (T-39, Ex. 12, p. 13). Respondent's recorded history of Patient C was below the minimum standard of care in that he failed to record adequate information (T-38-39, Exs. 11, 13, 15). Respondent failed to adequately question Patient C with respect to reporting complaints (T-39, Exs. 11, 13, 15). Respondent's questions were frequently closed-ended, not allowing Patient C to fully explain her complaints (T-39, Exs. 11, 13, 15).

21. Respondent's physical examination of Patient C was also below the minimum standard of care in that he inter alia physically removed Patient C's breast from her bra without warning to listen to her heart with his stethoscope (T-39-40, Exs. 11, 13, 15). When Respondent subsequently attempted to use the bell of the stethoscope to continue the

examination of Patient C's heart, he again attempted to physically handle her breast without request or warning. (Exs. 11, 13, 15). Patient C refused to allow Respondent to continue in such a fashion (Exs. 11 & 15).

22. Respondent was not receptive to the critique of Dr. Weber in the performance of his history and physical examination of Patient C (T-40, Exs.11 & 15). Respondent stated to Dr. Weber that the reason he did not perform portions of the physical examination consistent with her critique, was that he conducted the examination as instructed in Europe, implying that his method was the best way to perform the examination (T-40, Ex. 15).

23. During the course of Respondent's internship at St. Mary's Hospital, he was unreceptive to constructive criticism regarding his clinical techniques (T-43). Respondent also lacked honesty and responsibility for his actions (T-78-79).

CONCLUSIONS OF LAW

1. The Administrative Law Judge granted Petitioner's motion for a default judgment because Respondent did not appear at the hearing in this action in person or by counsel and failed to submit an answer to the charges although Respondent had ample notice of the charges and the hearing.

2. Therefore, the Statement of Charges and all specifications are deemed admitted.

3. There was ample documentary evidence and the testimony of Dr. Eric Richard to sustain the charges and specifications.

VOTE OF THE HEARING COMMITTEE

FIRST AND SECOND SPECIFICATIONS

(Practicing the profession fraudulently) SUSTAINED

THIRD SPECIFICATION

(Negligence on more than one occasion) SUSTAINED

FOURTH SPECIFICAION

(Incompetence on more than one occasion) SUSTAINED

FIFTH AND SIXTH SPECIFICATIONS

(Gross negligence) SUSTAINED

SEVETH SPECIFICATION

(Gross incompetence) SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE

Because Respondent is not a licensed physician in the state of New York, the penalties available are limited. Respondent should be censured and reprimanded pursuant to Public Health Law Section 230-a(1) for his professional actions with respect to patients in this matter.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent is issued a **CENSURE** and **REPRIMAND.**

2. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: 04-24-00, **New York**

_____, **2000**

George C. Simmons
GEORGE C. SIMMONS, Ed.D., Chairperson

SHARON KURITZSKY, M.D.
JAMES O. ROBERSON

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

---X

IN THE MATTER	:	NOTICE
OF	:	OF
THOMAS GERROWE, M.D.	:	HEARING

---X

TO: THOMAS GERROWE, M.D.

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 4th day of February, 2000, at 10:00 in the forenoon of that day at the Four Points Sheraton Inn at 120 East Main Street, Rochester, New York 14604 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), upon notice to the attorney for the Department of Health whose name

appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
December 23, 1999

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

LEE A. DAVIS
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

---X

IN THE MATTER	:	STATEMENT
OF	:	OF
THOMAS GERROWE, M.D.	:	CHARGES

---X

THOMAS GERROWE, M.D., the Respondent, was authorized to practice medicine in New York State without a license from July 1, 1997 to June 30, 1998, pursuant to New York Education Law § 6526.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached Appendix A), during an admission beginning on or about September 18, 1997 to St. Mary's Hospital, Rochester, New York. Respondent's care and treatment of Patient A did not meet acceptable standards of care in that:

1. Respondent fraudulently and/or inappropriately stated to the chief resident that he did not write an order for Imitrex for Patient A.

2. Respondent fraudulently and/or inappropriately stated to the residency director that he did not write an order for Imitrex for Patient A.

B. Respondent treated Patient B, during an admission beginning on or about October 2 or 3, 1997 to St. Mary's Hospital. Respondent's care and treatment of Patient B did not meet acceptable standards of care in that:

1. Respondent told Patient B's daughter and her husband that he was a "representative of God" or words to that effect.

C. Respondent treated Patient C at St. Mary's Hospital, Rochester, New York on or about October 22, 1997. Respondent's care and treatment of Patient C did not

meet acceptable standards of care in that:

1. Respondent failed to obtain or record an adequate history of Patient C.

2. For a portion of the cardiac examination, Respondent inappropriately and without warning to the patient, pulled her breast out of her brassiere.

SPECIFICATIONS OF MISCONDUCT

FIRST AND SECOND SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently within the meaning of New York Education Law § 6530(2), in that Petitioner charges:

1. The facts of paragraphs A and A.1.

2. The facts of paragraphs A and A.2.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of New York Education Law § 6530(3), in that Petitioner charges two or more of the following:

3. The facts of paragraphs A and A.1, A and A.2, B and B.1, C and C.1, and/or C and C.2.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion within the meaning of New York Education Law § 6530(5), in that Petitioner charges two or more of the following:

4. The facts of paragraphs B and B.1, C and C.1, and/or C and C.2.

FIFTH AND SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence within the meaning of New York Education Law § 6530(4), in that Petitioner charges:

5. The facts of paragraphs A and A.1, A and A.2

6. The facts of paragraphs B and B.1.

SEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence within the meaning of New York Education Law § 6530(6), in that Petitioner charges:

7. The facts of paragraphs B and B.1.

DATED: December 23, 1999
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct