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

IN THE MATTER

OF

ALEXANDER MATAS, M.D.

: SURRENDER ORDER
: BPMC # 98-192

DISTRICT OF COLUMBIA } ss.:

ALEXANDER MATAS. M.D., being duly sworn hereby deposes and says that:

On or about October 5, 1979, I was licensed to practice medicine as physician in the State of New York having been issued License No 140289 by the New York State Education Department.

My current address is 4124 Warren Street N.W., Washington, D.C. 20016 and I will advise the Director of the Office of Profession Medical Conduct of any change of my address.

I am not currently registered with the New York State Education Department to practice as a physician in the State of New York.

I understand that I have been charged with five specifications of professional misconduct as se forth in the Statement of Charges, annexed hereto , made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for an agreement to allow me to surrender my license as a physician in the State of New York and request that the Board issue this Surrender Order.

I hereby agree not to contest the allegations and five specifications set forth in the Statement of Charges (Exhibit "A").

I understand that, in the event that this proposed agreement is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such proposed agreement shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that in the event the State Board for Professional Medical Conduct agrees with my proposal, this Order shall be issued striking my name form the roster of physicians in the state of New York without further notice to me.

I am making this agreement of my own fee will and accord and not under duress, compulsion, or restraint of any kind or manner.

Alexander Matas M.D.
ALEXANDER MATAS, M.D.
[Respondent]

Subscribed before me this
29th day of July 1998.

Callen W. Bunty
NOTARY PUBLIC Expires 1/29/2000

AGREED TO:

Date: August 17, 1998

Peter D. Van Buren
Deputy Counsel Bureau of Professional
Medical Conduct

Date: August 18, 1998

Anne Saile
ANNE F. SAILE
Director, Office of Professional
Medical Conduct

ORDER

Upon the proposed agreement of ALEXANDER MATAS, M.D., to Surrender his license as a physician in the State of New York, which proposed agreement is made a part hereof, it is AGREED TO and

ORDERED, that the proposed agreement and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that this Order shall take effect as of the date of the personal service of this Order upon Respondent, upon mailing of this Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

DATED: 8/20/98

Patrick F. Carone, M.D.

PATRICK F. CARONE, M.D., M.P.H.
Chair
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
ALEXANDER L. MATAS, M.D.	:	CHARGES

_____X

ALEXANDER L. MATAS, M.D., the Respondent, was authorized to practice medicine in New York State on October 5, 1979, by the issuance of license number 140289 by the New York State Education Department to practice medicine and was last registered to practice medicine for the period ending February 28,1997, from 11 Cherry Street, Red Hook, New York 12571.

FACTUAL ALLEGATIONS

A. On or about January 29, 1990, Patient A , a nine month-old infant with history of shunt for hydrocephalus, presented at the Emergency Department at Community General Hospital of Sullivan County with complaints of cough, fever, diarrhea and a "bulging" soft spot.. The Respondent discharged Patient A and the patient

subsequently presented on January 31, 1990, at the Emergency Department of the Community General Hospital of Sullivan County with respiratory depression and was pronounced dead within thirty minutes of arrival.

1. On or about January 29, 1990, despite the presentation of the child with a "bulging" fontanel and a history of hydrocephalus, the Respondent failed to evaluate the signs and symptoms.

2. On or about January 29, 1990, the Respondent failed to evaluate and/or document the child's hydration status, a cough exhibited by the child, an appropriate evaluation of the respiratory status of the child, evaluation of the shunt, and/or an electrolyte abnormality.

3. On or about January 29, 1990, the Respondent failed to obtain a consult with an appropriate pediatrician.

4. On or about January 29, 1990, the Respondent prescribed Lomotil to this infant despite contraindications to prescribing to an infant less than two years of age..

5. On or about January 29, 1990, the Respondent prescribed Tigan despite its possible synergistic effect with Lomotil and/or also despite the child's age.

B. On or about October 15, 1991, Patient B, a fifty-eight year-old female, presented

at the Emergency Department at Community General Hospital of Sullivan County with complaints of difficulty in breathing, pain in the chest and a history of vomiting. Patient B was discharged by Respondent and returned on October 16, 1991, in cardiopulmonary arrest and was pronounced dead within fifteen minutes of her arrival.

1. Respondent failed to perform a sufficient evaluation pertinent to the presenting complaints of Patient B, including but not limited to a chest x-ray, cardiac enzyme study, and/or electrolyte study.

2. Respondent failed to perform or direct another to perform and/or document an adequate physical examination of Patient B.

3. Respondent failed to perform or direct another to perform an electrocardiogram upon Patient B.

4. The Respondent failed to appreciate and follow the patient in light of the abnormal laboratory date received, including but not limited to an elevated white count, elevated presence of glucose and ketones on urinalysis.

5. The Respondent failed to appreciate the hypothermia exhibited by the patient, particularly in light of the elevated white count.

6. The Respondent failed to admit Patient B to the hospital despite her presenting complaints and abnormal studies.

7. The Respondent failed to perform or direct another to perform arterial blood gas studies upon Patient B.

C. On or about October 2, 1990, Patient C, an eighty year-old male, presented to the Emergency Department of Community General Hospital of Sullivan County with a chief complaint of difficulty in breathing. The Respondent provided care and treatment to Patient C following his presentation.

1. The Respondent failed to respond appropriately to and treat Patient C's deteriorating condition which included increased respiratory rate, hypotension, shortness of breath, weakness, low hematocrit, metabolic acidosis and partially compensated respiratory alkalosis.

2. The Respondent failed to convey the seriousness of the patient's condition to Patient C's physician.

3. The Respondent failed to timely notify Patient C's primary care physician of the serious nature of the Patient's deteriorating condition.

D. On or about October 16, 1990, Patient D presented to the Emergency Department of Community General Hospital of Sullivan County with complaints of syncope.

1. The Respondent failed to elicit and/or document an adequate medical history of Patient D.

2. The Respondent should not have discharged the patient with Patient D's presenting symptoms.

3. The Respondent failed to appreciate the complaints and the medical history of Patient D in making a diagnosis.

4. The Respondent discharged Patient D without establishing a follow up visit with his private physician or recommending admission to the hospital.

5. The Respondent failed to perform a full neurologic examination of the Patient D.

E. On or about November 19,1990, Patient E, a fifty-eight year old male, presented at the Emergency Department of the Community General Hospital of Sullivan County with complaints of having a "mini stroke".

1. The Respondent failed to perform an appropriate and adequate neurologic

examination of Patient E.

2. The Respondent failed to order sufficient and appropiate tests for the diagnosis of Patient E's presenting symptoms which included slurred speech, weakness of the arms, and an elevated blood pressure.

3. The Respondent prematurely discharged Patient E.

F. On or about August 30, 1990, Patient F presented to the Emergency Department for the Community General Hospital of Sullivan County upon complaints of falling without loss of consciousness.

1. The Respondent failed to ascertain and/or document an adequate medical history of Patient F.

2. The Respondent failed to perform, direct another to perform, and/or failed to document a physical examination appropriate to the presenting complaints of the Patient F.

3. The Respondent failed to order cervical spine films of Patient F.

4. The Respondent failed to perform an/or document the performance of a neurologic examination appropriate to the complaints of the Patient F.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts in Paragraphs A and A(1), A and A(2), A and A(3), A and A(4), and/or A and A(5); B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), B and B(6), and/or B and B(7); C and C(1), C and C(2), C and C(3), and/or C and C(4); D and D(1), D and D(2), D and D(3), D and D(4), and/or D and D(5); E and E(1), E and E(2), and/or E and E(3); and/or F and F(1), F and F(2), F and F(3) and/or F and F(4).

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under the N.Y. Educ. Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges the following:

2. The facts in Paragraphs A and A(1), A and A(2), A and A(3), A and A(4), and/or A and

A(5); B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), B and B(6), and/or B and B(7); C and C(1), C and C(2), C and C(3), and/or C and C(4); D and D(1), D and D(2), D and D(3), D and D(4), and/or D and D(5); E and E(1), E and E(2), and/or E and E(3); and/or F and F(1), F and F(2), F and F(3) and/or F and F(4).

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges the following:

3. The facts in Paragraphs A and A(1), A and A(2), A and A(3), A and A(4), and/or A and A(5), B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), B and B(6), and/or B and B(7), C and C(1), C and C(2), C and C(3), and/or C and C(4), D and D(1), D and D(2), D and D(3), D and D(4), and/or D and D(5), E and E(1), E and E(2), and/or E and E(3), F and F(1), F and F(2), F and F(3) and/or F and F(4).

FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) by reason of his practicing the profession of medicine with incompetence on more than one occasion,

in that Petitioner charges:

4. The facts in Paragraphs A and A(1), A and A(2), A and A(3), A and A(4), and/or A and A(5), B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), B and B(6), and/or B and B(7), C and C(1), C and C(2), C and C(3), and/or C and C(4), D and D(1), D and D(2), D and D(3), D and D(4), and/or D and D(5), E and E(1), E and E(2), and/or E and E(3), F and F(1), F and F(2), F and F(3) and/or F and F(4).

FIFTH SPECIFICATION

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

5. The facts in Paragraphs A and A(2), B and B(2), C and C(1), D and D(1), F and F(1), F and F(2), and/or F and F(4).

Dated: August 17, 1998
Albany, New York

Peter D. Van Buren

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