STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

November 21, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael J. McTighe, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

Gregory O'Keefe, III, M.D.
Redacted Address

James Resila, Esq.
Carter, Conboy, Case, Blackmore
Napierski & Maloney, P.C.
20 Corporate Woods Boulevard
Albany, New York 12211

RE: In the Matter of Gregory O'Keefe, III, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-326) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either certified mail or in person to:

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

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

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

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

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

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

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

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

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

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

COPY

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

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
GREGORY O'KEEFE, III, M.D.	:	ORDER

BPMC-00-326

A Notice of Hearing and Statement of Charges, both dated November 16, 1999, were served upon the Respondent, Gregory O'Keefe, III, M.D.. **JOHN W. CHOATE, M.D. (CHAIR), PETER S. KOENIG, AND CALVIN J. SIMONS, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Michael J. McTighe, Esq., Senior Attorney. The Respondent appeared by Carter, Conboy, Case, Blackmore, Napierski & Maloney, P.C., James A. Resila, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CASE

Petitioner has charged Respondent, a physician who is board-certified in internal medicine, with six specifications of

professional misconduct. The charges relate to Respondent's medical care and treatment of nine patients. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. 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.

1. Gregory O'Keefe, III, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 195984 on June 10, 1994. (Pet. Ex. #2).

2. On November 29, 1999, Respondent was personally served with the Notice of Hearing, with copies of the

Statement of Charges and Health Hearing Rules Summary annexed thereto. (Pet. Ex. #1).

3. The administrative hearing on this matter was conducted over five days before a Hearing Committee of the State Board for Professional Medical Conduct on January 12, 2000, March 21, 2000, March 28, 2000, and April 10-11, 2000, at the offices of the Department of Health, 433 River Street, Troy, New York.

Patient A

4. Respondent was Patient A's primary care attending physician during the period August 21, 1997 to December 8, 1997 (Pet. Ex. #3, pp. 2-4).

5. Patient A was a 74 year-old female resident of Valley Health Services (hereinafter "VHS"), a subacute rehabilitation facility. (T. 188).

6. Patient A entered VHS for rehabilitation services after surgical treatment of a hip fracture on August 14, 1997. Her medical history included a stroke the previous year, hypertension, and atrial fibrillation (T. 188). Due to her atrial fibrillation and consequent risk for embolic stroke, Patient A was on long-term Coumadin therapy to reduce the risk of catastrophic disability or death. (T. 203-204, 206).

7. On September 16, 1997, Respondent performed two trigger point injections for the purpose of alleviating pain, one at the base of the posterior neck, and one into the posterior trapezial area. (T. 192, 194-195).

8. Respondent's aftercare plan provided for a routine chest x-ray evaluation for pneumothorax the day following the injections, and transport of the patient to an emergency room if she became symptomatic. (T. 195; Pet. Ex. #3, p. 70).

9. On the morning of September 17, 1997, Terri Vivyan, a radiological technologist, took a single AP standard wheelchair x-ray of the patient before she had obtained written requisition papers signed by Respondent specifying the need to rule out pneumothorax post trigger point injections. (T. 10-12, 22-25).

10. After she took the single AP x-ray, but before it was developed, Respondent entered the x-ray department and inquired of Ms. Vivyan what x-rays needed to be taken to visualize pneumothorax (t. 12); after Ms. Vivyan told him she would have to take a 2nd "expiratory" x-ray, Respondent ordered the 2nd "expiratory" x-ray, which Ms. Vivyan then took. (T. 12). At that point, Respondent filled out a requisition with clinical information on it specifying the need to rule out pneumothorax post trigger point injection. (T. 12-13).

11. After viewing the developed x-rays, and observing that they showed a pneumothorax, Respondent told Ms. Vivyan that he knew he had "hit" the patient's lung the prior evening. (T. 14-16).

12. When asked, Respondent stated that his planned response to the patient's condition was to wait and see whether his patient became symptomatic before ordering another x-ray evaluation or taking any other therapeutic action in response to his patient's condition. (T. 17, 27-28, 47-48, 63-64).

13. Lacking confidence in Respondent's clinical judgment, non-physician providers at the clinic contacted Dr. Ong and requested his intervention. (T. 39-43, 420-423).

14. Based on a consult with Dr. May, the on-call pulmonologist at the Bassett main campus in Cooperstown, Dr. Ong formed an opinion that Patient A should be seen at Bassett, in either the emergency room or the pulmonary clinic, in view of the fact that the patient was a frail, elderly nursing home resident at risk for acute respiratory distress. (T. 44-46, 48, 61-62, 63-64).

15. At the time he performed the injections, Respondent became aware that he had punctured Patient A's lung and caused a pneumothorax, or believed that it was likely that

the injection had caused a pneumothorax. (T. 15-16, 198-199; Pet. Ex. #3, p. 70).

16. The trigger point injection in the mid-posterior supraclavicular inner fossa area posed a risk of pneumothorax. (T. 52, 192-193; Pet. Ex. #3, p. 70).

17. The standard of care in these circumstances required the performance of chest x-rays shortly after performing trigger point injections of this nature, and also to assure availability of the appropriate personnel and equipment to deal with a possible pneumothorax. (T. 193-197, 202-203).

18. Due to her medical history and frail condition, Patient A required a heightened level of vigilance after performance of the trigger point injections. (T. 197).

19. Given Respondent's awareness of the fact or the likelihood that his patient had suffered a pneumothorax on the evening of September 16, 1997, he should have ordered immediate x-ray evaluation of the patient. (T. 198-199).

20. Patient A was receiving a regimen of Coumadin anti-coagulation therapy, with an INR marker range of 2 to 3 deemed therapeutic. (T. 188, 203-204).

21. Sub-therapeutic INR's indicate a heightened risk for embolic stroke. (T. 206).

22. Respondent performed appropriate tests of Patient A's coagulation status. However, these test results showed sub-therapeutic levels of Coumadin in the patient's system, with the exception of a brief period in October, 1997. (T. 205-211).

23. Respondent did not address the sub-therapeutic Coumadin levels. This failure placed the patient at a greater risk of embolic stroke due to her history of atrial fibrillation. (T. 211).

24. Serum Digoxin test laboratory values of 0.5 on August 22, 1997, and 0.6 on September 27, 1997 were sub-therapeutic, and the patient's medication dosage should have been adjusted upwards. Respondent failed to do so. (T. 212-213).

25. Respondent incorrectly interpreted Patient A's August 22, 1997 thyroid stimulating hormone (TSH) test results. As a result, Patient A did not begin thyroid replacement therapy until December 1, 1997, when her cardiologist intervened in her care. (T. 190, 214-218).

Patient B

26. Respondent believed that this patient was in congestive heart failure. (T. 82-83, 86; Pet. Ex. #5, p. 134).

27. Respondent's clinical evaluation of the patient was incorrect since the patient was not in left ventricular heart failure. (T. 85-86, 101-102).

28. Respondent prescribed Carvedilol for Patient B. Carvedilol is reserved for NYSHA Class II and III heart failure. (T. 87, 101, 307; Pet. Ex. #5).

29. Patient B had advanced lung disease of the asthmatic obstructive type, had been on bronchodilators, and exhibited elevated pulmonary pressures. (T. 86-87).

30. The use of Carvedilol was contraindicated since the patient did not have Class II or III congestive heart failure. The use of the drug was also contraindicated by the patient's bronchospastic pulmonary disease. (T. 87, 107).

31. The use of Carvedilol was dangerous in the clinical circumstances presented by this patient. (T. 87-88).

32. Respondent did not consult a cardiologist before prescribing Carvedilol for Patient B. (T. 92).

33. Respondent's failure to obtain a cardiology consult was a deviation from the standard of, given his lack of experience with Carvedilol. (T. 92).

34. Respondent placed Patient B on Rezulin to improve control of the patient's diabetes. (T. 236).

35. Rezulin was a new drug on the market at the time. Few internists were prescribing Rezulin without the guidance of an endocrinologist. (T. 238-240, 242).

36. Rezulin was a second-line medication for the treatment of diabetes, meant to be used after more conservative, and less risky options had been tried. (T. 238, 240).

37. Respondent did not try other first line therapeutic options before commencing use of Rezulin. (T. 238).

38. Respondent did not obtain an endocrinology consult prior to prescribing Rezulin for Patient B. (T. 242-243).

Patient C

39. Respondent believed that Patient C was suffering from congestive heart failure. Respondent was incorrect. (T. 109-112, 118).

40. Patient C had pulmonary fibrosis and smoking-related emphysema. (T. 133-114).

41. Respondent prescribed Carvedilol for Patient C. The use of Carvedilol was contraindicated by the patient's condition, and potentially dangerous. (T. 114, 116-117).

42. Respondent did not consult a cardiologist before initiating Carvedilol therapy for Patient C. This was a deviation in the standard of care. (T. 117-119).

Patient D

43. Respondent's August 23, 1996 decision to prescribe Monopril for Patient D was appropriate. (T. 125). However, initiation of Monopril therapy created the need to follow the patient's potassium levels and renal function. (T. 125, 127).

44. Beginning on September 11, 1996 there were clear indications of renal insufficiency. Beginning on December 5, 1996, potassium levels were trending upwards into abnormal levels, indicating progressive potassium retention. (T. 128-130; Pet. Ex. #7).

45. Respondent failed to adopt effective measures to follow and address his patient's abnormal potassium test on February 27, 1997. (T. 130, 331-332).

46. Respondent failed to address Patient D's hyperkalemia during the period March 12, 1997 through July 7, 1997. (T. 132-133).

47. Respondent did not document any compliance or communications difficulties during this period. (Pet. Ex. #7).

Patient E

48. Respondent ordered a diagnostic test designed to detect an acute human parvovirus infection for Patient D. The test was administered on July 17, 1996. (T. 139-140; Pet. Ex. #8).

49. Respondent incorrectly interpreted the test results as indicating an acute infection in Patient D. Respondent compounded his error by electing to treat Patient D with multiple administrations of intravenous immunoglobulin. (T. 139-140, 142-143).

Patient F

50. On September 12, 1996, Respondent administered an ACTH or cosyntropin stimulation test for adrenal insufficiency to Patient F. The results were within normal limits. (T. 153-154, 159-160).

51. It is questionable whether there were sufficient presenting clinical indications of Addison's disease which would justify the performance of the ACTH stimulation test for this patient. (T. 154, 156).

52. Respondent misinterpreted the ACTH test results, and diagnosed Patient F as suffering from Addison's disease. Respondent treated the patient's presumed Addison's by prescribing cortisone acetate 25 mg twice a day. (T. 157).

53. Respondent's misinterpretation of the ACTH test and prescription of cortisone acetate for Patient F was a deviation from the standard of care. (T. 156-158, 162).

54. On September 12, 1996, Respondent also administered a serum ferritin test for Patient F. Respondent misinterpreted the test result, incorrectly diagnosing a iron deficiency. (T. 161-162).

Patient G

55. On November 7, 1995, Respondent administered an ACTH stimulation test to Patient G, and the results were normal. (T. 250-251).

56. Respondent misinterpreted the results of the test, and diagnosed Patient G with Addison's disease. (T. 251-252).

57. Respondent elected to treat the patient with cortisone acetate 25 mg twice a day. (T. 252).

58. Respondent's misinterpretation of the ACTH test and prescription of cortisone acetate for Patient G was a deviation from the standard of care. (T. 252-253).

Patient H

59. On November 27, 1995, Respondent administered an ACTH stimulation test to Patient H, and the results were within normal limits. (T. 264-265).

60. Respondent misinterpreted the test results and diagnosed the patient with Addison's disease. (T. 265).

61. Respondent elected to treat the patient by prescribing cortisone acetate 25 mg twice a day. (T. 268).

62. Respondent's misinterpretation of the ACTH test and prescription of cortisone acetate for Patient H was a deviation from the standard of care. (T. T. 266-269).

Patient I

63. On October 21, 1996, Respondent administered an ACTH stimulation test to Patient I, and the results were within normal limits. (T. 167-169).

64. Respondent misinterpreted the test results and diagnosed the patient as having Addison's disease. (T. 268-269).

65. Respondent elected to treat the patient by prescribing cortisone acetate 25 mg twice a day. (T. 269).

66. Respondent's misinterpretation of the ACTH test and prescription of cortisone acetate for Patient I was a deviation from the standard of care. (T. 269-270).

CONCLUSIONS OF LAW

Respondent is charged with six specifications alleging professional misconduct within the meaning of Education Law

§6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg, Esq., then General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is sole to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation

from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. Petitioner presented two fact witnesses (Terri Lyn Vivyan and Ferdo R. Ong, M.D.), and two experts (Michael E.

McGrath, M.D. and Irene S. Snow, M.D.). Respondent presented the expert testimony of Kirk R. Panneton, M.D., and also testified on his own behalf.

Ms. Vivyan was the x-ray technician who took the x-rays regarding Patient A's pneumothorax. The Hearing Committee found her testimony as to her interactions with Respondent on the dates in question to be forthright and believable. Similarly, Dr. Ong, a former colleague of Respondent's, gave direct and credible testimony about his interactions with Respondent.

Petitioner also presented the testimony of Michael E. McGrath, M.D. and Irene S. Snow, M.D. Both are board-certified in internal medicine. Neither has any stake in the outcome of this case, and testified in a forthright manner. The Hearing Committee, after hearing and evaluating their testimony, found it to be credible, and gave great weight to their opinions regarding Respondent's treatment of the patient's in question.

Respondent presented the testimony of Kirk R. Panneton, M.D. Dr. Panneton is also board-certified in internal medicine, as well as in geriatrics. Although he testified on Respondent's behalf, in many respects his testimony was in essential agreement with the opinions expressed by Drs. McGrath and Snow.

Respondent also testified on his own behalf. He has an obvious stake in the outcome of the case. His testimony demonstrated a tendency to blame others (physician colleagues, non-physician staff) for his problems, rather than any deficiencies on his own part.

Patient A

Respondent was the primary care physician during the period August 21, 1997 to December 8, 1997. At the time, Patient A was a 74 year-old resident of Valley Health Services, a subacute rehabilitation facility. She entered the facility for rehabilitation services after surgical treatment of a hip fracture. Her medical history included a stroke the previous year, hypertension and atrial fibrillation. On the evening of September 16, 1997, Respondent performed two trigger point injections to relieve the patient's arthritic pain. One injection was placed at the base of the posterior neck, and one into the posterior trapezial area.

Respondent's aftercare plan provided for a routine chest x-ray evaluation for pneumothorax the day following the injections, and transport of the patient to an emergency room if she became symptomatic. The next day, an x-ray revealed that the patient had developed a pneumothorax. Respondent told Ms. Vivyan, the radiological technologist, that he knew that he

"hit" the patient's lung the prior evening. When Ms. Vivyan asked him what his treatment plan for the patient was, Respondent told her that he would wait to see whether the patient became symptomatic before taking any further therapeutic action.

Respondent's treatment of Patient A's pneumothorax constituted a particularly serious deviation from the standards of care. The standard of care required the performance of chest x-rays shortly after the injections. Given Respondent's awareness of the fact that he had "hit" the patient's lung, he should have ordered an immediate x-ray evaluation of the patient. Further, given the patient's frail condition, upon confirmation of the pneumothorax, Respondent should have transported the patient to the hospital for further evaluation and/or treatment.

Respondent's failure to apprehend the seriousness of Patient A's condition, placed the patient in danger. The Hearing Committee unanimously concluded that Respondent's treatment of Patient A's pneumothorax constituted both negligence and incompetence. Moreover, the Committee further concluded that Respondent's actions were of such an egregious nature as to constitute gross negligence and gross incompetence, as defined above. Accordingly, the Hearing Committee voted to

sustain the First through Fourth Specifications of professional misconduct set forth in the Statement of Charges.

Patient A received Coumadin, due to her atrial fibrillation, and attendant risk of embolic stroke. The patient's systemic Coumadin levels were measured by the INR marker. An INR value of 2 to 3 is considered to be a therapeutic level of the medication. Coumadin levels below 2 indicate a heightened risk for embolic stroke.

Respondent performed appropriate tests of Patient A's coagulation status. However, when the tests showed sub-therapeutic levels of Coumadin, Respondent took no action. This value to recognize the low levels, and increase the patient's Coumadin dosage place the patient at increased risk of embolic stroke. The Committee concluded that this failure constituted both negligence and incompetence.

Patient A was also receiving Digoxin. Despite laboratory values which demonstrated that the patient's Digoxin levels were sub-therapeutic on August 22, 1997 and September 28, 1997, Respondent failed to respond by increasing her Digoxin dosage. Similarly, Respondent failed to correctly interpret Patient A's August 22, 1997 thyroid stimulating hormone (TSH) test results. Consequently, the patient did not begin thyroid

replacement therapy until her cardiologist intervened in her care in December, 1997.

The Hearing Committee concluded that Respondent's failure to appropriately address the patient's Digoxin and thyroid levels constituted both negligence and incompetence.

Patient B

Respondent provided medical care to Patient B commencing on January 27, 1997. Patient B suffered from multiple medical conditions, including chronic obstructive pulmonary disease ("COPD"), Type II diabetes, chronic renal insufficiency, atrial fibrillation, coronary artery disease and angina.

Respondent diagnosed Patient B as also suffering from congestive heart failure. This diagnosis was incorrect, as the patient was not experiencing left ventricular heart failure. Nevertheless, Respondent prescribed Carvedilol for Patient B. Carvedilol is a medication whose use is reserved for NYSHA Class II and III heart failure. Respondent did not have a good deal of clinical experience with Carvedilol before prescribing it for this patient. Consequently, Respondent should have obtained a cardiology consultation before putting Patient B on the drug. Had he done so, Respondent would have learned that the use of Carvedilol was directly contraindicated for Patient B, because

of his bronchospastic pulmonary disease. By prescribing Carvedilol for Patient B, Respondent placed the patient in danger. The Hearing Committee concluded that Respondent's treatment of Patient B with Carvedilol demonstrated negligence and incompetence.

Respondent also prescribed Rezulin for Patient B, in an attempt to improve control of the patient's Type II diabetes. Rezulin was a new drug on the market at the time. It was considered a second-line medication for the treatment of diabetes, meant to be used after more conservative options had been tried. Respondent did not try other first line therapeutic options for Patient B before prescribing Rezulin, nor did he obtain an endocrinology consultation. This was a significant error in judgement. The Committee concluded that Respondent's use of Rezulin for Patient B also demonstrated negligence and incompetence.

Patient C

Respondent also provided medical care to Patient C commencing on August 29, 1997. Patient C suffered from rheumatoid arthritis, COPD, primary pulmonary hypertension, pulmonary fibrosis, and had previously experienced pulmonary emboli.

Respondent diagnosed the patient as suffering from congestive heart failure, and prescribed Carvedilol. As with Patient B, this diagnosis was incorrect. Moreover, the use of Carvedilol was contraindicated by the patient's pre-existing pulmonary condition. The Hearing Committee unanimously concluded that Respondent's treatment of Patient C with Carvedilol (Factual Allegation C.1), and his failure to obtain a cardiology consultation prior to instituting the therapy (Factual Allegation C.2), demonstrated both negligence and incompetence. No proof was presented regarding Factual Allegation C.3, so the Hearing Committee did not sustain this allegation.

Patient D

Patient D was a Type II diabetic with multiple complications, including diabetic retinopathy and circulatory complications which had resulted in a right below-the-knee amputation in 1994. On August 23, 1996, Respondent appropriately prescribed Monopril for Patient D. The initiation of Monopril therapy created the need to monitor the patient's potassium levels and renal function. Beginning on September 11, 1996 there were clear indications that the patient was experiencing renal insufficiency. Beginning on December 5,

1996, the patient's potassium levels were trending upward into abnormal levels, indicating progressive potassium retention.

Respondent failed to adopt effective measures to follow and address Patient D's developing hyperkalemia during the period March 12, 1997 through July 7, 1997. Having started Patient D on a course of treatment, it was incumbent upon Respondent to appropriately monitor him, and to follow up on abnormal laboratory values. Respondent's failure to address the patient's hyperkalemia for nearly four months was inexcusable. At hearing, Respondent claimed that the patient did not respond to requests to return to the office. If that were the case, it was incumbent upon Respondent to document his efforts to contact the patient and the response to those efforts. In the absence of such evidence, the Hearing Committee concluded that Respondent's conduct regarding Patient D demonstrated both negligence and incompetence, as defined above.

Patient E

On July 22, 1996, Respondent ordered a diagnostic test to determine whether Patient E, a farmer, was suffering from an acute Parvovirus infection. The test results indicated the absence of an acute infection. Respondent incorrectly interpreted the test as showing the presence of an acute infection. He then began treating the patient with a series of

intravenous immunoglobulin injections. The Hearing Committee concluded that Respondent's treatment of Patient E constituted both negligence and incompetence, as defined above. Respondent was also charged with failing to obtain a timely rheumatology consult for Patient E. Although it was apparent that the patient had some type of arthritic condition, it is not clear that a consultation was indicated. A reasonably prudent and competent internist would not necessarily refer a patient to a specialist for routine arthritic changes. Accordingly, the Committee did not sustain the factual allegation (E.3) relating to this charge.

Patients F, G, H and I

Respondent administered an ACTH or cosyntropin stimulation test to each of Patients F, G, H and I, in order to test them for adrenal insufficiency. In each case, the test results were within normal limits. Notwithstanding the test results, Respondent erroneously diagnosed each of the four patients as having Addison's disease. In each case, Respondent then began prescribing a course of cortisone acetate, 25 mg, twice a day. The Hearing Committee concluded that Respondent's failure to accurately interpret the test results and avoid unnecessary medications demonstrated both negligence and incompetence.

Respondent also performed a ferritin blood test on Patient F. The test results were within normal limits. Respondent incorrectly interpreted the results as abnormal, and prescribed ferrous sulfate for the patient. The Committee concluded that, while a relatively minor deviation from standards of care, this misdiagnosis also demonstrated negligence and incompetence.

Petitioner also charged Respondent with a failure to obtain endocrinology consultations before beginning cortisone treatments. The Committee decided not to sustain these allegations. Had the diagnoses of Addison's disease been correct, it would have been within the purview of a general internal medicine physician to treat the condition. Petitioner further charged Respondent with failing to evaluate and/or address Patient H's acute adrenal insufficiency on or about March 20, 1996. (Factual Allegation H.4). However, the records indicate that Patient H was hospitalized at the time, and not under Respondent's care. Therefore, this allegation was not sustained.

As noted previously, the Hearing Committee concluded that Respondent's medical care and treatment of Patients A through I, inclusive, demonstrated both negligence and

incompetence. As a result, the Committee voted to sustain the Fifth Specification (negligence on more than one occasion), and the Sixth Specification (incompetence on more than one occasion).

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The record in this case demonstrated that Respondent has fundamental and pervasive deficiencies in his medical knowledge and judgement. By failing to appropriately address Patient A's pneumothorax, Respondent put the patient at serious risk. Indeed, in virtually all of the cases at issue, there was a striking discontinuity between the good workups performed by Respondent, and the poor judgements which then followed. Moreover, Respondent failed to correctly interpret a wide range of laboratory tests, and thereby failed to appropriately prescribe medications for his patients.

Where a physician demonstrates serious deficiencies in his or her medical skill or knowledge, a mere period of suspension or probation would not be of value. The Hearing Committee gave strong consideration to the possibility of remedial training in this case. Given the breadth and depth of Respondent's deficiencies, any such re-training would need to be on the level of a complete residency program. However, the Committee was of the unanimous opinion that Respondent has little insight into his problems. He persisted in blaming his colleagues for his problems. When he was asked how he might correct his deficiencies, Respondent could only suggest a lessened reluctance to obtain specialist consultations. Consequently, the Hearing Committee determined that re-training was not a viable option.

The Hearing Committee does not doubt that Respondent is a caring physician who tried to help his patients. Nevertheless, the people of the State of New York are not well-served by a physician with such serious deficiencies in his medical skills and judgement. Under the totality of the circumstances, the Hearing Committee unanimously determined that revocation was the only sanction which would adequately protect the public.

ORDER

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

1. The First through Sixth Specifications of professional misconduct, as set forth in the Statement of Charges, (Petitioner's Exhibit #1) are **SUSTAINED**;

2. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order;

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's 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: Troy, New York
20 **November ,2000**

Redacted Signature

JOHN W. CHOATE, M.D. (CHAIR)

PETER S. KOENIG
CALVIN J. SIMONS, M.D.

TO: Michael J. McTighe, Esq.
Senior Attorney
New York State Department of Health
Corning Tower Building - Room 2509
Empire State Plaza
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20 Corporate Woods Boulevard
Albany, New York 12211

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	**NOTICE**
OF	:	**OF**
GREGORY O'KEEFE, M.D.	:	**HEARING**

TO: GREGORY O'KEEFE, M.D.
Redacted Address

GREGORY O'KEEFE, M.D.
Little Falls Hospital -
Primary Care Center at Herkimer
201 East State Street
Herkimer, NY 13350
(315) 866-7248

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 commencing at 10:00 a.m. on the 12th day of January, 2000, at the Holiday Inn ("Presidential Room"), 1777 Burrstone Road, Utica, New York 13413 (telephone 315-797-2131), and 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
November 16, 1999

Redacted Signature

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

Inquiries should be directed to:

MICHAEL J. McTIGHE
Senior Attorney
Bureau of Professional
Medical Conduct
Corning Tower Room 2585
Empire State Plaza
Albany, New York 12237-0029
(518) 474-5168

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
GREGORY O'KEEFE, III, M.D.	:	CHARGES

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GREGORY O'KEEFE, III, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 10, 1994, by the issuance of license number 195984 by the New York State Education Department. Respondent is currently registered with the New York State Education Department, and has a residential address at Redacted Address

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the Appendix) commencing on or about August 13, 1997, at Valley Health Services, Inc. and/or Bassett Healthcare Herkimer, in Herkimer, New York. Respondent performed two trigger point injections on or about September 16, 1997, to address Patient A's complaint of arthritic neck pain. Due to a medical history of atrial fibrillation, Patient A was on Coumadin anticoagulation therapy. Respondent's medical care of Patient A deviated from accepted standards of medical care in the following respects:

1. Despite potential risk of pneumothorax, Respondent failed to make provision for a chest x-ray immediately following performance of the trigger point injections.

2. Respondent failed to respond timely and/or appropriately to the sizable right apical pneumothorax suffered by Patient A as a direct result of the trigger point injections.

3. Respondent failed to make timely and/or appropriate adjustments in Patient's A's anti-coagulation therapy despite PT/INR testing which showed that Patient A's INR was in the sub-therapeutic range on multiple occasions in the period between August 13, 1997 and December 8, 1997.

4. Despite digoxin testing which showed that digoxin levels were sub-therapeutic on August 22, 1997, and/or September 28, 1997, Respondent failed to make timely adjustments in Patient A's medication to achieve a therapeutic dose.

5. Respondent's interpretation of Patient A's elevated TSH test on August 22, 1997, was incorrect.

6. Respondent failed to order timely thyroid replacement therapy for Patient A's hypothyroidism after tests on August 22, 1997.

B. Respondent provided medical care to Patient B commencing on or about January 27, 1997, at Bassett Healthcare Herkimer, in Herkimer, New York. Patient B's problems included COPD, type II noninsulin dependent diabetes, chronic renal insufficiency, atrial fibrillation, and inoperable coronary artery disease which led to recurrent angina. Respondent's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent's order to commence use of Rezulin on June 27, 1997, was inappropriate in the clinical circumstances.

2. Respondent's failure to consider stopping administration of prednisone prior to commencing use of Rezulin was inappropriate.

3. Respondent's use of Carvedilol was inappropriate. in the clinical circumstances.

4. Respondent failed to obtain a timely Cardiology consult.

C. Respondent provided medical care to Patient C commencing on or about August 29, 1997, at Bassett Healthcare Herkimer, in Herkimer, New York. Patient C's diagnoses included rheumatoid arthritis, COPD, primary pulmonary hypertension, status post pulmonary emboli (12/96), and pulmonary fibrosis felt to be secondary to gold therapy for rheumatoid arthritis. Respondent's medical care of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent's use of Carvedilol was inappropriate and/or contraindicated.

2. Respondent failed to obtain a Cardiology consult prior to ordering use of Carvedilol.

3. Respondent failed to order use of a diuretic prior to commencing use of Carvedilol.

D. Respondent provided medical care to Patient D commencing on or about August 23, 1996, at Bassett Healthcare Herkimer, in Herkimer, New York. Patient D presented as a Type II adult-onset diabetic with significant complications including severe diabetic retinopathy and circulatory complications which had resulted in a right below-the-knee amputation in 1994. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to obtain timely laboratory tests of Patient D's potassium after starting Patient D on Monopril, despite indications of underlying renal insufficiency and/or peripheral vascular disease.

2. Respondent did not address Patient D's hyperkalemia in a timely and/or appropriate manner in the period October 17, 1996 through July 3, 1997.

E. Respondent provided medical care to Patient E commencing on or about July 3, 1996, at Bassett Healthcare Herkimer, in Herkimer, New York. Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent's interpretation of Patient E's test for human Parvovirus performed on July 22, 1996, was incorrect.

2. Respondent's order to administer serum gammaglobulin to treat the misdiagnosed human Parvovirus was inappropriate.

3. Respondent failed to obtain a timely Rheumatology consult.

F. Respondent provided medical care to Patient F commencing on July 17, 1996, at Bassett Healthcare Herkimer, in Herkimer, New York. Patient F's medical problems included hypothyroidism, obesity (height 5'3" weight 192 lbs. on 7/17/96), and borderline hypertension (blood pressure was 130/90 on 7/17/96). Patient F's hemoglobin was 15.1 on 7/17/96. Respondent's medical care of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent's interpretation of Patient F's Cosyntropin stimulation test performed on September 12, 1996, was incorrect.

2. Respondent's prescription order of cortisone 25 mg b.i.d. was inappropriate.

3. Respondent failed to obtain an Endocrinology consult before initiating steroid treatment.

4. Respondent's interpretation of Patient F's ferritin blood test on September 12, 1996, was incorrect.

5. Respondent's prescription of ferrous sulfate was inappropriate.

G. Respondent provided medical care to Patient G commencing on or about November 28, 1994, at Bassett Healthcare Herkimer, in Herkimer, New York. On October 31, 1995, Respondent noted a complaint of lightheadedness reported by Patient G. Respondent's medical care of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent's interpretation of Patient G's Cosyntropin stimulation test performed on November 7, 1995, was incorrect.

2. Respondent's prescription order of cortisone 25 mg b.i.d. was inappropriate.

3. Respondent failed to obtain an Endocrinology consult before initiating steroid treatment.

H. Respondent provided medical care to Patient H commencing on or about November 9, 1995, at Valley Health Services, in Herkimer, New York. Respondent's medical care of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent's interpretation of Patient H's Cosyntropin stimulation test performed on November 27, 1995, was incorrect.

2. Respondent's prescription order of hydrocortisone 25 mg p.o. b.i.d. was inappropriate.

3. Respondent failed to obtain an Endocrinology consult before initiating steroid treatment.

4. Respondent failed to evaluate and/or address an episode of acute adrenal insufficiency suffered by Patient H on or about March 20, 1996.

I. Respondent provided medical care to Patient I commencing on or about May 6, 1996, at Bassett Healthcare Herkimer, in Herkimer, New York. Respondent's medical care of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent's interpretation of Patient I's Cosyntropin stimulation test performed on October 2, 1996, was incorrect.

2. Respondent's prescription order of cortisone 25 mg b.i.d. was inappropriate.

3. Respondent failed to obtain an Endocrinology consult before initiating steroid treatment.

SPECIFICATIONS

FIRST AND SECOND SPECIFICATIONS

(Gross Negligence)

Respondent is charged with professional misconduct as defined by N.Y.Educ.Law Sec. 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 set forth in Paragraphs A and A-1.

2. The facts set forth in Paragraphs A and A-2.

THIRD AND FOURTH SPECIFICATIONS

(Gross Incompetence)

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

3. The facts set forth in Paragraphs A and A-1.

4. The facts set forth in Paragraphs A and A-2.

FIFTH SPECIFICATION

(Negligence On More Than One Occasion)

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

5. The facts set forth in Paragraphs A and A-1, &/or A and A-2, &/or A and A-3, &/or A and A-4, &/or A and A-5, &/or A and A-6, &/or B and B-1, &/or B and B-2, &/or B and B-3, &/or B and B-4, &/or C and C-1, &/or C and C-2, &/or C and C-3, &/or D and D-1, &/or D and D-2, &/or E and E-1, &/or E and E-2, &/or E and E-3, &/or F and F-1, &/or F and F-2, &/or F and F-3, &/or F and F-4, &/or F and F-5, &/or G and G-1, &/or G and G-2, &/or G and G-3, &/or H and H-1, &/or H and H-2, &/or H and H-3, &/or H and H-4, &/or I and I-1, &/or I and I-2, &/or I and I-3.

SIXTH SPECIFICATION

(Incompetence On More Than One Occasion)

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

6. The facts set forth in Paragraphs A and A-1, &/or A and A-2, &/or A and A-3, &/or A and A-4, &/or A and A-5, &/or A and A-6, &/or B and B-1,. &/or B and B-2, &/or B and B-3, &/or B and B-4, &/or C and C-1, &/or C and C-2, &/or C and C-3, &/or D and D-1, &/or D and D-2, &/or E and E-1, &/or E and E-2, &/or E and E-3, &/or F and F-1, &/or F and F-2, &/or F and F-3, &/or F and F-4, &/or F and F-5, &/or G and G-1, &/or G and G-2, &/or G and G-3, &/or H and H-1, &/or H and H-2, &/or H and H-3, &/or H and H-4, &/or I and I-1, &/or I and I-2, &/or I and I-3.

DATED: November 16, 1999
Albany, NY

Redacted Signature

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