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

May 13, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael Hiser, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237

Joseph McCarthy, Esq.
1620 Liberty Building
420 Main Street
Buffalo, New York 14202

Jorge M. Pardo, M.D.
2777 Harlem Road
Cheektowaga, New York 14225

RE: In the Matter of Jorge M. Pardo, M.D.

Dear Parties:

Enclosed please find the Corrected and Revised Determination and Order (No. 02-137) of the Hearing Committee in the above referenced matter. Please discard the previous Determination and Order you have received. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

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IN THE MATTER

OF

JORGE M. PARDO, M.D.

DETERMINATION

AND

ORDER

----------X

BPMC-02-137

STEPHEN V. GRABIEC, M.D., Chairperson, **SANDRA L. WILLIAMS, R.N.** and **STEVEN M. LAPIDUS, M.D.**, duly designated members of the State Board for 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 THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	July 26, 2001
Pre-Hearing Conference:	August 21, 2001
Hearing Dates:	August 22, 2001 January 28, 2002 January 29, 2002 March 19, 2002 March 20, 2002
Place of Hearing:	Airport Radisson Buffalo, NY 14225
Date of Deliberation:	March 20, 2002
Petitioner appeared by:	Michael Hiser, Esq. Assoc. Counsel OPMC Corning Tower, ESP Albany, NY 12237
Respondent appeared by:	Joseph McCarthy, Esq. 1620 Liberty Building 420 Main Street Buffalo, NY 14202

WITNESSES

For the Petitioner:	Joseph Saliponte, M.D. (T. 18-405, 8/22/01, 1/28/02)
	Marlene Kraft (T. 415-436, 1/29/02)
For the Respondent:	Paresh Dandona, M.D., Ph.D. (T. 447-576, 3/19/02)
	Respondent, Jorge M. Pardo, M.D. (T. 578-671, 3/19/02)

STATEMENT OF CHARGES

By Statement of Charges dated July 26, 2001, the NYS Department of Health, Office of Professional Medical Conduct (OPMC) charged Jorge Pardo, M.D. (Respondent) with twelve specifications of professional misconduct. The charges included gross negligence and gross incompetence, negligence and incompetence on more than one occasion, fraud in the practice of medicine, moral unfitness, willfully making and filing a false report, and poor records.

INSTRUCTIONS TO COMMITTEE

The definitions of misconduct used in this case are those set out in the Memorandum from Health Department General Counsel Henry Greenberg dated November 25, 1999. This Memorandum provides as follows:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is negligence that is egregious. That is, it is negligence, which involves serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is lack of the skill or knowledge necessary to practice the profession that is significantly or seriously substandard and poses potentially grave consequences.

Practicing the profession fraudulently involves the intentional misrepresentation or concealment of a known fact, in some connection with the practice of medicine and made with the intent to deceive. An individual's knowledge that he or she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. Fraud is also a statement or representation with reckless disregard as to the truth of the statement or representation.

Moral unfitness – proposed definition.

Conduct in the practice of medicine which evidences moral unfitness to practice medicine has been defined as conduct which violates the moral standards of the professional community which the Hearing Committee represents or alternatively, conduct which violates the trust conferred upon a physician by virtue of his licensure. Matter of Rojas v. Sobol, 167 AD2d 707 (3d. 1990), leave denied 77 NY2d 806 (1991). There is no specific definition of moral unfitness in the "Definitions" memo. It is the purpose of this section to suggest an approach for the Committee analysis.

To sustain an allegation of moral unfitness, Petitioner must show Respondent committed an act or acts which "evidence moral unfitness." Petitioner is not required to prove the Respondent is a morally unfit person or has a pattern of immoral behavior to sustain such a charge. Neither is the Committee required to make any overall judgment regarding Respondent's moral character to determine that the conduct in question is conduct which evidences moral unfitness to practice medicine. Matter of Charles T. Williams, R.P.A. D.O., Decision and Order of the Hearing Committee. BPMC Order No. 98-18, at Page 7.

Is it submitted that the following provides an appropriate framework for determining how the facts of this case fit the above definition:

1. To sustain an allegation of moral unfitness, the State must show Respondent committed acts which "evidence moral unfitness." There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Committee is not called upon to make an overall judgement regarding the moral character of any Respondent. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

2. The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust which is bestowed upon one solely by virtue of his earning a license to practice medicine in this state. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based upon the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon him by virtue of his professional status. This leads to the second aspect of the standard: Moral unfitness can be seen as a violation of the moral standards of the medical community which the Committee, as delegated members of that community, represent.

The other charged specifications of misconduct should be interpreted in light of their "ordinary and popular significance," and are to be given their "ordinary and usual meaning." (N.Y. Statutes, §232).

FINDINGS OF FACT AND DISCUSSION

Consecutively numbered below are findings of fact on Patients A through D, and Paragraphs E and K. The references after each proposed finding are to the exhibit in evidence or transcript page on which the finding is based. Finding of Fact 1, set forth immediately below, precedes the substantive findings on the patients. The references represent evidence found to be persuasive by the Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Committee findings were unanimous unless otherwise specified. Exhibits with numbers are Petitioner's Exhibits. Exhibits with letters are Respondent's Exhibits.

1. JORGE M. PARDO, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 5, 1979, by the issuance of license number 140080 by the New York State Education Department. Stipulation, Prehearing Transcript, page 51.

Findings related to Patient A:

2. Respondent treated Patient A, a 50-year-old male, from on or about July 5, 1995 to July 22, 1995 at Our Lady of Victory Hospital, 55 Melroy F. Ridge Road, Lackawanna, New York, 14218 ("OLV Hospital"). Patient A was admitted after having been seen in the OLV Hospital emergency department on July 5, 1995 with complaints of low back pain and a 105-degree temperature. Petitioner's Exhibit 4, page 7, 50 (hereafter, Ex. _ at __")

3. The patient had been treated in the emergency department on July 1, 1995 for pain in the right shoulder. A few days later he developed fever, weakness and back pain. He came to the hospital at approximately 6:45 p.m. complaining of low back pain, with a temperature of 105°. Ex. 4 at 50.

4. Lab work done in the emergency department showed a significantly elevated white count of 14.1. The patient also had anemia as shown by a hematocrit of 34. Ex. 4 at 50, 89; Salipante, T. 29-30.

5. The patient was admitted to the hospital about 10:00 p.m. on July 5, 1995 with a diagnosis of "sepsis, right shoulder effusion and GI bleed" i.e. gastrointestinal bleed. He was admitted to Dr. Pardo's service from the ER. Ex. 4 at 50-1.

6. Respondent's admitting orders, given about the same time, included a request for a consult with an orthopedic surgeon, Dr. Moscato. A short time later, Respondent gave orders for the patient to be seen by an infectious disease consultant and a rheumatologist. Ex. 4 at 117.

7. In issuing his verbal orders Dr. Pardo, who did not see the patient that first night, had to rely upon the experience and knowledge of the emergency room physician. (T. 91) The State's expert, Dr. Salipante, acknowledged that Dr. Pardo was entitled to rely on the emergency room physician in the manner he did. (T. 91)

8. Dr. Pardo then took the right steps to care for Patient A in seeking a consultation from Dr. Moscato, an orthopedic surgeon, to address the right shoulder complaint, an action Dr. Salipante judged appropriate. (T. 91-2) That same night Dr. Pardo ordered consultations by Dr. Grisanti, a rheumatologist, and Dr. Frost, an infectious disease expert. (T. 93) Dr. Salipante affirmed that these consultations were appropriate in view of the diagnosis that had been reached. (T. 93)

9. A plan of care is a blue print for what the physician is going to do in the treatment of a patient. It details what tests are going to be ordered, and what treatments are going to be performed. It is typically outlined at the end of physical history and physical examination. Then there is a notation, at least briefly in the daily progress notes, of what the next steps are going to be in the management of the patient. Salipante T. 56-57

10. The initial progress note made by Respondent is on July 6, 1995. Although it refers that the patient has been admitted to the hospital, there is no plan of care written in the note. Absence of a plan of care presents a risk to the patient since there is no focus where the diagnostic and treatment plan will go. A lack of a plan of care also loses the focus of the health care team on the evaluation and treatment of the patient. Salipante T. 57-58.

11. A differential diagnosis is also important in the treatment of a patient. The differential diagnosis is the initial formulation by the physician of the most likely causes for the patient's condition. It is the method of training by which physicians develop the diagnostic and treatment plan based on the most likely causes of the illness. A physician learns about formulating a differential diagnosis early in their clinical training. Salipante T. 57-58.

12. Again, there can be a very significant risk to the patient if a physician does not consider the relevant illnesses in the differential diagnosis. Moreover, unless it is documented on the chart, it is difficult to know the physician's thoughts regarding the differential diagnosis. Salipante T. 58-59.

13. The medical record for Patient A does not contain a differential diagnosis documented by the Respondent. Neither is there a plan of care documented by the Respondent. Salipante T. 59.

14. Even if the various consultants had formulated their own differential diagnoses or plans of care, that would not be sufficient as a substitute for Respondent having documented his own. Respondent should take their opinions and findings into account in developing his plan of care. Salipante T. 60.

15. Respondent's failure to document a plan of care and differential diagnosis is not in accordance with what a reasonably prudent physician would do. Salipante T. 60-61.

16. A physician requests a consultation when they believe their expertise may not be adequate in a particular area. It is to request the help of another physician with expertise in particular illnesses or areas of the body. Salipante T. 61.

17. On July 6, 1995, the day after admission, orthopedic consultant Dr. Moscato saw the patient and prepared a written consultation. Dr. Moscato's consult indicates that the patient "is unable to sit up because of shoulder and back pain." He further indicated that "low back pain to be evaluated by spine consultation." Dr. Moscato ordered a spine consult. This evaluation could have assisted in the evaluation of the spinal abscess. Ex. 4 at 40, 118; Salipante T. 155.

18. A spine consult would normally be performed by another orthopedist who specializes in the spine, or a neurosurgeon. This depends on the particular hospital and the area of expertise of the medical staff of the hospital. Salipante T. 63.

19. The same day, Respondent issued an order to "hold" the spinal consult ordered by Dr. Moscato. There are no documented medical indications for why Respondent held the spinal consult. Ex. 4, 118; Salipante T. 63.

20. Respondent's order to hold the spinal consult on July 6, 1995 was accompanied by a request for several other studies to be performed, including a CBC and an SMA. The ordering of such other tests would not be an appropriate basis for withholding the spinal consult. This is because the tests could have variable results, but they would not preclude an examination of the spine, either by Respondent or by a specialist. Specifically, if the white count in the CBC continues to be elevated, it continues to confirm an ongoing inflammatory process. If it is normal, it may very well be that the infection has reached a point of exhausting the white cells in the inflammatory process. The study for an SMA12, which usually includes electrolytes, liver tests, and a renal function test, would not dissuade a physician with a patient who has back pain and fever from doing a further evaluation in that area. Salipante T. 65.

21. Although Respondent "held" the spinal consult, he never re-ordered it. It was later ordered on an emergency basis by the infectious disease consultant on July 10, 1995. Ex. 4 at 125.

22. Respondent's conduct in countermanding the consultant's order for a spinal consult should have been addressed in his notes. His failure to do so is contrary to what a reasonably prudent physician would do. Salipante T. 66.

23. The patient's condition deteriorated after his admission to the hospital. The patient's vital signs remained abnormal, including repeatedly elevated temperatures from the date of admission on July 5. He was also found to have blood cultures positive for staphylococcus aureus. The patient's mental status was also fluctuating. Ex. 4, 157-158; Salipante T. 67.

24. That the patient had periods of confusion with increased temperature on July 7 was significant since it could be due to an infection in the blood or the fluid around the brain. Ex. 4 at 170; Salipante T. 69.

25. As of July 8 at about 8:00 in the morning, the patient's mental status was found to be altered. For example, the nurses documented that the patient was "found trying to get out of bed." "[He was] holding on to curtain wanting to 'get behind the wall'. Did not know where he was." Ex. 4 at 174.

26. By 9:30 a.m. on July 8, the patient still showed altered mental status. He was described by the nurses as "trying to get out of bed again saying it was too dusty in the school." The findings would be significant for the patient. Ex. 4 at 174; Salipante T. 71.

27. Respondent knew about these episodes. He documented in his note of July 8, 1995 that the patient had "intermittent high fever and confusion." Yet there is no neurologic status examination at the time of Respondent's visit, and there is no notation of the cause of the patient's confusion possibly being related to an underlying illness. Salipante T. 71.

28. In addition, there was a notation by Respondent that the patient's blood culture had shown infection by staphylococcus aureus. That is a very significant finding, as the bacteria's introduction in the bloodstream is typically a very serious illness. Moreover, the organism can seed many areas of the body, most notably, the brain, the heart, the bones and joints. By "seeding", this means that the bacteria is in the bloodstream and through the small blood vessels, it can go to particular areas of the body, lodge there, and start to grow. Ex. 4 at 18; Salipante T. 71-72.

29. Other consultants also documented that the patient had an altered mental status prior to July 10. On July 9, the rheumatologist indicated that the patient was "responding inappropriately with questions. Unaware of place or time." Ex. 4 at 18.

30. On July 9, the nurses noted the patient's continuing deteriorating mental status. At about 6:00 a.m., the patient was "talking about a parking ramp at West Seneca. He believes it is right outside his window. When patient is told he is at OLV Hospital in Lackawanna, he says 'oh'". Respondent was aware of the patient's mental status and gave orders thereafter. Ex. 4 at 178.

31. Later the same day, and throughout the shift, further notes were made by the nursing staff of the patient's deteriorating mental status. For example, "in a.m. – patient thought he was at Orchard Park Hospital for surgery. He was also seeing sneakers on the wall but said it was only the tongue." "Wife in with patient. Was telling wife he wanted to move the walls and go behind them." Finally, at about 1900 on that same July date, the patient was telling his wife that "he needs to scrub the walls and ceiling in the room". Ex. 4 at 180.

32. All of these notes of altered mental status have medical significance. In Respondent's next note (for July 10, 1995), however, he merely notes that the patient was "still confused at times." Ex. 4 at 20; Salipante T. 74.

33. On the same day that Respondent saw the patient and felt the patient was "still confused at times", the infectious disease consultant, Dr. Frost, saw the patient. Dr. Frost notes that the patient had been confused since July the 7th and has been complaining of severe low back pain. At the time of Frost's examination, the patient was "totally confused and agitated. The patient could move his legs but would not raise them off the bed and resisted further examination." Ex. 4 at 20.

34. Given the presenting conditions, Dr. Frost ordered, among others, an MRI of the spine along with increasing antibiotic treatment. Ex. 4 at 20-21.

35. Respondent's failure to more aggressively evaluate and treat the patient after the patient began to show deterioration in his condition after July 8, 1995 was contrary to what a reasonably prudent physician would have done. Respondent should have done many of the things Dr. Frost ordered, but he should have done them earlier. For example, ordering an MRI of the spine, and increasing Oxacillin, (the antibiotic the patient was taking) to 2

grams intravenously every four hours. He should also have ordered a lumbar puncture, a two dimensional echocardiogram of the heart, and a sedimentation rate to determine the degree of inflammation in the body. Once the tests as ordered by Dr. Frost had been done, the MRI showed an area of abscess of the spine which required emergency surgery by a neurosurgeon. Ex. 4 at 69-70.

36. If this patient had received only the evaluation and treatment that was done by Dr. Pardo on the morning of July 10, i.e. without the intervention ordered by Dr. Frost, the patient would have continued to deteriorate. He could have developed a paralysis of his legs from the continued expansion of the abscess compressing the spine, or an overwhelming infection could have lead to his death. Salipante T. 80.

PATIENT A – DISCUSSION

It is important to note that this case is not about the specific failure to diagnose this patient's spinal abscess. It is rather, about Dr. Pardo's failure to undertake the ongoing evaluation of the patient that would have put him in the best position to have diagnosed the abscess. In this way, Patient A's case provides a microcosm of the shortcomings of Dr. Pardo's approach to medicine: As Dr. Salipante said, "It is not sufficient [for a physician] to simply refer to a consult by another physician in place of doing their own evaluation." "The attending physician is responsible for the overall care of the patient." Respondent did not discharge that responsibility in his care of Patient A.

A brief review of the patient's medical record at page 14 shows Respondent's careless approach began shortly after admission. Doctor Pardo did not document any focused examination of that part of the patient's anatomy which caused the most pain, i.e. the back and lower extremities. Although he was justified in relying on the findings of other physicians, Respondent alone was responsible for synthesizing the information from all of the myriad consultants, marshaling that information, and implementing it into a reasonable plan of care. He failed in this fundamental aspect of patient care.

This failure was compounded by the absence of a differential diagnosis or plan of care for the patient. The differential diagnoses and plans of care adopted by the various consultants were limited in scope to their specialized areas of interest, and in time to whether they were needed or not. Four consultants saw this patient between July 6 and July 10. The specialties were infectious disease, orthopedics, rheumatology, and gastroenterology. Importantly, Dr. Frost (the infectious disease specialist) did not even see the patient on July 7, July 8, or July 9. He was merely available "if needed", as his note makes clear (Ex. 4 at 15). The person who should have made the determination if he was needed was Respondent. That he was needed is shown by the patient's deteriorating mental status during those three days, and by Dr. Frost's flurry of activity once he saw the patient on the morning of July 10.

The danger of such an unfocused and unplanned approach to the care of Patient A was shown within a day of the patient's admission. On July 6, 1995, Dr. Moscato, the orthopedic consultant, indicated that a spine consultation should be obtained to further evaluate the patient's low back pain. Respondent ordered that the spine consultant should be "held". It was not reordered until days later, by Dr. Frost on an emergent basis on July 10, 1995. By that time, the infectious process on the patient's spine had an additional four days to proceed. Dr. Pardo never documented an explanation for canceling the order, nor did he ever renew the order. Dr. Pardo is not faulted for not being the one to initially order the spine consult. But he bears the responsibility for canceling an evaluation without explanation that could have been diagnostic of the patient's problem much earlier.

Respondent's hands-off approach to the care of Patient A is most starkly revealed by his lack of response in the face of the patient's ongoing deterioration, especially of mental status, and in light of consistently abnormal vital signs, on and after July 7 and 8. For example, the patient was noted to have "periods of confusion" on July 7; by July 8 – when Respondent learned that the patient had a blood infection with staphylococcus aureus – the nursing staff documented numerous times when the patient's mental status was becoming confused, and his behavior bizarre.

Dr. Pardo's (lack of) response, despite knowledge of it, was simply to note that the patient was "still confused at times." (Note of July 10). Shortly afterwards, the infectious disease consultant also saw the patient. He found a patient who had been confused since July 7th, who had also been complaining of low back pain on admission, and thereafter, and who was then complaining of "severe low back pain." At the time of Dr. Frost's examination, the patient was "totally confused and agitated." Dr. Frost ordered an MRI of the spine along with increasing antibiotic treatment. The Respondent's non-actions were substandard in comparison.

In light of the above, Respondent's care of Patient A was contrary to minimally accepted standards of practice. It was not in accordance with what a reasonably prudent physician would have done. Because of the risks to which the patient was exposed by Respondent, his care is, found to be, gross negligence, as well as negligence on more than one occasion. Accordingly, Specifications One (gross negligence) and, Four (negligence on more than one occasion) are upheld. The Committee determines that the Respondent did not possess the requisite knowledge to treat this patient, thus Specification Eight (incompetence on more than one occasion), is upheld.

Findings related to Patient B

37. Respondent treated Patient B, an eighty-eight year old female, on or about December 5 - 8, 1996, at the St. Joseph Hospital, 2605 Harlem Road, Cheektowaga, New York, 14225 ("St. Joseph Hospital"), and prior to that time at the Williamsville Manor Nursing Home, 165 South Union Road, Williamsville, New York. Ex. 6.

38. Patient B presented to the St. Joseph Hospital emergency room, on oxygen, on December 5, 1996. There she was seen by an emergency room doctor, who performed an x-ray. The x-ray report notes that "[e]xamination of the abdomen show[ed] considerable content in the course of the colon." (T. 199) This finding, according to Dr. Salipante, suggested constipation. (T. 200) The emergency room doctor's diagnosis of constipation of the colon, the only diagnosis reached, was entered into the record and conveyed to Dr. Pardo. (T. 194-95) At no time on December 5th was Dr. Pardo present in the emergency room, nor was he required to be present. (T. 200)

39. Respondent was consulted by the emergency department physician and agreed to the discharge of the patient on December 5. Ex. 6 at 4.

40. Respondent did not see this patient in the hospital on the day of admission i.e. December 7, 1996. He came to see the patient on December 8, 1996 and found out about the patient's death at 1:00 p.m. The patient had expired at approximately midnight on December 7. Ex. 6 at 25.

41. The medical record for this patient contains a physical examination sheet signed by the Respondent. It indicates that he examined the patient's breasts, and they were "normal". It indicates that he performed a rectal examination, and the rectal exam was "normal". It indicates that the patient "declined" to have a pelvic examination done. Ex. 6 at 22.

42. There is no notation in the emergency department notes that indicated that either a breast exam or rectal exam was done, or that a pelvic exam was declined. Therefore, Respondent did not obtain these results from other parts of the record. Ex. 6 at 18-20; Salipante T. 193.

43. A breast or rectal exam would not normally be performed after a patient is dead. Salipante T. 193-194.

44. Respondent falsely documented that he performed these examinations.

PATIENT B – DISCUSSION

Patient B's record provides evidence by which to evaluate Dr. Pardo's credibility. This patient's record includes a history and physical examination sheet in which Dr. Pardo purports to have conducted and documented a partial physical examination of Patient B. He noted that he did a breast exam, and his findings were "normal". He noted that he did a rectal exam, and that the results were "normal". He noted that he did not do a pelvic exam, because the patient "declined" such a pelvic exam. He confirmed these findings by initialing the form in two places, and made a checkmark to reflect that the rectal exam had been "performed, results documented"; and that the breast exam had been "performed, results documented."

As is clear from Respondent's own handwritten note of 12/8/96, he was not notified of the patient's death until approximately 1:00 p.m. on December 8. He did not see her to perform a breast exam. He did not see her to perform a rectal exam. She did not decline a pelvic examination. He did none of these things – yet he documented that he did them in the medical record. The record is false. No explanation can erase the fact that he documented that he performed multiple physical examinations that were not done. That is fraud.

This is also conduct that evidences "moral unfitness" to practice medicine. First, Dr. Pardo's conduct violated the public trust which is bestowed upon one solely by virtue of his earning a license to practice medicine in this state. The public has a right to expect that physicians will not enter information into medical records that bear no possible relation to fact. The medical record is a legal document, and the public has a right to expect more. Dr. Pardo violated that trust. Second, the Respondent violated the moral standards of the medical community which the Committee, as delegated members of that community, represent. This medical record was intentionally falsified. It is no answer to say that "no one could have been" mislead by the misrepresentations.

Together with the multiple instances of fraud set out elsewhere in this brief, they support a finding that Respondent not only failed to maintain an accurate record for the patient, but also that in the practice of medicine, he has engaged in conduct which evidences moral unfitness. Specification Nine (fraudulent practice) and Eleven (moral unfitness) are thus upheld. By creating a false record for Patient B, Respondent has failed to maintain a record for the patient which is accurate. Thus, Specification Twelve (failure to maintain records) is upheld.

Findings related to Patient C

45. Respondent treated Patient C, an 89-year-old male, from on or about May 15 - 19, 1996, at the St. Joseph Hospital, and prior to that time at the Manhattan Manor Nursing Home, 300 Manhattan Avenue, Buffalo, New York. Ex. 7.

46. Patient C was transferred from a nursing home to the St. Joseph Hospital emergency department in extremely fragile health on May 15, 1996. (T. 297)

47. Dr. Pardo had seen and examined Patient C who was listed as a DNR patient, at the nursing home on May 14, 1996. (T. 296) The doctor noted that the patient had neither a cough nor congestion. (T. 299) These observations, it is reasonable to believe, were generated by a lung examination.

48. The examination documented by Respondent on May 14, 1996 was an incomplete evaluation of the patient. As written in the chart, there is no record of a lung examination and no record of a cardiac examination. It was not in accordance with minimum standards of practice. Ex. 7 at 413; Salipante T. 250.

49. The patient was admitted to the emergency department at St. Joseph Hospital at approximately 5:50 a.m. Although the patient's temperature was lowered at 97.4°, the blood pressure was at 170 over 80. Moreover, the saturation of the oxygen was low at 85 percent. (It should be minimally 88 percent or somewhat higher). Finally, the respirations were 44 per minute, which was very rapid. Ex. 8 at 7; Salipante T. 253.

50. The nursing notes indicate that the patient had "rales." Rales are a crackling sound in the lungs which suggest secretions or fluid in the lungs. This suggests lung congestion. With a temperature elevation, it would be considered a good sign that there is a lung infection. The emergency department physician's lung evaluation also found rales in both lung fields. Ex. 8 at 6-7; Salipante T. 256.

51. Laboratory studies were done on the patient's admission to the emergency department. The patient's white blood count was found to be very high at 32.7. The elevated white blood count is indicative that this is a bacterial infection rather than another type of infection (such as viral). The patient was also noted to have granulocytes of 91.2 percent. This is also very significant and suggests that the patient has an active infection. Other lab work was also drawn that included blood glucose. The patient had a significantly elevated blood glucose level of 417. Ex. 8 at 41, 45; Salipante T. 257-259.

52. Respondent's physical examination "form" for the patient on May 15, 1996 is documented on page 9. There is no information on the lung examination that is in accordance with minimum standards as an evaluation of the patient's lungs on the day of admission. The progress note documented by Respondent on 5/15/96, however, does contain information relating to the lungs of the patient that accords with minimum standards of practice. Ex. 8 at 9, 22; Salipante T. 259-60.

53. After the day of admission, a reasonably prudent physician would conduct a daily lung examination. The purpose of that would be to determine if the patient is improving or worsening. Such examinations by a physician should be documented. Salipante T. 261-263.

54. The Respondent's documented notes of the care of the patient following the admission of May 15, 1996, that is, on May 16, May 17, May 18, and May 19, do not contain the information that a reasonably prudent physician would document for the lung examination of the patient. There is no reference to ausculation of the lungs, i.e. listening to the lungs and recording the findings. The variety of findings by a physician examining such a patient might include the sounds of secretions and rales. The physician would also listen for different parts of the lungs to look for wheezing, and to determine if the patient has broncho- spasm or decrease in breath sounds. This would suggest a collection of fluid or a blockage of part of the lung. Salipante T. 263-265.

55. No in-depth examinations of the lungs were done by the Respondent despite the fact that a chest x-ray performed on the day of admission, May 15, 1996, did not exclude that the patient might have been developing an infiltrated infection. The radiology finding was that there was a minimal infiltrate at the left lower lung field. Ex. 8 at 53; Salipante T. 265-266.

56. The radiologist's impression from the repeat x-ray done on May 17, 1996, was that there was a "left lower lobe pneumonic infiltrate. These findings have progressed since the most recent study of two days ago." Ex. 8 at 54.

57. Although at least one other consultant saw the patient, including infectious disease specialist Dr. Hocko, it is the physician that is caring for the patient – Respondent – who would be expected to perform the parts of the examination which are relevant to the patient's illness during the hospitalization. Salipante T. 269-270.

58. From the documentation of the record, the lung examinations were not performed by Dr. Pardo in accordance with what a reasonably prudent physician would do. Salipante T. 270-271.

59. With regard to a patient who has an infection, there must be adequate hydration of the patient so that the tissues are perfused. When patients become ill, their oral intake decreases. They also have a greater loss of fluid from their body called "insensible losses." Finally, fluids are necessary in the case of pneumonia to mobilize secretions, because with dehydration the secretions in the lungs will become thicker. They are hard to clear without adequate fluid. The general approach is to be certain that the patients are well hydrated. Salipante T. 271-272.

60. Blood studies done of this patient upon admission indicate the patient was significantly dehydrated. The blood urea nitrogen (BUN) was 49, which is a significant elevation. The sodium level was significantly elevated at 158. In fact, the sodium level of 158 was actually even higher when the figure is corrected for elevated sugar, as this patient had. The higher blood sugar causes the sodium to be, if anything, artificially low. With correction, the sodium is actually higher than 158. Ex. 8 at 45; Salipante T. 272-273.

61. Other lab findings are also indicative of dehydration. For example, the chloride is elevated, which suggests a fluid volume contraction. Finally, the "A Gap" which is anion gap is also elevated. This suggests there is a decreased perfusion of the tissues. Again, this indicates that volume is contracted, i.e. a dehydrated state. Ex. 8 at 45; Salipante T. 273.

62. Respondent gave, on admission, orders relating to fluid management for this patient. At about 6:20 a.m. on May 15, 1996, the order related to the patient's fluid status was for Ringer's Lactate to be given at 100 cc's per hour intravenously. Ex. 8 at 34.

63. Ringer's Lactate was an inappropriate choice for this patient. It is a high sodium solution. This patient, with his abnormal lab results, required a solution with a lesser amount of salt. A preferred solution would have been, for example, half normal saline or perhaps quarter normal saline. The salt content of Ringer's Lactate would not allow the dehydration to correct. Salipante T. 275-276.

64. Respondent continued the administration of Ringer's Lactate from May 15 through 1:30 p.m. on May 17, two days after admission. Again, this was inappropriate. The lab results demonstrate that the sodium concentration and dehydration became worse in that time. This is shown from the lab studies of 5/16/96, which indicate that the sodium concentration increased from 158 to 162, while the BUN increased from 49 to 59. Additionally, the chloride also increased, from 115 to 122. The increasing lab values as noted indicate that the fluid deficit is becoming worse. The lab results of 5/17/96 show similar figures as on 5/16. Ex. 8 at 36, 45; Salipante T. 276-277.

65. The Respondent's orders for fluid management for the patient for the first three days of admission, 5/15, 5/16, and 5/17, 1996, as to the type of fluid given, were inappropriate and not what a reasonably prudent physician would have done for this patient. Salipante T. 278.

66. Respondent's initial admission orders for the patient did not provide for nutrition. The order of the consultant, Dr. Hocko, was at least partially consistent with this, as it provided that the patient should receive nothing by mouth. Ex. 8 at 34-35.

67. The patient did not receive anything into the stomach, i.e. entero-nutrition, during the hospitalization. The patient did receive a small amount of glucose by intravenous route when Respondent ordered the dextrose with 5 percent water on 5/17/96. Ex. 8 at 36.

68. The management of the patient's nutrition other than the glucose, during the time that the patient was admitted, was not in accordance with accepted standards of practice, and the patient received inadequate nutrition during the hospitalization. The basis for this conclusion is that the patient was very ill, was dehydrated, and had an infection. Nutrition would have been one of the supportive treatments for the patient. Even if there was a concern that the patient could not properly swallow, due to a risk of aspiration, a decision should have been made after the swallowing evaluation on May 16 to begin feeding the patient with a route of administration that would decrease the risk of aspiration. For example, a nasogastric tube could have been used. Such intervention was eventually ordered, but not until 5/19, the same day the patient died. Ex. 8 at 39; Salipante T. 283-284.

69. Patient C had a history of non-insulin dependent diabetes mellitus. Diabetes is the problem that the body has with control of blood sugar. It can be either a relative insulin lack, i.e. there is some insulin in the body but not enough to totally control the blood sugar. That is called non-insulin dependent diabetes, whereby oral medications or diet can control the blood sugar. There is also insulin dependent diabetes, where there is an absolute lack of insulin in the body in which case insulin supplements must be given. Ex. 8 at 4; Salipante T. 285.

70. The patient received insulin on occasion while at the nursing home prior to admission at St. Joseph Hospital. For example, on May 7, 1996, the patient received two units of insulin. On May 8, 1996, the patient received also some regular insulin. Ex. 7 at 32 and 33.

71. A physician learns whether they are managing a patient's diabetes properly by checking the patient's blood sugar. Such evaluation is the standard for determining blood glucose control. There are two different ways to check blood sugar. A finger stick check can be done for a more rapid determination, or a blood test can be done in the laboratory. Those determinations indicate how well the blood sugar is controlled. Salipante T. 288-289.

72. Several medical factors or conditions make it more difficult to manage a patient's diabetes. The medical conditions are infections and dehydration. Infection and dehydration have an impact on the blood sugar by making the blood sugar go up. They both are responses to stress in the body. The body releases a number of hormones which cause the sugar to increase more as sugar is released from the liver. Both infection and dehydration were present when Patient C was admitted to the hospital on May 15. Ex. 8 at 6-8, 41-45; Salipante T. 289-290.

73. Given this patient's presenting symptoms of infection, dehydration, and elevated blood glucose on admission, a reasonably prudent physician would give sufficient doses of insulin to control the blood sugar to a level of approximately 250 mg percent or less. Respondent did not do that. Salipante T. 290.

74. The orders given on admission by Respondent relating to blood glucose were to obtain finger stick blood sugar evaluations at 7:00 a.m. and 4:00 p.m., and then make a decision about regular insulin based on the results of those blood sugars. Ex. 8 at 34.

75. This was partially an appropriate order. However, the blood glucoses should have been obtained more frequently than twice a day, which was not adequate to check it. Moreover, ordering sliding scale insulin involves trial and error. The physician estimates how the patient is going to respond to a level of glucose, and then the physician may need to make adjustments in the sliding scale based on the patient's responses to the initial doses of insulin. Salipante T. 291-292.

76. The blood glucose levels for this patient from the time of admission on May 15 through his demise on May 19 remained elevated, at the following levels: 5/15–417; 5/16-336; 5/17–266; 5/18--406; 5/19 (at 12:07)–374; and 5/19 (16:53) at 461. These amounts were all significantly elevated, with a number of them being about four times the upper limits of normal. In addition, all of the finger stick glucose levels were elevated, as follows: 5/15–396; 5/16–335; 5/17–342; 5/18–375; and 5/19–398. Ex. 8 at 45-46, 48; Salipante T. 291-293.

77. Respondent should have adjusted the sliding scale to better control the blood glucose. That is the most reasonable step he could have taken. In addition, there could have been perhaps some more frequent determinations of the blood glucose. Salipante T. 294.

78. Respondent's management of the patient's blood glucose and diabetes after admission of May 15, 1996 was not in accordance with what a reasonably prudent physician would have done, as blood glucose was inadequately controlled at that time. The patient had an elevated blood glucose because of the stress of infection and the worsening of the blood glucose. Controlling dehydration and treatment of the blood glucose was important to help in the patient's management of both the fluid management, and to keep the dehydration from becoming worse. Salipante. T. 294

PATIENT C – DISCUSSION

Dr. Pardo's care of Patient C reflects a "too little, too late" approach. From May 14, 1996, when the patient's condition first deteriorated in the nursing home, to May 19, 1996, when he died in the hospital, Dr. Pardo's care was intermittent and superficial. Deficiencies are seen in a number of areas – initial and follow on evaluation; treatment of dehydration; treatment of diabetes; and response to nutritional needs. It can be no answer to say that Patient C had a "do not resuscitate" order in place during the hospitalization.

For example, the patient had an elevated temperature, elevated blood sugar, and elevated respiratory rates on May 14, 1996 while still at the nursing home. In the afternoon of May 14, after approximately 12 hours of these conditions, Dr. Pardo saw the patient. Despite all indications that the patient had a respiratory problem, Dr. Pardo's progress notes record no adequate cardiac exams.

By the early morning of May 15, 1996, the patient's temperature was again elevated, he had a pulse of 108, and a markedly rapid respiration rate of 50. On his admission to the hospital, his oxygen saturation was low while the respirations remained high at 44 per minute. Emergency department findings of "rales" suggested lung congestion. Moreover, his white blood count was very high at 32.7. Fortunately, on the day of admission, May 15, Dr. Pardo documented an adequate lung exam of the patient. Dr. Salipante did not hesitate to recognize this.

Nonetheless, Dr. Pardo documented no further adequate lung exams after that exam early in the morning of May 15. Therefore, he did no adequate exam on May 16, May 17, May 18, and May 19 when the patient finally expired. Such exams may have given Respondent sufficient information to determine if the patient's lungs were improving or deteriorating. In fact, a chest x-ray done on May 15 was suggestive of pneumonia. By May 17, two days later, the radiologist's impression was that there was in fact a pneumonia. Adequate lung exams by Respondent could have helped to stay on top of the situation.

Respondent's choice of fluid to hydrate the patient on admission was inappropriate. Ringer's Lactate has significant salt in it, and this patient needed a lower salt solution. For approximately two and a half days, the patient was administered a salt solution that exacerbated his dehydration. The lab studies confirmed this. Dr. Pardo attempted to provide intravenous fluids to the patient, but he chose the wrong one.

The Respondent failed to order nutrition from the day of admission to May 19 because he simply moved too slowly to order it. A PEG tube was to be inserted after May 18. Unfortunately, by the time the patient was to receive that nutrition via the PEG tube, he died.

Respondent failed to appropriately treat the patient's diabetes. Dr. Pardo's choice of insulin coverage was unaggressive, and he failed to adjust his treatment to keep the patient's blood sugar under appropriate control. That it was not kept under appropriate control was shown by both the serum lab reports and the finger sticks. Dr. Pardo did not follow this patient closely enough.

Accordingly, Respondent provided inappropriate care to the patient that was contrary to what a reasonably prudent physician would have done. The deviations from the accepted standards of care were significant, especially in the manner in which Dr. Pardo sought to deal with (and yet exacerbated) the patient's dehydration, the patient's nutrition, and the patient's diabetes. Accordingly, the Third Specification (gross negligence) is upheld, as is the Fourth Specification (negligence on more than one occasion). Respondent lacked sufficient knowledge to provide these aspects of the patient's care, thus the Eighth Specification (incompetence on more than one occasion) is upheld. Respondent performed but did not document an adequate lung exam on May 14. Thus, the Twelfth Specification (failure to maintain records) is upheld.

Findings related to Patient D

79. Respondent treated Patient D, an 80-year-old male, from on or about January 23, 1996 to February 2, 1996, at the St. Joseph Hospital, and prior to that time at the Manor Oak Nursing Home, 3600 Harlem Road, Cheektowaga, New York, 15225. Ex. 10 at 4-5.

80. Patient D was transferred from the nursing home to the St. Joseph emergency department on January 23, 1996 due to having been found with a lump on the forehead. Ex. 10 at 7.

81. Patient D was admitted to the hospital and treated there by the Respondent until February 2, 1996, when he was pronounced dead at approximately 10:50 p.m. with diagnoses of hematoma forehead, diabetic ketoacidosis Type I, and AC Respiratory distress, among others. Ex. 10 at 2-3, 6.

82. Patient D was an 80 year old who had a history of prior strokes, atrial fibrillation, contractures of his limbs, and dementia. He was being fed with a gastrostomy tube in his stomach. He had a head injury, undefined as to cause, and was admitted to the St. Joseph Hospital emergency room, and then to the hospital, with an initial diagnosis of head injury and possible stroke. Ex.10 at 7; Salipante T. 348-349.

83. The patient was evaluated at 4:07 p.m. on January 23, 1996 in the emergency department. The patient could not give a history because he was aphasic, i.e., he could not speak. Ex.10 at 7.

84. At the time of admission to the hospital, his blood glucose was evaluated, and found to be 104. This is an acceptable figure. Ex.10 at 48.

85. Respondent's admission orders for the patient included orders for a mixture of insulin, short acting and long acting, to be given twice a day. The admission orders were appropriate. Ex.10 at 39; Salipante T. 357-358.

86. Respondent sought to manage the patient's diabetes by giving him tube feedings of glucose and Humulin. The management required a monitoring of blood glucose on a periodic basis during the stay in the hospital. No monitoring of the patient's blood sugar was done from January 23 through February 2. Ex. 10; Salipante T. 361-362.

87. There is, therefore, no indication in the record what the patient's blood sugar was on any of the days from January 23 up through February 2. Some monitoring should have been done during that time, because the patient was in a new environment. Even though the tube feedings that the patient had received in the nursing home and which were continued in the hospital were standard feedings, they were not given consistently and regularly. The fluids are typically problematic and being given on a frequent basis. And the patient was in a new environment. The typical approach would be to check the blood sugar for a couple of days to be certain that the patient is in control in the new venue. Salipante T. 262.

88. Respondent failed to monitor the patient after the initial blood glucose monitoring had been done on admission. Ex.10.

89. The blood glucose findings done in the hospital show the marked increase the patient experienced between January 23 and February 2 when the next reading was done. On January 23, the figure was 104. By February 2, the figure was 840. Later in the day on February 2 the figure was 947. The final figure taken on February 2, the date that the patient died, was 617. These figures are all markedly abnormal, life threatening values. They require immediate treatment. Ex.10 at 48; Salipante T. 364-366.

90. Respondent's management of the patient's diabetes from January 23, 1996 through the end of the hospitalization was not in accordance with what a reasonably prudent physician would have done, because a reasonably prudent physician would have checked the blood glucose on additional occasions after the hospitalization and then periodically thereafter. Salipante T. 366-367.

91. Vital signs for the patient were routinely charted during the hospitalization. On 1/31 96, the vital signs showed that the temperature was elevated to near 101° at 10:00 p.m. That was a significant increase for the patient and should have been monitored and evaluated. Ex.10 at 101; Salipante T. 368.

92. The vital signs for February 1, 1996 show that the patient had an elevated temperature of approximately 102°at 6:00 a.m. Temperature elevations in a hospitalized patient require further evaluation. Ex.10 at 105; Salipante T. 368-369.

93. In addition, the patient's respiratory rate beginning at approximately 2:00 p.m. on January 31, 1996 was at a rate of 40, which is high. With such a respiratory rate elevation, the patient could have a respiratory problem or a febrile illness causing the temperature to be elevated. Ex.10 at 101; Salipante T. 369.

94. The patient's respiratory rate was still markedly abnormal on February 1. At 6:00 a.m., the respiratory rate was 28. It then progressed into the 40's as charted at 2 p.m., 6 p.m. and 10 p.m.. This is a very significant respiratory rate. It can be a sign that there is a process going on that requires additional treatment, either an infection or supplemental treatments with oxygen. Ex. 10 at 105; Salipante T. 369-370.

95. Therefore, based on the temperature elevations on January 31 and February 1, there should have been an evaluation of the patient to determine the cause of the fever and the likely cause of an infection with the respiratory rate being high. The evaluation would be done using blood tests such as a complete blood count (CBC). Patients who are diabetic and receiving insulin might well have a high blood glucose because of the incipient infection. It is reasonable to obtain cultures of likely sources of infection. Salipante T. 370.

96. Respondent did not order a CBC. Neither did Respondent order a blood culture. Finally, Respondent did not order a blood glucose evaluation on either January 31 or February 1. Ex.10.

97. An x-ray was ordered at approximately 7:00 a.m. on February 1; a urine specimen for culture and sensitivity was also taken at that time. Antibiotics were ordered. Ex.10 at 41

98. Respondent failed to properly evaluate the patient in light of the increased temperature that was evident by February 1, 1996. Blood cultures would have been indicated at that time, including a CBC. Respondent's order for a urine sample for a culture and sensitivity, reflecting his view that the most likely cause of the fever was simply due to urinary tract infection, was too narrow an evaluation. Salipante T. 373.

99. Respondent wrote an order to discharge the patient on January 29, 1996. The patient was not thereafter discharged, however, since there was no room to place the patient in a nursing home. Ex.10 at 40, 6.

100. The fact that Respondent sought to discharge the patient on January 29th, but that the patient was not discharged on that date but remained in the hospital, does not alter the treatment the patient should have received after January 29. The patient was still in the hospital, and still being monitored. Moreover, Respondent was still seeing the patient. Salipante T. 374-375.

PATIENT D – DISCUSSION

After the testimony of Dr. Salipante, the questions of Respondent's care of Patient D were reduced. The criticisms that remain are strikingly similar, however, to those seen in the care of Patients A and C: that is, poor response to a patient's markedly deteriorating condition (as in Patient A), and poor control of the patient's blood sugar during the time of admission (as in Patient C). As with the care of Patients B and C, the patient's DNR order does not end the inquiry and there were no orders for limitation of treatment. Once Dr. Pardo undertook to treat the patient, he should have done so in a proper fashion. If he intended to provide only palliative care, he should have documented this intent. He documented nothing of the sort.

The charges relating to Respondent's failure to properly manage the patient's diabetes rest on undisputed facts. This patient had previously lived in a nursing home wherein he had received feedings through a stomach tube for some period of time. A month or so before the patient's admission on January 23, 1996, Respondent ordered the patient's blood sugar monitoring to be reduced from several times a day to once a week. At once a week, the blood sugar appeared under control. In fact, it was at an entirely appropriate level of 104 at the patient's admission on January 23. No criticisms were raised on this point.

However, the patient was admitted to the hospital on January 23 after suffering a head injury significant enough to warrant hospitalization. There was a possible neurologic injury. He was placed in a new environment, with care provided by different people, under different circumstances. The impact of his injury and those new circumstances should have lead Respondent to monitor the patient's blood sugar at least in the first several days of admission to ensure continuity. He did not do so. By the time the patient's blood sugar was finally monitored, on February 2, the level was 840, described by Dr. Salipante as "markedly abnormal", and "life threatening." Such interval monitoring would have been done by a reasonably prudent physician. Respondent failed to do so.

Dr. Pardo also failed to react to the patient's deteriorating condition beginning January 31, 1996. On that date the patient's temperature went to 101°, and the respiratory rate went to a high level (40). Temperature and respiratory rates remained elevated after that time. Yet Respondent did not evaluate the cause of the fever and the likely cause of the patient's infection with such an elevated respiratory rate. Appropriate lab work was not ordered. By the time Dr. Pardo reacted to the patient's sharply deteriorating condition, it was too late.

It is no answer for Respondent to say that he sought to discharge the patient on January 29. Obviously the patient was still in the hospital, still being seen by the Respondent, and still entitled to care. Again, no note exists that Respondent was going to provide palliative care or a lower level of care from that point onward. And in fact, Respondent did seek to treat the patient (although too late) by requesting consultations from a pulmonologist and cardiologist on February 2. His efforts to treat the patient at that time undermine any argument that he was simply following the undocumented wishes of the patient or his family.

Accordingly, Specification Four is upheld (negligence on more than one occasion). Dr. Pardo did not have the knowledge to treat the patient, thus Specification Eight (incompetence on more than one occasion) is upheld.

Findings related to Statement of Charges Paragraphs E, F, G, H, I, J, and K
Wilfully making false statement/ Fraud/Moral unfitness
[1996]

101. Several of the Respondent's cases were reviewed by the Peer Review Committee in Medicine at the St. Joseph Hospital (SJH). These reviews occurred starting in June 1996. Cases were identified for review by the PRC by quality management staff. The assigned PRC physician would then look at the record and determine whether care was appropriate or the case needed further discussion by the PRC. Exs. 18a, 20a - 33a; Kraft T. 426.[1]

102. If the PRC decided that questions had been raised of care that were not clearly answered by review of the medical record, or the PRC questioned that the management was not what an average physician would have done, input was obtained from the physician involved. Kraft T. 426.

103. If the physician did not respond, then the PRC would render their final decision at their next meeting. If the physician did respond, the PRC would take that information into consideration and render a final decision. Kraft T. 426.

104. The SJH PRC requested Respondent's input on one of his cases in July 1996. The Respondent provided information to the PRC, and also met with members of the PRC. After hearing from the Respondent, the PRC's original decision critical of the Respondent was allowed to stand. The PRC determination was that the Respondent was to be monitored and required to attend a Continuing Medical Education offering in August 1996. Ex.22a

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[1] At the hearing on January 29, 2002, instructions to the Hearing Committee were read into the record relating to the St. Joseph Hospital peer review process, as follows:

The panel is instructed that the substance of any decision made by any of the St. Joseph Hospital peer review committees relating to the care provided by Dr. Pardo to any patient is not before you. That is, whether the PRC committee felt that the care provided by Dr. Pardo was substandard or exemplary is not relevant for your decision in this case. Your decision on those medical issues should be based on the evidence you have heard or seen, including expert testimony presented on behalf of the State or the Respondent. Note that you have no idea of the evidence that the PRC may have heard or seen. Your decision on the medical issues must therefore be independent of what the SJH, through its PRC, may have done. That does not mean that the SJH proceedings and the SJH decision is not relevant on other aspects of this case. For example, it could well be relevant in analyzing Dr. Pardo's statements on other hospital applications, if he made representations as to what happened at SJH relating to his privileges. T. 421-422

105. Respondent thereafter submitted two (2) letters in response to the PRC's critique relating to the care of the named patient. After considering the matter, the PRC did not change its decision in the case. Respondent was so advised by memo dated July 25, 1996. Ex. 26a.

106. Dr. Pardo submitted an expert's review to the PRC in the Fall of 1996 to support his view that his care of the same patient was appropriate. Despite this, the PRC and the Hospital Executive Committee found no reason to change the PRC's earlier conclusions, and so advised the Respondent by their memo of October 17, 1996. Ex. 25a.

107. Respondent's involvement in the PRC process continued shortly afterwards, as he appealed from the PRC determination by his letter dated October 30, 1996. Ex. 33a.

[1997]

108. By June 1997, the PRC was looking critically at Respondent's care of another patient. He was asked to provide information on his care of that patient as well. Respondent was contacted by telephone by Marlene Kraft of SJH and advised that he could present his views at the August meeting of the PRC. Ex. 27a, 24a.

109. As before, Respondent submitted a detailed, 2 page response to the PRC providing information on his care of the second of the patients. He did this by his letter dated August 10, 1997. Ex. 28a.

110. In November 1997, the PRC was looking at yet a third case of the Respondent's. He was asked to provide information on his care of that patient as well. The seriousness of the matter was underscored by the PRC's statement that: "the Committee requests, yet once again, the imperative need of your attention to matters of patient care." Ex. 30a.

111. As in the first two cases, Respondent submitted a detailed, 2 paged response to the PRC providing information on his care of the third of the patients. He did this by his letter dated December 1, 1997. Ex. 29a.

SOC Paragraph E -- <u>Application of December 10, 1997 to Choice Care section of the HCP Health Care Plan</u>

112. Respondent, on or about December 10, 1997, signed and submitted a "Reaffirmation of Professional Status" to the Choice Care section of the HCP Health Care Plan, Guaranty Building, 28 Church Street, room 100, Buffalo, New York 14202-3998. Ex. 13.

113. By signing the form, Respondent "affirm[ed] and represent[ed] that all statements, answers, and information contained in this application are true to the best of my knowledge and belief". Ex. 13.

114. Respondent's written response to Question "5" of the Reaffirmation represented that: "There are no professional medical misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or in any other state or country." Ex. 13.

115. That sworn statement was not true, and Respondent knew it was not true. In fact, Respondent had by that date responded to numerous questions from the St. Joseph Hospital Peer Review Committee in Medicine relating to his care of patients in St. Joseph Hospital. Just 9 days earlier, he had submitted additional materials in the SJH PRC process. Exs. 21a– 33a.

116. Respondent's written response to Question "8" of the Reaffirmation represented that: "I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or government licensing or other authority." Ex. 13.

117. Again, the sworn statement was not true, and Respondent knew it was not true. Beginning in June of 1996 and continuing on almost a monthly basis from then through December of 1997, Respondent had responded to numerous questions from the St. Joseph Hospital Peer Review Committee relating to his care of patients at St. Joseph. For example, as recently as December 1, 1997, Respondent had provided a detailed response to the Peer Review Committee to explain his care of a patient. (Exs. 13, 29a[Memo of December 1, 1997]). He had also initiated an appeal process. (Kraft T. 430).

[1998]

118. As the PRC process continued in February 1998, the Respondent requested to appear personally before the PRC to discuss two cases. Respondent appeared and made a presentation, and there was further review and discussion. The final decision was the same, however -- the decision of the PRC was unanimous to abide by an earlier decision critical of the Respondent. Respondent was to be advised. Ex. 31a, 23a.

119. Ultimately, the Respondent's privileges in Medicine and Surgery came up for renewal at the SJH. The hospital renewed the Respondent's surgical privileges, but denied his reapplication for privileges in medicine. The letter to the Respondent, dated April 23, 1998, read in part as follows: "This denial of privileges was made primarily as a result of concerns regarding your ability to properly manage general medicine patients." Ex. 18.

120. Respondent immediately contested his loss of medical privileges by non-renewal. He did this by his appeal letter dated April 27, 1998. Ex. 32a.

SOC -- Paragraph F; <u>Application to Kaleida Health dated September 9, 1998</u>

121. Respondent, on or about September 9, 1998, signed and submitted an "Application for Medical/Dental Staff Reappointment" to Kaleida Health (Buffalo General Hospital), 901 Washington Street, Buffalo, New York 14203. Ex. 14.

122. By signing the form, Respondent stated that "all information submitted by me in connection with this application is true and complete to the best of my belief and no pertinent information has been omitted." Ex. 14.

123. Respondent checked "No" as his written response to the fifth question under Section VIII of the Application, and thus he denied that his "clinical privileges at any health care facility" had been "denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction". Ex. 14

124. Respondent's answer was not true, and Respondent knew it was not true. Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, that is, had not been renewed, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients". Ex. 18.

SOC Paragraph G – Application to Independent Health Association of November 18, 1998

125. Respondent, on or about November 18,1998, signed and submitted material for recredentialling to Independent Health, 511 Farber Lakes Drive, Buffalo, New York 14221. Included in this material was a one-page document entitled "Professional Questions and Attestation". Ex. 11.

126. By signing the form, Respondent "certified that the information contained in this document is complete and accurate . . . ". Ex. 11.

127. Respondent read over the "Professional Questions and Attestation" Sheet as part of signing it, since he corrected and personally initialed Question "8". Ex. 11.

128. Respondent checked "No" as his written response to Question "3" of the Professional Questions sheet, which read as follows: [During the past two years] have your hospital privileges been revoked, suspended, reduced, not renewed? Have disciplinary proceedings been instituted against you? Are any of these actions pending with respect to your hospital privileges? Ex. 11.

129. Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, and thus not been renewed, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients". Ex. 18.

130. In the meantime, by letter dated December 30, 1998, the Buffalo office of the Office of Professional Medical Conduct, requested records of the Respondent for 4 named patients. The letter specifically stated, in the very first sentence, that OPMC "is investigating a complaint filed with this office against you." Ex. 17.

[1999]

SOC Paragraph H -- Application to Community Blue of January 7, 1999

131. Respondent, on or about January 7, 1999, signed and submitted recredentialling information to Community Blue, the HMO of Blue Cross & Blue Shield in Western New York, 1901 Main Street, Buffalo, New York 14208. Ex. 12.

132. By signing the form, Respondent "affirm[ed] and attest[ed] that all statements, answers, and information contained in this application/reapplication are true to the best of my knowledge, information and belief". Ex. 12.

133. Respondent checked "No" as his written response to the fifth question under the section entitled "Sanction/Practice Limitations Statement", which read in relevant part as follows: Has any hospital, . . .ever limited, denied, revoked, or restricted your professional privileges? Ex. 12.

134. Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients". Ex. 18.

135. Respondent's status as a physician who could no longer admit "purely medical cases" was reiterated and stressed in a letter to him dated January 15, 1999 by Dr. Gamziukas, the Vice President for Medical Affairs at SJH. Ex. 21.

136. Respondent, on or about November June 12, 1999, signed and submitted a "Request for Re-Appointment and Renewal of Clinical Privileges" to Our Lady of Victory Hospital, 55 Melroy at Ridge Road, Lackawanna, New York 14218. Respondent had been last appointed to the OLV medical staff on our about November 6, 1997. Ex. 16.

SOC Paragraph I -- Application to Our Lady of Victory Hospital Dated June 12, 1999

137. By signing the form, Respondent agreed that "all information submitted by me in this application is true to my best knowledge and belief." Ex. 16.

138. Respondent read over the "Request for Reappointment" as part of signing it, since he corrected and personally initialed Question "1" on page 2. Ex. 16.

139. Respondent put "No" as his written response to Question "3" of the Clinical Privileges Questions, which read as follows: [Since appointment or last re-appointment to the Staff] Has there been any voluntary or involuntary limitation, reduction, suspension, or loss of your clinical privileges at any hospital or institution? Ex. 16.

140. Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients". Ex. 18.

SOC Paragraph J -- Application to Universa Health Care dated September 22, 1999

141. Respondent, on or about September 22, 1999, signed and submitted a "Reaffirmation of Professional Status" to the Univera Healthcare, 205 Park Club Lane, Buffalo, New York 14221-5239. Ex. 15.

142. By signing the form, Respondent "affirm[ed] and represent[ed] that all statements, answers, and information contained in this application are true and accurate to the best of my knowledge and belief". Ex. 15.

143. Respondent's written response to Question "3" of the Reaffirmation represented that it was true that "I have never relinquished nor have had my privileges reduced at any hospital." Ex. 15.

144. In fact, the statement was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients". Ex. 18.

145. Respondent's written response to Question "8" of the Reaffirmation represented that it was true that "I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or government licensing or other authority." Ex. 15.

146. In fact, the statement was not true, and Respondent knew it was not true, since Respondent had already been advised in writing by the Office of Professional Medical conduct, by letter date December 30, 1998, that his care of patients was being investigated. Ex. 17.

[2000]

SOC Paragraph K -- Application to St. Joseph Hospital dated January 14, 2000

147. Respondent, on or about January 14, 2000, signed and submitted documentation for Medical Staff Reappointment to the St. Joseph Hospital, Cheektowaga, New York. Ex. 19.

148. By signing the Reappointment Application, Respondent "affirm[ed], subject to the penalties for perjury, that the statements contained herein and on the accompanying papers have been examined by me and to the best of my knowledge and belief are true and accurate." Ex. 19.

149. Respondent answered "No"to the eleventh question listed under Section "8", which read as follows: "Is there a pending disciplinary action or investigation involving you by either Office of Professional Medical Conduct, Federal or State Health Authorities"? Ex. 19.

150. Respondent's answer was not true, and Respondent knew it was not true, based on his own personal contact with the OPMC investigatory personnel for over a year prior to that time. Ex. 17, 19.

DISCUSSION -- WILFULLY MAKING A FALSE STATEMENT; FRAUD; MORAL UNFITNESS

The Respondent signed seven different forms in which he represented to seven different organizations that specific facts were true. The forms in which he made these representations were intended to provide information on which Respondent would be evaluated on whether he would be retained as a provider for insurance carriers, or for continued membership on hospital staffs. The questions were unambiguous, and so were his responses. They were also false.

Two questions are therefore raised: First, did the questions seek information on nuanced or little noticed technical matters that the Respondent could reasonably be said to have overlooked or of which he was unaware? Second, if he did not overlook them, then why did Dr. Pardo sign seven forms (six of which contained affirmations by which Dr. Pardo swore, under penalty of perjury, that his responses were accurate) and yet provide false information. These misrepresentations amount to fraud and moral unfitness.

The evidence strongly supports this finding that Respondent had knowledge of the correct information, given his lengthy and personal involvement in the Peer Review Committee process that ultimately led St. Joseph Hospital to not renew his privileges in medicine. Second, Dr. Pardo signed each of these forms personally, and made handwritten notations to some of them. He clearly knew what was in the forms. Finally, in light of Dr. Pardo's pattern of false representations over a period of years in submitting these forms, and as shown in the "false physical examination" aspect of Patient B's case, this is not a limited or one time aspect of Respondent's medical practice. It does justify a finding of fraud and moral unfitness.

Respondent's involvement in the Peer Review Committee Process at St. Joseph:

Many exhibits were introduced into evidence on this point, as supported by the testimony of Marlene Kraft. This information showed that Respondent not only was familiar with the Peer Review process at St. Joseph that reviewed his care of a number of patients, but that he was intimately involved in it in many ways. Dr. Pardo submitted written responses regarding the care of the patients; he submitted at least one expert opinion relating to his care; he met with the Peer Review Committee on more than one occasion; he received instruction from them on various continuing medical education options for him. Ultimately, the peer review process at the hospital led to the hospital to deny Dr. Pardo's medical privileges (but not his surgical privileges) in April 1998. The letter that advised him of his denial of privileges in medicine indicated that it "was made primarily as a result of concern regarding your ability to properly manage general medicine patients." (Ex. 18). Respondent was involved in multiple level of appeals of this and other aspects of the peer review process. It began in June of 1996, and continued for years after. There can be no doubt that the hospital had multiple concerns, that these were communicated to him, that they were serious, and that he dealt with them in that fashion.

Dr. Pardo's misrepresentations relating to the hospital action and other investigations:

A physician practices the profession fraudulently when he or she intentionally misrepresents or conceals a known fact, in connection with the practice of medicine, and with the intent to deceive. A person's knowledge that he or she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. Most significantly for this case, fraudulent intent may also be inferred from evidence that the licensee was aware of the true state of facts at the time false responses were given. Saldanha v. DeBuono, 256 A.D. 935 (3d. Dept. 1998). All of the necessary elements to support a finding

of fraud are present. Respondent misrepresented or concealed facts surely known to him. These facts were in connection with the practice of medicine. He had the motive to deceive, for he was seeking, by the applications and statements, valuable commodities -- the right to be on hospital staffs, and the right to participate with insurance carriers as an approved provider. On several of the forms, he made notes and corrections, thereby indicating that he read the form over. (See, for example, Exs. 11, 16). There is surely evidence of intent. And, overall, his fraudulent intent can be inferred because he was aware of the true state of facts at the time his false responses were given.

It is well known that misrepresentations in applications for hospital privileges is considered to be the practice of medicine for which revocation is appropriate. See, Kim v. Board of Regents, 172 A.D. 2d 880 (Third 1991), app. denied, 78 N.Y. 2d 856 (1991). Finally, Respondent made these willfully false statements in applications required by law or by the Department of Health. [2]

The Hearing Committee is wary of the representations made by Respondent to the effect that his secretary or other staff member filled out these forms, and that he merely signed them without looking at them. The best that can be said about such a physician is that he was willing to swear that facts were true in his practice of medicine which he had no basis of knowing whether they were true or not (though this is exactly what Respondent did in the false physical examination matter relating to Patient B.) In other cases, the court's have rejected a physician's attempt to excuse the submission of falsehoods in his name by blaming computer inadequacies or billing staff. Physicians "are ultimately responsible for the actions of their staff." Matter of Corines v. State Board for Professional Medical Conduct, 267 A.D. 2d 796, 799-800 (3d Dept. 1999)(citations omitted). Dr. Corines also "failed to answer, answered falsely, or failed to provide required explanations to questions regarding other hospital affiliations". Those acts "permit[ted] an inference of the intent to mislead, which is a factual determination for the Hearing Committee to make."276 A.D. 2d at 800 (citations omitted).

Dr. Pardo should not be given the benefit of the doubt. First, in order to believe him, he must be accepted to be a person who submits sworn information that will directly control his ability to function as a physician without even reading the information. This asks too much. Second, he did read over at least some of these documents, and make changes to them. This suggests the more likely pattern that he did in fact look each of the forms over. Third, he has already showed himself to be a person willing to falsify medical documentation in Patient B's case, with the false "physical examination" notations. Fourth, and most importantly, he submitted the information, he swore to the accuracy of the contents; and he stood to gain the benefits.

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[2] The Panel took judicial notice of the requirements of Public Health Law Section 2805-k, setting froth the investigation required of Article 28 facilities such as hospitals. Respondent's misrepresentations to Kaleida Health (Ex. 14), Our Lady of Victory (Ex. 16), and St. Joseph Hospital (Ex.19) all fit into this category.

The conduct constitutes moral unfitness. What Dr. Pardo did violated the public's trust, since patients at the hospitals he practiced at, and patients whose care was reimbursed by providers, had the right to receive care from a physician who met the standards of the two institutions. Respondent's misrepresentations to the facilities/ providers prevented them from determining his applications on their merits. His actions also contravened the moral standards of the medical community. While other physicians submitted truthful information, Respondent submitted falsehoods.

In light of the above, the Ninth Specification (fraudulent practice) is upheld, and the Eleventh Specification (moral unfitness). Additionally, the Tenth Specification is upheld (willfully making or filing a false report required by law or by the Department of Health or the Education Department).

DISCUSSION OF EXPERT TESTIMONY AND WITNESS CREDIBILITY

Petitioner's Expert and Witnesses

Expert testimony was not needed in some aspects of this case. For example, an expert did not need to confirm that a physician with actual knowledge of a professional misconduct investigation should, in a sworn statement, fully and truthfully answer a unambiguous question as to whether such an investigation existed. In other aspects of the case, however, it was surely necessary. Only one expert, Dr. Joseph Salipante, has been heard from so far. His testimony is discussed below.

Joseph Salipante, M.D.

Petitioner produced Joseph Salipante, M.D. as an expert to testify both as to the accepted standard of care and how Respondent's medical care fell below the generally accepted standard. Dr. Salipante is well trained and experienced, a practitioner with ample clinical experience and appropriate Board certification who also acts as the Vice President for Medical Affairs at his hospital. He testified directly, completely, in an informed fashion, and at length regarding the Respondent's substandard care of Patients A, B, C, and D. His testimony was noticeably evenhanded -- while he criticized specific aspects of Respondent's care of the charged patients, he voiced no quarrel with other parts. In fact, based on a portion of his testimony, several of the allegations in the charges were withdrawn by Petitioner. Of course, the fullest assessment of Dr. Salipante's testimony will be available only when comparing his comments with those of the Respondent, or with those of any expert called by the Respondent. Despite concessions on peripheral issues during cross-examination, Dr. Salipante's testimony as given on direct exam remained firm. Given his education, training, and experience, and in light of his even-handed approach, his testimony is entitled to great weight.

Marlene Kraft

Mrs. Kraft provided additional background information by which the Hearing Committee could more intelligently evaluate the exhibits that related to Dr. Pardo's role in the Peer Review process at St. Joseph Hospital. She too was evenhanded in her testimony; it too is entitled to be received as credible.

The Respondent produced Dr. Paresh Dandona for expert testimony. Dr. Dandona's person and credentials are very impressive but his testimony was too guarded. He was put in a very difficult situation of defending conduct which he knew was marginal or outright lacking. In many instances he had to agree on cross-examination that the care was substandard. In other instances he simply agreed with the leading questions posed by Respondent's lawyer. The only convincing point which he made was in defining the medical standard about the use or non-use of Lasix wherein either approach would have been acceptable in Patient B's case. (T. 515, 516, 523, 524)

Overall, however, Dr. Dandona's testimony did not contradict the points made by the State's expert nor did it serve to exonerate the Respondent.

Unfortunately, the same is true about the testimony of the Respondent. He was not helpful to his cause. His attempt at explaining the false answers on questionnaires was repetitive, confused and delivered in halting speech. He obviously understood the futility of maintaining the position that, although he acknowledged responsibility on the one hand, the secretary really did the dastardly deed, which fact should tend to relieve him of that responsibility. Once having advanced such a position it is easy to see why one would become evasive in attempting to explain the rationale. Although he gave the appearance of a proud and dignified man, the Respondent was NOT credible on this issue. It was uncomfortable to watch that dignity crumble.

The Respondent's testimony on the medical issues was equally unconvincing and insubstantial. Two members of this panel are veterans of the U.S. Army Medical Service, the quality of which they hold in high regard. Thus, it was implied that because of similar service by the Respondent he was once a first-rate physician. However, the physician whom this Committee observed testifying before them had clearly lost that edge.

Nothing that he said served to justify his conduct, even though some of the factual allegations stated only marginal departures from the standard of care. On the other hand, everything that he said and the tentative, perhaps spiritless manner in which he spoke served rather to bolster the allegations of the State that this person was NOT a sharp and attentive professional at the time when he cared for the four patients involved in this case.

CONCLUSIONS OF LAW

The Specifications of Misconduct that are supported by the factual allegations are summarized below, with reference to the Findings of Fact (FOF) for each:

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is found to have committed 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 the evidence showed that Dr. Pardo did the following:

FIRST -- A and A.4(FOF 9-15), A and A.5(FOF 16-22), and/or A and A.6 (FOF 23-36). SUSTAINED

SECOND – NOT SUSTAINED

THIRD -- C and C.3 (FOF 59-65), C and C.4(FOF 66-68), and/or C and C.5 (FOF 69-78). SUSTAINED

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is found to have committed 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 the evidence showed that Dr. Pardo did the following:

FOURTH -- A and A.4, A and A.5, and/or A and A.6, C and C.2 (FOD 49-58), C and C.3, C and C.4, and/or C and C.5, D and D.4(FOF 82-90), D and D.5 (FOF 91-100). SUSTAINED

FIFTH THROUGH SEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

FIFTH -- NOT SUSTAINED

SIXTH -- NOT SUSTAINED

SEVENTH -- NOT SUSTAINED

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is found to have committed professional misconduct as defined in N.Y. Educ. Law §6530(5) by reason of practicing the profession of medicine with incompetence on more than one occasion, in that the evidence showed that Dr. Pardo did the following:

EIGHTH – A and A.4, A and A.5, and/or A and A.6, C and C.2, C and C.3, C and C.4, and/or C and C.5, D and D.4, D and D.5. SUSTAINED

NINTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is found to have committed professional misconduct as defined by N.Y. Educ. Law §6530(2) by reason of practicing the profession of medicine fraudulently, in that the evidence showed that Dr. Pardo did the following:

NINTH -- B and B.4 (FOF 40-44), E and E.1, E and E.2, F and F.1, G and G.1, H and H.1, I and I.1, J and J.1, J and J.2, and/or K and K.1. SUSTAINED

TENTH SPECIFICATION

FALSE REPORT

Respondent is found to have committed professional misconduct as defined in N.Y. Educ. Law §6530(21) by reason of willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, in that the evidence showed that Dr. Pardo did the following:

TENTH -- F and F.1, I and I.1, and/or K and K.1. SUSTAINED

ELEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is found to have committed professional misconduct as defined in N.Y. Educ. Law §6530(20) by reason of engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice, in that the evidence showed that Dr. Pardo did the following:

ELEVENTH -- B and B.4, E and E.1, E and E.2, F and F.1, G and G.1, H and H.1, I and I.1, J and J.1, J and J.2, and/or K and K.1. SUSTAINED

TWELFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is found to have committed professional misconduct as defined in N.Y. Educ. Law §6530(32) by reason of failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, in that the evidence showed that Dr. Pardo did the following: TWELFTH -- A and A.4, A and A.5, B and B.4, C and C.1, C and C.2. SUSTAINED

DISCUSSION OF THE PENALTY

The Committee agrees with Counsel for the Petitioner that the appropriate penalty in this case is Revocation. The Respondent has exhibited a lax and careless attitude for the well being of his patients which runs the gamut from not adequately following the patient's course of hospital care to failing to coordinate and evaluate the services of consultants, to documentation failures. Issues of negligence and competence arose in three of the four patient cases.

The Respondent has assumably practiced General Medicine for many years beginning with the U.S. Army for nine years and then twenty-three years in private practice. He has significant experience in this field. His care of the patients in this case exemplifies a pattern which suggests that Respondent is becoming less rigorous in the pursuit of his profession; or perhaps the new developments of science have overwhelmed him. This shortcoming appears to be systemic in nature. Respondent had the opportunity to seize the day and submit to re-training any time from 1997 to the present, during the period when his professional abilities were being challenged both at St. Joseph's Hospital and by the OPMC. He did not do this. He is clearly in the "second half" of his medical career. It would not be appropriate to force retraining upon the Respondent under these circumstances and expect meaningful results, especially if he did not have the interest or the foresight to do it for himself. One vexing question concerned how the Respondent maintained surgical privileges in the face of the rigorous peer review proceeding at St. Joseph" Hospital. Would it be appropriate to revoke a capable surgeon in the face of perhaps correctable shortcomings in the general medicine field?

The analysis of that question follows.

The obvious first question is how could one be called careless and inept in the practice of general medicine yet remain a sharp and capable surgeon? It would seem that surgery is the more rigorous and demanding discipline. Furthermore, experience tells us that carelessness observed in one area must pervade all areas of medical practice as well. Carelessness is not a lack of judgment or knowledge but a condition which results in the loosening of high standards generally. Thus, the evidence has at least raised the question that Respondent's surgical patients would be equally at risk with his general medicine patients.

Secondly, Respondent has voluntarily (?) given up abdominal surgery, a most substantial portion of a general surgical practice. This fact is consistent with the observations made above that the evidence points to a general decline in Respondent's attention to high standards or his ability to maintain them.

Therefore, the gravity of the situation, both professionally and morally, far outweighs any inclination to save a dwindling surgical practice the safety of which has also been called into question by the evidence in this case.

Finally, the false statements on so many applications suggests a state of desperation caused by the recognition of failing abilities or declining interest in maintaining high standards. For all of these reasons, leniency was rejected. The Respondent is a danger to patients. If any more evidence was needed to support the penalty, the evidence of fraud and moral unfitness would, in itself, be sufficient to sustain the penalty of revocation even if leniency were appropriate regarding the patient care issues, the sheer volume of the false statements and the degree of certainty that the same were intentional shows that the Respondent is morally unfit to hold a medical license.

After review of the entire record of this case the Hearing Committee determines that the Respondent's license to practice medicine should be REVOKED.

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice medicine in the State of New York is hereby REVOKED.
2. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or certified or registered mail.

DATED: Niagara Falls, New York
29 April, **2002**

STEPHEN V. GRABIEC, M.D.

SANDRA L. WILLIAMS, R.N.
STEVEN M. LAPIDUS, M.D.

APPENDIX I

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

IN THE MATTER OF JORGE M. PARDO, M.D.	NOTICE OF HEARING

TO: **JORGE M. PARDO, M.D.**
2777 Harlem Road
Cheektowaga, New York 14225

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medica Conduct on August 22, 2001, at 10:00 a.m., at the Buffalo Airport Radisson, 4243 Genesee Street, Buffalo, New York, and at such other adjourned dates, times and place 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 appe 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 ma 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 New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for

EX 1

the Department of Health whose name appears below, and at least five days prior to t scheduled hearing date. Adjournment requests are not routinely granted as schedule 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 §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prio 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 §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 2001) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidenc and a description of physical or other evidence which cannot be photocopied.

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 OTHER SANCTIONS SET

OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
July 26, 2001

~~Peter D. Van Buren~~ Barbara M. Murphy
Chief ~~Deputy~~ Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Michael A. Hiser
Associate Counsel
Bureau of Professional
Medical Conduct
Room 2588, Corning Tower
Empire State Plaza
Albany, New York 12237
518-473-4282

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

IN THE MATTER

OF

JORGE M. PARDO, M.D.

STATEMENT

OF

CHARGES

JORGE M. PARDO, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 5, 1979, by the issuance of license number 140080 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached Appendix), a fifty year old male, from on or about July 5, 1995 to July 22, 1995, at Our Lady of Victory Hospital, 55 Melroy at Ridge Road, Lackawanna, New York, 14218 ("Our Lady of Victory Hospital"). Patient A was admitted after having been seen in the Our Lady of Victory Hospital emergency department on July 5, 1995 with complaints of low back pain and a 105 degree temperature. Respondent's medical care of Patient A failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to perform or record the performance of an adequate history and physical examination of the patient at the time of admission or within 24 hours thereafter.

2. Respondent failed to perform or record the performance of an adequate physical examination of the patient's musculoskeletal or neurologic status relating to the back or lower extremities at the time of admission or within 24 hours thereafter.

3. Respondent failed to perform or record the performance of an adequate physical examination of the patient's musculoskeletal or neurologic status relating to the back or lower extremities after the patient's admission and throughout the patient's entire hospitalization.

4. Respondent failed to reach or record a differential diagnosis or plan of care for the patient either at the time of admission or throughout the entire

course of the patient's admission.

5. Respondent, despite the orthopedic consultant's order for a spinal consult on or about July 6, 1995, canceled the order without adequate medical indication and/or without documenting such indication.

6. Respondent, after the patient showed significant deterioration in his condition beginning on or about July 8, 1995, failed to adequately evaluate and treat Patient A.

B. Respondent treated Patient B, an eighty-eight year old female, on or about December 5 - 8, 1996, at the St. Joseph Hospital, 2605 Harlem Road, Cheektowaga, New York, 14225 ("St. Joseph Hospital"), and prior to that time at the Williamsville Manor Nursing home,165 South Union Road, Williamsville, New York. After the Respondent was consulted by the nursing home staff, Patient B was transferred from the nursing home to the St. Joseph emergency department on December 5, 1996 due to a noted decrease in her level of consciousness. After the Respondent was consulted by the emergency department physician, Patient B was discharged from the emergency department a few hours later on December 5, 1996. Patient B was thereafter admitted to the St. Joseph Hospital through the emergency department on December 7, 1996 after being noted as being unresponsive. Respondent was consulted by the emergency department physician and provided admitting orders for the patient. Patient B was pronounced dead at approximately midnight on December 7, 1996. Respondent's medical care of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent, prior to agreeing to the discharge of the patient from the St. Joseph Hospital Emergency Department on December 5, 1996, failed to adequately evaluate, treat, or follow up on abnormal findings in Patient B's laboratory findings, including elevated bands, BUN, and serum carbon dioxide, despite medical indications.

2. Respondent, after agreeing to admit the patient to the hospital at

Withdrawn in part. Brief after review of evidence 3/19/02 TMR.

approximately 8:00 p.m. on December 7, 1996, failed to perform or order the performance of tests to adequately evaluate the patient's presenting symptoms, including an abdominal CT or sonography.

3. Respondent failed to provide adequate admission orders for the patient at approximately 8:00 p.m. on December 7, 1996, in that Respondent ordered Lasix, which was contraindicated in light of the patient's dehydration; and Respondent failed to order supplemental oxygen despite medical indications.

4. Respondent falsely documented that he performed an admission physical examination of the patient consisting of a breast and rectal exam, and that the patient had "declined" a pelvic exam. In fact, Respondent performed no such exams, since the Respondent did not see the patient on her admission date of December 7, 1996, and the patient died before the Respondent saw her on December 8, 1996.

C. Respondent treated Patient C, an eighty-nine year old male, from on or about May 15 to 19, 1996, at the St. Joseph Hospital, and prior to that time at the Manhatten Manor nursing home, 300 Manhatten Avenue, Buffalo, New York. Patient C was transferred from the nursing home to the St. Joseph emergency department on May 15, 1996 due to a noted increase in his respiratory rate associated with an elevated temperature. Patient C was pronounced dead at approximately 10:00 p.m. on May 19, 1996, with diagnoses of sepsis and pneumonia, among others. Respondent's medical care of Patient C failed to meet accepted standards of medical care in the following respects:

1. Respondent, during his examination of the patient in the nursing home on or about May 14, 1996, failed to perform and/or document the performance of an adequate lung or heart examination.

2. Respondent, after the patient was admitted to St. Joseph Hospital on May 15, 1996, failed to perform and/or document the performance of adequate examinations of the patient's lungs or respiratory status.

3. Respondent, after the patient was admitted to St. Joseph Hospital on May 15, 1996, failed to order proper fluid management to address the patient's marked dehydration.

4. Respondent, after the patient was admitted to St. Joseph Hospital on May 15, 1996, failed to order proper nutrition for the patient.

5. Respondent, after the patient was admitted to St. Joseph Hospital on May

15, 1996, failed to properly manage the patient's diabetes.

D. Respondent treated Patient D, an eighty year old male, from on or about January 23, 1996 to February 2, 1996, at the St. Joseph Hospital, and prior to that time at the Manor Oak Nursing Home,3600 Harlem Road, Cheektowaga, New York, 15225. Patient D was transferred from the nursing home to the St. Joseph emergency department on January 23, 1996 due to having been found with a lump on the forehead. Patient D was admitted to the hospital and treated there by the Respondent until February 2, 1996, when he was pronounced dead at approximately 10:50 p.m., with diagnoses of hematoma forehead, diabetic ketoacidosis Type I, and AC Respiratory distress, among others. Respondent's medical care of Patient D failed to meet accepted standards of medical care in the following respects:

1. Respondent, at the patient's admission to St. Joseph Hospital on January 23, 1996, failed to perform and/or document the performance of an adequate investigation of the cause of the patient's head injury and facial laceration.

2. Respondent, at the patient's admission to St. Joseph Hospital on January 23, 1996, failed to adequately evaluate or manage the patient's nutritional status, hydration, or level of blood glucose control, and/or record the adequate evaluation or management of these.

3. Respondent, after the patient was admitted to St. Joseph Hospital on January 23, 1996, failed to order proper nutrition for the patient.

4. Respondent, after the patient was admitted to St. Joseph Hospital on January 23, 1996, failed to properly manage the patient's diabetes by, among other things, monitoring the patient's blood sugar levels.

5. Respondent, after the patient's temperature became markedly elevated o or about February 1, 1996, failed to properly evaluate the cause of the temperature increase, including by checking a CBC and serum glucose.

6. Respondent, after the patient's temperature became markedly elevated o or about February 1, 1996, and the patient had abnormally high potassium levels, failed to order an electrocardiogram to evaluate heart

function.

E. Respondent, on or about December 10, 1997, signed and submitted a "Reaffirmation of Professional Status" to the Choice Care section of the HCP Health Care Plan, Guaranty Building, 28 Church Street, room 100, Buffalo, New York 14202-3998.

1. Question "5" of the Reaffirmation was as follows:

"5. There are no professional medical misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or in any other state or country."

Respondent represented that the above statement was true. In fact, the statement was not true, and Respondent knew it was not true, since Respondent had by that date responded to numerous questions from the St. Joseph Hospital Peer Review Committee relating to his care of patients in St. Joseph Hospital.

2. Question "8" of the Reaffirmation was as follows:

"8. I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or government licensing or other authority."

Respondent represented that the above statement was true. In fact, the statement was not true, and Respondent knew it was not true, since Respondent had already responded to numerous questions from the St. Joseph Hospital Peer Review Committee relating to his care of patients at St. Joseph.

AMENDED 11/28/02 TC/Tad

F. Respondent, on or about September 8, 1999, signed and submitted an "Application for Medical/Dental Staff Reappointment" to Kaleida Health (Buffalo General Hospital), 901 Washington Street, Buffalo, New York 14203.

1. Under Section VII of the Application, Respondent denied that his "clinical privileges at any health care facility" had been "denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction".

Respondent's answer was not true, and Respondent knew this was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, that is, had not been renewed, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients".

G. Respondent, on or about November 18,1998, signed and submitted materia for recredentialling to Independent Health, 511 Farber Lakes Drive, Buffalo, New York 14221. Included in this material was a one page document entitled "Professional Questions and Attestation".

1. Question "3" of the Professional Questions sheet, which Respondent answered "No", read as follows:

   [During the past two years] have your hospital privileges been revoked, suspended, reduced, not renewed? Have disciplinary proceedings been instituted against you? Are any of these actions pending with respect to your hospital privileges?

   Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, and thus not been renewed, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients".

H. Respondent, on or about January 7, 1999, signed and submitted recredentialling information to Community Blue, the HMO of Blue Cross & Blue Shield in Western New York, 1901 Main Street, Buffalo, New York 14208.

1. The fifth question under the section entitled "Sanction/Practice Limitations Statement", which Respondent answered "No", read in relevant part as follows:

   Has any hospital, . . .ever limited, denied, revoked, or restricted your professional privileges?

   Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted or

his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients".

I. Respondent, on or about November June 12, 1999, signed and submitted a "Request for Re-Appointment and Renewal of Clinical Privileges" to Our Lady of Victory Hospital, 55 Melroy at Ridge Road, Lackawanna, New York 14218. Respondent had been last appointed to the OLV medical staff on our about November 6, 1997.

1. Question "3" of the Clinical Privileges Questions, which Respondent answered "No", read as follows:

   [Since appointment or last re-appointment to the Staff] Has there been any voluntary or involuntary limitation, reduction, suspension, or loss of your clinical privileges at any hospital or institution?

   Respondent's answer was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients".

J. Respondent, on or about September 22, 1999, signed and submitted a "Reaffirmation of Professional Status" to the Univera Healthcare, 205 Park Club Lane, Buffalo, New York 14221-5239.

1. Question "3" of the "Reaffirmation, which Respondent represented was true, was as follows:

   "3. I have never relinquished nor have had my privileges reduced at any hospital."

   In fact, the statement was not true, and Respondent knew it was not true, since Respondent had been advised on or about April 23, 1998, that his general medical privileges at St. Joseph Hospital had been not granted on his re-application, "primarily as a result of serious concerns regarding [his] ability to properly manage general medicine patients".

2. Question "8" of the "Reaffirmation, which Respondent also represented was true, was as follows:

"8. I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or government licensing or other authority."

In fact, the statement was not true, and Respondent knew it was not true, since Respondent had already been advised in writing by the Office of Professional Medical conduct, by letter date December 30, 1998, that his care of patients was being investigated.

K. Respondent, on or about January 14, 2000, signed and submitted documentation for Medical Staff Reappointment to the St. Joseph Hospital, Cheektowaga, New York.

1. The eleventh question listed under Section "8", to which Respondent answered "No", was as follows:

"Is there a pending disciplinary action or investigation involving you by either Office of Professional Medical Conduct, Federal or State Health Authorities"?

Respondent's answer was not true, and Respondent knew it was not true, based on his own personal contact with the OPMC investigatory personne for over a year.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts of Paragraphs A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6.
2. The facts of Paragraphs B and B.1, B and B.2, and/or B and B.3.
3. The facts of Paragraphs C and C.3, C and C.4, and/or C and C.5.

FOURTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

4. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, and/or D and D.6.

FIFTH THROUGH SEVENTH SPECIFICATIONS
GROSS INCOMPETENCE

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

5. The facts of Paragraphs A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A.6.

6. The facts of Paragraphs B and B.1, B and B.2, and/or B and B.3.

7. The facts of Paragraphs C and C.3, C and C.4, and/or C and C.5.

EIGHTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

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

8. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, and/or D and D.6.

NINTH SPECIFICATION
FRAUDULENT PRACTICE

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

9. The facts in Paragraphs B and B.4, E and E.1, E and E.2, F and F.1, G and G.1, H and H.1, I and I.1, J and J.1, J and J.2, and/or K and K.1

TENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as

alleged in the facts of:

10. The facts in Paragraphs E and E.1, E and E.2, F and F.1, G and G.1, H and H.1, I and I.1, J and J.1, J and J.2, and/or K and K.1

ELEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

11. The facts in Paragraphs B and B.4, E and E.1, E and E.2, F and F.1, G and G.1, H and H.1, I and I.1, J and J.1, J and J.2, and K and K.1.

TWELFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

~~10.~~ 12. The facts of Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.4, C and C.1, C and C.2, D and D.1, and/or D and D.2.

DATED: July 26, 2001
Albany, New York

~~Peter D. Van Buren~~ Barbara M. Wrapp
Ch. of ~~Deputy~~ Counsel
Bureau of Professional
Medical Conduct