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

IN THE MATTER

OF

WALESKA M. TULIER-PASTEWISKI, M.D.

MODIFICATION ORDER

BPMC No. #03-132

Upon the proposed Application for a Modification Order of WALESKA M. TULIER-PASTEWSKI, M.D. (Licensee), and the Director of the Office of Professional Medical Conduct, which is made a part of this Modification Order, it is agreed to and

ORDERED, that the attached Application and its terms are adopted and it is further

ORDERED, that this Modification Order shall be effective upon issuance by the Board, either by mailing of a copy of this Modification Order by first class mail to Licensee at the address in the attached Application or by certified mail to Licensee's attorney, OR upon facsimile transmission to Licensee or Licensee's attorney, whichever is first.

SO ORDERED.

DATE: 6/9/09

Redacted Signature

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

WALESKA M. TULIER-PASTEWISKI, M.D.

PETITION FOR MODIFICATION ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF)

WALESKA M. TULIER-PASTEWSKI, M.D., (Licensee), represents that all of the following statements are true:

That on or about September 29, 1994, I was licensed to practice as a physician in the State of New York, and issued License Number 197311 by the New York State Education Department. My New York license is currently inactive. I am currently licensed to practice medicine in Florida pursuant to Florida medical license number ME74075.

My current address is Redacted Address, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I am currently subject to BPMC Order # 03-132 (Attachment I) (henceforth "Original Order"), which was issued subsequent to the final conclusion of a professional misconduct proceeding against me, upon the determination and order of the administrative review board issued pursuant to N.Y. Pub. Health Law § 230-c(4)(d), effective September 19, 2003.

I am filing this petition with the Director of the Office of Professional Medical Conduct to request that BPMC Order # 03-132 be modified, and ask the Director to join me in an application to the chairperson of the state board for professional medical conduct to modify BPMC Order # 03-132, and to issue a Modification

Order, based upon my showing to the Director that circumstances have occurred subsequent to the original determination that warrant a reconsideration of the measure of discipline.

I ask that the State Board for Professional Medical Conduct issue an Order (henceforth "Modification Order"), modifying the Original Order, as follows:

- The Original Order shall be modified.
- The sanction imposed in the Original Order was a suspension for two years, stayed; probation commencing upon the active practice of medicine in New York State for two years (under the terms that appear in the Committee's Determination, Appendix II, as modified by the ARB in the Original Order); a permanent license limitation restricting Licensee's practice of medicine to a facility-based practice, and a $5000 fine.
- The sanction imposed shall be modified to remove the permanent license limitation restricting the physician's practice of medicine to a facility-based practice.
- All remaining Terms and Conditions will continue as written in the Original Order.

I make this petition to the Director, and application to the Chairperson of the Board, of my own free will and accord and not under duress, compulsion or restraint, and seek the anticipated benefit of the requested Modification. In consideration of the value to me of the acceptance by the Director of this petition, and the Chairperson of the Board of this application, I knowingly waive my right to contest the Original Order or the Modification Order for which I apply, whether administratively or judicially, and ask that my petition to the Director, and my application to the Chairperson of the Board, be granted.

I understand and agree that the Director of the Office of Professional Medical Conduct shall exercise reasonable discretion upon my petition, and that the Chairperson of the State Board for Professional Medical Conduct has the authority to grant or deny any application jointly made by the Director and me to modify the Original Order. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE: 5/26/09

Redacted Signature

WALESKA M. TULIER-PASTEWSKI, M.D.
Licensee

In accordance with the requirements of N.Y. Pub. Health Law § 230(10)(q), I have received and reviewed Licensee's petition for modification of Determination and Order No. 03-132, as set forth above.

Having reviewed the matter, and consulted with department counsel, I have determined that circumstances have occurred subsequent to the original determination that warrant a reconsideration of the measure of discipline.

I therefore join the Licensee in an application to the chairperson of the state board for professional medical conduct to modify Determination and Order No. 03-132, as follows:

- *The Original Order shall be modified.*
- *The sanction imposed in the Original Order was a suspension for two years, stayed; probation commencing upon the active practice of medicine in New York State for two years (under the terms that appear in the Committee's Determination, Appendix II, as modified by the ARB in the Original Order); a permanent license limitation restricting Licensee's practice of medicine to a facility-based practice, and a $5000 fine.*
- *The sanction imposed shall be modified to remove the permanent license limitation restricting the physician's practice of medicine to a facility-based practice.*
- *All remaining Terms and Conditions will continue as written in the Original Order.*

Licensee's signed petition, above, is specifically incorporated as part of this joint application.

DATE: 6/8/09

Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

Attachment I

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

PUBLIC

September 12, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
14 Harwood Court – Suite 512
Scarsdale, New York 10583

Waleska Tulier-Pastewski, M.D.
Redacted Address

RE: In the Matter of Waleska M. Tulier-Pastewski, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-132) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Redacted Signature

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

In the Matter of

Waleska M. Tulier-Pastewski, M.D.
(Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 03-132

COPY

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Dianne Abeloff, Esq.**
For the Respondent: **Anthony Z. Scher, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced medicine fraudulently and practiced with negligence on more than one occasion. The Committee voted to suspend the Respondent's license to practice medicine in New York (License), to stay the suspension and to place the Respondent on probation for two years. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2003), both parties ask the ARB to nullify or modify that Determination. After considering the hearing record and the parties' review submissions, we affirm the Committee's Determination on the charges and we affirm the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for two years. We vote to modify or delete certain probation terms. We also vote to place a permanent restriction on the Respondent's License and to fine the Respondent $5000.00.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-6) (McKinney Supp. 2003) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing with incompetence on more than one occasion, and,
- practicing with gross incompetence.

The charges arose from the care that the Respondent provided to six persons (Patients A-F) and from the Respondent's response to a question on the New York State biennial physician registration application (Application). The record refers to the Patients by initials to protect privacy. A hearing on the charges followed before the Committee that rendered the Determination now on review.

The Committee found that the Respondent committed fraud by making a knowing false answer on her 2001 Application. The Committee found that the Respondent failed to report that she resigned from Brookhaven Memorial Hospital (Brookhaven) to avoid disciplinary action by Brookhaven. The Committee concluded that the Respondent made the false answer with intent to deceive.

On the charges involving patient care, the Committee dismissed all charges alleging incompetence, gross incompetence and gross negligence and all charges concerning Patient B. The Committee sustained charges that the Respondent practiced with negligence on more than one occasion in treating Patients A, C, D, E and F. The Committee found that the Respondent documented an examination for Patient A falsely and without examining the Patient. The Committee found that the Respondent performed an examination on Patient C that failed to meet accepted standards and the Committee found that the Respondent prescribed the drug Ecotrin inappropriately for the Respondent. The Committee concluded that the order for Ecotrin affected treatment and risked harm to the Patient. The Committee also found that the Respondent failed to

examine or document cardiac status for Patients C, E and F. The Committee concluded that such omissions could have could have affected adversely the treatment for the Patients. The Committee also found that the Respondent ordered inappropriately gastroenterological and rheumatalogical consultations for Patient F.

The Committee voted to require the Respondent to complete 500 hours community service for the false answer on the Application. The Committee voted further to place the Respondent's License on suspension for two years, to stay the suspension and to place the Respondent on suspension for two years under the terms that appear as Appendix II to the Committee's Determination. The probation terms require that the Respondent practice with a monitor, who would mentor the Respondent to use her oral and written skills more effectively in medical practice [Probation Terms 9-11]. The Committee concluded that stress and the Respondent's problems with written and oral communications contributed to the Respondent's failure to deliver acceptable medical care.

Review History and Issues

The Committee rendered their Determination on May 21, 2003. This proceeding commenced on May 29 and June 4, 2003, when the ARB received the Respondent's and then the Petitioner's Notices requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's brief and response brief. The record closed when the ARB received the response brief on July 7, 2003.

The Petitioner disputed the Committee's conclusion that the Respondent's problems resulted from poor oral and written skills. The Petitioner argued instead that the Respondent failed to understand the medicine involved in the cases at issue. The Petitioner also argued that the Committee failed to address sufficiently the Respondent's misrepresentation about performing an examination on Patient A and the false answer on the Application. The Petitioner

requested that the ARB modify the Committee's Determination to include a substantial period on actual suspension, a practice monitor to evaluate the Respondent's practice, continuing education courses in English and continuing education courses on histories, examinations and charting.

The Respondent asks that the ARB dismiss all charges against the Respondent. The Respondent argues that she answered all the Application questions truthfully, because she actually resigned from Brookhaven to adopt a child and cut back on her practice, rather than due to the threat from disciplinary action. On the negligence findings, the Respondent challenges the opinions on which the Committee based the findings. The Respondent also argues that the Committee sustained negligence charges that involved errors in record keeping. The Respondent argues that record keeping can amount to negligence only when record-keeping errors can impact on patient care, Matter of Bogdan v. Office for Professional Medical Conduct, 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993). The Respondent contends that no expert testimony established that the records at issue contained errors that could have impacted patient care.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion and practiced fraudulently. We modify the penalty that the Committee imposed and we place a permanent limitation on the Respondent's License.

The Committee found that the Respondent practiced fraudulently by answering falsely on the Application concerning the circumstances under which she left Brookhaven. The Committee found that the Respondent left Brookhaven to avoid disciplinary action and the Committee

rejected the Respondent's explanation that she resigned to adopt a child and cut back on her practice. At page 22 in the Determination, the Committee provided the reasons that they found the Respondent a less than credible witness, including bias and a convenient lack of memory. In challenging the Committee's Determination on fraud charges, the Respondent in effect asks the ARB to overrule the Committee's judgement on credibility. The ARB rejects the Respondent's request. In considering fraud charges against a physician, a committee may reject a licensee's explanation for false answers and draw the inference that the licensee intended or was aware of the misrepresentation, with other evidence as the basis, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986). The ARB defers to the Committee, as the fact-finder, in their judgement on credibility and their judgment to reject the Respondent's explanation for the answer at issue on the Application. The Committee based their Determination on the fraud charges on a letter from Brookhaven, concerning an upcoming hearing, and on testimony from Marc Salzberg, M.D., the Chief Medical Officer at Brookhaven. The ARB concludes that such evidence as the Committee found credible provided preponderant evidence to prove that the Respondent practiced fraudulently.

The Respondent's challenge to the Committee's Determination on the negligence charges once again relied in part on a challenge to the Committee's judgement on credibility. We again defer to the Committee's judgement on credibility. The Respondent also argued that the sustained factual allegations on the negligence charges involved record keeping. We disagree that the charges involved record keeping only. In the Patient A case, the Committee found that the Respondent failed to practice according to accepted standards by indicating that she examined the Patient when the Respondent had failed to perform an examination. In the Patient C case, the Committee found that the Respondent prescribed Ecotrin inappropriately. In the

Patient F case, the Committee found that the Respondent ordered consultations inappropriately. We find sufficient credible evidence in the record to prove those charges by preponderant evidence and we hold that such evidence proved that the Respondent practiced with negligence on more than one occasion.

The Committee also found that the Respondent failed to perform and/or document information on cardiac status for Patients C, E and F. The Respondent argued correctly that a record keeping error amounts to negligence only if the failure could affect patient care. The Respondent pointed out that no expert testimony indicated that the records for Patients C, E and F could have affected patient care. The evidence at the hearing did indicate, however, that Patients C and E suffered chest pains and that Patient F had a history of heart failure. The ARB concludes that the evidence in the hearing record provided the Committee sufficient grounds to conclude that the failure to provide cardiac information could have affected care, even without an expert testifying specifically that the failure to provide the information could have affected care. We affirm the Committee's Determination that the failure to perform or document examinations for Patients C, E and F constituted negligence on more than one occasion.

The Committee voted to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation, under the terms that appear at the Committee's Determination, Appendix II. We agree with the Committee that the Respondent's practice problems may have resulted from stress and poor oral or written skills. We disagree with how the Committee addressed those issues in their penalty and we vote to modify the probation terms and to add a License limitation. We vote to sustain the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for two years.

At paragraph 9 in the probation terms, the Committee requires a practice monitor to mentor the Respondent in oral and written skills. The ARB agrees that the Respondent should practice with a monitor during the probation, but we overturn the Committee and hold that the monitor should monitor the Respondent's practice, rather than mentor the Respondent in oral and written skills. We conclude that the Respondent should improve her English skills through continuing education courses. We also amend the probation terms to provide that the monitor shall file a report quarterly. We amend Probation Term paragraph 9, to delete the words: "oral and written skills". In Probation Term paragraph 11, we delete the phrase: "on a schedule to be determined by the office" and we add in it's place the phrase: "every three months". We delete the current Probation Term paragraph 8, concerning community service, for reasons we will discuss below. We substitute a new Probation Term paragraph 8, to read: "During the probation, the Respondent shall complete twenty-hours in continuing education courses to improve her written and oral skills in English. The Respondent shall select the courses, subject to the approval by OPMC".

In addition to the probation, the ARB concludes that the we should limit the Respondent's License to restrict her to practice in a hospital that operates under a government license, such as a license under Public Health Law Article 28, or a hospital which the government operates, such as a Veteran's Administration facility. The evidence in this hearing showed that the Respondent encountered problems with stress and showed confusion in trying to conduct a private practice and in working at more than one hospital. The limitation to one, supervised setting will relieve some administrative and management burdens from the Respondent and allow her to concentrate on patient care.

The Committee also ordered the Respondent to perform 500 hours community service as a sanction for her fraudulent conduct. We find the order for community service in conflict with the Committee's conclusion that the Respondent encounters practice problems in stressful situations. We conclude that the community service may cause the Respondent additional stress by adding to her workload. The ARB votes to overturn the Committee's community service order. As a partial sanction for the Respondent's fraudulent activity, we fine the Respondent

$5000.00. We also conclude that probation and the License limitation will provide further sanctions for the Respondent's fraudulent conduct.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB affirms the Committee's Determination that the Respondent practiced medicine fraudulently and practiced medicine with negligence on more than one occasion.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License, to stay the suspension in full and to place the Respondent on probation for two years.
3. The ARB modifies the probation terms as we provide in our Determination.
4. The ARB overturns the Committee's order that the Respondent perform community service.
5. The ARB fines the Respondent $ 5000.00.
6. The ARB limits the Respondent's License permanently to restrict the Respondent to a facility-based practice, under the conditions that we discuss in our Determination.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Waleska M. Tulier-Pastewski, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Tulier-Pastewski.

Dated: August 18, 2003

Redacted Signature

Robert M. Briber

In the Matter of Waleska M. Tulier-Pastewski, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Tulier-Pastewski.

Dated: Aug 18, **2003**

Redacted Signature

Thea Graves Pellman

In the Matter of Waleska M. Tulier-Pastewski, M.D.

Winston S. Price, M.D., **an ARB Member concurs in the Determination and Order in the Matter of Dr. Tulier-Pastewski.**

Dated: 09/02, 2003

Redacted Signature

Winston S. Price, M.D.

In the Matter of Waleska M. Tulier-Pastewski, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Tulier-Pastewski.

Dated: August 17, 2003

Redacted Signature

Stanley L Grossman, M.D.

In the Matter of Waleska M. Tulier-Pastewski, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Tulier-Pastewski.

Dated: August 17, **2003**

Redacted Signature

—

Therese G. Lynch, M.D.

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 21, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
14 Harwood Court – Suite 512
Scarsdale, New York 10583

Waleska Tulier-Pastewski, M.D.
Redacted Address

RE: In the Matter of Waleska M. Tulier-Pastewski, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-132) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah

Enclosure

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

IN THE MATTER

OF

WALESKA M. TULIER-PASTEWSKI, M.D.

DETERMINATION

AND

ORDER

COPY

The undersigned Hearing Committee (hereinafter referred to as "the Committee") consisting of **KENNETH KOWALD**, Chairperson, **RALPH LUCARIELLO, M.D., JOEL PAULL, M.D., D.D.S.** was duly designated and appointed by the State Board for Professional Medical Conduct (hereinafter referred to as "the State" or "Petitioner").

FREDERICK ZIMMER, ESQ., served as Administrative Law Judge.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307, 401 and 501 of the New York State Administrative Procedure Act. The purpose of the hearing was to receive evidence concerning alleged violations of Section 6530 of the New York State Education Law by **WALESKA M. TULIER-PASTEWSKI, M.D.** (hereinafter referred to as "Respondent").

The Petitioner appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, **DIANNE ABELOFF, ESQ.,** , of Counsel. Respondent appeared by **WOOD & SCHER, ANTHONY Z. SCHER, ESQ.**, of Counsel.

Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record. There were numerous motions and/or briefs which are all part of the record herein whether submitted to the Committee or not.

The Committee has considered the entire evidentiary record, including all exhibits and testimony, in the above captioned matter and hereby renders its decision.

RECORD OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges:	11/1/02
Amended Statement of Charges Dated:	12/2/02
Respondent's Answer Dated:	12/4/02
Second Amended Statement of Charges Dated:	1/16/03
Hearing Dates:	12/11/02 1/17/03 1/23/03 1/27/03
Witnesses for Petitioner:	Abe Levy, M.D. Marc Salzberg, M.D.
Witnesses for Respondent:	Waleska M. Tulier-Pastewski, M.D. Carol Clayton Ernest Bilmes, M.D. Andrew Pastewski, M.D. Craig Smestad, M.D.
Date of Deliberations:	3/24/03

STATEMENT OF CHARGES

The Statement of Charges (Petitioner's Exhibit 1 [hereinafter referred to as "Pet. Ex."] originally alleged six specifications of gross negligence, one specification of negligence on more than one occasion, one specification of gross negligence, one specification of incompetence on more than one occasion and one specification of fraudulent practice. A first Amended Statement of Charges (Pet. Ex. 1A) was accepted into evidence on December 4, 2002 which amended Factual Allegation A.1 to include an allegation that Respondent inappropriately documented a physical examination of Patient A, and added a new Factual Allegation C.1 which alleged that Respondent failed to obtain and document an adequate history and physical examination of Patient C. A second Amended Statement of Charges (Pet. Ex. 1B) was accepted into evidence on January 17, 2003. The second Amended Statement of Charges added Factual Allegation G which alleged that Respondent knowingly and with intent to deceive failed to disclose on her 2001 New York State biennial registration application that she had resigned from Brookhaven Memorial Hospital on June 15, 2001. The specification concerning fraudulent practice was also amended to include the new Factual Allegation G.

Factual Allegation D.2 was withdrawn by the Petitioner on the June 27, 2003 hearing date. A copy of the second Amended Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact and Conclusions made by the Committee were established by a preponderance of the evidence.

Having heard testimony and considered evidence presented by the Petitioner and Respondent respectively, the Committee hereby makes the following Findings of Fact;

1. The Respondent, Waleska M. Tulier-Pastewski, M.D., was authorized to practice medicine in New York State on September 29, 1994 by the issuance of license number 197311 by the New York State Education Department, and has a current registration address of 1025 E Portion Road, Farmingville, New York 11738-0000. (Pet. Ex. 2 and 2A)

2. Respondent is a board certified family practitioner who obtained privileges at Brookhaven Memorial Hospital Medical Center ("Brookhaven") in 1995. (T. 333, 335)

PATIENT A

3. Respondent had an arrangement with Dr. Chandrasekaran, a primary care physician at Brookhaven, whereby they would cover for each other's patients. (T. 336-337)

4. On April 27, 2000, Patient A, a 61 year old female, was hospitalized at Brookhaven under the care of Dr. Chandrasekaran due to congestive heart failure ("CHF"). Dr. Chandrasekaran was called away on an emergency and Respondent assumed the care of 12-15 of his patients including Patient A on May 1, 2000. (Pet. Ex. 3, pg.12; T.338-341)

5. CHF is a condition where the heart's pumping power is inadequate, often accompanied by a retention of fluid. CHF is generally treated by medication, including diuretics which induce a loss of water and by other drugs, to increase the pumping power of the heart. (T. 22)

6. On May 2, 2000, the renal consultant recommended that intravenous ("i.v.") fluids be discontinued. (Pet. Ex. 3, pg. 40, 48; T. 24-25)

7. On May 3, 2000, Respondent ordered that i.v. fluids be resumed for Patient A in that she ordered the administration of normal saline solution i.v. at 50 cc per hour. 50 cc hourly is a low dose of i.v. fluids. (Pet. Ex.3, pg. 48; T. 25, 42)

8. Patient A's creatinine and BUN levels were elevated on May 3, 2000. These elevated levels were an indication that Patient A may have been dehydrated. (Pet. Ex. 3, pg. 77; T. 43-44)

9. Notwithstanding her CHF, the administration of a small dose of i.v. fluid to Patient A was not a deviation from acceptable medical standards given the possibility of dehydration. (T. 44-48, 640)

10. Respondent, on May 4, 2000, at 9:30 a.m., documented findings indicating she had performed a physical examination upon Patient A. Respondent did not, in fact, examine Patient A that morning. (Pet. Ex. 3 p. 19; T. 37-38, 242, 269)

11. Respondent, on May 4, 2000, at 9:30 A.M., ordered that Patient A be discharged home. (Pet. Ex. 3, pg. 49)

12. On May 4, 2000, at approximately 11:00 A.M., Dr. Marc Salzberg, Vice President of Medical Affairs and Chief Medical Officer of Brookhaven, received a telephone call from both the case manager and nurse manager that Patient A was very upset. Patient A had been told that she was being discharged, but claimed that she had not been examined by Respondent on that date prior to the order to discharge her from the hospital. (T. 235- 237)

13. Dr. Salzberg called Respondent at her office. Respondent stated that she had seen Patient A and that Patient A was lying. She further stated that Patient A had a significant psychiatric history and was totally confused. (T. 237-238)

14. Dr. Salzberg responded that the patient was staying in the hospital and Respondent needed to go examine her. (T. 238-239)

15. Respondent cancelled the discharge order and examined Patient A on her lunch hour. She ordered surgical, neurological and psychiatric consults for Patient A. (T. 350; Pet. Ex. 3, pg. 20, 50)

16. Respondent's ordering of a neurologic consultation did not deviate from acceptable standards of medical care based on Patient A's complaints of tremors and seizures (T. 52-54, 57; Pet. Ex.3, pg. 20, 33)

17. Respondent's ordering of a psychiatric consultation did not deviate from acceptable standards of medical care based on the documentation that Patient A had a prior history of depression and might be somatizing her problems (T.54-58; Pet. Ex. 3, pg. 12, 20)

18. Dr. Salzberg contacted Dr. Bilmes, the Chief of Family Practice. They agreed to examine the patient at 5:00 p.m. that afternoon. When they arrived at Patient A's room, another physician, Dr. Babicz, was present. Dr. Babicz examined Patient A and indicated that her mental status was excellent, that day as well as on prior days. (T. 237-240)

19. Drs. Bilmes and Salzberg spoke with Patient A and she told them that she had not seen Respondent that day prior to the discharge order. (T. 240-241, 521)

20. Dr. Salzberg then called Respondent and told her that he had serious concerns about the veracity of her statements regarding Patient A. He asked her to come to his office either that evening or the next morning. (T. 241)

21. Respondent along with her husband went to Dr. Salzberg's office on May 5th and met with Drs. Salzberg and Bilmes. Drs. Salzberg and Bilmes confronted Respondent by stating that they did not believe that her responses about Patient A were accurate. Respondent started to cry and said that she was overwhelmed and had made a mistake. (T. 242- 243)

22. Documenting an examination that did not occur deviated from accepted standards of care. (T. 36-39)

RESPONDENT'S REGISTRATION APPLICATION

23. Respondent asked Dr. Bilmes to be relieved immediately of all clinical responsibility. Arrangements to relieve her of patient care duties at Brookhaven were promptly made, and a May 17, 2000 letter was sent to Respondent's counsel, T. Lawrence Tabak, Esq., confirming that pending a final determination as to whether any corrective action would be taken by Brookhaven, Respondent voluntarily agreed not to admit patients to the hospital or to exercise her hospital clinical privileges in any respect. (T.243-245, 485; Pet. Ex.12)

24. Mr. Tabak was sent a June 1, 2000 letter by Brookhaven's attorneys which offered Respondent the choice of resigning or proceeding to a hearing at which Brookhaven would seek to revoke Respondent's hospital privileges. (Pet. Ex. 13)

25. Mr. Tabak was sent a January 24, 2001 letter by Brookhaven's attorneys with a resignation agreement attached for Respondent's signature. Respondent was requested to sign the agreement, and resign by June 30, 2001. The terms of the agreement required that Respondent acknowledge that she had been offered the exercise of her due process rights. (Pet. Ex. 14)

26. By a June 15, 2001 letter, Respondent resigned from Brookhaven's medical staff claiming that new personal commitments necessitated her resignation. (Pet. Ex. 15)

27. The resignation was submitted to avoid disciplinary action by the hospital. (T. 248-251, 312; Pet. Ex. 13 and 14)

28. Dr. Andrew Pastewski, Respondent's husband, knew that Respondent would be facing disciplinary action at the hospital if she did not resign. He went to Dr. Salzberg's office to talk to him to see if he could make the matter disappear. (T. 257-258)

29. Respondent checked "no" in response to the following question on her medical license registration form for the period of September 1, 2001 through August 31, 2003: "Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?". (Pet. Ex. 2A)

30. Respondent knew that she had resigned from Brookhaven in lieu of disciplinary or corrective action. She intentionally and with the intent to deceive answered the question incorrectly. (Pet. Ex. 2A, 12, 13, 14; T. 248-251, 257-258, 312)

PATIENT B

31. Patient B was hospitalized at Brookhaven with difficulty breathing, productive cough, shortness of breath and severe weight loss. (Pet. Ex. 4, pg. 12; T. 73)

32. On June 16, 1999, Respondent ordered that Patient B receive "Prednisone 180 mg. PO (by mouth) today" which was later changed to "Prednisone 40 mg. PO" to be tapered at the rate of 5 mg. per day. Respondent did not order that the 180 mg. of Prednisone PO be received every 8 hours. (Pet. Ex. 4, pg. 46; T. 74-75).

PATIENT C

33. On April 29, 1998, Respondent admitted Patient C to Brookhaven. Patient C was a 69 year old female diabetic with hypertension who was found unconscious by a neighbor and was brought to the Brookhaven emergency room with anemia and shortness of breath. (Pet. Ex. 5, pg. 4, 5, 8)

34. In order to meet accepted standards of medical care, a history should document prior hospitalizations, prior surgery, social habits, and family history. (T.83)

35. Respondent's admission note did not adequately document Patient C's past medical history including prior hospitalizations and surgeries. (Pet. Ex. 5, pg. 8; T. 83-84)

36. At the time of Respondent's examination of Patient C, the patient was awake, alert and oriented x 3. (Pet. Ex. 5, pg. 8; T.688)

37. Respondent's physical examination of Patient C failed to meet accepted standards of medical care in light of Patient C's history of diabetes and hypertension. Respondent did not sufficiently document cardiovascular findings. There was no description of the heart except for blood pressure, pulse and heart regular. Respondent never noted anything about heart murmurs or enlargement, or any other abnormal sounds. Nor did she document a sufficient examination of the neurological system. (Pet. Ex. 5; T. 88-89, 692-694)

38. Patient C's documented physical examination failed to convey important information about Patient C's status vis-à-vis diabetes and cardiovascular disease. (T. 88-89; Pet. Ex. 5, pg. 8)

39. On April 29, 1998, Respondent prescribed Ecotrin, an enteric coated aspirin, 325 mg. daily, for Patient C notwithstanding the patient's anemia. Patient C was not on Ecotrin prior to her hospitalization. (Pet. Ex. 5, pg. 8, 41; T. 708)

40. On April 29, 1998, Patient C's hemoglobin was 14.0. Patient C declined a rectal examination upon admission. (Pet. Ex. 5, pg. 11, 74)

41. Patient C's hemoglobin dropped to 11.1 on April 30, rose to 11.6 on May 2, dropped to 9.6 on May 3 and rose to 11.5 on May 4. On the date of discharge, May 6, 1998, her hemoglobin dropped to 9.1. (Pet. Ex. 5, pg. 74)

42. In instances where a reasonably prudent physician is concerned about anemia and a patient declines a rectal examination, ordering a stool test would be appropriate. (T.91)

43. Stools for occult blood were performed on April 29, May 2 and May 5, 1998 with negative results (T. 105-106, 128; Pet. Ex. 5, pg. 16, 19, 78)

44. On May 3, 1998, Respondent ordered Patient C to be transfused in the event that her hemoglobin dropped to 8 or less. Patient C's hemoglobin did not drop to 8 or less during her hospital stay. (Pet. Ex. 5, pg. 49, 74; T. 103-104)

45. On May 4, 1998, the gastroenterologist ordered the discontinuance of Ecotrin. He also recommended in his report of consultation that the patient avoid aspirin and non-steroidals. (Pet. Ex. 5, pg. 50, 55; T. 709)

46. Respondent did not discontinue the Ecotrin. (T. 709; Pet. Ex. 5)

47. Respondent did not adequately record why she prescribed Ecotrin for a patient with active bleeding. In addition, the cardiac enzymes were normal. The prescription of Ecotrin in a patient with active bleeding deviated from accepted medical standards. (Pet. Ex. 5; T. 708-711, 793-800)

48. A May 4, 1998 progress note authored by another health care professional, states that Patient C was "s/p (status/post) 2 units" packed with red blood cells. However, Respondent's transfusion history indicates that a reservation for two units of red blood cells was cancelled on May 3, 1998. (Pet. Ex. 5, pg. 18, 82; T. 103, 124)

49. Respondent called in consultants to determine the source of Patient C's anemia with the result that Patient C's upper and lower gastrointestinal ("GI") tracts were thoroughly investigated. An endoscopy and colonoscopy were performed on May 5, 1998. Findings were made that there was evidence of erosive esophagitis with ulceration and frank oozing of blood from this area. These findings could have accounted for Patient C's anemia (Pet. Ex. 5, pg. 53-54; T. 112-114)

50. Respondent's discharge summary notes that the anemia was due to the erosive esophagitis and that Patient C would be followed up in two to three days with a complete blood count and a check up by a gastroenterologist. (Pet. Ex. 5, pg. 5)

51. Respondent discharged Patient C on Ecotrin. 325 mg. daily. (Pet. Ex. 5, pg. 5)

52. Respondent's plan of care for Patient C deviated from acceptable standards of medical care in that she prescribed Ecotrin to a patient with active GI bleeding during the course of her hospital stay and thereafter. (T. 708, 711; Pet. Ex. 5, pg. 5, 41)

53. Respondent discharged Patient C on both Axid and Prevacid. Axid partially inhibits the stomach's secretion of acid while Prevacid totally blocks such secretion. (T. 98-99, 115; Pet. Ex. 5, pg. 5)

54. Respondent's discharge of Patient C with instructions that she take Axid and Prevacid did not deviate from acceptable standards of medical care. (T. 101-102, 682)

PATIENT D

55. Patient D, a 92 year old male, was admitted by Respondent to Brookhaven, on April 29, 1998, with complaints of chest pain. Patient D was given Nitroglycerin in the ambulance which relieved the pain of the left side of his chest. (Pet. Ex. 6, pg. 11)

56. A chest x-ray of Patient D was taken that evening. An EKG was performed at 11:46 p.m. which was abnormal (T. 730, 744; Pet. Ex. 6, pg. 74, 82)

57. The history failed to meet accepted standards of medical care in that there is no record of previous hospitalizations and surgeries or of family and social history or reference to the EKG or chest x-ray. (Pet. Ex. 6, pg. 11, 13; T. 129-130, 730-731, 743)

58. The documentation of Patient D's physical examination failed to meet accepted standards of medical care in that Respondent merely described Patient D's heart as irregular. There is no mention of murmurs, heart size, abnormal sounds, findings concerning right sided heart failure or reference to the EKG or chest x-ray. (T. 130-132, 725-731, 743; Pet Ex. 6, pg. 11, 13)

59. Respondent's inadequate documentation of Patient D's history and physical examination, particularly the omission of the EKG results, potentially impacted Patient D's treatment. (T. 730-731, 743)

60. Respondent discharged Patient D with a final diagnosis of renal insufficiency. (Pet. Ex. 6, pg. 5)

61. Renal insufficiency occurs when the kidneys do not excrete sufficient amounts of accumulated toxic substances and, in severe cases, water. Renal insufficiency is

determined through a review of creatinine and blood urea nitrogen ("BUN") levels. (T. 139-140)

62. Although Patient D's BUN levels were modestly elevated, Patient D's BUN and creatinine levels were not reflective of renal insufficiency. (T. 139-140, 718; Pet. Ex. 6, pg. 61).

63. A diagnosis of renal insufficiency when a patient has elevated BUN levels does not rise to the level of a significant deviation from accepted practice. (T. 147)

PATIENT E

64. Patient E, an 82 year old female, was admitted by Respondent to Brookhaven on May 8, 1998 with chest pain, shortness of breath and congestion. (Pet. Ex. 7, pg. 10)

65. Patient E's admission note states that she was on the medications Coumadin and Lanoxin at the time of admission. (Pet. Ex. 7, pg. 10)

66. Coumadin and Lanoxin are typical medications for atrial fibrillation. (T. 752)

67. Respondent's history for Patient E failed to meet accepted medical standards in that she failed to document the type and degree of Patient E's chest pain, her prior cardiac surgery including valve replacements, prior hospitalizations, family history and social history. (Pet. Ex. 7, pg. 10; ;T. 159-160, 166, 751-753, 824-827: Pet. Ex. 7, pg. 102)

68. Respondent's documentation of Patient E's physical examination failed to meet accepted standards of medical care in that there was no mention of the presence or absence of murmurs and edemas or even of the heart rhythm being regular. Valve replacements were apparent on the chest x-ray which had been performed in the emergency room and should have been incorporated into the documented physical examination. Nothing about a scar or sternotomy was documented in the physical examination. (T.160-161, 166, 176-177, 751-753, 824-827, 844-848; Pet. Ex.. 7, pg. 102,

239)

69. Atrial fibrillation is a significant condition which is manifested by an irregular heartbeat with no discernable pattern. The upper heart chambers beat irregularly with the result that the lower heart chambers may also beat irregularly depending on how they are influenced by the upper chambers. Documentation of atrial fibrillation is particularly significant for a patient with chest pain because in considering whether a heart attack has occurred or is imminent, the presence or absence of atrial fibrillation could significantly impact on treatment decisions including the choice of medication (T. 159-161)

70. Respondent documented that Patient E had "1 episode of AF (atrial fibrillation) in her chart in a May 9, 1998 progress note. She also documented that she had put Patient E's "Coumadin on hold due to possible GI bleeding". (Pet. Ex. 7, pg. 12-13; T. 750-751, 820)

71. Respondent's order for a consultation with a pulmonologist did not deviate from accepted standards of medical care based on an x-ray showing pleural effusion and no clear evidence of congestive heart failure. (T. 749; Pet. Ex. 7, pg. 104)

72. Respondent's order for a consultation with a nephrologist did not deviate from accepted standards of medical care based on Patient E's Creatinine and BUN levels. (T. 162, 747-748; Pet. Ex. 7, pg.36)

73. Respondent's order for a consultation with a psychiatrist did not deviate from accepted standards of medical care in light of objections by Patient E's family's to her decision to undergo a colonoscopy. Patient E's family questioned her competency to make this decision. (T. 167-168, 748-749, 753-755; Pet. Ex. 7, pg. 25)

74. Respondent's order for a consultation with a gastroenterologist did not deviate from accepted standards of medical care based on Patient E's May 10 positive stool sample, her hemoglobin level and and an abnormal CT showing a possible mass in her right colon.

(T. 165, 750; Pet. Ex. 7, pg. 13)

75. Respondent's order for a consultation with a surgeon did not deviate from accepted standards of medical care based on Patient E's lack of venous access for IV medication (T. 173, 747; Pet. Ex. 7, pg. 34)

PATIENT F

76. On April 30, 1998, Patient F, a 65 year old male, was admitted to Respondent's care at Brookhaven, between 2:50 and 3:30 A.M., with shortness of breath and congestive heart failure. (Pet. Ex. 8, pg. 4, 12, 23; T. 181)

77. Respondent was apprised of Patient F's admission status via a telephone call. (T. 896).

78. Respondent dictated an admission note at 9:50 A.M. on April 30, 1998 which included a history and physical examination of Patient F. (Pet. Ex. 8, pg. 12-13)

79. The history taken by Respondent from Patient F failed to meet accepted medical standards in that Respondent failed to describe the nature of Patient F's past cardiac surgery. This omission was medically significant. (T. 181-182, 765; Pet. Ex. 8, pg. 12)

80. The physical examination recorded by Respondent failed to meet accepted standards of medical care in that it only described the heart as regular and listed Patient F's pulse and blood pressure. She did not describe anything else about the heart. (Pet. Ex. 8, pg. 12; T.182)

81. Respondent documented in Patient F's admission note that a consultation had been called with a gastroenterologist at the time of admission due to anemia. The consultation was ordered by Respondent. (Pet. Ex. 8, pg. 12-13, 22; T. 861-862)

82. Respondent's order for a gastroenterology consultation failed to meet accepted

standards of medical care because there was no indication that Patient F was experiencing GI blood loss. (T. 184, 192-193)

83. Respondent documented in Patient F's admission note that a consultation had been called with a rheumatologist at the time of admission due to Patient F's past history of Sjogren's syndrome. Respondent ordered the rheumatology consult (Pet. Ex. 8, pg. 12-13, 24; T. 861-863)

84. Sjogren's syndrome is an autoimmune disease in which antibodies result in the obliteration of the salivary glands and tear production glands causing severe dryness of the mouth and eyes. (T. 188, 759)

85. Respondent's order for a rheumatology consultation failed to meet accepted standards of medical care because Patient F was not experiencing an episode or recurrence of Sjogren's syndrome. In the absence of present complaints relative to the Sjogren's syndrome, there was no medical indication for a rheumatology consultation. (T. 183-184, 193-194)

86. Respondent ordered the administration of i.v. normal saline at 60 cc.'s per hour with Potassium replacement (KCL). The rate of administration of the i.v. fluid was slightly above the requirement for insensible daily losses of fluid. (Pet. Ex. 8, pg. 23; T. 757)

87. At the time of the order, Patient F had an elevated Creatinine level of 2.3. (T. 187, Pet. Ex. 8, pg. 44)

88. The order for administration of i.v. saline with Potassium replacement did not violate accepted standards of medical care as Patient F was significantly diuresed and in need of maintenance fluid. It is not unusual to begin an i.v. line even when a patient is in acute congestive heart failure or has acute pulmonary edema. (T. 757-758, T. 863-866)

89. A 9:30 A.M. progress note states that Patient F was being discharged home because he did not want to stay at the hospital and did not want to go to the VA because his "GP M.D. is not there". (Pet. Ex. 8, pg. 16; T. 900, 903-904)

90. A transfer summary, dictated by Respondent on April 30, 1998 at 10:14 A.M., states that Patient F was being transferred to the VA Hospital. The transfer summary also indicates that Patient F was seen by the consultants at the time of admission. (Pet. Ex. 8, pg. 6-7)

91. Patient F refused to go to the VA and the VA ultimately rejected his transfer. Patient F was discharged home on May 1, 1998. (Pet. Ex. 8, pg. 5, 17, 82; T. 866-867, 872-873)

DISCUSSION

Respondent is charged with eleven specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. The Respondent's attorney, Wood & Scher, through Anthony Z. Scher, acknowledged that he was in possession of this memorandum (Transcript of pre-hearing conference at 13). The memorandum which is entitled "Definitions of Professional Misconduct Under the New York State Education Law " sets forth suggested definitions for negligence, gross negligence, incompetence, gross incompetence and fraudulent practice.

The following definitions were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding. (Id.).

Gross Negligence may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." Rho v. Ambach, 74 N.Y. 2d 318, 322, 546 N.Y.S. 2d 1005 (1989). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion (Rho, supra at 322). No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad", articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence, if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient. Post v. State of New York Department of Health, 245 A.D. 2d 985, 986, 667 N.Y.S. 2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct, Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752, 634 N.Y.S. 2d 856 (3d Dept. 1995).

Incompetence is the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with incompetence "on more than one occasion". "On more than one occasion" carries the same meaning it does in relation to negligence on more than one occasion as set forth above.

Gross Incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences, Post, Supra, at 986.

The **fraudulent practice of medicine** is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine and with the intent to deceive. Choudry v. Sobol ("Choudry"), 170 A.D. 2d 893, 566 N.Y.S. 2d 723 (3d Dept. 1991) citing Brestin v. Commissioner of Education ("Brestin") 116 A.D. 2d 357, 501 N.Y.S. 2d 923 (3d Dept. 1986) (dentistry). To sustain a charge that a licensee has engaged in the fraudulent practice of medicine, the Committee must find that 1)a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, 2) the licensee knew the representation was false, and 3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D. 2d 315, 266 N.Y.S. 2d 39 (3d Dept. 1966), aff'd. 19 N.Y. 2d 679, 278 N.Y.S. 2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the Committee, but the Committee must specifically state the inferences it is drawing regarding knowledge and intent, Choudry, supra at 894 citing Brestin. Fraudulent intent may 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.2d 935, 681 N.Y.S. 2d 874 (3d Dept. 1998).

Giving false testimony in connection with the practice of medicine constitutes fraudulent practice. Such false testimony may relate to the licensee's credentials (Lazachek v. Board of Regents, 101 A.D.2d 639, 475 N.Y.S. 2d 160 (3d Dept. 1984). False statements made on application for hospital privileges have also been found to constitute fraudulent practice. Kim v. Board of Regents, 172 A.D. 2d 880, 567 N.Y.S. 2d 949 (3d Dept. 1991), appeal denied, 78 N.Y, 2d 856, 574 N.Y.S. 2d 938 (1991).

While "the mere making or filing of a false report, without intent or knowledge of the falsity..." (Brestin, supra at 359) does not constitute fraudulent practice, the Committee is free to reject, as not credible, 1) a licensee's mitigating explanations Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S. 2d 351 (3d Dept., 1978) ("Kenna"), 2) a claim of mere "mistake" (Dilluvio v. Board of Regents, 60 A.D. 2d 699, 400 N.Y.S. 2d 871 (3d Dept., 1977) or a claim that negligence was the cause of the misrepresentation (Schmelzer v. Ambach, 86 A.D. 2d 901, 448 N.Y.S. 2d 270 (3d Dept., 1982). The Committee must base its inferences on that which it accepts as the truth. Klein v. Sobol, 167 A.D. 2d 625, 562 N.Y.S. 2d 856 (3d Dept., 1990), appeal denied at 77 N.Y. 2d 809 (1991) (podiatry) citing Ragazzino v. Ross, 52 N.Y. 2d 858, 437 N.Y.S. 2d 74 (1981).

Fraud can also be established when a person makes a statement or representation with reckless disregard as to its truth. See Kountze v. Kennedy, 147 N.Y. 124, 129-130 (1895); State Street Trust Co. v. Ernst, 278 N.Y. 104, 112 (1938). This is so because representation of a fact to another carries with it the implied assurance that the party has adequate knowledge to make the assertion. Kountze, supra at 130; State Street Trust Co., supra at 112.

The Committee was also instructed that in finding whether or not Respondent was guilty of negligence with respect to her documentation of histories and physical examinations, the Committee must determine whether or not Respondent's record keeping failed to convey meaningful medical information such that the patient's treatment could be impacted, Bogdan, supra.

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

The Committee first considered the credibility of the various witnesses and the weight to be accorded to their testimony. The Committee found both the Petitioner's expert, Dr. Levy, and the Respondent's expert, Dr. Smestad, to be credible. However, because Dr. Levy's testimony was less forceful and definitive, the Committee found him generally not as persuasive as Dr. Smestad. Nevertheless, as is clear from the conclusions made by the Committee, Dr. Levy's testimony, on many issues, was found persuasive by the Committee.

Two of the Committee members found Dr. Salzberg's testimony to be credible. The Committee as a whole viewed Dr. Salzberg as being zealously committed to making sweeping changes in the Brookhaven medical staff. One Committee member questioned whether Dr. Salzberg's testimony was affected by his strong views on making staff changes at Brookhaven.

The Committee viewed Dr. Bilmes as being credible but as having little recollection of the events which he testified to. Ms. Clayton's testimony was very credible but of little value based on her acknowledgement that she heard only one side of Respondent's telephone conversation with Mr. Tabak.

The Committee viewed both the testimony of Respondent and her husband, Dr. Andrew Pastewski, as somewhat less than credible. Both witnesses were believed to be biased based on their self interests in the case. Respondent's testimony, in particular, was judged by the Committee to be replete with instances in which she exhibited a convenient lack of memory. For example, upon cross examination, Respondent's testimony concerning the number of patients she admitted to Brookhaven and Stony Brook was not credible (T. 333-334, 403-405). Respondent also testified that her office assistant, Ms. Clayton, was on the telephone with her when she received legal advice from Mr. Tabak as to how the registration form should be answered (T. 365). In fact, Ms. Clayton testified that she only heard one part of that conversation and was standing in Respondent's office during most of the telephone conversation (T. 465-466, 473).

In considering whether Respondent elicited acceptable medical histories, the Committee reviewed testimony and evidence concerning the ability of various patients to relate necessary historical information to the Respondent. This testimony and evidence was often inconclusive. The Committee, however, believed that in each of the instances where an inadequate history was alleged, Respondent could have subsequently supplemented the information. While there was testimony that Respondent's histories and physical examinations for Patient C and F were in effect supplemented by the physician's assistant's history and physical examination which were countersigned by Respondent, the Committee did not accept that the mere act of countersigning a physician assistant's notes

absolved Respondent of the responsibility for documenting a complete history and physical examination. At very least, her own notes should have referenced the physician assistant's documentation.

CONCLUSIONS OF LAW

The Committee initially notes that it does not sustain the Specifications of gross negligence (First through Sixth Specifications[1]), gross incompetence (Eighth Specification) or incompetence on more than one occasion (Ninth Specification). With regard to the Specifications of incompetence and gross incompetence, the Committee concludes based on Respondent's testimony and her board certification in family practice that she does not lack the requisite skill or knowledge to practice medicine safely. The Committee also believes that the misconduct which is described below does not rise to a level of seriousness such that Respondent would be guilty of gross negligence .

CONCLUSIONS REGARDING PATIENT A

Factual Allegation A.1 is sustained. The Committee did not find Respondent to be a credible witness and, thus, did not accept her testimony that she had examined Patient A prior to documenting a physical examination and ordering Patient A's discharge at 9:30

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[1] The gross negligence specifications are incorrectly referred to as "First through Seventh Specification" in the 2d Amended Statement of Charges (Pet. Ex. 1B). In fact, there are six specifications of gross negligence. This misnumbering resulted in there being two Eighth Specifications in that both "negligence on more than one occasion " and "gross incompetence" are referred to as the Eighth Specification. In the interests of clarity, "negligence on more than one occasion" will henceforth be referred to as the Seventh Specification.

a.m. on May 4, 2000.

Two members of the Committee accept Dr. Salzberg's testimony that Respondent's acknowledgement of having made a mistake referred to her failure to examine Patient A., and not to her having documented that Patient A was "alert" when she was sleeping. The Committee accepts Dr. Salzberg's and Dr. Bilmes' testimony that Patient A told them that she had not been examined by Respondent. Additionally, Dr. Salzberg's testimony that Respondent stated that Patient A was lying and was totally confused, is judged to be credible. In fact, Patient A's mental status was found to be excellent when she was examined by Dr. Babicz on May 4, 2000.

The Committee sustains Factual Allegation A.1 and further concludes that documenting the results of a physical examination which never occurred was a deviation from accepted medical standards. This deviation could have potentially effected Patient A's treatment were the documentation of such a physical examination to be relied on by other physicians. Consequently, the Committee unanimously sustains Factual Allegation A.1 as negligence.

The Committee would have been inclined to sustain Factual Allegation A.1 as the fraudulent practice of medicine. However, the Statement of Charges was inelegant in the sense that the Factual Allegations did not match the Specifications charged. Specifically, Factual Allegations A.1 and A.4 which logically would have been charged as fraudulent practice, were not charged as such. The Committee, therefore, did not find Respondent guilty of the fraudulent practice of medicine with regard to Factual Allegations A..1 or A.4. Although Factual Allegation A.4 was charged as negligence on more than one occasion, it

is evident that A.4 is an allegation concerning fraud rather negligence and, consequently, it is not sustained with regard to the negligence specification.

While the Committee sustains Factual Allegation A.2 as being factually true, Factual A.2 is not sustained as negligence. According to the expert testimony, neither the ordering of the neurological or of the psychiatric consultations deviated from accepted standards of medical care. No expert testimony was elicited to demonstrate that the surgical consultation deviated from accepted standards of medical care.

While Factual Allegation A.2 was alleged to be the fraudulent practice of medicine, the Committee declines to find that such was the case with regard to the ordering of the consultations. Whatever Respondent's intent was with regard to her documentation of the purported 9:30 A.M. physical examination of Patient A, the Committee believes that the issue of the consultation orders must be considered separately from the physical examination. Patient A was examined by Respondent at lunchtime and consultations were then ordered. The consultations were medically indicated. It was Respondent's practice to order consultations on a regular basis. The Committee does not find the requisite fraudulent intent to be present in order to sustain Factual Allegation A.2 as fraud.

Based on the testimony of both Drs. Smestad and Levy, Factual Allegation A.3 is not sustained. As conceded by Dr. Levy, even in a case of congestive heart failure, the administration of a small dose of i.v. fluid to a possibly dehydrated patient is not inappropriate or a deviation from accepted standards of medical care. The allegation is, thus, not sustained as negligence. Factual Allegation A.3 is also not sustained as the fraudulent practice of medicine, as A.3 is clearly not intended to be a fraud charge.

PATIENT B

Factual Allegation B.1 is not sustained. The allegation states that Respondent inappropriately ordered 180 mg. of Prednisone every 8 hours to be tapered at the rate of 5 mg. per day. Patient B's medical record, in fact, states "Prednisone 180 mg PO today" and does not reflect that Respondent ordered the Prednisone to be received in that amount every 8 hours.

PATIENT C

Factual Allegation C.1 is sustained as negligence. Respondent's documentation of Patient C's history and physical examination do not meet accepted standards of care. Particularly with regard to Patient C's documented physical examination, important information was not present regarding Patient C's status vis-à-vis her diabetes and cardiovascular disease. Respondent either did not obtain or did not document this information. Thus, Patient C's treatment could have been impacted in the event that another physician relied on Respondent's note.

Factual Allegation C.2 is not sustained. The Committee did not believe that Respondent's care of Patient C vis-a-vis her fluctuations in hemoglobin was inappropriate or a deviation from accepted medical standards. It was noted that Patient C declined a rectal examination upon admission. Dr. Levy testified that in instances where a reasonably prudent physician is concerned about anemia and a patient declines a rectal examination, ordering a stool for occult blood is an appropriate follow up. Dr. Levy testified that he was unaware of any such follow up (T. 91-93). In fact, three stools were performed upon Patient A with negative results. Dr. Levy also premised his thinking regarding the

inappropriateness of Patient C's discharge upon a supposition that Patient C's hemoglobin dropped to 9.1 notwithstanding her having been transfused (T. 93-96). In fact, Respondent had only ordered a transfusion in the event that Patient C's hemoglobin dropped below 8, and it was another physician who ordered the transfusion. It appears that this transfusion was not actually performed as the order for two units of red blood cells was cancelled. Ultimately, Patient C's upper and lower GI tracts were thoroughly investigated through an endoscopy and colonoscopy with findings being made of erosive esophagitis with ulceration and frank oozing of blood. Dr. Levy acknowledged this could have accounted for Patient C's anemia (T. 114) and, in fact, this was noted in Respondent's discharge summary to be the cause of Patient C's bleeding. The discharge summary also states that Patient C would be followed up by a gastroenterologist in 2-3 days and receive a complete blood count. The Committee concludes that Respondent appropriately followed up on and investigated Patient C's drop in hemoglobin.

Factual Allegation C.3 that Respondent discharged Patient C on an inappropriate medication is not sustained. Dr. Levy testified that all of the discharge medications were appropriate individually but that the combination of Axid and Prevacid which are both used to counteract stomach acid was redundant. Neither expert testified that the combination of Axid and Prevacid deviated from accepted standards of care . Factual Allegation C.3 is, therefore, not sustained.

Factual Allegation C.4 is sustained. Notwithstanding the assessment of anemia, Respondent prescribed Ecotrin. She continued with this care plan even though the gastroenterologist recommended discontinuance of the regimen, and even discharged

Patient C on Ecotrin[2]. This care plan constituted a deviation from accepted medical standards. Given Patient C's active GI bleeding, the order for Ecotrin directly affected her treatment and risked harm to Patient C. Factual Allegation C.4 is, therefore, sustained as negligence.

PATIENT D

Factual Allegation D.1 is sustained based on the inadequacy of the documented history and physical examination. The Committee sustains Factual Allegation D.1 as negligence based on the omission of information concerning Patient D's cardiac status. Respondent either did not obtain this information or did not document it. In either event, the Committee was very concerned that the mere description of Patient D's heart as irregular with a lack of reference to detailed findings or to Patient D's EKG and chest x-ray risked adverse consequences with regard to Patient D's treatment.

Factual Allegation D.3 is sustained. Respondent's discharge diagnosis of renal insufficiency was incorrect given Patient D's BUN and Creatinine levels. Nevertheless, the Committee does not sustain D.3 as negligence. The Committee notes that to the extent that the diagnosis was a deviation, it was viewed as an insignificant one by Dr. Levy particularly in light of Patient D's elevated BUN levels. The Committee agrees with Dr. Levy's

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[2] It is noted that with respect to Factual Allegation C.3, Dr. Levy did not testify that the discharge of Patient C on Ecotrin was a deviation from accepted standards of care. Petitioner did not raise the issue of whether Patient C's discharge on Ecotrin was improper until Dr. Smestad was cross examined. The Administrative Law Judge ruled that with respect to C.3, the issue of Ecotrin was an improper avenue of cross examination because it did not relate to the Petitioner's case in chief as presented through Dr. Levy's testimony.

assessment and concludes that the deviation, if any, was too trivial to sustain as negligence.

PATIENT E

Factual Allegation E.1 is sustained as negligence based on the inadequacy of the documented history and physical examination. Again, there was an omission of information concerning cardiac status, in this case, vis-à-vis Patient E's prior cardiac surgery. Respondent either did not obtain this information or did not document it. In either event, the Committee believed that this information was critical medical information, and that the omission of this information could have adversely impacted Patient E's treatment.

Factual Allegation E.2 is not sustained. The Committee accepts Dr. Smestad's testimony that the consultations were medically indicated.

Factual Allegation E.3 is not sustained. The Committee concludes that Respondent did document Patient E's atrial fibrillation in her hospital chart.

PATIENT F

Factual Allegation F.1 is sustained based on the inadequacy of the documented history and physical examination. Similar to the previous cases, there was an omission of information concerning cardiac status, in this case, vis-à-vis Patient F's prior cardiac surgery. Respondent either did not obtain this information or did not document it. In either event, the Committee believed that this information was critical medical information, and that omission of this information could have adversely impacted Patient F's treatment. F.1 is sustained as negligence.

Factual Allegation F.2 is not sustained. The Committee views that it is standard treatment to begin an IV line, and that in this case the rate of fluid was not such as to endanger Patient F. The Committee does not view Respondent's actions as rising to the level of inappropriate care.

Factual Allegation F.3 is sustained as negligence. The Committee concludes that unlike the orders for consultations in the previous cases, the ordering of gastroenterological and rheumatological consultations for Patient F did not meet accepted medical standards. The Committee was particularly concerned about the circumstances under which these consultations were ordered. There was ambiguity in the record as to when the consultations were ordered. It appeared that Respondent either telephoned in the consultation orders at the time of Patient F's admission in the early morning hours of April 30, 1998 without seeing the patient, or that she ordered the consultations at approximately 9:50 A.M. when Patient F was due to be imminently transferred to the VA. In either set of circumstances, the Committee concluded that the ordering of consultations was not medically appropriate.

FACTUAL ALLEGATION G

Factual Allegation G is sustained. The Committee concluded that Respondent's negative answer on her registration form to the question of whether she had resigned to avoid disciplinary action, was false. Respondent knew her answer was false. She had agreed to relinquish her hospital privileges pending a final determination of corrective action by Brookhaven. Her attorney, Mr. Tabak had received a letter from Brookhaven which offered Respondent the choice of either resigning or proceeding to a hearing at which Brookhaven would seek to revoke Respondent's hospital privileges. He was also

sent a letter which referred to the exercise of Respondent's due process rights. Respondent would also have been aware that she was facing disciplinary action through her husband's conversations with Dr. Salzberg. The Committee draws an inference based on the correspondence and her husband's conversations with Dr. Salzberg that Respondent knew that she would be facing disciplinary action at Brookhaven if she did not resign.

The Committee believes that the testimony given by Respondent and her husband with regard to Factual Allegation G was self serving and does not accept her explanation that she resigned for reasons other than the threat of disciplinary action.

The Committee also concludes that Respondent knew that her answer on the registration form was false. The Committee is not persuaded by the testimony of Respondent's office manager, Ms. Clayton, with regard to a telephone conversation between Respondent and Mr. Tabak. Mr. Tabak had purportedly advised Respondent during this telephone conversation that she could answer "no" to the question on the registration form. Because Ms. Clayton heard only one side of the telephone conversation, the Committee accords her testimony little weight. Additionally, there was no presentation of testimony from Mr. Tabak or of documentation from his office in support of the proposition that he advised Respondent to check "no" on the registration form.

The Committee was instructed that while it could consider the issue of whether Respondent received legal advice from Mr. Tabak to answer "no" on the registration form, the ultimate responsibility for truthfully answering the question resided with Respondent. In other words, if Respondent understood that the answer was false, she could not be absolved of responsibility for that answer through her attorney's advice. In this instance, the Committee was not convinced that Mr. Tabak had, in fact, advised Respondent to

answer in the negative. The Committee also concluded that whatever advice Respondent received, she understood that her answer was false and intended to mislead through her answer on the application.

The Committee, therefore, sustains Factual Allegation G as the fraudulent practice of medicine.

Pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Committee unanimously determines that the charges should be disposed of in the following manner;

The following Specifications are **SUSTAINED**;

The Seventh Specification of practicing the profession with negligence on more than one occasion is **SUSTAINED** based on Factual Allegations A and A.1, C and C.1 and C.4, D and D.1, E and E.1 and F and F.1 and F.3.

The Eleventh Specification of practicing the profession fraudulently is **SUSTAINED** based on Factual Allegation G.

The remaining Specifications are **DISMISSED**

PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above and taking all of the facts, details, circumstances and particulars in this matter into consideration, unanimously determines that the penalty set forth below should be imposed.

The Committee determines that a two year stayed suspension of Respondent's medical license with probation is an appropriate penalty and that as part of that probation, a

practice monitor should be appointed who is capable of evaluating and assisting Respondent with the development of her written and oral skills. The Committee also directs that as part of her probation, Respondent provide 500 hours of community medical service in an underserved area in a manner and in an area to be approved by the Office of Professional Medical Conduct.

The Committee believes that Respondent has the ability to practice medicine competently and in accord with accepted standards of medical care. The record did not demonstrate that Respondent is incompetent. However, the Committee felt that based upon Respondent's testimony, she may have an inability to deal with overwhelming circumstances such as occurred when she took over for Dr. Chandrasekaran's patients. The Committee also believes that Respondent's testimony and written records demonstrate that her medical practice would benefit from a practice monitor who could mentor Respondent to use her oral and written skills more effectively in the practice of medicine. The Committee believes that stress and Respondent's oral and written communication problems contributed to her failure to deliver acceptable medical care.

Along with the stayed suspension, the community service requirement is deemed to be sufficient punishment for Respondent's fraudulent answer on the registration form.

Revocation and actual suspension were considered overly harsh penalties. Many of the charged Factual Allegations were dismissed. While Respondent's care of Patient A raised serious concerns, the Committee viewed that Respondent's actions were caused by the stress of having to take over Dr. Dr. Chandrasekaran's patients.

By execution of this Determination and Order, all members of the Committee certify that they have considered the complete evidentiary record of this proceeding including all exhibits and testimony.

ORDER

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

1. The Seventh Specification and Eleventh Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Pet. Ex. 1B) are **SUSTAINED**;

2. The First through Sixth and Eighth through Tenth Specifications of professional misconduct, as set forth in the Amended Statement of Charges are **DISMISSED**;

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of two years. The suspension shall be **STAYED**. Respondent shall also be placed on **PROBATION** for a period of two years in accord with the Terms of Probation, which are attached hereto as Appendix II and made a part of this Determination and Order. The Terms of Probation shall include the provision by Respondent of Five Hundred (500) hours of **COMMUNITY MEDICAL SERVICE** in an under served area; and

4. This Determination and Order shall be effective upon service on the Respondent at her last known address or upon her attorney. Such service shall be effective upon receipt or seven days after mailing by certified mail whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Richmond Hill, New York
May 16 **, 2003**

Redacted Signature

KENNETH KOWALD
Chairperson

RALPH LUCARIELLO, M.D.
JOEL PAULL, M.D., D.D.S.

TO: Dianne Abeloff, Esq.
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APPENDIX I

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

IN THE MATTER

OF

WALESKA M. TULIER - PASTWESKI, M.D.

AMENDED STATEMENT OF CHARGES

WALESKA M. TULIER- PASTWESKI , M.D., the Respondent, was authorized to practice medicine in New York State on or about September 29, 1994, by the issuance of license number 197311 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about April 27, 2000, Patient A (the patients are identified in the attached Appendix) was admitted to Brookhaven Hospital. Respondent's care of Patient A deviated from minimally accepted medical standards, in that:

1. On or about May 4, 2000,at or about 9:30 a.m., Respondent inappropriately documented a physical examination of Patient A and wrote discharge orders in Patient A's chart without examining the patient.

2. Patient A indicated that she had not been examined by Respondent. Respondent then canceled the discharge order and ordered surgical, neurological and psychiatric consults for Patient A.

3. Respondent inappropriately ordered I.V. fluid for Patient A, despite the patient's congestive heart failure.

PETITIONER'S EXHIBIT 1-B
1/7/03

4. Respondent falsely and with intent to mislead told officials at Brookhaven Hospital that she had examined Patient A on the day she wrote the discharge summary when she had not.

B. On or about June 11, 1999, Respondent admitted Patient B to Brookhaven Hospital due to an exacerbation of COPD and congestive heart failure. Respondent's care of Patient B deviated from minimally acceptable medical standards, in that:

1. On or about June 16, 1999, Respondent inappropriately wrote an order for 180 mg. of prednisone every 8 hours to be tapered at the rate of 5 mg. per day.

C. On or about April 30, 1998, Respondent admitted Patient C to Brookhaven Hospital due to anemia, shortness of breath and uncontrolled diabetes. Respondent's care of Patient C deviated from minimally acceptable medical standards, in that:

1. Respondent failed to obtain and document an adequate history and physical examination.

2. Respondent inappropriately ordered the patient to be discharged from the hospital with a hemoglobin of 9.1 without appropriate explanation for the drop in the patient's hemoglobin from 11.5 earlier in the hospitalization.

3. Respondent discharged Patient C on an inappropriate medication.

4. Respondent failed to document an appropriate plan of care of Patient C's illness.

D. On or about April 30, 1998, Respondent admitted Patient D to Brookhaven Hospital. Respondent's care of Patient D deviated from minimally acceptable medical standards, in that:

1. Respondent failed to obtain and document an adequate history and physical examination.

2. Patient D had a blood culture on April 30, 1998 which revealed staphylococcus infection. Respondent failed to address this potentially life threatening condition. withdrawn

3. In Patient D's discharge summary, Respondent reported that Patient D suffered from renal insufficiency when there was no clinical documentation of this condition.

E. On or about May 8, 1998, Respondent admitted Patient E to Brookhaven Hospital. Respondent's care of Patient E deviated from minimally acceptable medical standards, in that:

1. Respondent failed to obtain and document an adequate history and physical exam of Patient E.

2. Respondent ordered consultations with a nephrologist, pulmonologist, psychiatrist, gastroenterologist, surgeon without medical indication.

3. Respondent failed to document Patient E's atrial fibrillation in her hospital chart.

F. On or about April 30, 1998, Respondent admitted Patient F to Brookhaven Hospital. Respondent's conduct failed to meet minimally acceptable medical standards, in that:

1. Respondent failed to obtain and document an adequate history and physical examination.

2. On or about April 30, 1998, Respondent inappropriately ordered I.V. saline for a patient in acute pulmonary edema.

3. In the emergency room, Respondent ordered consultations with a gastroenterologist and rheumatologist for Patient F. These consultations were not medically indicated.

G. Respondent, in her 2001 New York State biennial registration application in response to the following question: "[S]ince you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privilege or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to

professional misconduct, unprofessional conduct, incompetence or negligence?" knowingly and with the intent to deceive failed to disclosed that she had resigned from Brookhaven Memorial Hospital on June 15, 2001.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATION

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. Paragraph A and its subparagraphs
2. Paragraph B and its subparagraphs
3. Paragraph C and its subparagraphs
4. Paragraph D and its subparagraphs
5. Paragraph E and its subparagraphs
6. Paragraph F and its subparagraphs.

EIGHTH 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:

7. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraphs C and its subparagraphs; Paragraph

D and its subparagraphs; Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs.

EIGHTH SPECIFICATION

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:

8. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraphs C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs.

NINTH 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:

9. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraphs C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs.

TENTH THROUGH ELEVENTH SPECIFICATIONS

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:

10. Paragraph A, A 2 and A 3

11. Paragraph G.

DATED: January 16, 2003
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Terms of Probation

1. Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by her profession. Respondent acknowledges that if she commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law Section 171(27); State Finance Law Section 18; CPLR Section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall provide 500 hours of community medical service in an under served area in a manner and in a location to be approved by OPMC.

9. Respondent's practice of medicine shall be monitored by a physician monitor, board certified in an appropriate specialty, ("practice monitor") approved in advance, in writing, by the Director of OPMC or designee. The practice monitor shall be an individual qualified to evaluate and assist Respondent with her oral and written skills in the practice of medicine. The practice monitor shall not be a relative or personal friend or in a professional relationship with Respondent which would pose a conflict with monitoring responsibilities.

10. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of a proposed practice monitor will be determined to be a violation of probation.

11. The practice monitor shall report in writing to the Director of the OPMC or designee, on a schedule to be determined by the office. The practice monitor shall visit Respondent's medical practice at each and every location, at least monthly and shall examine a random (no less than 50) selection of records maintained by Respondent, including patient histories, prescribing information and billing records. Respondent will make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall immediately be reported to the OPMC by the monitor.

12. Any change in practice monitor must be approved in writing, in advance, by OPMC.

13. All expenses associated with monitoring, including fees to the monitoring physician, shall be the sole responsibility of the Respondent.

14. It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

15. Respondent must maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance

with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director or designee prior to the placement of a practice monitor.

16. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.