PUBLIC

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

IN THE MATTER OF DAVID W. STOBIE, P.A.	CONSENT ORDER BPMC No. 03-195

Upon the application of (Respondent) DAVID W. STOBIE, P.A. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney,

Whichever is first.

SO ORDERED.

DATED: 9-24-03

MICHAEL A. GONZALEZ, R.P.A.-C.
Vice Chair
State Board for Professional Medical Conduct

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

IN THE MATTER OF DAVID W. STOBIE, P.A.	CONSENT AGREEMENT AND ORDER

DAVID W. STOBIE, P.A., representing that all of the following statements are true, deposes and says:

That on or about August 30, 1985, I was licensed to practice as a physician's assistant in the State of New York, and issued License No. 002800 by the New York State Education Department.

My current address is 1597 Mills Road, Waterloo, New York 13165, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 14 specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I plead guilty to the first specification, in full satisfaction of the charges against me, and agree to the following penalty:

> Pursuant to §230-a(2) (b) (c) and (8) of the Public Health Law, my license to practice medicine in the State of New York shall be suspended until such time that I successfully complete a 30 credit hour Masters of Medical Science Program at Saint Francis University at Loretto, Pennsylvania, and pass the NCCPA re-certification examination. The suspension shall be

an actual suspension, with the limited exception of performing the clinical requirements of the Masters of Medical Science Program. I agree that I shall be prohibited from using my license for any employment purposes during the period of actual suspension;

Following my suspension, I shall be placed on probation for a period of three years pursuant to the terms set forth in Exhibit B, attached hereto.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date and will continue so long as Respondent remains licensed in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic

verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

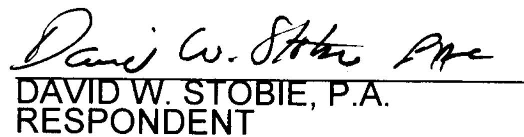
I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

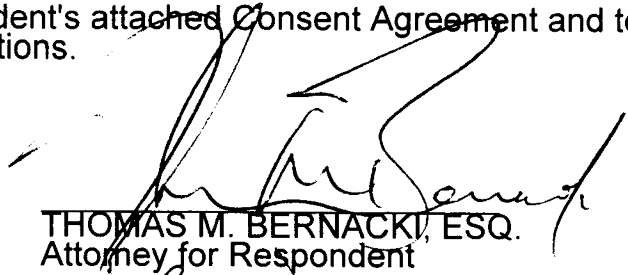


DAVID W. STOBIE, P.A.
RESPONDENT

DATED 8/22/03

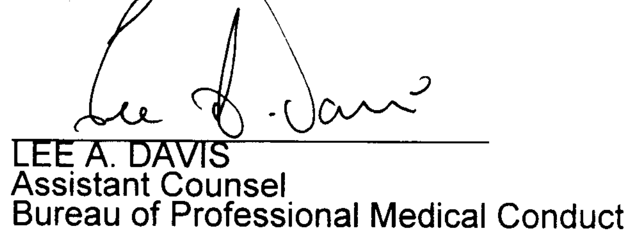
The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 9/2/03



THOMAS M. BERNACKI, ESQ.
Attorney for Respondent

DATE: 9-8-03



LEE A. DAVIS
Assistant Counsel
Bureau of Professional Medical Conduct

DATE: 9/22/03

DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

IN THE MATTER OF DAVID W. STOBIE, RPA	STATEMENT OF CHARGES

DAVID W. STOBIE, RPA, the Respondent, was licensed as a Physician's Assistant in New York State on or about August 30, 1985, by the issuance of license number 2800 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a female patient 38 years old when treated, on or about January 28, 1999 at Lifetime Health, 800 Ayrault Road, Fairport, New York. Respondent's care and treatment of Patient A on that date deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an adequate history and physical examination of Patient A despite the symptoms she reported and displayed, including the "Coronary Risk" profile of blood work that was collected on January 13, 1998 indicating that she was a high risk for heart disease;
2. Respondent failed to interpret Patient A's complaints of arm numbness as an anginal equivalent, and therefore failed to rule out heart disease before proceeding with other differential diagnoses, despite evidence in Patient A's chart which contained evidence of cardiac risk factors, including cigarette smoking, obesity, hyperlipidemia and sedentary life style
3. Respondent failed to obtain and/or record Patient A's vital signs;
4. Respondent failed to obtain and/or record an ECG for Patient A;
5. Respondent failed to perform and/or record a heart and lung examination;
6. Respondent failed to perform and/or record a review of appropriate

7. Respondent inappropriately ruled out heart disease, despite Patient A's reported symptoms of a "numb feeling" in both arms, and evidence contained in her chart indicative of cardiac risk factors, including cigarette smoking, obesity, hyperlipidemia and sedentary life style; and

8. Respondent inappropriately prescribed Elavil 50 mg. QHS despite its potential for arrhythmogenic potential in a patient who displayed evidence of cardiac risk.

B. Respondent provided medical care and treatment to Patient B, a male patient 40 years old when treated, on or about April 22, 2001 at the Marion B. Folsom Center, 1850 Brighton-Henrietta Town Line Road, Rochester, New York 14623, when Patient B presented with complaints of increased cough, fever, fatigue, dizziness, vomiting, diarrhea, right side back and rib pain and decreased urination. Respondent's care and treatment of Patient B on that date deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an adequate history of Patient B in light of the first entry under "chief complaint" of the patient's chart, reflecting an increased cough;

2. Respondent inappropriately failed to consider and/or record a pulmonary ailment as a differential diagnosis for Patient B given the presenting symptoms of Patient B, particularly the "↑ cough";

3. Respondent inappropriately failed to order, and/or record the ordering of laboratory data such as electrolytes and a CBC which were indicated by the presenting symptoms of Patient B and by administration of intravenous fluids;

4. Respondent inappropriately failed to obtain and/or record repeat orthostatic pulse and blood pressure measurements following the fluid replacement in Patient B;

5. Respondent inappropriately failed to order and/or record the ordering of a chest radiograph for Patient B, which was indicated by the presenting symptoms;

6. Respondent inappropriately failed to observe and/or record the observation of objective data in the chart regarding the description of Patient B's physical appearance and presentation; and

7. Respondent inappropriately failed to obtain and/or record a pulse oximetry for the patient.

C. Respondent provided medical care and treatment to Patient C, a male patient 55 years old when treated, from on or about May 8, 1998 through on or about October 27, 1998 at Lifetime Health, 1880 East Ridge Road, Rochester, New York 14622, for renal insufficiency, hypertension, dyspnea, cardiomyopathy and congestive heart failure. Respondent's care and treatment of Patient C on that date deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely consider and/or record the consideration of a cardiology etiology based upon Patient C's persisting symptoms;
2. Respondent failed to order and/or record a timely echocardiogram for Patient C to accurately define the type of cardiomyopathy present in the patient;
3. Respondent failed to order and/or record a timely cardiology consult, in response to Patient C's refractory congestive heart failure;
4. Respondent failed to timely communicate with his supervising physician regarding Patient C's condition and his difficulty diagnosing and controlling it; and
5. Respondent inappropriately continued Patient C on a calcium channel blocker for blood pressure control, which was contraindicated following symptoms of congestive heart failure.

D. Respondent provided medical care and treatment to Patient D, a male patient 54 years old when treated, on or about June 18, 1999 at Lifetime Health Perinton Internal Medical Group, Fairport, New York, for 24 hours of right lower quadrant abdominal pain. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an adequate history of Patient D in light of the recorded differential diagnosis of appendicitis, specifically whether Patient D experienced anorexia and/or vomiting;
2. Respondent failed to perform and/or record an adequate physical examination of Patient D in light of the presenting symptoms and differential diagnosis of appendicitis, specifically failing to perform a rectal examination on the patient;
3. Respondent inappropriately considered renal colic as a differential

rectal examination on the patient;

3. Respondent inappropriately considered renal colic as a differential diagnosis without considering appendicitis as his primary diagnosis until that ailment was disproved;

4. Respondent inappropriately prescribed Vicodin, a narcotic analgesic that masks pain, without first ruling out appendicitis as a differential diagnosis, which may have contributed to the perforation of the appendix and subsequent peritonitis and post operative pneumonia;

5. Respondent inappropriately failed to order a CT Scan for Patient D to assist in determining whether the ailment was renal colic or appendicitis;

6. Respondent inappropriately failed to order an x-ray for Patient D to assist in determining whether the ailment was renal colic or appendicitis; and

7. Respondent failed to refer Patient D to an emergency room or a surgeon while considering appendicitis as a differential diagnosis.

E. Respondent provided medical care and treatment to Patient E, a male patient 32 years old when treated, on or about August 19, 2000 at Health Services Medical Group Extended Hours Acute Care facility, Baldwinsville, New York for sudden onset of “extreme dizziness”, nausea, weakness and vomiting soon after a Taebo workout. Respondent's care and treatment of Patient E on that date deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform and/or record an adequate history of Patient E, given the patient’s symptoms, specifically whether Patient E experienced sudden or violent neck movements;

2. Respondent failed to perform and/or record an adequate physical examination of Patient E, including a neurological examination, given the symptoms of abrupt onset of vertigo and gait disturbance in association with possible neck or head trauma; and

3. Respondent inappropriately failed to rule out a cerebellar lesion given the severe abrupt onset of vertigo, before incorrectly diagnosing Patient E with viral gastritis.

SPECIFICATION OF CHARGES

FIRST 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:

1. A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, A. and A.7, A. and A.8, B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, B. and B.7, C. and C.1, C. and C.2, C. and C.3, C. and C.4, C. and C.5, D. and D.1, D. and D.2, D. and D.3, D. and D.4, D. and D.5, D. and D.6, D. and D.7, E. and E.1, E. and E.2, and E. E.3.

SECOND THROUGH TWELFTH SPECIFICATIONS
GROSS NEGLIGENCE

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

2. A. and A. 2;
3. A. and A.7;
4. B. and B.1;
5. B. and B.2;
6. C. and C.1;
7. C. and C.4;
8. D. and D.3;
9. D. and D.4;
10. D. and D.7;
11. E. and E.2; and
12. E. and E.3.

THIRTEENTH 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:

13. A. and A.1, A. and A.2, A. and A.3, B. and B.2, C. and C.1, C. and C.4, D. and D.3, D. and D.4, D. and D.7, E. and E.2, and E. and E.3.

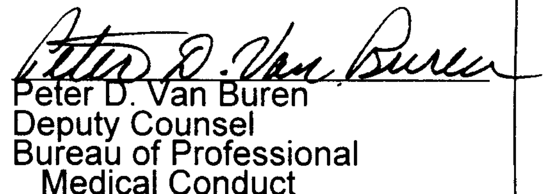
FOURTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

14. A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, B. and B.7, C. and C.1, C. and C.2, C. and C.3, D. and D.1, D. and D.2, E. and E.1, and E. and E.2.

DATED: September 8, 2003
Albany, New York



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

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230 (19).

2. Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that such information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but 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].

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.

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

8. Respondent shall maintain complete and legible medical records that

accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE SUPERVISOR

9. Respondent shall practice medicine only when supervised in his/her medical practice. The practice supervisor shall be on-site at all locations, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.

10. Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess Respondent's medical practice. Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

11. Respondent shall authorize the practice supervisor to have access to his/her patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review and other such on-duty conduct as the supervisor deems appropriate to report.

12. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.