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

July 22, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

Justin O'Corcoran, Esq.
O'Connor, O'Connor, Bresee & First
20 Corporate Woods Boulevard
Albany, New York 12211

Michael Weinberger, M.D.
211 Church Street
Saratoga Springs, New York 12866

RE: In the Matter of Michael Weinberger, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 04-163) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Sincerely,

Sean D. O'Brien/nm

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm
Enclosure

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

COPY

IN THE MATTER
OF
MICHAEL WEINBERGER, M.D.

DETERMINATION AND ORDER

BPMC-04-163

A Notice of Hearing and a Statement of Charges, dated October 22, 2003, were served upon the Respondent, **MICHAEL WEINBERGER, M.D.** **WILLIAM K. MAJOR, Jr., M.D. (Chair), DAVID T. LYON, M.D. and DEANNA KRUSENSTJERNA** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter "the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. Dr. Lyon replaced Dr. Lawrence Kessler, who recused himself from serving on the Committee after the first two days of the hearing. Accordingly, Dr. Lyon affirmed in writing that he has read and considered all the evidence and transcripts pursuant to Public Health law §230(10)(f). **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by **DONALD P. BERENS, JR., ESQ.,** General Counsel, **CINDY M. FASCIA, ESQ.,** Associate Counsel, of counsel. The

Respondent appeared by O'Connor, O'Connor, Bresee & First, **JUSTIN O'C. CORCORAN, ESQ.** of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	October 22, 2003
Dates of Hearing:	December 10, 2003 December 11, 2003 January 9, 2004 January 20, 2004 February 6, 2004 February 23, 2004
Witnesses for Department of Health:	Pat Barinello, M.D. Linda Tripoli, RN
Witnesses for Respondent:	Michael Weinberger, M.D. Maureen E. Roberts, M.D. Joel M. Bartfield, M.D.
Deliberations Held:	April 16, 2004

STATEMENT OF CASE

The Respondent was charged with twelve specifications of professional misconduct. The specifications included practicing with gross negligence, practicing with negligence on more than one occasion, practicing with gross incompetence and practicing with incompetence on more than one occasion. The charges arise from the Respondent's treatment of five emergency department patients from December 1999 through October 2000. A copy of the 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. All Findings and Conclusions herein are the unanimous determination of the Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact. 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 made by the Committee were established by at least a preponderance of the evidence.

FINDINGS

1. MICHAEL WEINBERGER, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on July 9, 1998, by the issuance of license number 211189 by the New York State Education Department. (Petitioner's Exhibit [hereinafter "Ex."] 1)

PATIENT A

2. Respondent treated Patient A, a 41-year-old woman in theEmergency Department of the Saratoga Hospital on December 3, 1999, at approximately 5:00 p.m. (Ex. 4B)

3. Patient A had called her OB-GYN practice on the morning of December 3, 1999, complaining of tenderness, intermenstrual bleeding and cramping and had been seen that same day at approximately 3:30 p.m., by a nurse practitioner at her regular OB-GYN practitioner's office (T. 40, 42; Ex.4B)

4. The nurse practitioner obtained a history and performed a physical exam on Patient A and noted she had had bleeding for 5 days, was crying due to pelvic pain, lower left pelvic tenderness without rebound, adnexa tenderness and fullness, a last menstrual period of 2 ½ to 3 weeks prior and she had had unprotected sexual intercourse. Patient A was referred to the Saratoga Hospital emergency room for pelvic imaging and a stat BHCG test. The Respondent was aware of this information. (Ex. 4B)

5. Patient A presented in the Saratoga Hospital Emergency Department, with a chief complaint of pain in the area of the left ovary. She was referred to the hospital by a nurse practitioner from her regular OB-GYN practice for blood work, an ultrasound and for evaluation. At the Saratoga Hospital she was given a possible diagnosis of ectopic pregnancy or cyst. (T. 43, 740; Ex. 4B)

6. When a patient presents at an emergency department with a history and clinical presentation as Patient A did, the emergency room physician who treats her should do a pelvic examination. The Respondent did not perform a pelvic examination on Patient A. (T. 53- 61, 109-110; Ex. 4B)

7. Patient A had a beta HCG test done at the Saratoga Hospital Emergency Department. A beta HCG test is a test for pregnancy. Her result was 727 miu/ml. A normal beta HCG test result for a nonpregnant female is less than 5 miu/ml. While

values of between 5 and 25 are indeterminate, a value of 727 miu/ml. indicated Patient A was pregnant. (T. 50, 715, 741, 748-749; Ex. 4B)

8. Patient A had a pelvic ultrasound test, which revealed no gestational sac in her uterus. Given Patient A's presentation at the Saratoga Hospital ER of lower abdominal-pelvic pain, vaginal bleeding, a positive beta HCG test and no gestational sac in the uterus an ER physician's first differential diagnosis should have been ectopic pregnancy and required that the physician treat her condition as pregnancy-related. The diagnosis of ectopic pregnancy should have remained the primary diagnosis for this patient unless there was adequate information to conclude otherwise. The Respondent failed to appropriately diagnose this patient. (T. 49, 50-53, 61, 68, 7071, 749, 759-761; Ex. 4B)

9. When a patient presents at an emergency room as Patient A did on the date in question, the treating emergency department doctor should obtain a consult with a gynecologist prior to discharging the patient. The Respondent failed to obtain a consultation with a gynecologist prior to discharging Patient A. (T. 61-65, 78-79, 160; Ex. 4B)

PATIENT B

10. Respondent treated Patient B, a 67-year-old man in the Emergency Department of the Saratoga Hospital on October 12, 2000, from approximately 1:00 a.m. to 6:00 a.m. (Ex. 5A)

11. Patient B's chief complaint upon presenting at Saratoga Hospital was a sudden onset of abdominal pain. Patient B had no significant medical history, was on no medication and had been awakened by a sudden onset of severe upper abdominal pain, which radiated to his back with nausea and vomiting. (T. 168-169; Ex. 5A)

12. When a patient presents to an ER physician as Patient B did, it is a judgment call as to whether or not to perform a rectal exam and test the stool for occult blood. (T. 1120)

13. Patient B was given a number of medications to relieve his pain. The patient's pain did not subside during his five-hour course of treatmentin the Saratoga Hospital ER. The diagnosis of gastritis is not an appropriate diagnosis for a patient who presents as Patient B did and who does not respond to medication. Given Patient B's presentation, an ER physician should consider an alternative diagnosis and/or treatment approach. The Respondent diagnosed Patient B with gastritis and failed to consider an alternative diagnosis. (T. 172-176, 178-181, 189, 191-192, 238-240, 243-

244; Ex 5A)

14. When a patient presents with Patient B's symptoms anddoes not respond to medication, an ER physician should obtain a consultation and/or admit the patient. Respondent did not obtain a consultation or admit Patient B, but discharged him. (T. 183-185, 216-217, 255-257; Ex. 5A)

PATIENT C

15. Respondent treated Patient C, a five-year-old girl on July 13, 2000, in the Emergency Department of Nathan Littauer Hospital. (Ex. 6A)

16. Patient C presented with a three-day history of abdominal pains, vomiting and fever. Her physical examination revealed periumbilical and diffuse abdominal tenderness. Her bowel sounds were normal and no masses were palpated. (T. 1220-1221; Ex. 6A)

17. When a patient presents as Patient C did on the date in question, an adequate history would include the patient's specific symptoms and their duration and a physical examination would include a complete abdominal, head, neck and chest examination, and a checking and recording of all vital signs. The Respondent did this with respect to Patient C. (T. 1221-1223; Ex. 6A)

18. When a patient presents, as Patient C did, laboratory tests such as a CBC are not required. The Respondent did not order any laboratory tests for Patient C. (T1228-1229, 1262-1263; Ex. 6A)

19. The Respondent's diagnosis for Patient C was gastritis. Based on Patient C's history, physical exam, the presentation of symptoms and the improvement of some of those symptoms, a diagnosis of gastritis was a reasonable one (T. 276, 1223, 1226-1227, 1233-1235, 1257-1258; Ex. 6A)

20. The prescribing of Levsin, an antispasmodic, to a patient who presents as Patient C did, was appropriate. (T. 287, 296, 1224-1225, 1231-1232; Ex. 6A)

21. When a patient with Patient C's presentation is prescribed Levsin and Phenergan, both of which have a sedating effect, and no laboratory tests are conducted, the ER physician who treats such a patient shall ensure timely follow-up care on the next day. The Respondent did not ensure for such timely followup care. (T. 283-289, 295-296, 359-360; Ex. 6A)

PATIENT D

22. Respondent treated Patient D, a 72-year-old man, on February 9, 2000, in the Emergency Department of Nathan Littauer Hospital. (T. 404; Ex. 7A)

23. Patient D presented at the Nathan Littauer Hospital Emergency Department with auditory hallucination episodes, complaining that he was hearing a hymn. On physical examination he was found to have tremors and he had started taking Selegiline approximately a week before for the treatment of Parkinson's Disease. All systems were reviewed and found to be negative, and the patient's vital signs were stable. The patient's past medical history indicated Parkinson's, hypothyroidism, cardiac problems and a degree of mental handicap. (Ex. 7A)

24. When a patient presents as Patient D did to an ER physician, a screening neurological examination is adequate. The Respondent performed such examination on Patient D. (T. 410-411, 1272-1273; Ex. 7A)

25. One of the medications that Patient D was taking was Amiodarone, which is an anti-arrhythmic medicine for patients with severe life threatening abnormal heart rhythms. (T. 406-407; Ex 7)

26. The Respondent determined that the Selegiline was causing the patient's auditory hallucinations and ordered this medication stopped. (T. 411-412, 417; Ex. 7A)

27. The Respondent prescribed Mellaril, an antipsychotic medication which is contraindicated for a patient taking Amiodarone. Mellaril is an arrhythmogenicand can make arrhythmias worse. The risk of prescribing Mellaril for a patient who is

taking Amiodarone were known on the date in question. Prior to prescribing Mellaril for a patient taking Amiodarone, a physician should consult with a cardiologist or a psychiatrist. The Respondent did not do this. (T. 410-411, 413, 415; Ex. 7A)

28. Before prescribing a medication for a patient a physician should know the side effects of the medicine he is prescribing in relation to the known medications the patient is taking. The Respondent did not have this knowledge when he prescribed Mellaril for Patient D. (T. 1281-1283, 1294-1295; Exs. 7A and 9)

29. The Respondent was aware that Patient D was taking Amiodarone. A reasonably prudent physician when treating a Patient who presented as Patient D did, would not have prescribed Mellaril for that patient without greater pharmacologic insight or consultation. The Respondent prescribed Mellaril for Patient D. (T. 414-415, 417; Ex. 7A)

PATIENT E

30. Respondent treated Patient E, a 51-year-old man, on August 8, 2000, in the Emergency Department of St. Mary's Hospital. (Ex. 8)

31. Patient E had awoke from sleep with severe epigastric pain radiating to his back and nausea. He had a history of peptic ulcer. Other than the epigastric tenderness, his physical examination was unremarkable. The patient was given Levsin, Maalox,

Lidocaine and Donnatal which provided complete relief for his symptoms. Given Patient B's presentation and the relief he got from the medication he was given, gastritis was an appropriate diagnosis for this patient. The Respondent diagnosed Patient B as having gastritis. (T. 1297-1301, 1305, 1315-1316; Ex. 8)

32. Given Patient B's presentation the physical examination conducted by the Respondent was adequate and did not require any additional testing or laboratory studies. (T. 1302-1304, 1306-1307,1309; Ex. 8)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact as listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual allegation:

Paragraph A.1: (3-6);

Paragraph A.2: (7-8);

Paragraph A.3: (9);

Paragraph B.: (10);

Paragraph B.3: (10, 11, 13);

Paragraph B.4: (13);

Paragraph B.5: (14);

Paragraph C.: (15);

Paragraph C.6: (21);

Paragraph D: (22);

Paragraph D.2.: (23, 25-29).

The Committee concluded that the following Allegations were not sustained: B.1.-2., C.1.-5., D.1. and E.1-2.

The Committee further concluded that the following Specifications are sustained. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Sixth Specification: (Paragraphs A., A.1.-3. ; B., B.4.-5.; C., C.6; D., D.2.);

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Twelfth Specification: (Paragraphs A., A.2.-3.; B., B.3.-5.; C., C.6.);

DISCUSSION

Respondent was charged with four specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these charges, the Committee was provided with instructions which included definitions of " Negligence," "Gross Negligence," "Incompetence" and "Gross Incompetence." (ALJ Ex. 1)

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

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. It requires a deviation from accepted medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding.

Gross Negligence may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." Multiple acts of negligence occurring during one event, can amount to gross negligence on a particular occasion. 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. There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of requisite skill or knowledge to practice medicine safely. 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.

Using the above-referenced definitions where applicable as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the Sixth and Twelfth specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Dr. Pat Barinello, as its expert witness. Dr. Barinello is board certified in internal medicine and in emergency medicine and is a full time ER physician. There was no evidence of any bias on the part of Dr. Barinello or his unsuitability as an expert witness. The Committee found him to be credible in part. With respect to Patient A the Committee found his testimony to be much more convincing than that of the Respondent's expert as noted below. Dr. Barinello repeatedly testified that the Respondent's treatment of Patients A through E did not meet acceptable standards of medical care. With the exception of Patient E the Committee found his testimony to be convincing and accurate with respect to certain aspects of the care provided by the Respondent. In some instances the Committee found his opinion to be too absolute.

The Respondent presented Dr. Maureen E. Roberts, a board certified OB-GYN as his expert for Patient A and Dr. Joel M. Bartfield, who is board certified in internal medicine and in emergency medicine, as his expert for Patients B through E. The Committee found Dr. Bartfield to be credible in part as reflected above in the Findings of Fact. Although Dr. Bartfield is not a full time clinical ER practitioner, the Committee found him to be a fully qualified expert in this matter.

Although the Committee found Dr. Roberts to be a qualified expert, Dr. Barinello's testimony with respect to Patient A, was found to be more credible. Of some relevance in assessing Dr. Roberts' testimony, was the fact that Patient A was a patient of Dr. Roberts' medical group practice. The Committee found this to affect the weight they attributed to her opinion.

The Committee also received testimony from the Respondent on his conduct in these cases. In general the Committee found that the Respondent did not fully appreciate the alleged deficiencies in behavior and judgment that were the subject of this hearing.

PATIENT A

With respect to Patient A, the Committee concurs with Dr. Barinello's opinion. The Respondent should have conducted a pelvic examination of the patient or in the alternative documented the patient's refusal to submit to such an examination. Respondent's rationale for not performing a pelvic examination, that she had one just prior to coming to the ER and her condition had not changed, begs the question of how one would know whether her condition changed unless a pelvic examination is done. The Respondent also erroneously ruled out the diagnosis of an ectopic pregnancy based primarily on the radiologist's oral report and the fact that the patient's os was open. The patient's open os did not lower the likelihood of a diagnosis of ectopic pregnancy. An ectopic pregnancy can develop into a life-threatening condition. Given the fact that pregnancy related disorders, including ectopic pregnancy, were supported by the findings, a consultation with an OB-GYN became the standard of care for this patient. The Respondent's failure to do so was a breach in the standard of care and his reliance on the Patient having an ongoing relationship with an OB-GYN practice and his instructions to "follow up with them" did not suffice.

The Committee determined that the Respondent's conduct with respect to Patient A constituted negligence and incompetence.

PATIENT B

With respect to Patient B the Committee concurred with the Respondent's expert that it was not a violation of the standard of care to not perform a rectal exam or check for occult blood in the stool. In this instance to do so was a matter of judgment. However, the Committee found the Patient's being awakened from sleep by his pain and the lack of response to the numerous medications should have led the Respondent to both a different diagnosis and a different course of action. The Patient was not responding to medications which usually would have provided relief if the patient was suffering from gastritis. The Respondent's diagnosis did not fit the patient's presentation and should have prompted the Respondent to either admit him or get a consultation to explore why the patient was not responding to the course of medication.

The Committee determined that the Respondent's conduct with respect to Patient B constituted negligence and incompetence.

PATIENT C

With respect to Patient C the Committee concurred with the Respondent's expert that the Respondent's history and physical were adequate. The Committee also concluded it was not a violation of the standard of care to not perform a rectal exam or check for occult blood in the stool. In this instance to do so was a matter of judgment. The Hearing Committee agreed with Dr. Bartfield's opinion that laboratory studies were not required in this case based on the presentation of the patient and that it was unlikely that laboratory results would have yielded any useful information. The Committee also concurred with Dr. Bartfield's opinion that abdominal pain of unknown etiology was not the only diagnosis that fit this patient's presentation. Many of the patient's symptoms were consistent with the diagnosis which the Respondent assigned to the patient. The Committee also agreed that the prescribing of Levsin was not inappropriate in that the sedating properties of the medication would not mask the symptoms were they to worsen. The Committee did feel that although the presentation of Patient C did not warrant a physician to have a high suspicion of appendicitis, given the potential risk of such an eventuality, minimally the Respondent needed to inform Patient C's parents of the need for next day follow-up with the child's pediatrician. The Respondent did not do this. The

Committee determined that Respondent's failure to ensure for follow-up care with respect to Patient C constituted negligence and incompetence.

PATIENT D

The Committee concluded that the Respondent did perform an adequate neurological examination on Patient D as evidenced in the medical record. A full blown neurological examination of this patient was not warranted in this case. It was reasonable to conclude that the cause of the patient's hallucinations was the Selegiline that he was taking, since this was a known side effect of that medication and the hallucinations started about the same time that he started taking it.

On the other hand the Committee concurred with the Department's expert that prescribing Mellaril was inappropriate for this patient. The Respondent was aware that the patient was on Amiodarone, an antiarrhythmic used for patients with serious heart abnormalities. Before he prescribed Mellaril for this patient the Respondent had a duty to familiarize himself with the potentially harmful effects it could have on Patient D's health. The Respondent admitted he was not aware of this nor did he take steps to obtain this information or consult with either a cardiologist or a psychiatrist before putting the patient on this drug.

The Committee determined that Respondent's prescribing of Mellaril to Patient C constituted negligence and incompetence.

PATIENT E

With respect to Patient E, the Committee concluded that the Respondent's actions did not constitute misconduct. The Committee found that the Respondent's diagnosis was appropriate. The Committee concurs with the Respondent's expert that the patient's presentation, in particular his history of peptic ulcer and his response to the medication justified the Respondent's diagnosis. The Committee also agrees with the Respondent's expert that the Respondent performed an adequate physical examination of the patient and that based on the results of that physical the standard of care did not require additional tests be conducted on this patient. There was no indication from the patient's condition at the time that the Respondent treated the patient, to increase the level of suspicion that the patient's symptoms were cardiac related.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be suspended for a period of 3 years with all but 3 months of the suspension stayed. In addition, the Respondent's license to practice medicine is placed on probation for a period of 3 years. The terms of the suspension and probation are more specifically set forth in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The record in this case clearly established instances where the medical care the Respondent provided was deficient. In those instances the Respondent either failed to recognize the risk, failed to fully investigate the patient's presentation before arriving at a diagnosis or presumed that the most severe complications would not develop.

The Committee determined that the Respondent's deficiencies in the care provided were sufficient to require at a minimum, the actual suspension of his license followed by a period of probation with a practice monitor who is approved by and who reports to the Office of Professional Medical Conduct. The Committee felt that a suspension is warranted given the pattern of these deficiencies in patient care.

ORDER

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

1. The Sixth and Twelfth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED**;

2. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** , for 3 (three) years, with all but 3 months of the suspension stayed. The terms of the suspension are contained in Appendix II, attached hereto and made a part of this Determination and Order.

3. The Respondent shall complete 125 hours of Category I Continuing Medical Education within 3 months of the effective date of this Order as set forth in Appendix II.

4. Respondent is placed on **PROBATION FOR 3 (THREE) YEARS**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Buffalo, New York
July 20 ,2004

William K. Major Jr. M.D.
WILLIAM K. MAJOR, JR., M.D.

DAVID T. LYON, M.D.
DEANNA KRUSENSTJERNA

TO: Cindy M. Fascia, Esq.
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Michael Weinberger, M.D.
211 Church Street
Saratoga Springs, New York 12866

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
MICHAEL WEINBERGER, M.D.

STATEMENT
OF
CHARGES

MICHAEL WEINBERGER, M.D., Respondent, was authorized to practice medicine in New York State on July 9, 1998, by the issuance of license number 211189 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine in New York State.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (identified in Appendix) a then 41 year old woman, on December 3, 1999, in the Emergency Department of Saratoga Hospital, Saratoga Springs, New York.

1. Respondent failed to perform a pelvic examination of Patient A.
2. Respondent failed to adequately consider a diagnosis of ectopic pregnancy and/or inappropriately diagnosed Patient A as "very early pregnancy and miscarried" without adequately ruling out a diagnosis of ectopic pregnancy.
3. Respondent failed to obtain timely consultation from a gynecologist prior to discharging Patient A.

B. Respondent provided medical care to Patient B, a 67 year old man, on October 12, 2000, in the Emergency Department of Saratoga Hospital.

1. Respondent failed to perform a rectal exam and/or failed to document said exam.
2. Respondent failed to test Patient B's stool for occult blood, and/or failed to document said test.
3. Respondent made a diagnosis of gastritis, which diagnosis was not appropriate for this patient.
4. Respondent failed to consider an alternative diagnosis and/or pursue a different treatment approach when Patient B's "gastritis" did not adequately respond to treatment.
5. Respondent failed to obtain surgical consultation and/or to admit Patient B for further observation, and/or discharged Patient B despite the fact that Patient B's severe abdominal pain had failed to adequately improve.

C. Respondent provided medical care to Patient C, a then 5 year old girl, on July 13, 2000 in the Emergency Department of Nathan Littauer Hospital, Gloversville, New York.

1. Respondent failed to obtain and/or record an adequate history.
2. Respondent failed to perform and/or record an adequate physical exam.
3. Respondent failed to order appropriate laboratory studies.
4. Respondent failed to appropriately diagnose Patient C's abdominal pain of unknown etiology.

5. Respondent prescribed Levsin inappropriately and/or without adequate regard for its sedating and/or masking effects.

6. Respondent failed to recommend and/or make provisions for timely and/or specific medical follow-up for Patient C.

D. Respondent provided medical care to Patient D, a then 72 year old man, on February 9, 2000 in the Emergency Department of Nathan Littauer Hospital.

1. Respondent failed to perform and/or record an adequate neurologic examination of Patient D.

2. Respondent prescribed Mellaril inappropriately and/or without adequate medical justification and/or without adequate consideration for Patient D's heart disease and/or without obtaining consultation.

E. Respondent provided medical care to Patient E, a then 51 year old man, on August 8, 2000, in the Emergency Department of St. Mary's Hospital, Amsterdam, New York.

1. Respondent failed to appropriately diagnose Patient E and/or failed to adequately consider conditions other than gastritis.

2. Respondent failed to perform an adequate physical examination of Patient E and/or failed to perform and/or order adequate testing and/or laboratory studies.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross negligence on a particular occasion in violation of New York Education Law §6530(4), in that Petitioner charges:

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

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAT ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3), in that Petitioner charges that Respondent committed two or more of the following:

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

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of his practicing medicine with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

7. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3.
8. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6.
9. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6.
10. The facts in Paragraphs D and D.1 and/or D.2.
11. The facts in Paragraphs E and E.1 and/or E.2.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of his practicing medicine with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges that Respondent committed two or more of the following:

12. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3; B and B.1 and/or B.2 and/or B.3; and/or B.4 and/or B.5 and/or B.6; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6; D and D.1 and/or D.2; E and E.1 and/or E.2.

DATED: October 22, 2003
Albany, New York

Peter D. Van Buren

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

APPENDIX II

TERMS OF SUSPENSION

Dr. Weinberger's (Respondent) license to practice medicine in the State of New York shall be suspended for 3 (three) years with 2 (two) years and 9 (nine) months of said suspension stayed. During the 3 months of actual suspension, the Respondent shall not actively practice medicine.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

Within 3 months of the effective date of this Order the Respondent shall complete 125 hours of Category I Continuing Medical Education credits in the areas of obstetrics-gynecology emergencies, vascular emergencies and adult and pediatric gastrointestinal emergencies. The CME courses that the Respondent takes to fulfill this condition must be acceptable to the New York State Department of Health, Office of Professional Medical Conduct (OPMC) and the Respondent must obtain prior written approval from OPMC of the courses taken to meet this condition. The cost of these CME courses if any, shall be the responsibility of the Respondent. Prior approval and determination of successful fulfillment of this condition will be in the sole discretion of OPMC. The Director of OPMC shall have the discretion to extend the time required for the Respondent to complete the 125 hours of CME credits

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

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. 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.

5. 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 his staff at practice locations or OPMC offices. The Respondent shall cause all hospitals with which he has an affiliation to provide access to Respondent's Quality Assurance files.

6. 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.

7. Respondent shall practice medicine only when monitored by a licensed physician or physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor(s) any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor(s) shall visit Respondent's medical practice at each and every location, on a random, unannounced basis at least monthly and shall examine 10% but no more than 25 charts of records maintained by Respondent, including patient records, prescribing information and office records. 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 be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall 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 of OPMC prior to Respondent's practice after the effective date of this Order.

e. After 6 (six) months, the Director of OPMC may at his discretion, increase or reduce the number of patient records the practice monitor(s) reviews per month.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he 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.