STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

November 22, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy Runge, M.D.
19 Stetson Avenue
Plattsburgh, New York 12901

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111 Washington Avenue
Albany, New York 12110-2211

Cindy M. Fascia, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
Albany, New York 12237-0032

RE: In the Matter of Timothy Runge, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-271) 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,

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:djh

Enclosure

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

COPY

IN THE MATTER OF TIMOTHY RUNGE, M.D.	DETERMINATION AND ORDER

BPMC NO. 05-271

ANDREW J. MERRITT, M.D., Chairperson, **DIANE SIXSMITH, M.D.** and **FRANK KING, R.P.A.,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.,** General Counsel, **CINDY MARIE FASCIA, ESQ.,** Associate Counsel, of Counsel. The Respondent appeared by **BOND, SCHOENCK & KING, PLLC., CAROLYN SHEARER ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged eighteen (18) specifications of professional misconduct including allegations of negligence, incompetence, gross negligence and gross incompetence. The charges are more specifically set forth in the Amended Statement of Charges dated June 10, 2005, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	May 20, 2005
Pre-Hearing Conference	June 6, 2005
Hearing Dates:	June 15 and 16, 2005
	July 26 and 27 , 2005
	August 9 and 17, 2005

WITNESSES

For the Petitioner:	Daniel M. .Mayer, M.D. Linda Tripoli
For the Respondent:	Joel M. Bartfield, M.D. Hans Theodor Klaudt, M.D. Timothy Runge, M.D.

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on or about February 15, 2000 by issuance of license number 216782 by the New York State Education Department. (Ex. 1)

2. Respondent is board-certified in emergency medicine. (T. 896-897)

3. Respondent provided medical care to Patient A, a 35 year old man, in the Emergency Department of Champlain Valley Physicians' Hospital (hereafter CVPH) on or about July 28, 2001. (Pet. Ex. 5) Patient A was a race car driver, and had been involved in a motor vehicle accident in his race car, which had been "T-boned." (Pet. Ex. 5)

4. Respondent ordered x-rays of Patient A's cervical spine, pelvis and chest. (Pet. Ex. 5, 5A, B, C (x-rays)) Respondent noted Patient A had complained of pain in the left side of his pelvis and left hip. (Pet. Ex. 5) Respondent, after reading Patient A's x-ray films, diagnosed Patient A as having a comminuted, displaced left hip fracture. Respondent did not detect, diagnose or document the presence of any other pelvic fractures in Patient A. (Pet. Ex. 5; T.)

5. Patient A's hip fracture was in fact a severely comminuted fracture of the femur, the thigh bone, below the hip joint. (T. 42-43 ; Pet. Ex. 5B)

T. ____ and Ex. _____ indicate a reference to the transcript of the hearing or to an exhibit in evidence.

6. In fact, Patient A had obvious pelvis fractures. He had a fracture of the left iliac wing, the left superior pubis ramus, and a left interotrochanteric fracture. (Pet. Ex. 5, pp.34-35, p.5, pp.10-13, p.57) Patient A's pelvic fractures included an obvious fracture that any competent physician would be expected to see without difficulty. (T. 46-48, T. 53)

7. Pelvic fractures are associated with large amounts of bleeding. They can cause large amounts of bleeding in the pelvic region. (T. 51-52)

8. Respondent failed to order adequate fluid resuscitation for Patient A. A reasonably prudent physician would have ordered at least one liter of intravenous fluids to be given to Patient A immediately. (T. 54-55)

9. Respondent ordered a chest x-ray for Patient A. Patient A's chest x-ray showed a glaring, obvious abnormality, a widening of Patient A's mediastinum. (Pet. Ex. 5A) Given Patient A's mechanism of injury, a serious high-speed motor vehicle accident with much damage to the vehicle and the presence of other known, serious injury to the patient, a reasonably prudent physician would be concerned about damage to internal organs. The presence of a widened mediastinum would immediately prompt a reasonably prudent physician to aggressively look for and attempt to rule out the presence of vascular injury, such as a tear of one of the great vessels in the chest. (T. 56-57)

10. In order to adequately rule out great vessel injury or other vascular injury, Patient A needed immediate evaluation with studies such as CT scan. He needed a computerized tomography angiogram to determine whether or not the widened mediastinum was being caused by bleeding. (T. 57-59)

11. Respondent admitted that he should have ordered a CT scan of Patient A's chest to rule out aortic injury. Respondent admitted that in a trauma patient such as Patient A, who had sustained significant injury, he should have definitively ruled out aortic injury first, regardless of any other competing theory he might have had about Patient A. (T. 1066-1067) Respondent admitted that he may have been "a little too impressed with [Patient A's] affirmative answers with regard to other symptoms" such as coughing and pain on swallowing, that he failed to take definitive measures to rule out great vessel injury in Patient A. (T. 1067-1068 ; Pet. Ex. 4)

12. Respondent admitted that he did not diagnose any other fractures in Patient A other than the comminuted, displaced left hip fracture. (T. 1069-1071) Respondent further admitted that if he had not missed the pelvic fractures, and if he had recognized they were present, he would have given Patient A intravenous fluids. Respondent acknowledged that he usually gives IV fluids to patients who had been in high speed car accidents and had pelvic fractures, because pelvic fractures that are a result of high speed trauma or trauma from a significant force are associated with bleeding. (T. 1072-1073)

13. Even Dr. Bartfield had to concede that the fracture of Patient A's superior ramus was obvious and Respondent should have seen it:

> **To my read the super...the superior ramus fracture is fairly obvious on this film, so I think that he should have picked that up. (T. 874 [Dr. Bartfield])**

14. Even Dr. Bartfield conceded that Patient A's chest film definitely raised the concern of great vessel injury, and that in this patient "it would be imperative to rule out great vessel injury." Dr. Bartfield agreed that without a CAT scan, great vessel injury could not be excluded in Patient A even if there were a potential alternate explanation for his widened mediastinum. Dr. Bartfield agreed that if great vessel injury could not be excluded, Patient A needed to be transferred to a Level 1 trauma center. (T. 869-871)

Patient B

15. Respondent provided medical care to Patient B, a 37 year old woman, on or about February 20, 2002, in the Emergency Department of CVPH. Patient B had undergone bladder suspension surgery approximately one week earlier. Subsequent to that surgery she had suffered a DVT, and was placed on Coumadin. (Pet. Ex. 6)

16. Patient B came to the Emergency Department the night of February 20, 2002 complaining of vaginal bleeding for the past 2 hours. Patient B stated the amount of vaginal bleeding was "much more than her usual period." She complained of nausea and abdominal pain. Patient B was noted by nursing staff to be "very anxious and pale - patient anxious about amount of blood found on pads and in toilet." (Pet. Ex. 6)

17. Respondent performed a pelvic exam. He noted that Patient B had blood and clots in her vagina, and that a "mild to moderate amount of blood" was passing through her cervix. (Pet. Ex. 6) Respondent ordered a type and screen, a complete blood count, coagulation studies (PT and PTT), a basic metabolic profile, and a pregnancy test. (Pet. Ex. 6)

INR was 3.1. Respondent also ordered that Patient B receive a liter of IV fluids. (Pet. Ex. 6)

18. A patient who is having heavy vaginal bleeding due to mennorrhagia does not usually have blood and clots passing through her cervix on a continuous basis, as even Respondent's expert conceded. Such a finding signifies significant bleeding. (T. 792)

19. Patient B's initial blood pressure was 115/89. When her orthostatic vital signs were obtained, her blood pressure lying down was 109/60. Her blood pressure when she was sitting up was 93/58. Her standing blood pressure was not obtained. In a patient with ongoing bleeding, a sitting blood pressure of approximately 90/60 would indicate a significant amount of volume loss, as even Respondent's expert conceded. (T. 793-794)

20. Respondent conceded that even in a patient who was having heavy bleeding due to her period, while it was common to see a little bit of blood oozing from the cervix, it would be very unusual to see what Respondent described was happening with Patient B, who had a "mild to moderate amount of blood passing through her cervix." (T. 1031-1032 [Respondent]) Respondent further admitted, in his interview with OPMC and in his testimony before the Hearing Committee, that Patient B's bleeding represented "an impending, life-threatening problem," and that in light of her recent surgery and subsequent DVT, and the fact that she was on anticoagulants, her situation was "dicey." (Pet. Ex. 4; T. 1032-1033)

21. Respondent did not order a repeat hematocrit for Patient B after she had received IV fluids. Respondent could not have determined adequately how much blood Patient B had lost with the assessment he performed. (T. 179-184)

22.. Respondent, after he performed the initial pelvic exam on Patient B in which he observed significant active bleeding, failed to adequately re-assess Patient B before he ordered that she be discharged. Respondent did not make sure that Patient B had stopped bleeding before he discharged her. (T. 186-187)

23.. Respondent admitted that on his re-exam of Patient B he did not do a speculum exam to see if there was still blood coming out of her cervix. He admitted that he only looked at her vagina externally "to make sure that she did not have blood dripping out of her vagina." (T. 1028-1031)

24.. Respondent did not document having performed any re-examination of Patient B prior to discharging her from the Emergency Department. (Pet. Ex. 6; T. 1028-1029)

25. Respondent did not admit Patient B to CVPH. Patient B, who had surgery a week before and was on Coumadin, was having a significant amount of active bleeding which Respondent himself visualized on his pelvic exam of Patient B. Patient B was at risk of bleeding excessively. She was at risk of bleeding to dangerously low levels, or even exsanguinating. By failing to adequately assess Patient B, and discharging her based on his dangerously inadequate assessment rather than admitting her to the hospital, Respondent placed Patient B at significant risk of harm for continued, excessive bleeding. (T. 182-186,)

26. Even Respondent's expert acknowledged that Respondent's discharge instructions to Patient B were "somewhat confusing." Respondent's instruction "return if you have increased bleeding," given to a patient such as Patient B who was already bleeding heavily, further exposed Patient B to risk of harm from continued, excessive bleeding. (T. 792-793)

27. Patient B returned to the Emergency Department of CVPH by ambulance approximately eight hours after Respondent discharged her. (Patient B had called the ambulance at approximately 8:30 am. She was discharged by Respondent at approximately 1:30am). She was hemorrhaging from her uterus and bladder, and her hematocrit had dropped to 17. She received two units of packed red cells and three units of fresh frozen plasma. She was admitted. (Pet. Ex. 6A)

Patient C

28. Respondent provided medical care to Patient C, a 77 year old man, in the Emergency Department of CVPH on or about March 6, 2002. (Pet. Ex. 7)

29. While Patient C was en route to CVPH on March 6, 2002, ambulance personnel were in communication with Respondent, who was the base station physician. (Pet. Ex. 7,p.10; T. 796) The base station physician's documentation is incorporated into and a part of the ECC record. (T. 555; T.797)

30. In the base sation documentation, Respondent listed the chief complaints as chest pain ad dyspnea, with wheezing as an associated sign and symptom.(Pet. Ex. 7, p.10; T. 311; T.797)

31. As base station physician, Respondent gave orders for medications to be administered to Patient C en route to CVPH. He appropriately ordered aspirin as presumptive treatment for possible cardiac problems (Pet. Ex. 7, p.10; T. 797); Albuterol and Atrovent for wheezing (T. 330) and COPD exacerbation(T. 797); and nitroglycerine for chest pain. (T. 330, T. 797.) Nitroglycerine was administered minutes before Patient C's arrival. (T. 811)

32. Upon Patient C's arrival at the ECC, Respondent documented the presenting complaints as a one-day history of worsening dyspnea, unrelieved by oral Lasix and inhalers, and weight gain of five to ten pounds over the prior five to seven days. (Ex. 7; T. 308.)

33. Respondent obtained an appropriate history, including a description of the measures that the patient had taken at home without relief. (T. 799)

34. Respondent performed an appropriate review of systems and physical examination. The findings, including jugular venous distension and pitting edema, were consistent with congestive heart failure. (T. 308; T. 337) Respondent also documented pertinent negatives in the review of systems. (T. 799)

35. In evaluating Patient C, Respondent appropriately reviewed prior records, including the record of a normal Persantine myoview performed on August 25, 2001. (Pet. Ex. 7, p. 24; T. 335; T. 799-800)

36. Patient C reported a one day history of worsening dyspnea which was not at all relieved by oral Lasix or the use of his inhalers. Patient C also reported a weight gain of five to ten pounds in the past five to seven days. The pre-hospital note of the ambulance transport for Patient C states the patient had chest pain and difficulty breathing.

Respondent was the CVPH base station physician administering medical control for the transport. Respondent lists Patient C's chief complaint as chest pain and dyspnea. (Pet. Ex. 7; T. 307, 311-312)

37. Patient C had a history of COPD (chronic obstructive pulmonary disease), coronary artery disease and hypertension. His medications included Lasix, Indur, Coumadin, Prilosec, Glucotrol, Paroxetine, Flomax and other medications. The triage nurse at CVPH noted Patient C had difficulty breathing and complained of chest pain. (Pet. Ex. 7)

38. Respondent performed a physical examination of Patient C. Patient C's blood pressure was noted as 157/106 and as 133/80. His pulse was 115 and his respirations were 24. He had JVD (jugular venous distention) and pitting edema in his lower extremities. He had poor air entry at both lung bases with bilateral expiratory wheezes. Conjunctival pallor was present. (Pet. Ex. 7) Respondent ordered a cardiac panel, coagulation studies (PT and PTT) and a chest x-ray. The CBC showed a normal white count, a low hemoglobin and low hematocrit. His BUN was slightly elevated, as was his creatinine, and also his glucose. His PT and PTT were elevated, as was his INR. His cardiac enzymes were normal. (Pet. Ex. 7)

39. Respondent ordered a chest x-ray for Patient C. The results of the chest x-ray were consistent with congestive heart failure (CHF). Respondent also ordered an EKG, which showed atrial fibrillation. (Pet. Ex. 7)

40. Respondent ordered intravenous Lasix, intravenous Solu-Medrol, and Albuterol and Atrovent by nebulizer at approximately 1 a.m. At about 2 a.m., Patient C was beginning to diurese, and was feeling better. His oxygen saturation on room air was 95 percent. At approximately 3:30 a.m., Patient C was noted to have diuresed about one liter of fluid, and his chest pain and dyspnea had improved. Respondent discharged Patient C at 3:30 a.m., approximately two and one half hours after Patient C's arrival at the Emergency Department of CVPH. (Pet. Ex. 7)

41. Even Respondent's expert agreed, upon questioning by the Hearing Committee, that Patient C's vital signs on discharge were "somewhat worrisome." Even Dr. Bartfield admitted that an acute cardiac event had not been ruled out as the cause of Patient C's acute decompensation / exacerbation of his heart failure. (T. 815-817) A cardiac event, silent or otherwise, is a common cause for precipitating or exacerbating CHF, and a reasonably prudent physician should consider this. (T. 811-813

42. Patient C's heart rate on discharge was 122, and he had diuresed only a small portion of his weight gain. Even Respondent's expert acknowledged that if a patient does not respond adequately to therapy, the patient should be admitted to the hospital. (T. 816-817)

43. Respondent had been involved in Patient C's care on a prior occasion. The patient had been placed on the chest pain pathway, and had three sets of cardiac enzymes ordered by another physician. (T. 319-321; Resp. Ex. B1 and B2) On that occasion, Patient C had been kept in the Emergency Department for a prolonged observation time.

44. Respondent chose not to admit Patient C to the chest pain pathway at CVPH for observation and monitoring. Respondent decided to discharge Patient C instead. (T. 1183-1184)

45. Respondent admitted that "in the vast majority of patients with chest pain," he orders more than one set of cardiac enzymes. (T. 1181-1182) Yet Respondent chose not to order more than one set for Patient C, despite his history and risk factors.

46. Patient C was brought back to the Emergency Department of CVPH approximately seven and a half hours after Respondent discharged him. Patient C was admitted at that time for complaints of chest pain and shortness of breath. His heart rate had increased to 147. (Pet. Ex. 7, p. 64; T. 327-328)

Patient D

47. Patient D, a fifteen month old child, was seen by Respondent for medical care in the Emergency Department of CVPH on July 10, 2002, at approximately 1:45 am. The patient had a two day history of dry cough, runny nose and diarrhea, and was noted to be pulling at his ears. His temperature, taken rectally, was 100.4 (Pet. Ex. 8; T. 274)

48. Respondent ordered a chest x-ray. Respondent ordered the chest x-ray for the specific purpose of seeing whether or not Patient D had pneumonia. (Pet. Ex. 8; T. 1158-1159)

49. Respondent read the chest x-ray himself while Patient D was in the Emergency Department. Respondent read the chest x-ray at that time as being negative. (Pet. Ex. 8; T. 1159) Respondent noted no abnormalities on the film at that time. (Pet. Ex. 8)

50. Respondent discharged Patient D from the ECC on ibuprofen, with appropriate instructions to see the pediatrician the next day and to return to the ECC in the event of any problems. (Pet. Ex. 8, p.5; T. 277, T.282)

51. The following morning, when the x-ray was routinely over-read, the radiologist interpreted the chest x-ray as showing a right middle-lobe infiltrate. (Pet. Ex. 8, pp. 8 and 11; T. 278)

52. That morning, CVPH notified the patient's pediatrician by phone of the radiologist's report. On the strength of that report, the pediatrician ordered antibiotics for the patient; the patient was not seen in the pediatrician's office on that date. (Pet. Ex. 8C; T. 461)

53. There were no clinically significant abnormalities in Patient D's chest x-ray. (T. 454) Although the right heart border was partially obscured and there was a small bronchogram, both findings are very subtle. (T. 1158, 1160-1161) and did not warrant a diagnosis of pneumonia. (T. 458)

Patient E

54. Respondent provided medical care to Patient E, a nineteen year old woman, in the Emergency Department of CVPH on July 16, 2002. (Pet. Ex. 9) Respondent saw Patient E at approximately 11:00 p.m. Patient E had been seen in the Fast Track portion of the Emergency Department at CVPH earlier that same day. Approximately twelve hours after she had been discharged from the Fast Track, Patient E returned to the CVPH Emergency Department, and was then seen by Respondent. (Pet. Ex. 9)

55. Patient E had presented in the CVPH Emergency Department Fast Track for a blister which she had for 4 days. The patient reported increasing pain when standing, and she had noticed that she had redness and streaking up the dorsum. On examination, she was noted to have erythema across the dorsum of her toe, with a streak across the dorsum. She had limited ability to bear weight secondary to pain, and she had tenderness in her medial thigh. Patient E was diagnosed as having cellulitis. She was given Levaquin 500, to be taken orally three times a day. She was told to return to the Fast Track in two days to have her wound checked. (Pet. Ex. 9)

56. When Patient E returned to the Emergency Department approximately twelve hours later, her condition had deteriorated. Her temperature, which had been 98.5 at her earlier visit, was now 101.3. She had a fever, chills, nausea and vomiting. The streaking across the dorsum of her foot had increased, and was up onto the interior aspect of her leg. She had a tender inguinal lymph node. (Pet. Ex. 9) Her pulse, which had been 95, was now 135. She was noted by Respondent to be in moderate distress. (Pet. Ex. 9)

57. Patient E vomited in the Emergency Department of CVPH at about 11:45 a.m. Pursuant to Respondent's orders, she received some intravenous fluids, IV Phenergan and IV Clindamycin. However, at 1:55 a.m., approximately five minutes prior to being discharged from the CVPH Emergency Department pursuant to Respondent's orders, Patient E's systolic blood pressure had dropped to the 90's, and her diastolic to 40. Her blood pressure in the Fast Track had been 122/72. On her return to the Emergency Department that night it was 133/82. Her pulse at 1:55 a.m. was 108. (Pet. Ex. 9)

58. Respondent adequately assessed Patient E for dehydration by noting her vomiting (Pet. Ex. 9; T. 649) and by evaluating her heart rate (T. 649), her urine specific gravity (T. 1037, T. 649; T. 938-939) and her basic metabolic panel results. (T. 250)

59. Respondent aggressively treated Patient E's dehydration. (T. 649; T. 938-939) by appropriately ordering two liters of intravenous saline (Ex. 9; T. 237; T. 938), which is a significant amount of fluid. (T. 643, T. 649) In-patient admission for administration of intravenous fluids was not indicated. (T. 648, T. 649-650)

60. Respondent appropriately treated Patient E's nausea and vomiting by ordering intravenous administration of the anti-emetic Phenergan and by giving her oral Phenergan at discharge. (T. 243, T. 238, T. 643)

61. Respondent appropriately treated Patient E's pain by ordering intravenous morphine (T. 642) and by giving her oral Lorcet at discharge. (Pet. Ex. 13, p.10)

62. Respondent appropriately broadened Patient E's antibiotic coverage by administering a large dose of intravenous Clindamycin and by giving her oral Clindamycin at discharge. (Pet. Ex. 9; T. 235, T. 241, T. 643)

63. Respondent adequately assessed Patient E's ability to tolerate and respond to oral medication. (T. 646-647, T. 682) Patient E received an oral medication at one minute before midnight. (Pet. Ex. 9; T. 239) A reasonably prudent physician would observe the patient for about 30 minutes after administration of an oral medication, to make sure that the patient did not vomit. (T. 227, T. 647, T. 682) Patient E was noted to have no further vomiting at 30 minutes past midnight (T. 239), and she remained under observation in the ECC until nearly 2:00 a.m. with no further vomiting noted. (Pet. Ex. 9, p.12)

Patient F

64. Respondent provided medical care to Patient F, a twenty year old male, in the Emergency Department of CVPH on September 2, 2002. (Pet. Ex. 10) Patient F had fallen about ten feet out of a tree stand, and struck the left side of his pelvis and left hip. Respondent ordered x-rays of Patient F's pelvis, chest, left hip, femur and knee, as well as spinal x-rays. Respondent read these films as showing a fracture of L4, and a posterior left hip dislocation. (Pet. Ex. 10; T. 1118-1120)

65. Respondent consulted with Dr. Black, an orthopedic surgeon, about whether Patient F's hip dislocation should be relocated in light of the possibility Patient F had an L4 fracture. (Pet. Ex. 10; T. 1118-1119) Respondent also spoke to Dr. Rogers, a trauma surgeon at Fletcher Allen Health Center. Given that there is no neurosurgeon at CVPH, their recommendation was not to relocate the hip prior to transfer. Patient F was transferred from CVPH to Fletcher Allen. (Pet. Ex. 10; Pet. Ex. 10A; T. 1119-1120)

66. Respondent ordered no intravenous fluids for Patient F. Patient F had a single IV line, with no fluids attached. Patient F's line had a saline lock, and he received IV Morphine and Phenergan, but no fluids. Pursuant to Respondent's orders, Patient F was also NPO. (Pet. Ex. 10)

67. Respondent's care and treatment of Patient F significantly deviated from accepted standards of care. The standard of care for a patient such as Patient F would be to give initial fluid resuscitation of a liter of fluids, and then to reassess the patient. The standard of care also requires that in trauma patients such as Patient F, two large bore IVs should be started. In a patient with significant trauma, the standard of care requires that a

second IV line be started and available in case a large volume of fluid needs to be given quickly, or in the event that the first IV line fails. (T. 125-128)

68. Patient F had significant trauma, both by the mechanism of his injuries and by clear evidence on x-ray and physical exam. He had a dislocated hip and a spinal fracture. In light of his significant trauma, a reasonably prudent physician would have ordered IV fluids for Patient F, and would have ordered two large bore IVs. Furthermore, in addition to his known significant trauma, Patient F had a persistently elevated heart rate during his time in CVPH. (Pet. Ex. 10; T. 125-129) This would raise concern that the patient had an internal injury that was not obvious on physical examination and which was causing internal bleeding. (T. 128-129) In the presence of significant trauma, the presence of an elevated heart rate would have to be considered by a reasonably prudent physician as a possible sign of early shock, and a warning that early intervention and fluid resuscitation is important. (T. 128-131) A reasonably prudent physician would know that the presence of a non-tender abdomen does not exclude the possibility of active internal bleeding. (T. 131-132)

69. In a patient with suspected major trauma, the standard of care promulgated by both the American Board of Emergency Medicine and in the Advanced Trauma Life Support guidelines is that two large bore IVs should be established immediately. (T. 97)

70. Respondent, in response to questions by the Hearing Committee, admitted that he does not usually leave trauma patients such as Patient F who are being transferred to another facility NPO and fluid less for several hours. He further admitted that normally he does not hesitate to give trauma patients such as Patient F IV fluids. Respondent admitted that

there was nothing particular about Patient F that caused Respondent to hesitate to give him fluids, and to decide to keep him fluid less:

By Mr. King: (T. 1134-1135)

Q. Is [this] your typical approach to a trauma patient?

A. I think normally I don't hesitate to give patients IV fluids, trauma patients IV fluids.

71. Respondent admitted that it was "certainly possible" that he had forgotten to order IV fluids for Patient F, rather than having made an active decision not to order fluids for Patient F. (T. 1136)

Patient G

72. Respondent provided medical care to Patient G, a 63 year old man, in the Emergency Department of CVPH on or about December 15, 2002. Patient G presented to the Emergency Department complaining of dyspnea and chest pain. He was diaphoretic and complained of nausea. Patient G had a history of COPD and CAD with a 40% left anterior descending artery obstruction. (Pet. Ex. 11)

73. Patient G was brought to the ECC on December 15, 2002 by ambulance. Pet. Ex. 11, p.11) While en route with Patient G, the ambulance personnel were in contact with the CVPH base station. Respondent was the base station physician, who had the

responsibility to communicate with incoming ambulances and issue patient care orders if indicated. The base station physician's documentation is part of the ECC record. (T. 554-555)

74. Prior to Patient G's arrival at the ECC, Respondent documented the patient's chief complaint as shortness of breath for three days, with chest pain as an associated sign or symptom. Respondent ordered sublingual nitroglycerine, and documented that the chest pain resolved after two baby aspirin and one sublingual nitroglycerine. (T. 555-556)

75. When Patient G arrived at the ECC, Respondent documented the presenting complaints as dyspnea, increased cough productive of white phlegm, and chest pain, constant and without interruption for about three days, substernal and dull with no radiation. (Pet. Ex. 11; T. 354, 556)

76. Respondent ordered a cardiac panel, a type and screen, two sets of blood cultures, a sputum culture, a chest x-ray, and am EKG. The laboratory results were essentially unremarkable. The chest x-ray showed hyperinflation, consistent with COPD exacerbation. (T. 374, 560)

77. Respondent adequately evaluated Patient G on December 15, 2002. Taking into account the location and duration of chest pain in light of the patients' clinical presentation, Patient G's chest pain was unlikely to be a symptom of an acute cardiac syndrome; of chest pain of three days duration were of cardiac origin, the cardiac enzymes would have been abnormal. T. 561-563; 996)

78. As therapeutic interventions, Respondent appropriately increased the patient's Prednisone, ordered intravenous Solu-Medrol, and increased the patient's Albuterol and Atrovent nebulizer treatments. (T. 560-561)

79. Respondent discharged Patient G with a diagnosis of COPD exacerbation. At the time of discharge, Patient G was pain free. (T. 374-375; 378-379; 561)

80. Patient G presented to the ECC again the following day, December 16, 2002, at which time he was not seen by Respondent. (Pet. Ex. 11; T. 358) On that occasion, the emergency department physician ordered a D-dimer, a laboratory test that is used to screen for pulmonary embolism in patients for whom there is a low clinical probability of pulmonary embolism. (T. 359-360) The emergency physician noted the result as "D-dimer positive. Low clinical probability of PE. I was hoping it would be negative." (Pet. Ex. 11, p.34) That physician did not take any steps to follow up on the positive result. (T. 360-361; 567)

81. During Patient G's December 16, 2002 visit, he underwent a Persantine myoview study of heart muscle functioning. (T. 379; 55-556) The result of that study was negative, showing no activity suggestive of ischemia. A prior study in April, 2002 had also been negative. (T. 556)

82. Patient G again presented to the ECC on December 18, 2002 and was treated by Respondent. (Pet. Ex. 11, p.76) The patient's presenting complaints were persistent cough productive of white phlegm; shortness of breath, ongoing for several years; and a constant sensation of tightness in the chest. (T. 567-568)

83. Respondent ordered an EKG and interpreted it as similar to the previous EKG tracing. (T. 364-365; T. 569) He appropriately ordered a chest x-ray, and correctly interpreted it as being consistent with COPD, similar to the previous chest x-ray. (T. 379; 569)

84. To treat Patient G's respiratory symptoms, Respondent ordered Albuterol and Atrovent nebulizers, to be followed by Xopenex nebulizer. (T. 379; 570)

85. Respondent discharged Patient G with a diagnosis of acute exacerbation of COPD, and issued discharge instructions for him to follow up wit the primary care physician and return to the ECC in the event of further problems. (Pet. Ex. 11, p.76; T. 613)

86. When Respondent saw Patient G on December 18, 2002, he did not see the entry on the December 16th chart concerning the positive D-dimer result. (T. 978)

87. Although there was a way that the December 16th D-dimer result could have been retrieved via computer, had Respondent been aware of a reason to seek that particular result, the means of accessing that data was very difficult and cumbersome. (T. 437; 610-611; 986; 989)

88. Dr. Klaudt agreed that Respondent did nothing definitive to prevent Patient G from continuing to come to the Emergency Department on a nearly daily basis, and that no real intervention or investigation was done by Respondent to prevent this recurring presentation. (T. 612-613) Respondent himself, on questioning by the Chairperson, agreed he had done nothing on December 18, other than more frequent nebulizer treatments, to prevent Patient G from returning in the same or worse condition. (See: T. 1002)

Patient H

89. Respondent provided medical care to Patient H, a nine month old child, in the Emergency Department of CVPH on February 17, 2003. (Pet. Ex. 12)

89. Patient H was noted to have had intermittent rapid breathing, a cough, runny nose and a fever during the past week. Respondent noted on physical examination that Patient H had bilateral expiratory wheezing. Patient H's temperature was 100.8. His left tympanic membrane was dull and red; the right one was only slightly pink. (Pet. Ex. 12)

90. The presence of bilateral expiratory wheezes indicates that there is some kind of airway obstruction in the medium to small airways. Such wheezes could be due to asthma, to reactive airway disease from a viral infection, or to bronchiolitis. (T. 288-289)

91. The standard of care for a reasonably prudent emergency physician is to treat a child who is wheezing with Albuterol, either with a nebulizer or an inhaler, to attempt to stop the wheezing, or at least to try to reduce it or prevent it from becoming worse. Oral Albuterol may also be used. (T. 291)

92. Patient H had a pulse oximetry oxygen saturation of 92 at 11:35 a.m. The test was not repeated or rechecked, nor was Patient H re-evaluated after the 92 percent reading. (Pet. Ex. 12; T. 289-293)

93. Patient H, pursuant to Respondent's orders, was discharged from the Emergency Department of CVPH at approximately 1:00 p.m. Respondent's discharge diagnosis was left otitis media. Respondent's discharge diagnosis did not address the documented chief complaints in the record for this child, including wheezing and a rapid rate of breathing; fever, coughing and runny nose.

Patient I

94. Respondent provided medical care to Patient I, a 56 year old woman, in the Emergency Department of CVPH on February 18, 2003. (Pet. Ex. 13) Patient I presented to the Emergency Department of CVPH complaining of generalized weakness, increased shortness of breath for the past three days, coughing and vomiting. Patient I had lung cancer with metastases to the liver and mediastinum. Her most recent chemotherapy had been ten days earlier. Respondent described Patient I as being in mild distress, with bilateral expiratory wheezes. (Pet. Ex. 13, p. 362)

95. Respondent ordered an EKG and a chest x-ray. Respondent read the chest x-ray, which he described as showing a "hilar mass with L diaphragmatic elevation." Respondent interpreted Patient I's EKG as showing "ST @ 121; similar to previous tracing." (Pet. Ex. 13, p. 362; Pet. Ex. 13A [EKG]; Pet. Ex. 13B [CXR])

96. Respondent failed to detect and/or diagnose and/or document the presence of cardiomegaly in Patient I. This was an obvious abnormality on Patient I's chest x-ray. On the chest x-ray, Patient I's heart is huge, measuring well over half the diameter of her chest. Her heart is not only grossly enlarged, but has an abnormal, globular shape. Respondent did not even document the presence of, nor did he document any consideration of these abnormalities in his diagnosis and treatment of Patient I. (T. 148-151)

97. Respondent's reading of Patient I's February 18, 2003 EKG was that it was similar to her previous tracing. Patient I had a previous EKG performed at CVPH on August 7, 2002. (Pet. Ex. 13A) Patient I's February 18, 2003 EKG showed low voltage throughout the

EKG. Any reasonably prudent emergency physician practicing within the standard of care should have been able to tell by looking at Patient I's EKG that low voltage was present. The machine reading of the February 18, 2003 EKG states "Low Voltage Throughout" and contains the asterisk marked finding "* Since 8/7/02 Low Voltage Now Present- Consider Pericardial Effusion." (Pet. Ex. 13, p. 304) Regardless of whether or not the machine reading was printed on the EKG when Respondent read it, a competent emergency medicine physician should have been able to see low voltage was present. (T. 152-157)

98. Respondent did nothing to set in motion the process to further evaluate and/or treat Patient I for pericardial effusion. Respondent did not recognize and/or document the presence of either the cardiomegaly on Patient I's chest x-ray or the low voltage on her EKG. He did not diagnose and/or consider the presence of a pericardial effusion. He did not document anything that might have alerted others assuming care of Patient I after admission to order further studies to pursue the diagnosis of pericardial effusion. (T. 172, 166-167) While Patient I's attending physician should have done his own evaluation, admitting physicians often rely on the emergency physician's evaluation of the patient as part of their own initial evaluation. (T. 171-172)

99. Respondent admitted in his testimony at the hearing and in his interview with OPMC that he had missed the finding of low voltage on Patient I's EKG. (T. 1092, 1095 ; Pet. Ex. 4) Respondent admitted that if he had seen that low voltage was in fact present on the EKG, he would have advised the patient's admitting physician and primary care physician. Respondent admitted that he would have done so because it would be part of his role as

an emergency physician to advise the patient's admitting and attending physicians of abnormal findings such as the low voltage. (T. 1095-1096)

100. Respondent admitted that Patient I's heart on the chest x-ray was in fact huge and bottle-shaped. (Pet. Ex. 4; T. 1098) Respondent admitted that as the emergency physician for Patient I, he had the responsibility of relating diagnostic information and discussing important findings with the admitting physician. (T. 1100) Respondent also admitted that his responsibilities also included therapeutic intervention as well as relaying results and any important diagnostic information. (T. 1101)

CONCLUSIONS OF LAW

Respondent is charged with eighteen (18) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

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

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

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

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

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that three (3) of the eighteen (18) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Daniel Mayer, M.D., who is board certified in emergency medicine and family practice testified for the Department. At present, Dr. Mayer is an attending physician at Albany Medical Center and is also a Professor in the Department of Emergency Medicine. (Pet. Ex. 3) The Hearing Committee found Dr. Mayer to be a credible witness. They found him to be highly knowledgeable but, more dogmatic with respect to guidelines and less "real world. " on

day to day issues in the emergency room. The Department also offered the testimony of Investigator Linda Tripoli, who testified from her Report of Interview with Respondent. The Hearing Committee did not put a lot of weight on her testimony because they found that questioning Respondent directly at the hearing yielded more beneficial information.

Respondent offered the testimony of Joel M. Bartfield, M.D. who is also a Professor and attending physician at Albany Medical Center. Dr. Bartfield also serves as Associate Dean for Graduate Medical Education and is board certified in both internal medicine and emergency medicine. (Resp. Ex. F) The Hearing Committee found Dr. Bartfield to be a credible and knowledgeable witness. They further found that he had a greater "day to day" working knowledge of the emergency room in contrast to Dr. Mayer. The Hearing Committee however found that upon further questioning, Dr. Bartfield conceded some issues and waivered on some of his positions. As a result, the Hearing Committee could not give the same degree of confidence to Dr. Bartfield as they did to Dr. Mayer.

Hans Theodor Klaudt, MD, the Medical Director of the Emergency Care Center at CVPH also testified for Respondent. The Hearing Committee found Dr. Klaudt to be a credible witness. His testimony was forthcoming and clinically based. While he came to the defense of Respondent with respect to Patients D and G, he freely admitted that things could have been done differently. Respondent also took the stand on his own behalf. The Hearing Committee found Respondent credible and that he provided direct, non-evasive testimony. They note that his answers were not in conflict with the statements he gave at his initial interview with the Department where he appeared

without an attorney. While the Committee found Respondent to be bright and articulate, they were disturbed about his lack of insight on some of the patients involved in this matter.

PATIENT A

Factual Allegations A, A.1, A.2 (vote 2 to 1), and A.3: SUSTAINED

Factual Allegations A.4 : NOT SUSTAINED

The Hearing Committee sustains Charge A.1 only with respect to Respondent's failure to document his consideration of great vessel injury. The Hearing Committee believes that Respondent detected a widened mediastinum from the chest x-ray but he did not document his thought process. Respondent admitted that he should have ordered a CAT scan of the chest to more definitely rule out an aortic injury even though it turned out that Patient A had a mediastinal lymphoma. (T. 1059, 1067-1068) A majority of the Hearing Committee concurs with Dr. Mayer that Respondent failed to order adequate fluid resuscitation.(T. 54-55) The Hearing Committee unanimously concurs with both experts that Respondent missed an obvious call regarding the patient's pelvic fracture. Charge A.4 presupposes that there was some sort of aortic tear that would have warranted a transfer. Since that was not the case, the Hearing Committee does not sustain this charge. All charges sustained with respect to Patient A are deemed as acts of negligence by Respondent.

PATIENT B

Factual Allegations B, B.1, B.2, and B4: SUSTAINED

Factual Allegation B.3 : NOT SUSTAINED

The Hearing Committee notes that both experts agreed that Patient B's vaginal bleeding was significant. They find that Respondent assumed a more benign diagnosis and then failed to establish it. Respondent's assessment of Patient B deviated from accepted standards of care because he should have ordered a repeat hematocrit after the patient received a liter of IV fluid. A reasonably prudent physician would have assessed Patient B in this fashion to determine how much blood she lost. (T. 179-184) Charges B.1, B.2 and B.4 are sustained as gross negligence. Charge B.3 is not sustained since there was no need to observe Patient B in the emergency room if she should have been admitted to the hospital.

PATIENT C

Factual Allegations C and C.2 : SUSTAINED

Factual Allegations C.1: NOT SUSTAINED

The Hearing Committee finds that there is no proof in the record in support of the allegation that the physical exam and assessment done by Respondent or the patient history obtained was inadequate. The Hearing Committee however finds that Respondent was negligent for his failure to rule out myocardial infarction. They concur with

Dr. Mayer that in the context of the Patient C's worsening CHF, weight gain, shortness of breath, known CAD, and failing to respond to his usual medications, a reasonably prudent physician would have admitted Patient C for evaluation of his chest pain to rule out a cardiac event.(T. 316-317)

PATIENT D

Factual Allegations D and D.1: NOT SUSTAINED

The Hearing Committee agrees with Dr. Klaudt that in this instance, a reasonably prudent emergency physician would interpret Patient D's x-ray as negative. (T. 454) They find that the child acted well and the fact that the faintness of x-ray was difficult to interpret does not constitute a deviation from the standard of care. Even Dr. Mayer conceded that adult radiologists tend to over-interpret x-rays , i.e. the reading may or may not be there. (T. 284) Thus this charge is not sustained.

PATIENT E

Factual Allegations E and E.1 and E.2 : NOT SUSTAINED

When Respondent saw Patient E, she had received the full typical daily dose of Levaquin nearly 12 hours before. (T. 218, 249) Respondent broadened her antibiotic coverage, and fully addressed her dehydration, nausea and pain. On discharge, he prescribed Phenergan and Clindamycin which were actually dispensed to her in the

emergency room. (T. 904-905) Dr. Mayer conceded that the discharge instructions were appropriate (T. 247)

By the factors identified by Dr. Mayer, Patient E did not fit the criteria for in-patient admission. The criteria listed by Dr. Mayer were the patient's ability to keep down antibiotics and maintain hydration, the effectiveness of the antibiotics; and the presence of underlying illness or a compromised immune system. (T. 255-256) When Respondent discharged Patient E , she kept down an oral medication for two hours, she was re-hydrated, her antibiotic coverage had been broadened, and she had no underlying illness or immune system compromise. The Hearing Committee finds that the Petitioner failed to prove that the patient's admission was necessary. They conclude that Respondent's actions were reasonable in this instance.

PATIENT F

Factual Allegations F and F.1: SUSTAINED

The Hearing Committee concurs with Dr. Mayer that the standard of care for trauma patients like Patient F would be to give initial fluid resuscitation and dual IVs. (T. 125-128) Both Dr. Bartfield and Respondent typically would order some intravenous fluid for a trauma patient like this. (T. 848; 1135-1137) The Hearing Committee notes that Respondent acknowledged that his failure to do so in this instance may have been more an oversight that an conscious decision (T. 1135) As a result, the Hearing Committee finds negligence by Respondent in this instance.

PATIENT G

Factual Allegations G and G.2: SUSTAINED

Factual Allegations G.1 and G.3: NOT SUSTAINED

The Hearing Committee concurs with Dr. Klaudt that Respondent adequately evaluated Patient G's chest pain on December 15, 2002 because due to the location and three day duration of the chest pain, Respondent adequately ruled out an acute cardiac syndrome. (T. 561-563) However, the Hearing Committee finds that since no clear cut diagnosis for chest pain was found, Respondent should not have discharged Patient G with out further diagnostic evaluation through either admission to the hospital or sending the patient home with orders for a stress test or follow up with a cardiologist.

With respect to evaluating or following up on the patient's D dimer results, the Hearing Committee finds that it would have been very cumbersome for Respondent to access this information due to the computer system in place at that time. They accept Dr. Klaudt's explanation on this as reasonable and they do not sustain this particular allegation against Respondent.

PATIENT H

Factual Allegations H, H.1 and H.2 : SUSTAINED

The Hearing Committee concurs with Dr. Mayer's opinion that Respondent 's discharge diagnosis failed to adequately address Patient H's documented chief complaints. (T.303-305) They further note that upon questioning by the Committee, the

Respondent admitted that it would have been appropriate to have given the patient a trial dose of Albuterol. (T. 1153) The Hearing Committee sustains the above charges as acts of negligence.

PATIENT I

Factual Allegations I, I.1, I.2 and I.3: SUSTAINED

The Hearing Committee viewed Patient I's chest x-ray and found the presence of cardiomegaly to be very obvious. At the hearing, Respondent admitted that the cardiac silhouette is enlarged. (T. 1098) Similarly the patient's EKG s from February 2003 and August 2002 show a likewise obvious difference that the voltage was much lower. (T. 154-156) Respondent admitted that he had missed the finding of low voltage on the EKG. (T. 1092, 1095) The Hearing Committee finds that Respondent also missed the obvious diagnosis of pericardial effusion. They believe that despite this patient's terminal lung cancer, Respondent might have improved her quality of life by having the fluid drained around her heart. The Hearing Committee finds that all of the above rose to the level of gross negligence.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for a period of two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on probation with a

practice monitor. Respondent will not be permitted to work alone in the emergency room during the first year of his probation. Respondent will also be required to read films with a radiologist at his facility for a six month period. The complete terms of probation are attached to this Determination and Order as 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, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for a two year stayed suspension with probation, a practice monitor and other specific limitations because they do not believe that revocation is commensurate with the level of professional misconduct in this instance. The Hearing Committee was impressed with the quality of Respondent's evaluations. They found him to have a sufficient medical knowledge base and that he was not incompetent.

The Hearing Committee is concerned that Respondent focused on the best case and not the worst case scenario for some of the patients. They firmly believe that his decision making process regarding admissions and/or consultations requires more review. They believe that a practice monitor would require a change of habit and promote Respondent's effectiveness in using data for more appropriate clinical decision making for the disposition of patients.

The Hearing Committee believes that restricting Respondent from working alone in the emergency room for a one year period further safeguards the public health. Requiring him to spend a six month period reading films with a radiologist at the facility would also improve Respondent's unacceptable return rate to the emergency room.

Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The Second, Eighth and the Ninth of the Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The First, Third, Fourth, Fifth, Sixth, Seventh, Tenth, Eleventh, Twelfth, Thirteenth, Fourteenth, Fifteenth , Sixteenth, Seventeenth and Eighteenth of the Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **TWO (2) YEARS,** said suspension to be **STAYED;** and

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. Respondent shall not practice in the emergency room, **unless another physician is present,** for the first year of his probation;

6. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Syracuse, New York

11/21/05 **2005**

Andrew J Merritt MD

ANDREW J. MERRITT, M.D.

(Chairperson)

DIANE SIXSMITH, M.D.

FRANK KING, R.P.A

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Timothy Runge, M.D.
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Plattsburgh, NY 12901

APPENDIX I

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

IN THE MATTER

OF

TIMOTHY RUNGE, M.D.

AMENDED

STATEMENT

OF

CHARGES

Timothy Runge, M.D., Respondent, was authorized to practice medicine in New York State on or about, by the issuance of license number 216782 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A in the Emergency Department of Champlain Valley Physicians' Hospital (CVPH) in Plattsburgh, New York on or about July 28, 2001.

1. Respondent failed to detect and/or diagnose and/or document the presence of a widened mediastinum on Patient A's chest x-ray, and/or to consider and/or document consideration of great vessel injury.
2. Respondent failed to order adequate fluid resuscitation.
3. Respondent failed to detect and/or diagnose and/or document the presence of pelvic fractures other than a hip fracture in Patient A.
4. Respondent failed to order timely transfer of Patient A.

B. Respondent provided medical care to Patient B in the Emergency Department of CVPH on or about February 20, 2002.

1. Respondent failed to admit Patient B.
2. Respondent failed to adequately assess Patient B.
3. Respondent failed to have Patient B observed in the Emergency

4. Respondent underestimated Patient B's blood loss and/or the severity of Patient B's bleeding.

C. Respondent provided medical care to Patient C in the Emergency Department of CVPH on or about March 6, 2002.

1. Respondent failed to perform an adequate physical exam and/or assessment and/or to obtain an adequate history.

2. Respondent failed to admit Patient C and/or failed to adequately rule out myocardial infarction.

D. Respondent provided medical care to Patient D in the Emergency Department of CVPH on or about July 9, 2002.

1. Respondent failed to detect and/or diagnose and/or document the presence of a right middle lobe infiltrate on Patient D's x-ray.

E. Respondent provided medical care to Patient E in the Emergency Department of CVPH on or about July 16, 2002.

1. Respondent failed to admit Patient E for administration of intravenous antibiotics and/or failed to adequately assess whether Patient E would tolerate and/or respond to oral medication.

2. Respondent failed to adequately assess and/or treat Patient E for dehydration and/or failed to admit Patient E for administration of intravenous fluids.

F. Respondent provided medical care to Patient F in the Emergency Department of CVPH on or about September 2, 2002.

1. Respondent failed to order adequate intravenous fluids for Patient F prior to the patient's transfer and/or to order two large bore IVs.

G. Respondent provided medical care to Patient G in the Emergency Department of CVPH on or about December 15, 2002 and on or about December 18, 2002.

1. Respondent failed to adequately evaluate Patient G's chest pain.

2. Respondent discharged Patient G without adequately evaluating the patient's chest pain.

3. Respondent, on or about December 18, 2002, failed to adequately evaluate Patient G and/or follow up on Patient G's D dimer results.

H. Respondent provided medical care to Patient H in the Emergency Department of CVPH on or about February 17, 2003.

1. Respondent failed to order administration of Albuterol to Patient H.

2. Respondent failed to adequately respond to Patient H's respiratory distress.

I. Respondent provided medical care to Patient I in the Emergency Department of CVPH on or about February 18, 2003.

1. Respondent failed to detect and/or diagnose and/or document the presence of cardiomegaly.

2. Respondent failed to consider and/or to document consideration in Respondent's differential diagnosis of low voltage on Patient I's EKG.

3. Respondent failed to detect and/or diagnose and/or document the presence of a pericardial effusion.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH 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 and/or A.4.
2. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4.
3. The facts in Paragraphs C and C.1 and/or C.2.
4. The facts in Paragraphs E and E.1 and/or E.2.
5. The facts in Paragraphs F and F.1.
6. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3.
7. The facts in Paragraphs H and H.1 and/or H.2.
8. The facts in Paragraphs I and I.1 and/or I.2 and/or I.3.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN 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:

9. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4; B and B.1 and/or B.2 and/or B.3 and/or B.4; C and C.1 and/or C.2; D and D.1; E and E.1 and/or E.2; F and F.1; G and G.1 and/or G.2 and/or G.3; H and H.1 and/or H.2; I and I.1 and/or I.2 and/or I.3.

TENTH THROUGH SEVENTEENTH 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:

10. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4.
11. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.4.
12. The facts in Paragraphs C and C.1 and/or C.2.
13. The facts in Paragraphs E and E.1 and/or E.2.
14. The facts in Paragraphs F and F.1.
15. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3.
16. The facts in Paragraphs H and H.1 and/or H.2.
17. The facts in Paragraphs I and I.1 and/or I.2 and/or I.3.

EIGHTEENTH 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:

18. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4; B and B.1 and/or B.2 and/or B.3 and/or B.4; C and C.1 and/or C.2; D and D.1; E and E.1 and/or E.2; F and F.1; G and G.1 and/or G.2 and/or G.3; H and H.1 and/or H.2; I and I.1 and/or I.2 and/or I.3.

DATED: June 10, 2005
Albany, New York

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

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct him/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he 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 York12180-2299; 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 his/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 practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. An approved practice monitor shall be in place within thirty (30) days of the effective date of this Order.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unaccounted basis at least monthly and shall examine a selection (no less than ten (10) charts per month) 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.

9. During the first year of his probation, Respondent shall not work in the emergency room unless another physician is present.

10. During the first 6 months of his probation, Respondent shall be required to read x-rays and films in the presence of a radiologist at his facility for one hour per week. This shall be done at a time when Respondent is not on duty in the emergency room.

11. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and all 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 any/or any such other proceeding against Respondent as may be authorized pursuant to the law.