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

October 3, 2005

Public

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Alan Japzon Bautista, M.D.
385 South End Avenue, Apt. 1H
New York, New York 10280

Gerard J. Heubel, Esq.
Bartlett, McDonough, et al
81 Main Street
White Plains, New York 10601

Dianne Abeloff, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

RE: In the Matter of Alan Japzon Bautista, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-213) 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.

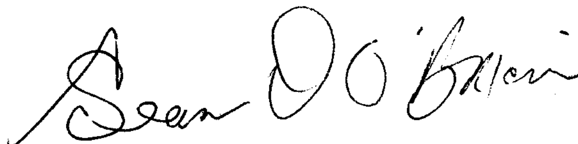
The notice of review served on the Administrative Review Board should be forwarded to:

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, 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 ALAN JAPZON BAUTISTA, M.D.	DETERMINATION AND ORDER BPMC # 05- 213

A Commissioner's Order and Notice of Hearing, dated April 1, 2005, and Statement of Charges, dated March 30, 2005, were served upon the Respondent, **ALAN JAPZON BAUTISTA, M.D.** **CALVIN J. SIMONS, M.D.**, Chairperson, **AIRLIE CAMERON, M.D.**, and **MR. PETER S. KOENIG, SR.**, 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 Sections 230(10)(e) and (12) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Law Judge for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF PROCEEDINGS

Service of Commissioner's Order, Notice of Hearing and Statement of Charges :	April 4, 2005
Pre-Hearing Conference :	April 22, 2005
Hearing Dates:	April 27, May 9, 20, 23, 26, June 13, 2005
Commissioner's Interim Order:	July 6, 2005
Department of Health appeared by:	DONALD P. BERENS, JR., ESQ., General Counsel, New York State Department of Health BY: **DIANNE ABELOFF, ESQ.**, of counsel
Respondent appeared by:	Bartlett, McDonough, Bastone & Monaghan, LLP BY: **GERARD J. HEUBEL, ESQ.**, of counsel

Witnesses for Department of Health:	Maureen Gang, M.D.
Witnesses for Respondent:	Timothy Haydock, M.D. Anthony C. Mustalish, M.D., M.P.H. Commander Robert Albinder Alan Japzon Bautista, M.D. (Respondent)
Receipt of Submissions (Close of Record):	August 2, 2005
Deliberations held:	August 8, 2005

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories 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 certain types of professional misconduct.

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

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

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

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

Conclusions of law were made pursuant to the Findings of Fact listed below. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee. A copy of the Statement of Charges (Ex. 1) is attached hereto as Appendix I.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T. = Transcript

GENERAL FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on July 5, 1994 by the issuance of license number 196406 by the New York State Education Department. (Ex. 10)

2. An emergency room physician's first responsibility is to rule out the most life threatening or limb threatening condition first. (T. 23, 24, 952, 953, 1021)

FINDINGS RELATED TO PATIENT A

3. On or about November 13, 2002, Patient A presented to Our Lady of Mercy Medical Center (OLOM) with complaints of pain in her left buttocks radiating down her left leg due to a sports injury. Patient A's pain was noted to be between 8 and 10 out of 10. A nursing note indicated the patient had limited range of motion. (Ex. 2, pp. 2-3)

4. There was no documentation in the medical record that verified Respondent examined or evaluated the patient's range of motion in her joints, or performed any other part of a musculoskeletal examination. (T. 29, 32,64-69; Ex. 2)

5. Respondent noted that the patient had pain in the upper part of her buttocks, exactly where the head of the femur would be dislodged with a posterior hip dislocation. The posterior part of the hip joint abuts the buttock. Respondent failed to inquire about the patient's hip. (T. 57, 71, 960, 961; Ex. 2)

6. Hip and pelvic x-rays were required to rule out fracture or hip dislocation when the patient complained of pain in the area of the hip or buttocks. (T. 27, 28, 31, 32, 66, 69, 966; Ex. 2)

7. A note in the record documented that no x-rays were performed on Patient A because she was in too much pain to get onto the x-ray table. (T. 32-36, 40, 70; Ex. 2, p.7)

8. Respondent treated Patient A's pain with a nonsteroidal antiinflammatory medication and subsequently ordered an opiate when her pain continued. (T.393, 410; Ex. 2, p. 7)

9. Respondent documented his impression of the patient's condition as muscle strain. He failed to rule out the most limb threatening condition, dislocation of the hip, prior to arriving at this final diagnosis. (T.30, 36, 37, 70, 980, 405; Ex. 2, p. 4)

10. The patient was discharged at about 5:30 a.m., approximately 6 ½ hours after she first presented. Respondent noted her condition as "improved" and did not record whether Patient A was ambulatory at the time of discharge. (Ex. 2, p. 4)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT A

The Committee **SUSTAINED** Factual Allegations A.1., A.2., and A.4. These were considered to constitute the practice of medicine with negligence. Factual Allegation A.1. was also found to be practice of medicine with incompetence, based on Respondent's failure have x-rays of the patient's hip and pelvis actually performed prior to her discharge. Allegation A.3. was **NOT SUSTAINED**.

Respondent testified that he was able to rock Patient A's hips during the course of his physical examination before administering any pain medication. The Committee found that statement to not be credible based on the nursing note that the patient had limited range of motion and also on the inability for an x-ray to be performed because of the extent of her pain. Respondent's documentation of a physical examination, particularly as related to her musculoskeletal system, was inadequate and led to the conclusion that an adequate examination was not performed. The inadequate examination resulted in an improper diagnosis which, in turn, caused Respondent to not appreciate the need for an x-ray of the hip.

The Committee believed the discharge of the patient without performance of the proper diagnostic test to be a clear deviation from accepted standards of practice. Respondent failed to rule out the most serious condition in the differential diagnosis. A mere check off that the patient was 'improved" without greater explanation was inadequate justification for not having an x-ray performed. Respondent felt such a test was required when he first saw the patient. The Committee believed he permitted himself to be persuaded by the patient to not have it performed following administration of several pain medications. It was also noted that Respondent alleged that Patient A actually refused to have the x-ray performed after she received pain medications (an item not documented in the record), but did not make such an allegation during interviews with staff of the OPMC.

The Committee concluded that Respondent's administration of pain medications was

appropriate and did not sustain Factual Allegation A.3. The dosage was gradually increased in response to the patient's continued pain. There was no documentation in the chart of her pain level after the initial ordering of medications and it could not be determined whether an alternative pain medication or a greater dosage would have been more appropriate.

FINDINGS RELATED TO PATIENT B

11. Patient B presented to OLOM emergency room on September 1, 1999, with a chief complaint of headache and vomiting. She was noted to be pale and in moderate distress and had a history of fibroid, kidney stones, migraine headaches and a shunt for hydrocephalus. (T. 81; Ex. 3)

12. The complaints of headache and vomiting with photophobia were indications of a possible central nervous system infection. (T. 86; Ex. 3)

13. Respondent and his resident found that the patient was febrile with tenderness over the shunt and photophobia. There was no mention of CVA tenderness nor abdominal findings and Respondent did not document a neurological evaluation. (T. 82-86; 1032; Pet. Exh. 3)

14. A CT scan of the head was ordered by Respondent and performed, the results of which were negative. A negative CAT scan would not rule out an infection in a shunt; only a sampling of the cerebral spinal fluid (CSF) could rule out such an infection. (T. 85-6; Ex. 3)

15. Patient B had a complicated history including headaches and a prior CSF sampling. The record did not indicate the date of the most recent CSF sampling. The names of three treating physicians, presumably including her neurologist or neurosurgeon, were noted in the patient's chart. Respondent did not attempt to contact any of those physicians to discuss the patient's

history or condition. The failure to contact either of these physicians was a deviation from accepted medical conduct. (T.90, 91, 111; Pet. Exh. 3)

16. Respondent did a fever work-up which included a urinalysis. The urinalysis came back consistent with a urinary tract infection (UTI). Respondent diagnosed the patient with a UTI and migraine headaches notwithstanding the absence of clinical symptoms for the diagnosis of UTI; the patient had no complaint of pain on urination, no frequency of urination and no back pain. In a patient with a history of kidney stones, it is not unusual to have a UTI without a complaint of frequency of urination. (T. 1005-1006; Ex. 3)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT B

The Committee **SUSTAINED** Factual Allegations B.1. and B.2. Factual Allegation B.3. was **NOT SUSTAINED**. Allegation B.1. was determined to be evidence of practicing with both negligence and incompetence due to Respondent's failure to recognize the indications of a shunt infection. Allegation B.2. was determined to be evidence of practicing with negligence.

The Committee agreed with the testimony of the Department's expert that Respondent should have recognized that Patient B presented with clear symptoms of the possibility of a central nervous system infection. The fact that the patient had a shunt in place should have made consideration of an infection more apparent. A sampling of the spinal fluid was the appropriate procedure to rule out a shunt infection and the failure to do so was found to constitute inappropriate evaluation of the patient. The Committee further concluded that Patient B's complicated medical history and presenting complaints necessitated a consult with her treating neurologist.

There was agreement with Respondent's expert that it was not uncommon for a person with Patient B's history to have a UTI in the absence of the usual symptoms. Factual Allegation B.3. did

not address the appropriateness of Respondent's treatment of the UTI and was therefore not sustained.

FINDINGS RELATED TO PATIENT C

17. Patient C, a 21 year old woman with complaints of abdominal pain and a psychiatric history, was brought to OLOM emergency room on December 11, 1999. Her last menstrual period was reported as a few months prior. (Ex. 4)

18. Patient C was initially uncooperative with the medical staff and Haldol was administered at or about 5:00 a.m. on the day of the emergency room visit. She was more compliant by 6:53 a.m. when Respondent examined her. Respondent's shift ended at 7:00 a.m. on that day. (T. 501-502; Ex. 4, p. 1, Ex. B)

19. Based on Patient C's complaints and history, Respondent should have immediately ruled out pregnancy, particularly an ectopic pregnancy. In a woman of her age with a missed menstrual period, a pelvic and abdominal examination must be promptly performed to assess the presence of acute peritoneum signs and to establish the presence of a pregnancy. (T. 121-124, 1076-1078)

20. There was no documentation in the medical record that Respondent ordered either a urine or blood test to rule out pregnancy. There was also no note in the chart that recorded that Respondent investigated the possibilities of an ectopic pregnancy through a physical examination, i.e, the adnexa, the size of the uterus, rectal, or laboratory tests. The failure to appropriately rule out the possibility of an ectopic pregnancy fell below accepted medical standards. (T. 131-132, 162-167, 1079-1080; Ex. 4)

21. Respondent found that Patient C was tachycardic during his physical examination. An earlier nurse's note and a subsequent note indicated that the patient's pulses were normal. (Ex. 4, p. 1)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT C

The Committee **SUSTAINED** Factual Allegation C.1. and did **NOT SUSTAIN** Factual Allegation C.2. The sustained Allegation was found to be the practice of medicine with negligence and incompetence.

Dr. Gang initially testified that Respondent's examination of Patient C met acceptable standards, but later clarified that opinion by stating that a complete gynecologic and abdominal exam was not performed. There was no documentation regarding findings of adnexal tenderness or uterine size. The absence of documentation led to the conclusion that a complete physical examination and the necessary tests were not performed or ordered by Respondent. The Committee rejected his contention that all appropriate laboratory tests were performed as a part of an ordinary workup for a patient complaining of abdominal pain and that he merely failed to confirm such fact by recording the tests in the chart. This was considered to be shifting the responsibility for a complete record to the nursing staff when Respondent himself should have clearly noted the ordering of blood and urine testing to rule out pregnancy. The Committee also believed that the fact that Respondent first saw the patient only a few minutes before the end of his shift would not have been a basis for not meeting acceptable standards of care.

The Committee did not believe that Respondent's finding during his examination that the patient was tachycardic was an abnormal finding that required further evaluation. Nursing notes from examinations before and after Respondent's reflected normal heart rates. The elevated rate may have been a result of the patient's state of agitation and was not considered to be significant.

FINDINGS RELATED TO PATIENT D

22. Patient D presented at OLM on November 20, 2000, with complaints of decreasing vision in her right eye, her only seeing eye, photophobia, and increasing pain in the back of her head. (Ex. 5)

23. Patient D was examined by a resident and Respondent between 11:25 a.m. and 1:25 p.m and the following findings were made: photophobia, decreased visual acuity, poorly visualized fundus, and headaches. The patient was then sent out of the emergency department to the ophthalmology clinic without the performance of a neurological examination in the emergency department. (T. 174, 597-600; Ex.5)

24. A patient with the above complaints required a neurological exam to ensure that there were no neurological emergencies. An intracranial mass can reach a critical size causing a herniation of the brain. Imaging studies to rule out intracranial mass should have been performed before the patient was taken from the emergency department to the ophthalmology clinic. An ophthalmology consult should have been performed in the emergency department. (T. 174- 176, 179, 182-183; Ex.5)

25. An emergency room physician should be able to determine if a patient has papilledema. Respondent could not make that determination; there is no documentation that the visual acuity of the patient's right eye was obtained. (T. 177-178, 603, 788-789, 1140)

26. Patient D was transported to the ophthalmology clinic at approximately 1:25 p.m. Respondent was subsequently informed that she was found to have three plus papilledema, indicating a significant swelling of the optic nerve. The patient returned from the clinic to the

emergency room at about 5:15 p.m. and, pursuant to an order from Respondent, was sent for a CAT scan of the head at approximately 5:30 p.m. The head CAT scan found a large meningioma with mass effect indicating increased cranial pressure (T. 175-176, 180, 600-601, 605-606; Ex. 5, 5A, pp. 69-70)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT D

The Committee **SUSTAINED** all Factual Allegations related to Patient D. Factual Allegation D.1. was determined to constitute the practice of medicine with gross negligence and gross incompetence. The failure to immediately perform imaging studies to rule out an intracranial mass was considered an egregious deviation from the standard of medical care. Allegation D.2. represented the practice of medicine with negligence and incompetence based on Respondent's inability to establish a visual acuity for the patient and his lack of knowledge of three plus papilledema. The remaining sustained Allegations was considered as the practice of medicine with negligence.

Patient D's complaints were consistent with that of a possible intracranial mass. Respondent should have performed and documented a full neurological examination and ordered a CAT scan based on her history and complaints alone without waiting for the results of an ophthalmology consult. The Committee also believed Respondent should have been capable of obtaining a visual acuity of the patient's only seeing eye, which was determined to have three plus papilledema. Respondent's admission that he did not know what three plus papilledema was until it was pointed out to him by the ophthalmologist was considered a clear showing of incompetence. Respondent unreasonably delayed treating a patient who demonstrated clear signs of a life-threatening condition.

FINDINGS RELATED TO PATIENT E

27. Patient E had a history of being HIV positive, suffered from toxoplasmosis and had undergone a recent craniotomy and brain biopsy. He presented at the OLOM emergency room at about 1:50 p.m. on August 21, 1998, complaining of weakness, dizziness, and altered medical status. He was found to be febrile in the triage assessment. (T. 208-210, Ex. 6)

28. Based on the patient's medical and surgical history and presenting complaints, a complete neurological evaluation, including an imaging study, and an evaluation for the source of the fever was required. A lumbar puncture could be indicated depending on the results of the imaging study. This protocol would be within the knowledge of an emergency room physician. (T. 210, 212)

29. An imaging study was necessary, based on the recent brain biopsy, to determine whether there was bleeding or swelling from the site. Knowledge of whether Patient E experienced any increased intracranial pressure was essential prior to performing a lumbar puncture. A lumbar puncture performed on a patient with increased intracranial pressure can cause herniation of the brain and death. (T. 211, 227, 235, 250, 738-739)

30. Respondent ordered a CAT scan for the patient at 2:09 p.m. and recorded the results as "no change from August 17, 1998, left to right mass effect, occipital soft swelling". This finding indicated that there was swelling in the head which was a contraindication for the lumbar puncture. A lumbar puncture is only performed in the presence of increased intracranial pressure when it is absolutely required. (T. 214-216, 733-738, 1225; Ex. 6, pp. 3-4, 6A)

31. A lumbar puncture was not required for this patient. The patient's fever and change in mental status should have been treated with a broad spectrum antibiotic for the possible meningitis and a specific antibiotic for the toxoplasmosis. Respondent's performance of a lumbar puncture on Patient E deviated from accepted medical standards. (T. 247, 253, 1252-1253; Ex. 6)

32. Respondent also wrote a note in the medical record indicating that he had discussed the case with the patient's treating neurosurgeon who suggested a CT scan of the head and a lumbar puncture. There was no documentation in the chart that verified that the neurosurgeon was made aware of the CAT scan results which demonstrated that there was left to right mass effect and there is nothing in the medical record that indicated Respondent disagreed with the suggestion to perform a lumbar puncture. A consultation note written by the neurosurgeon stated that he "suggested a CT be performed and if that was OK an LP may be necessary." (Ex. 6, 6A)

33. Patient E suffered a seizure at about 5:30 p.m., either just before or after Respondent performed a lumbar puncture, and subsequently became brain dead. (Ex. 6)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT E

The Committee **SUSTAINED** Factual Allegations E.1. and E.3. Factual Allegation E. 2. was **NOT SUSTAINED**. The performance of the lumbar puncture was found to be an egregious deviation from accepted practice standards and demonstrated an unmitigated absence of knowledge on the part of Respondent, thereby representing practice of the profession with gross negligence and incompetence. Factual Allegation E.3. was evidence of Respondent's practicing with negligence and incompetence.

The Committee fully agreed with the opinion of Dr. Gang that a lumbar puncture is contraindicated in a patient with increased intracranial pressure. The results of the CT scan

demonstrating a left to right mass effect was a clear contraindication to proceeding with the lumbar puncture. It could not be established whether Respondent contacted the neurosurgeon before or after actually performing the CT scan and receiving the results. The results were recorded as no change from a previous CT scan performed on August 17, 1998. There was no time recorded as to when Respondent wrote the note. There was no evidence that the mass effect was discussed during their telephone consult. Respondent's notation of their conversation agrees with that of the neurosurgeon in that the lumbar puncture was "suggested" based on the results of the CT scan. The Committee believed Respondent should have recognized that Patient E's condition made a spinal tap unacceptable. Treatment with a broad spectrum antibiotic for possible meningitis and a specific antibiotic for the toxoplasmosis would have been most appropriate.

Respondent's records and the consultation report prepared by the neurosurgeon are inconclusive as to whether the results of the CT scan were shared prior to performance of the lumbar puncture. From all evidence and testimony in the record, the members of the Committee were given the impression that Respondent had one contact with the neurosurgeon before performance of the CAT scan. However, the Committee concluded that this impression was not supported by the preponderance of the evidence in the record required for the Department to meet its burden of proof. Factual Allegation B.2. was not sustained.

FINDINGS RELATED TO PATIENT F

34. Patient F, a 73 year old male, arrived by ambulance at the Montefiore Hospital emergency room on April 7, 2003 with complaints of light headedness and dizziness, some slurred speech and difficulty in saying words. He reported feeling the same as he did 10 years prior when he had experienced a stroke. (T. 258; Ex.7)

35. Patient F had the following complicated medical history: insulin dependent diabetic; emphysema, prior CVA, a left nephrectomy, an MI and an implanted pacemaker/defibrilator. (T. 258; Pet. Exh. 7)

36. Based on the patient's complaints and presenting condition, a complete history and complete physical examination and diagnostic tests including cerebellar tests, blood work, imaging studies and an EKG were required. (T. 260, 262, 278, 293, 298)

37. Cerebellar testing can be performed either in the sitting or supine position; the fact that Patient F could not walk did not preclude cerebellar testing. (T. 1289)

38. Blood tests were performed; the results of some were abnormal. The CKMB was elevated and Patient F had elevated total protein and LDH. Respondent failed to document a review and/or evaluation of these abnormal findings. (T. 262, 263; Ex. 7, pp. 38-50)

39. Patient F's presenting complaints and history of a prior stroke should have led Respondent to the primary diagnosis of stroke. The complaint of dizziness was associated with neurologic complaints of slurred speech and difficulty with words; therefore, a CVA was the most important condition to rule out. In addition, Patient F had complaints of general weakness, nausea and vomiting, all of which were symptoms of an MI. Respondent should have also considered cardiac problems or uncontrolled diabetes. (T. 260, 261, 265-267, 1299, 1311, 1313; Ex.7)

40. Respondent spoke with Patient F's primary care physician at about 10:20 p.m. on the evening of April 7, 2003 and recorded that the primary "will follow up with patient as outpatient tomorrow". Respondent subsequently prescibed Meclizine, 25 mg., and discharged the patient

with a diagnosis of vertigo. Patient F should have been admitted to the hospital; it was not appropriate to have sent him home from the emergency room to be followed by his private physician the next day. The patient had new neurologic findings on a medical regimen that he had been following and had abnormal cardiac enzymes which should have been investigated. (T. 261, 265-271, 292-295, 1299; Ex. 7)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT F

The Committee **SUSTAINED** Factual Allegations F.1., F.2., F.4. and F.5. Factual Allegation F.3. was **NOT SUSTAINED**. The sustained Factual Allegations were each considered to constitute the practice of medicine with negligence.

Performance of cerebellar tests was considered essential to appropriately diagnose the condition of Patient F. Although Respondent testified that he did not perform such tests because the patient was unable to stand, his own expert testified the tests could be performed with a person in the sitting or supine position. Respondent also admitted that a heel to shin test could be conducted with the patient supine. The Committee agreed with the Department's expert that Respondent did not adequately rule out a CVA and thereby failed to appropriately diagnose the patient's condition. There was no evidence that Respondent evaluated the abnormal blood test results or took appropriate action to address those abnormalities. Respondent should have also ruled out a possible cardiac event by admitting the patient for further observation and testing. Patient F's medical history and complaints justified an admission, notwithstanding the indication that the primary care physician would follow up Patient F as an outpatient.

Based on Dr. Gang's testimony in which she opined that a cardiac consult would not have been necessary, Factual Allegation F.3. was not sustained.

FINDINGS RELATED TO PATIENT G

41. Patient G, a 58 year old female, presented at Montefiore Medical Center at about 10:00 p.m. on June 27, 2003 with complaints of abdominal pain, vomiting and diarrhea. She had been discharged that morning after undergoing an angioplasty three days earlier. (T. 305; Ex. 8)

42. Respondent worked a noon to midnight shift in the emergency department on June 27, 2003. He first encountered Patient G at about 11:20 p.m. He performed a physical examination and ordered nitropaste, aspirin and morphine sulfate for her. (T. 867-869; Ex. 8, p. 11, Ex. C)

43. The recent angioplasty made Patient G a high risk patient. Respondent should have examined the heart and her lungs for any signs of heart failure and evaluated the patient's vital signs and O2 saturation. Chest and abdominal pain specifically in women can be indicative of a cardiac event. It was necessary for Respondent to order an EKG and ensure that it was performed and to also obtain any prior EKG to determine if there had been any changes in the patient's status. (T. 305-308, 348, 349, 354, 355)

44. Two EKG's were performed on Patient G at 10:07 and 10:37 p.m. Each test result indicated that the patient was experiencing an acute MI. (Ex. 8, pp. 5, 6)

45. There was no documentation in Patient G's medical record that Respondent either ordered an EKG for Patient G or requested and reviewed any earlier EKG for the patient.
(T. 309, 312, 313, 321; Ex. 8)

46. Based on this patient's history, the catheterization lab or cardiologist should have been called immediately, even without an EKG. The patient should have been placed on a cardiac monitor because rales, diarrhea, and dehydration were noted on physical exam. (T. 315, 319, 322; Ex. 8)

47. At about 12:05 a.m., Respondent ordered 10 units of insulin for Patient G. Respondent then signed out the patient to the oncoming emergency department physician and left the hospital at the end of his shift. The Respondent did not see an EKG for the patient before leaving. (T. 879, 880; Ex. 8)

CONCLUSIONS OF LAW AND DISCUSSION RELATED TO PATIENT G

The Committee **SUSTAINED** Factual Allegation G.1. Factual Allegations G.2. and G.3. were **NOT SUSTAINED**. Respondent's failure to take more affirmative action to ensure the performance and evaluation of an EKG for Patient G was considered to represent the practice of the profession with gross negligence and gross incompetence.

The Committee accepted Respondent's statement that he never saw the EKG's that were performed shortly after 10 p.m. and which indicated an acute MI. Even though there was no documentation that an EKG was ordered at about 11:20 p.m. when he first saw Patient G, the Committee was willing to accept Respondent's assertion that he verbally ordered such a test as part of a comprehensive cardiac workup. Respondent did recognize that the primary differential for the patient, based on her recent angioplasty, was rule out MI. However, the Committee found it inexcuable that Respondent left the hospital shortly after midnight knowing that no EKG had been performed and evaluated for a patient with her history who had been in the emergency department for two hours. The patient had been discharged from the hospital for only a few hours following an angioplasty and returned with complaints suggestive of a cardiac problem. Respondent testified he made no attempt to accelerate the performance of an EKG; he ordered it as part of a cardiac workup and, without following up further, left the hospital about 45 minutes later at the end of his shift without actually seeing the results of the test.

The Committee members strongly and unanimously diagreed with Dr. Mustalish's opinion that Respondent's leaving the hospital under the circumstances presented by Patient G met acceptable standards of practice. In contrast, his subsequent testimony was noted:

> Q: What should an emergency room doctor do if he feels he needs an EKG urgently?
>
> A: One, he could grab a machine and put on the leads himself. Two, he could ask the primary nurse to do it. Three, he can find the EKG tech, if there is somebody available. Four, he can ask the clerk to see if there is the EKG strip around...
>
> Q: Do you see any evidence in the record that Dr. Bautista did any of those?
>
> A: No. (T. 1349-1350)

The Committee concluded that Respondent never saw findings of any EKG and believed it unreasonable to sustain Factual Allegation G.2. Dr. Gang testified that it would have been appropriate for Respondent to have performed a rectal exam to establish whether Patient G was experiencing internal bleeding. The Committee did not consider a rectal exam to have a priority at the time of Respondent's examination and did not sustain Factual Allegation G.3.

CREDIBILITY

The Committee closely reviewed the testimony of all witnesses to assess their credibility. The Department's case was exclusively based on the opinions offered by Dr. Gang. The Committee believed her to be well qualified in her experience. While she could have been more decisive in her opinions, she was considered to be direct and objective in her testimony. She was not dogmatic and modified her answers when presented with new information. Her testimony was accorded great weight by the Committee.

Dr. Haydock was a former supervisor of Respondent. He seemed to go out of his way to deflect criticism of Respondent's performance and treated clear deviations from accepted standards of care in a very casual and cavalier manner. The Committee did not give much weight to his testimony.

Dr. Mustalich was considered to have extensive experience in emergency medicine. However, he exhibited a clear bias in minimizing any of Respondent's deficiencies. He gave the impression of being a mere "hired gun" offering a total defense of Respondent even when presented with obvious deviations. The Committee took particular exception to his statements minimalizing the need for adequate emergency medicine documentation. Dr. Mustalich was often evasive and indirect in his answers and frequently responded in a flippant and sarcastic fashion which led the Committee members to believe that he did not treat this proceeding with appropriate respect. His testimony was completely lacking in objectivity and the Committee gave very little weight to it.

Respondent's testimony was evasive and not forthright. His answers were often confusing and contradictory and he had a poor memory of any of the cases that were addressed. He consistently refused to accept responsibility for his actions and inactions and attempted to shift blame to other physicians, nursing staff or even the patients themselves. He demonstrated a superficial medical knowledge at best and his emergency department recordkeeping was clearly below acceptable standards.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. 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.

Respondent's practice reflected a disturbing pattern of a failure to recognize, and an inability to rule out, the most serious diagnosis first. He failed to order appropriate tests or to evaluate their results. On other occasions, serious abnormalities were minimized and appropriate treatment was delayed. He relied on other medical specialists to examine and diagnose conditions more appropriately addressed in the emergency department. His failure to affirmatively act to ensure that an EKG was performed for Patient G was shocking in light of his knowledge that she had been in the emergency department for two hours without being evaluated after having been discharged earlier the

same day following an angioplasty procedure. Furthermore, Respondent also exhibited an absence of knowledge in areas of medicine with which he would be expected to be familiar.

The Committee believed that there are minimal standards of documentation that must be met even in busy emergency rooms. Adequate documentation is an essential part of medical care and treatment, particularly when the patient can be expected to be subsequently seen by many other medical professionals. Respondent's recordkeeping was too often non-existent leading to speculation as to what actually occurred in his care of the patients.

The Committee sustained multiple Specifications of Respondent's having practiced with gross negligence and gross incompetence and with negligence and incompetence on more than one occasion. His lack of any insight into his deficiencies and inability to recognize his errors caused the Committee to conclude that no amount of retraining or monitoring of his practice would adequately protect the public and that only a revocation of his license would be appropriate.

ORDER

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

1. The following Specifications of professional misconduct as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED in part**:

   Fourth, Fifth, Seventh through Tenth, and

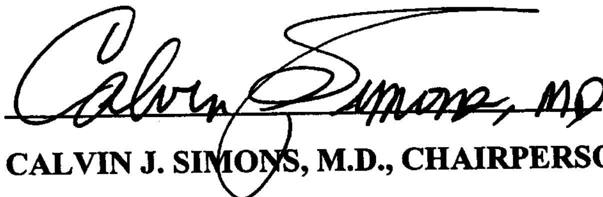
2. All other Specifications of professional misconduct are **NOT SUSTAINED** and are **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

4. 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: Troy, New York

September 27, **2005**



CALVIN J. SIMONS, M.D., CHAIRPERSON

AIRLIE CAMERON, M.D., M.P.H.
PETER S. KOENIG, SR.

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APPENDIX I

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

IN THE MATTER OF ALAN JAPZON BAUTISTA, M.D.	STATEMENT OF CHARGES

ALAN JAPZON BAUTISTA, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 5, 1994,by the issuance of license number 196406 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about November 13, 2002, Patient A (Patients are identified in Appendix A) went to the emergency room of Our Lady of Mercy Medical Center (OLOM) with complaints of severe pain in her left buttocks and leg following a fall sustained while jumping hurdles. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to order appropriate x-rays.
2. Failed to appropriately diagnose the patient's injury.
3. Failed to appropriately control the patient's pain.
4. Failed to ascertain and document patient's ability to ambulate prior to discharge from the OLOM emergency room (ER).

B. On or about September 1, 1999, Patient B went to OLOM E.R. with complaints of headache, nausea, vomiting and she was noted to be febrile. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to appropriately evaluate patient for ventricular peritoneal (vp) shunt infection.

shunt infection.

2. Failed to contact patient's treating neurologist and neurosurgeon prior to discharging a patient with a vp shunt.
3. Inappropriately diagnosed a urinary tract infection (UTI) in the absence of UTI symptoms.

C. On or about December 11, 1999, Patient C was brought to OLOM E.R. with complaints of abdominal pain. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to appropriately evaluate the cause of abdominal pain in a woman of reproductive age.
2. Failed to appropriately evaluate the patient's abnormal vital signs.

D. On or about November 20, 2000, Patient D, blind in her left eye, went to OLOM E.R. with complaints of two weeks of decreased vision in her right eye and pain to the back of her head. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to appropriately evaluate, in a timely manner, a patient for a possible intracranial mass.
2. Failed to appropriately treat a patient with evidence of an intracranial mass and increased intracranial pressure.
3. Failed to obtain a visual acuity in a patient's only seeing eye.
4. Failed to obtain an ophthalmology consult in the E.R.

E. On or about August 21, 1998, Patient E was brought by ambulance to the OLOM E.R. with complaints of altered mental status, weakness and dizziness. Respondent's care deviated from accepted medical standards in that Respondent:

1. Performed a lumbar puncture on a patient with mass effect of the brain and midline shift of the brain.
2. Failed to inform consult with the attending neurologist concerning the results of the CT scan prior to performing the lumbar puncture.
3. Failed to appropriately evaluate and treat a patient with increased intracranial pressure and with previously diagnosed intracranial pathology.

F. On or about April 7, 2003, Patient F was brought by ambulance to Montefiore Medical Center E.R. with complaints of light headedness, slurred speech and difficulty speaking. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to appropriately diagnose the patient's condition.
2. Failed to follow up on the abnormal findings of critical blood tests he had ordered.
3. Failed to obtain a cardiac consult to determine whether the patient's symptoms were precipitated by cardiac etiology.
4. Failed to order a full cardiac and central nervous system assessment.
5. Failed to admit the patient to the hospital for observation.

G. On or about June 27, 2003, Patient G went to Montefiore Medical Center E.R. with complaints of abdominal pain, vomiting and diarrhea. Respondent's care deviated from accepted medical standards in that Respondent:

1. Failed to timely evaluate and treat a patient with documented coronary artery disease who presented to the E.R. with complaints of chest pain.

~~symptoms, clinical findings and abnormal EKG~~.

5/9/05 JQ 2. Failed to appropriately respond to findings of an abnormal EKG.

3. Failed to perform a rectal exam and draw a hematocrit on patient with gastrointestinal symptoms.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

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

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

EIGHTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

8. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D

negligence on more than one occasion as alleged in the facts of two or more of the following:

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

NINTH SPECIFICATION

GROSS INCOMPETENCE

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

9. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs.

TENTH SPECIFICATION

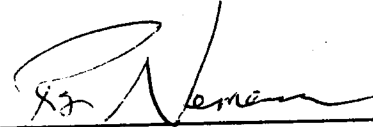
INCOMPETENCE ON MORE THAN ONE OCCASION

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

10. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph

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

DATED: March 30, 2005
New York, New York



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct