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

September 22, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Tyrone Walker, M.D.
1197 East 91st Street
Brooklyn, New York 11236

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein &
Deutsch, LLP
757 Third Avenue
New York, New York 10017

Terrence J. Sheehan, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street – 4th Floor
New York, New York 10007-2919

RE: In the Matter of Tyrone Walker, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-217) 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 Respondent 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/nm

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm

Enclosure

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

COPY

IN THE MATTER

OF

TYRONE WALKER, M.D.

DETERMINATION
AND
ORDER

BPMC 06 - 217

DANIEL W. MORRISSEY, O.P. (Chair), **FRED S. LEVINSON, M.D.** and **FERNANDO A. JARA, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) and §230(12) of the Public Health Law ("**P.H.L.**").

MARC P. ZYLBERBERG, ESQ., Administrative Law Judge, served as the Administrative Officer ("**ALJ**").

The Department of Health ("**Department**") appeared by **TERRENCE J. SHEEHAN, ESQ.**, Associate Counsel.

TYRONE WALKER, M.D., ("**Respondent**") appeared personally and was represented by Aaronson Rappaport Feinstein & Deutsch, LLP, by **BARBARA A. RYAN, ESQ.**, of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order in accordance with the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Commissioner's Order and Notice of Hearing:	March 22, 2006
Date of Statement of Charges:	March 21, 2006
Date of Answer to Charges:	March 29, 2006
Pre-Hearing Conference Held:	April 18, 2006
Hearings Held: - (First Hearing day): May 11, 2006; May 12, 2006; May 18, 2006; May 24, 2006; May 31, 2006; and June 27, 2006	April 27, 2006;
Intra-Hearing Conferences Held:	May 11, 2006 May 31, 2006
Department's Proposed Findings of Fact, Conclusions of Law and Recommended Sanction:	Received August 9, 2006
Respondent's Proposed Findings of Fact:	Received August 10, 2006
Witnesses called by the Department of Health:	Donald Barton, M.D.
Witnesses called by the Respondent, Tyrone Walker, M.D.:	Tyrone Walker, M.D. Michael Franklin, M.D. Asa William (Peter) Viccellio, M.D. Lewis Kohl. M.D. Elizabeth Romano Catherine Liberatore
Deliberations Held: - (Last Hearing day)	August 18, 2006

STATEMENT OF CASE

This case was brought by the Department pursuant to §230 of the P.H.L. Tyrone Walker, M.D., ("**Respondent**" or "**Dr. Walker**") is charged with nineteen (19) specifications of professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (14), (21), and (32) of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: (1) practicing the profession with gross negligence[1]; (2) practicing the profession with gross incompetence[2]; (3) practicing the profession with negligence on more than one occasion[3]; (4) practicing the profession with incompetence on more than one occasion[4]; (5) failing to maintain a record for each patient which accurately reflected the evaluation and treatment of that patient[5]; (6) practicing the profession of medicine fraudulently[6]; (8) wilfully making or filing a false report, or failing to file a report required by law[7]; and (9) violating Public Health Law §2805-k [8].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct in the care and treatment of five (5) patients (the record identifies the patients alphabetically to protect patient privacy) and several applications submitted or information not submitted by Respondent.

Respondent denies the factual allegations and denies all specifications of misconduct. A copy of the Commissioner's Order, Notice of Hearing, and the March 21, 2006 Statement of Charges is attached as Appendix 1.

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[1] Education Law §6530(4) - (First through Fifth Specification of the Statement of Charges [Department's Exhibit # 1].

[2] Education Law §6530(6) - (Sixth Specification of the Statement of Charges [Department's Exhibit # 1].

[3] Education Law §6530(3) - (Seventh Specification of the Statement of Charges [Department's Exhibit # 1].

[4] Education Law §6530(5) - (Eighth Specification of the Statement of Charges [Department's Exhibit # 1].

[5] Education Law §6530(32) - (Ninth through Thirteenth Specification of the Statement of Charges [Department's Exhibit # 1].

[6] Education Law §6530(2) - (Fourteenth through Fifteenth Specifications of the Statement of Charges [Department's Exhibit # 1].

[7] Education Law §6530(21) - (Sixteenth through Eighteenth Specification of the Statement of Charges [Department's Exhibit # 1].

[8] Education Law §6530(14) - (Nineteenth Specification of the Statement of Charges [Department's Exhibit # 1].

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which had the burden of proof, was required to prove its case by a preponderance of the evidence. Unless otherwise noted, the Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on or about July 7, 1999, by the issuance of license number 214741 by the New York State Education Department (Department's Exhibit # 12)[9].

2. Respondent is currently **not** authorized to practice medicine in the State of New York, due to the Commissioner's issuance and service of a Summary Order of Suspension, dated March 22, 2006, and the Commissioner's Interim Order to continue the Summary Order, dated June 8, 2006. Respondent's suspension is to continue until the Hearing Committee issues its Final Determination and Order (See Appendix 2).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ); Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d] & §230[12]); [P.H.T-5][10].

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[9] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Tyrone Walker (Respondent's Exhibit #).

[10] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing transcripts or the Intra-Hearing transcripts or the ALJ Exhibits but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

Patient A

4. On January 29, 2005, Respondent treated Patient A in the emergency room at Long Island College Hospital in Brooklyn, NY (Department's Exhibit # 2).

5. On January 29, 2005, Patient A was a 5-week-old baby boy who had been a 33-week premature baby discharged from the Neonatal Intensive Care Unit ("**NICU**") of Long Island College Hospital approximately seven days earlier (Department's Exhibit # 2).

6. Patient A had been in the NICU for approximately a 4 and ½ week course of treatment for obstructive uropathy, neonatal dehydration, urinary tract infection and sepsis of the newborn (Department's Exhibit # 2).

7. Respondent failed to appreciate the significance of Patient A's NICU history in his evaluation of the Patient (Department's Exhibit # 2); [T-845-849, 429-430]; (Department's Exhibit # 14).

8. Respondent did not admit Patient A and did not order a sepsis work up and did not order antibiotics (Department's Exhibit # 2).

9. Respondent did not order consultations (Department's Exhibit # 2); [T-842-844].

10. Respondent discharged Patient A with the diagnosis of "vomiting → resolved" (Department's Exhibit # 2).

11. Approximately eight (8) hours later Patient A was returned to the Emergency Room in full cardiopulmonary arrest and expired. The autopsy of Patient A indicated the causes of death included enterobacteria sepsis and pyelonephritis (Department's Exhibit # 1); [T-96, 125].

12. Respondent maintained an adequate medical record for Patient A which reflected the evaluation and treatment he provided to the patient (Department's Exhibit # 2); [T-71].

Patient B

13. On April 18, 2005, Respondent treated Patient B in the emergency room at Long Island College Hospital in Brooklyn, NY (Department's Exhibit # 3).

14. On April 18, 2005 Patient B was a 68-year-old woman who presented to the emergency room with main complaints of dizziness, shortness of breath and constipation (Department's Exhibit # 3); [T-138, 889].

15. Patient B's condition on presentation included an oxygen saturation of 87%, elevated pulse of 146 and respiration of 26 which, taken together, suggested significant respiratory distress (Department's Exhibit # 3); [T-138-141, 889-890].

16. Respondent saw Patient B about one hour after she was seen by the triage nurse. Respondent failed to perform and document an adequate history and physical examination, including orthostatic vital signs and rectal examination for occult blood (Department's Exhibit # 3); [T-141-149, 151-154, 889-890, 894-895].

17. Respondent failed to appreciate Patient B's emergent condition and failed to appropriately follow-up on signs that the Patient was seriously ill (Department's Exhibit # 3); [T-156-158, 167-168, 169, 889-924].

18. Respondent failed to make a differential diagnosis (Department's Exhibit # 3).

19. Respondent failed to undertake a thorough clinical investigation to ascertain the cause of Patient B's distress (Department's Exhibit # 3); [T486-487, 889-924].

20. An intensive care unit ("**ICU**") consult was called at the time the patient deteriorated, with coffee ground emesis and subsequent arrest (Department's Exhibit # 3); [T-206].

21. The Respondent ordered an EKG. It showed some abnormal, non-specific finding (Department's Exhibit # 3); [T-177-179, 947-948].

22. Approximately seven hours after presentation to the emergency room Patient B, who was still in the emergency room, became unresponsive with hypotension and cardiopulmonary arrest, after which she was resuscitated. Patient B arrested again the following morning. Resuscitative efforts were not successful (Department's Exhibit # 3); [T-903, 919].

23. Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment he provided , including patient history and physical, diagnoses and follow-up of test results (Department's Exhibit # 3); [T-180, 977].

Patient C

24. On July 21, 2004, Respondent treated Patient C, a seven-year-old girl, in the emergency room at Long Island College Hospital in Brooklyn, NY (Department's Exhibit # 5).

25. Respondent failed to document an adequate physical examination. Respondent did not perform an abdominal exam of Patient C (Department's Exhibit # 5); [T-877-879, 265-266].

26. Respondent failed to include the differential diagnosis of acute appendicitis in his evaluation of Patient C (Department's Exhibit # 5); [t-229-230, 234-235, 717-721].

27. Respondent did not order a CT scan of the abdomen of Patient C. Respondent did not request a surgical consultation (Department's Exhibit # 5); [T-861-862, 242].

28. Respondent made a diagnosis of urinary tract infection (Department's Exhibit # 5).

29. Respondent's discharge of the Patient was premature (Department's Exhibit # 5); [T-886-888].

30. Respondent prescribed oral antibiotics to Patient C (Department's Exhibit # 1); [T-238, 263].

31. Two days following her discharge from the emergency room Patient C returned. After reviewing an abdominal sonogram which showed a walled off appendiceal abscess, an exploratory laparotomy was performed. The post-operative diagnosis was necrotizing ruptured appendicitis with pelvic abscess. Surgery was followed by twelve days of IV antibiotic treatment (Department's Exhibit # 5); [T-239-240].

32. Respondent failed to maintain a medical record for Patient C which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for emergency room discharge (Department's Exhibit # 5); [T-877-879, 265-266, 227-228, 734-737, 754-758].

Patient D

33. On March 30, 2001, Respondent treated Patient D, a 73 year old woman, at Franklin Hospital in Valley Stream, NY (Department's Exhibit # 4).

34. Patient D presented with severe respiratory distress. On arrival to the emergency room she was tachypneic and tachycardic. Patient D's presumptive diagnosis was anaphylaxis and she was treated with albuterol (Department's Exhibit # 4); (Respondent's Exhibit # B).

35. Respondent's diagnosis of anaphylaxis and decisions to treat Patient D based on that diagnosis was proper (Department's Exhibits # 4 & # 7); (Respondent's Exhibit # B); [T-984-995].

36. Respondent ordered the administration of magnesium sulfate as "IVPB" (Intra-Venous piggyback) (Department's Exhibit # 4); [T-1035-1036, 298, 1087-1089].

37. Respondent ordered the intubation of Patient D (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-983-1039].

38. Despite multiple attempts at intubation, the patient expired (Department's Exhibit # 4 & # 7).

39. Respondent maintained an adequate medical record for Patient D which reflected the evaluation and treatment he provided to the patient (Department's Exhibit # 4); [T-1036-1038].

Patient E

40. On July 16, 2005, Respondent treated Patient E, a 68 year old male, at Peninsula Hospital Center in Far Rockaway, NY (Department's Exhibit # 6).

41. Patient E's primary complaints were severe abdominal pain and vomiting. Respondent failed to re-examine the patient's abdomen prior to discharge (Department's Exhibit # 6); [T-1049, 359, 1207-1208].

42. Respondent failed to properly interpret the abdominal x-ray films (Department's Exhibits # 6, # 15A & # 15B); [T-633-637].

43. Respondent failed to diagnose small bowel obstruction in Patient E (Department's Exhibit # 6); [T-1050, 1195-1197, 374].

44. Having incorrectly interpreted the abdominal x-ray films, Respondent's working diagnosis of acute gastroenteritis was consistent with Respondent's clinical findings that he indicated in the patient's medical records (Department's Exhibit # 6); [T-388, 1048].

45. Patient E's condition as observed clinically by Respondent was consistent with acute gastroenteritis and that would be an understandable impression if the abdominal x-ray films were negative. The one abdominal exam by Respondent was within normal range and the patient was given discharge instructions to follow-up within two days with his regular doctor, and to return to the ER if his symptoms worsened (Department's Exhibit # 6); [T-1041, 1185-1186].

46. Respondent maintained an adequate medical record for Patient D which reflected the evaluation and treatment he provided to the patient (Department's Exhibit # 6); [T-390-391].

Appointment Applications

47. Respondent signed and submitted an application, dated May 19, 2005, for appointment to the medical staff of Queens Hospital Center in Flushing, N.Y. Respondent correctly answered "No" to questions 1.d, 1.e, and 5 on page 7 of said application:

> "1. Have you ever been, or have Pending Challenges, or are you currently subject to denial, revocation, suspension, probation, non-renewal, voluntary/involuntary relinquishment/termination, reduction, limitation or diminution of a-g:
> ...
> d. Membership on any hospital medical staff?
> e. Clinical privileges at any hospital/medical facility?"
> ...
> 5. To the best of your knowledge, have you ever been or are you the subject of a focused review or under investigation by New York State or one of its designated agencies, e.g., DOH, DSS, etc?"

(Department's Exhibit # 10); (Respondent's Exhibit # H); [T-1422-1433, 456-457, 1230-1231, 1257-1259].

48. Respondent submitted an application, dated May 30, 2005, for appointment to the medical staff of Peninsula Hospital Center, Far Rockaway, N.Y.

Respondent entered the following information to the question:

> Certified by American Board of _____
> "American Board of Emergency Medicine (pending)"

(Department's Exhibit # 9).

49. Prior to May 30, 2005 Respondent had failed the first part of the American Board of Emergency Medicine test three (3) times, had never taken and was not eligible to take the second part (Department's Exhibits # 9 & # 10); [T-622-624].

License Registration

50. Respondent submitted a license registration renewal form, dated April 25, 2001, to the New York State Education Department for the period July 1, 2001 through March 31, 2003. Respondent falsely answered "Yes" to questions 2.a, 2.b, and 2.c of said form:

> "2. Since you last filed a registration application:
>
> a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?
>
> b. Has any other state or country instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or accepted surrender of a professional license held by you?
>
> c. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

(Department's Exhibit # 12); [T-1428-1431].

Physician Profile Summary

51. Physicians in New York State are required to complete and return to the Department of Health a Profile Summary which contains, *inter alia*, information about the physician and the nature of his or her practice. This information is then made available for review by members of the public. Between 2001 and 2005 Respondent willfully failed to submit a Profile Summary despite written requests for him to do so (Department's Exhibit # 11); [T-1373-1388]; (P.H.L. §2995-a).

CONCLUSIONS OF LAW

Unless otherwise indicated, all conclusions as to the factual allegations contained in the Statement of Charges were by a unanimous vote of the Hearing Committee. The Hearing Committee's specific conclusions as to each factual allegations from the March 21, 2006 Statement of Charges are indicated under each patient.

Based on the entire record, the Findings of Fact, and the Discussion that follows, the Hearing Committee concludes, unanimously unless otherwise noted, that the following seven (7) Specifications of Charges of misconduct contained in the Statement of Charges are **SUSTAINED**:

SEVENTH SPECIFICATION (Negligence on More than One Occasion): Paragraphs: A, and A.1, and A.2.; Paragraphs B, B.1, B.2, B.3, B.4, and B.8; Paragraphs C, C.1, C.2, C.5, and C.8.

TENTH SPECIFICATION: (Failure to Maintain Records): B, B.1, and B.8.

ELEVENTH SPECIFICATION: (Failure to Maintain Records): C, C.1 and C.8.

FOURTEENTH SPECIFICATION: (Fraudulent Practice): F.3 **vote of 2 to 1.**

SIXTEENTH SPECIFICATION: (Making or Filing a False Report): F.3.

EIGHTEENTH SPECIFICATION: (Failing to File a Report): H

NINETEENTH SPECIFICATION: (Violation of Public Health Law §2805-k): F.3.

The Hearing Committee unanimously concludes that the following Specifications of Charges of misconduct contained in the Statement of Charges are **NOT SUSTAINED**:

FIRST THROUGH FIFTH SPECIFICATIONS (Gross Negligence).

SIXTH SPECIFICATION (Gross Incompetence).

Negligence as to Patients D and E.

EIGHTH SPECIFICATION (Incompetence on More than One Occasion).

NINTH SPECIFICATION (Failure to Maintain Records) as to Patient A.

TWELFTH SPECIFICATION (Failure to Maintain Records) as to Patient D.

THIRTEENTH SPECIFICATION (Failure to Maintain Records) as to Patient E.

Fraudulent Practice as to the May 19, 2005 application for appointment to Queens Hospital Center: F.1 and F.2.

FIFTEENTH SPECIFICATION (Fraudulent Practice): G.

Making or Filing a False Report as to the May 19, 2005 application for appointment to the medical staff of Queens Hospital: F.1 and F.2.

SEVENTEENTH SPECIFICATION (Making or Filing a False Report): G

Violation of Public Health Law §2805-k as to the May 19, 2005 application for appointment to the medical staff of Queens Hospital: F.1 and F.2.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with a total of nineteen (19) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of many of the types of alleged misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were mostly obtained from the memoranda submitted by the Department, entitled: Definitions of Professional Misconduct under the New York Education Law[11]. During the course of its deliberations on these charges, the Hearing Committee was given the following instructions from the ALJ:

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits you find worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The

[11] A copy of this Memorandum was made available to both parties at the Pre-Hearing Conference [P.H.T-98-99].

evidence that supports the claim must appeal to you as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

Gross Negligence on a Particular Occasion

Gross Negligence is the 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. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

Gross Incompetence

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. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

Negligence on More Than One Occasion

Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by Dr. Walker caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed. Under the law, the failure to maintain records which accurately reflect the

evaluation and treatment of the patient and which does not affect patient treatment will not constitute negligence. Where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may constitute negligence.

Incompetence on More Than One Occasion

Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the safe practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning. These factors may include your impression of Dr. Walker's technical knowledge and competence on the various issues and the charges under consideration.

Practicing the Profession Fraudulently

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Walker made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; and (2) Dr. Walker knew that the representation was false; and (3) Dr. Walker intended to mislead through the false representation. As is true in other charges of misconduct (ie: negligence and incompetence), proof of actual injury to the patient is not required in order to sustain an act of practicing the profession fraudulently.

Failure to Maintain Records

A physician must record meaningful and accurate information in a patient's medical records, which accurately reflects the care and treatment of the patient, for a number of reasons. These reasons include: (1) for the physician's own use; (2) for the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards. The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility. The Hearing Committee understood that as the trier of fact they may accept so much of a witness' testimony as is deemed true and disregard what is deemed to be false.

Witnesses

Dr. Donald Barton, the Department's expert witness, was found to be not as clear and straight forward as would have been wished for. The Hearing Committee observed a knowledgeable physician who retracted his testimony numerous times. Dr. Barton was seen as being over critical of Respondent. Even the Department was frustrated with his testimony, to wit: "Sometimes he testified in a manner that appeared to surprise the party who called him". That characteristic did not increase his credibility with the Hearing Committee.

Dr. Asa William (Peter) Viccellio, the Respondent's expert witness, was found to be a very credible and more balanced witness. Dr. Viccellio was found to be a knowledgeable and persuasive witness by the Hearing Committee. He answered the questions posed succinctly and without evasion. He was critical of Respondent's conduct, when he felt it was warranted, yet realistic of the workings of a busy emergency room.

Dr. Michael Franklin and Dr. Lewis Kohl were found to be generally credible witnesses but had less to add to the patient care charges than to the other charges.

Obviously Respondent had the greatest amount of interest in the results of this proceeding. The Hearing Committee found Respondent's testimony to be similar to his medical records, that is, inconsistent and incomplete. Respondent was not a good witness in his own defense. Respondent's testimony was clouded by "a chip on his shoulder" responses. His testimony regarding having seen the wrong x-ray films for Patient E was a fabrication. Another fabrication was his explanation for the use and meaning of the word "pending". We found Respondent's lack of candor during the Hearing to be disappointing.

Using the above definitions and understanding, including the instructions and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

Patient A

Patient A presented with a history of two episodes of vomiting on the same day and episodes of rapid breathing and grunting. On examination by Respondent Patient A had normal temperature, normal respiratory rate and normal vital signs. The Emergency Medical Services ("**EMS**") noted no obvious signs of respiratory distress with a pulse oximetry reading of 100%. No hospital medical personnel saw any rapid respirations or grunting from the patient. There was evidence of good capillary refill noted by EMS and Patient A was able to feed by bottle. Patient A took in approximately 75% of what the expected feeding would be within 24 hours and he was consolable as observed by Respondent. The Hearing Committee cannot sustain the Department's allegation that Patient A presented with numerous complaints suggestive of sepsis.

Patient A's medical records contains a summary, by a resident, of the patient's NICU history. Although we cannot sustain the allegation that Respondent failed to review that history, we do sustain the fact that Respondent failed to appreciate the significance of Patient A's history when he

evaluated Patient A. Both Dr. Barton and Dr. Viccellio indicated that it was incumbent on Respondent to review the record of the previous admission to fully assess this case.

Based on Respondent's observations and his belief that nothing in the physical examination of Patient A was alarming we cannot sustain the allegations that Respondent should have admitted the patient or that he should have ordered consultations. After obtaining a normal exam, the decision to discharge Patient A following that examination was a judgment call.

Had Respondent not failed to appreciate Patient A's NICU history, Respondent course of treatment should have been a urine analysis or sepsis work up and possibly obtaining a consultation (not with a third year pediatric resident).

The Hearing Committee concludes that by failing to appreciate the patient's NICU history Respondent's conduct was below the minimum standard of care and Respondent was negligent. Respondent's subsequent actions, based on his observations and decision not to appreciate the patient's NICU history were not below the minimum standard of care.

The Department's own expert indicated that the medical record maintained by Respondent was adequate. Therefore the Hearing Committee cannot sustain factual allegation A.7.

Factual allegation A - first sentence sustained; second sentence - Respondent's management and treatment departed from accepted standards of medical practice when Respondent failed to appreciate the patient's history, including the NICU course of treatment, in Respondent's evaluation of Patient A.

Factual allegation A.1 - first sentence sustained; second sentence not sustained.

Factual allegation A.2 - first sentence sustained; second sentence - see discussion above and finding of fact # 6 and # 7 - sustained in part.

Factual allegation A.3 - see finding of fact # 8 - not sustained as written.

Factual allegation A.4 - see finding of fact # 9 - not sustained as written.

Factual allegation A.5 - see finding of fact # 10 - not sustained as written.

Factual allegation A.6 - see finding of fact # 11 - correct statement - not a charge.

Factual allegation A.7 - see discussion above and finding of fact # 12 - not sustained.

The Hearing Committee concludes that Respondent's actions do not rise to the level of gross negligence or gross incompetence in the care and treatment he provided to Patient A. There is nothing in the record which would indicate that Respondent's assessment was incompetent or that his failure to appreciate the NICU history was incompetence.

Patient B

This patient was in the emergency room for approximately seven (7) hours without a diagnosis or differential diagnosis. Respondent's expert, Dr. Viccellio, summarized the case as follows [T-910-912]:

Q. In the emergency room, in such a case as this, is it reasonable to do what was

911

...

done in this case, according to your evaluation from the record?

A. In looking at the -- at this record, what I am not seeing is a plan beyond the basics. For instance, does this patient need a chest CT or a belly CT, what diagnosis are we chasing after? There, again, can be a flurry of activity in the emergency department and I well appreciate the difficulties of documenting what you do or don't do, but I don't see orders for a CAT scan or anything like that, so it's very difficult for me to piece together any care plan for this patient beyond: Let's check the labs, see what the labs show and then go

from there.
....

Q. Before the vomiting of the coffee ground emesis, was there any clear indication

912

...
that there should have been more tests, such as studies, done?
A. My concern is how she presents. She presents tachycardic, a terrible pulse ox, and this can't be explained by issues of volume or GI bleed. There has to be a quest elsewhere for the diagnosis, possibly pulmonary embolus or congestive failure, pulmonary edema. Those last two didn't suggest themselves at all. But it's hard to piece together from this chart what the direction of the case was.

Factual allegation B - first sentence sustained; second sentence - Respondent's management and treatment departed from accepted standards of medical practice when Respondent failed to perform and document an adequate history, and examination including vital signs and rectal examination for occult blood and the factual findings regarding paragraphs B2, B.3, and B.4.

Factual allegation B.1 - sustained - finding of fact # 13, # 14, # 15, and # 16.

Factual allegation B.2 - sentence sustained except for the word "clear" and the conclusion that the patient was in a state of shock - see finding of fact # 17.

Factual allegation B.3 - sentence sustained except for the conclusion that the patient was in some form of shock - see finding of fact # 18.

Factual allegation B.4 - see finding of fact # 19 - partially sustained as written.

Factual allegation B.5 - see finding of fact # 20 - not sustained.

Factual allegation B.6 - see finding of fact # 21 - not sustained.

Factual allegation B.7 - see finding of fact # 22 - correct statement except as to the last sentence - not a charge.

Factual allegation B.8 - see finding of fact # 23 - sustained.

The Hearing Committee concludes that Respondent's actions do not rise to the level of gross negligence or gross incompetence in the care and treatment he provided to Patient B. Respondent's actions does constitute negligence as it was below the minimum standard of care. There is nothing in the record which would indicate that Respondent's assessment was incompetent especially since there was no real assessment of this patient (by anyone at the hospital).

Patient C

The medical records of Patient C contain an adequate history as done by the resident. As indicated by the Department's expert, Dr. Barton, an attending's history and physical should be more focused. Respondent's errors occurred in his failure to document his physical examination. Respondent also failed to perform a flank examination which was crucial to his working diagnosis of UTI. Respondent's subsequent actions are not necessarily unreasonable with a working diagnosis of UTI. Respondent's negligence occurred in his failure to document a physical examination, failure to include acute appendicitis in his evaluation and failure to maintain appropriate medical records.

Factual allegation C - first sentence sustained; second sentence - Respondent's management and treatment departed from accepted standards of medical practice when Respondent failed to document an adequate physical examination, including the documentation of an examination of the abdominal area and the performance of the flank area and the factual findings regarding paragraphs C.2, and C.8.

Factual allegation C.1 - sustained - see finding of fact # 24, and # 25.

Factual allegation C.2 - sentence sustained - see finding of fact # 26.

Factual allegation C.3 - sentence sustained in part - see finding of fact # 27.

Factual allegation C.4 - see finding of fact # 28 - partially sustained as written.

Factual allegation C.5 - see finding of fact # 29 - partially sustained as written.

Factual allegation C.6 - see finding of fact # 30 - partially sustained as written.

Factual allegation C.7 - see finding of fact # 31 - correct statement of fact - not a charge.

Factual allegation C.8 - see finding of fact # 32 - sustained.

The Hearing Committee concludes that Respondent's actions do not rise to the level of gross negligence or gross incompetence. Respondent's actions do constitute negligence as it was below the minimum standard of care. There is nothing in the record which would indicate that Respondent's assessment was incompetent. The Hearing Committee does not believe that Respondent lacks the necessary knowledge to diagnose appendicitis. This case had atypical presentations of appendicitis. Respondent made an incorrect diagnosis but he treated the patient in line with his chosen diagnosis.

Patient D

Respondent's expert, Dr. Viccellio, best summarized this case as follows [T-984-985, 986-987]:

> ...
> A. From a medical standpoint, I think this is a fantastic case because based on virtually no information, you have to make a major clinical decision that this is either
>
> 985
>
> ...
> anaphylaxis or it's a major heart attack or a severe asthma attack would go to the same. This is a seventy-three year-old with heart disease that you believe has

anaphylaxis. If you go down the anaphylaxis route and you are wrong, you kill her. But if you go down the heart route and treat the anaphylaxis, you kill her. So this makes this a fun case in emergency medicine. So Dr. Walker in this case makes the decision that this is most likely anaphylaxis and proceeds to treat her with a number of drugs that, were he wrong, could be very damaging to the heart, but very necessary to treat anaphylaxis.

....

986

...

Q. Does this tryptase level of 71.8

987

...

indicate to you that this was, indeed, anaphylaxis in this case?

A. I would think that that would be very suggestive of anaphylaxis.

Q. Based on the impression that you just testified to, that the patient likely had anaphylaxis, were the interventions appropriate in this case?

A. Yes.

The autopsy report for Patient D was very suggestive that this patient had anaphylaxis. Respondent's working diagnosis was probably correct. The autopsy report for Patient D indicated a toxicology presence of Benadryl which would have resulted from an order of H-1 and H-2 blockers. Given Respondent's working (apparently correct) diagnosis of anaphylaxis shock, a basic cardiac work up, including an electrocardiogram for Patient D was not required. The administration of magnesium sulfate to Patient D as an IVPB (Intra-Venous piggyback) was not contraindicated.

The magnesium sulfate would not harm the patient but might have helped. The Hearing Committee cannot conclude that intubation was not warranted given the patient's respiratory acidosis on the arterial blood gas report and accepts Respondent's judgment call.

The Hearing Committee accepted Dr Viccellio testimony that the medical record might leave more to be desired but that it is a somewhat of standard emergency room medical record. Therefore the Hearing Committee cannot sustain factual allegation D.9.

Factual allegation D - first sentence sustained; second sentence - not sustained - see findings of fact # 33 through # 39.

Factual allegation D.1 - not sustained.

Factual allegation D.2 - not sustained.

Factual allegation D.3 - not sustained.

Factual allegation D.4 - not sustained.

Factual allegation D.5 - see finding of fact # 36 - not sustained as written.

Factual allegation D.6 - see finding of fact # 37 - not sustained as written.

Factual allegation D.7 - first sentence not sustained - second sentence was withdrawn by the Department on May 11, 2006.

Factual allegation D.8 - see finding of fact # 38 - not sustained as written.

Factual allegation D.9 - see discussion above and finding of fact # 39 - not sustained.

The Hearing Committee concludes that Respondent's actions do not constitute gross negligence, gross incompetence, negligence, or incompetence in the care and treatment he provided to Patient D.

Patient E

The Hearing Committee reviewed the radiologist's result report which is dated the day after the patient was seen in the emergency room. The report provides an impression that the abdominal findings are suspicious for small bowel obstruction and that correlation with CT was suggested. The x-ray films themselves only provide subtle indications of small bowel obstruction. Given the patient's clinical presentation, Respondent's working diagnosis of acute gastroenteritis was not unreasonable if the x-ray films were incorrectly interpreted. The Hearing Committee does not believe Respondent's claim that he saw the wrong x-ray films. The error made by Respondent in their interpretation led him to miss the diagnosis of small bowel obstruction.

The other error which occurred in the care and treatment of Patient E was Respondent's failure to re-examine the patient's abdomen prior to discharge. Given all of the circumstances presented in this case the Hearing Committee concludes that the care and treatment Respondent provided to Patient E was at the minimum standard. We do not find that it was below the minimum and do not sustain the charge of negligence. The big picture in this case was the misinterpretation of the x-ray films. Although the Hearing Committee does not condone such errors, we understand that these errors may occur in a busy emergency room on a Saturday without having the immediate availability of a radiologist .

Factual allegation E - first sentence sustained; second sentence - not sustained - see findings of fact # 40 through # 46.

Factual allegation E.1 - sustained in part - see finding of fact # 41.

Factual allegation E.2 - not sustained.

Factual allegation E.3 - sustained in part - see finding of fact # 42.

Factual allegation E.4 - sustained - see finding of fact # 43.

Factual allegation E.5 - not sustained - see finding of fact # 44 & # 45.

Factual allegation E.6 - not sustained - see finding of fact # 46.

The Hearing Committee concludes that Respondent's actions do not constitute gross negligence, gross incompetence, negligence, or incompetence in the care and treatment he provided to Patient E.

Appointment Applications

Respondent's Exhibit # H is a letter, dated July 12, 2005, from Long Island College Hospital which refutes the Department's factual allegation that Respondent falsely answered the appointment application he submitted to Queens Hospital on May 19, 2005. The letter from Respondent's former employer clearly indicates that Respondent was a member in good standing of the medical staff with full staff privileges and no restrictions.

No evidence was presented that the New York State Office of Professional Medical Conduct notified Respondent that he was the subject of an investigation any earlier than October 2005. At best, the wording of paragraph # 5 of the Queens Hospital application is ambiguous. Respondent's answers of "NO" to the questions at issue contained in his application for appointment to the medical staff of Queens Hospital Center were not incorrect.

Respondent had failed the first part of the American Board of Emergency Medicine exam three (3) separate times. An intention to take the exam a fourth time, at some point in the future, would not invoke the word "pending". To the Hearing Committee "pending" might have been used if you took the exam and are awaiting results. The Hearing Committee **votes 2 to 1** that the information that Respondent submitted on his application for appointment to the medical staff of Peninsula Hospital Center was false and done with an intent to deceive.

Factual allegation F.1 - not sustained - see finding of fact # 47.

Factual allegation F.2 - not sustained - see finding of fact # 47.

Factual allegation F.3 - sustained - see finding of fact # 48 & # 49.

The Hearing Committee believes that Dr. Walker made a false representation, by indicating that his certification by the American Board of Emergency Medicine ("**ABEM**") was pending. Respondent knew that the ABEM pending representation was false. We infer, by a vote of 2 to 1, that since Respondent knew that he had failed three (3) times previously that this information would not be favorable to him and that Dr. Walker intended to mislead whoever read his application by indicating that his ABEM Board's were pending. We also believe that he wilfully made the false report.

Public Health Law §2805-k requires a physician to provide certain information to a hospital or Article 28 facility (see §2805-k[1] subdivisions [a] through [g]). By providing false information (ie "pending") Respondent did not provide the information that was requested by the hospital and required by P.H.L. §2805-k. Therefore Respondent committed professional misconduct under Education Law §6530(14).

License Registration

The three (3) "YES" answers in the license registration renewal forms, signed on April 25, 2001 by Dr. Walker, were incorrect. The correct answers were stated by Respondent at the Hearing. The Hearing Committee believes that these incorrect answers were submitted, possibly, because of indifference, carelessness, inattentiveness or maybe even contempt for the process. Respondent did make the false representations. The Hearing Committee does not believe the false (incorrect) answers were submitted by Respondent with any intention to deceive. Although Respondent may have been negligent in the way he responded, we do not believe that Respondent wilfully made or filed a false report under these circumstances.

Factual allegation G and G.2.a and G.2.b and G.2.c - correct statement of fact - see finding of fact # 50. Specifications of Misconduct not sustained.

Factual allegation G and G.3.a and G.3.b - withdrawn by Department.

Physician Profile Summary

The Hearing Committee believes that Respondent received the notices early on and probably put them aside. Four years of delay and procrastination is not excusable. The Hearing Committee does not believe Respondent's explanations nor accept his minimization.

Factual allegation H - sustained - see finding of fact # 51.

Respondent wilfully failed to file a report required to be filed.

Public Health Law §2995-a requires the Department to collect certain information and each physician to provide the information requested. By failing to provide the information requested Respondent violated P.H.L. §2995-a. Therefore Respondent committed professional misconduct under Education Law §6530(21).

The Department of Health has met its burden of proof as to separate and distinct acts of negligence in the care and treatment of Patients A, B, and C; failure to maintain accurate records in the care and treatment of Patient B and C; fraud by Respondent in the practice of medicine; wilfully making a false report, failing to file a report required to be filed; and violating Public Health Law §2805-k. Respondent has committed professional misconduct as defined in Education Law §§6530(2), (3), (14), (21), and (32).

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented during seven (7) days of Hearings and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee determines by a **vote of 2 to 1** that Respondent's license to practice medicine in New York State should be reinstated under the conditions set forth in this Determination and Order.

Respondent's suspension should be "time served " and should cease seven (7) days from the date this Determination and Order is served. Respondent should be placed on probation for five (5) years and should only practice medicine with a practice supervisor in accordance with the terms and conditions of probation annexed as Appendix 3. Respondent's license to practice medicine should be limited to the practice of medicine in an Article 28 facility.

This penalty determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

Given the nature of the professional misconduct committed by Respondent, censure and reprimand and performing community service is deemed inadequate. Although Respondent was found guilty of fraud, we do not assess a monetary fine because there was no proof that Respondent intended to financially gain from his fraud.

Respondent's license has been suspended for almost six (6) months. A majority of the Hearing Committee believes that this actual suspension, along with the probation discussed below, is an appropriate penalty for Respondent's misconduct. The majority believes that Respondent's negligence was serious but not egregious nor grave enough to revoke Respondent's license.

Respondent 's former supervisor and chief of the emergency room at a busy hospital indicated that Respondent is a good and caring physician. Respondent has treated thousands of patients in his brief career reasonably well at the standard of care expected. The Hearing Committee is concerned with Respondent's diagnostic abilities and lack of attention to details in his medical record keeping. We were also troubled with the misrepresentations made and apparent inattentiveness to paperwork type tasks.

A majority of the Hearing Committee believes that Respondent is salvageable or redeemable and should be allowed to practice medicine. Respondent's practice of medicine should be limited to an Article 28 facility with a practice supervisor who will report to the Office of Professional Medical Conduct on a regular basis. We do not limit Respondent to the practice of emergency medicine but would strongly suggest that if he wishes to continue in that field that he becomes serious about studying, taking, and passing his boards with the American Board of Emergency Medicine. We also observed that a number of the factual allegations involved residents who made preliminary work ups on the patients. We believe that when an attending works with residents he or she needs to be responsible for the final decision making regarding the care and treatment of the patient. Respondent needs to be in a situation where he is supervised, not where he is the supervisor. Although we considered a course of reeducation or retraining we conclude that a practice supervisor is appropriate protection for the public and provides Respondent an opportunity to continue the practice of medicine.

A majority of the Hearing Committee believes that a period of five (5) years of probation, with a limitation that Respondent can only practice with a practice supervisor and under the terms indicated in Appendix 3, should be imposed on Respondent.

One member of the Hearing Committee believed that Respondent license to practice should be revoked. He believed that his testimony was unconvincing and that Respondent has not learned from this experience. One Hearing Committee member believed that Respondent is just not a good fit in the practice of medicine.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction imposed strikes the appropriate balance between the need to punish Respondent, to deter future misconduct, and to protect the public.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, by the Chair, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The SEVENTH, TENTH, ELEVENTH, FOURTEENTH, SIXTEENTH, EIGHTEENTH, and NINETEENTH Specifications of professional misconduct from the March 21, 2006 Statement of Charges (Department's Exhibit # 1) are **SUSTAINED,** and;

2. The FIRST through SIXTH, EIGHTH, NINTH, TWELFTH, THIRTEENTH, FIFTEENTH, and SEVENTEENTH Specification of professional misconduct from the March 21, 2006 Statement of Charges (Department's Exhibit # 1) are **NOT SUSTAINED,** and;

3. Respondent's license SUSPENSION is lifted effective seven (7) days from the date this Determination and Order is served; and

4. Respondent's actual SUSPENSION shall be part of his penalty; and

5. Respondent is placed on probation for five (5) years and shall practice in accordance with the attached terms of probation (Appendix 3); and

6. Respondent shall be authorized to practice medicine in the State of New York only when supervised by a practice supervisor; and

7. Respondent's license to practice medicine is limited to the practice of medicine in an Article 28 facility; and

8 This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: New York, New York
September 15, 2006

DANIEL W. MORRISSEY, O.P. (Chair)
FRED S. LEVINSON, M.D.
FERNANDO A. JARA, M.D.

Tyrone Walker, M.D.
1197 East 91st Street
Brooklyn, NY 11236

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein, &
Deutsch, LLP
757 Third Avenue
New York, NY 10017

Terrence J. Sheehan, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007-2919

APPENDIX 1

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

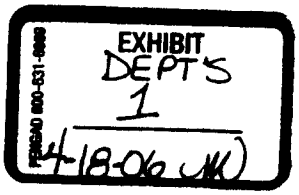
IN THE MATTER

OF

TYRONE WALKER, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: TYRONE WALKER, M.D.
Peninsula Hospital Center
5115 Beach Channel Dr.
Far Rockaway, NY 11691



The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by TYRONE WALKER, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately TYRONE WALKER, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 29, 2006, at 10:00 a.m., at the offices of the New York State Health Department, 90 Church Street, 4th floor, New York, NY 10007, and at such other adjourned dates, times and places as the

committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed

or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

March 22 ,2006

ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Terrence Sheehan
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
90 Church Street, 4th Floor
New York, NY 10007

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

IN THE MATTER

OF

TYRONE WALKER, M.D.

STATEMENT

OF

CHARGES

TYRONE WALKER, M.D., the Respondent, was authorized to practice medicine in New York State in 1999, by the issuance of license number 214741 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about January 29, 2005, Respondent treated Patient A (whose name together with other patient names are contained in the attached Appendix) in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient A was a 5-week-old ex 33-week premature baby who had been discharged from the Neonatal Intensive Care Unit (NICU) seven days earlier. Patient A presented with numerous complaints suggestive of sepsis. Respondent failed to follow-up these complaints or appreciate their medical significance.

2. Patient A had had a 4 1/2 week course of treatment in the NICU for obstructive uropathy, neonatal dehydration, urinary tract infection and sepsis of the newborn. Respondent failed to

review this history or failed to appreciate its significance in his evaluation of Patient A.

3. Respondent failed to admit Patient A and to order a sepsis workup and antibiotics.

4. Respondent failed to order appropriate consultations.

5. Respondent improperly discharged Patient A with the diagnosis of "vomiting (resolved)".

6. Approximately eight hours later Patient A returned to the Emergency Room in full cardiopulmonary arrest and expired. Upon autopsy, the causes of death included enterobacteria sepsis and pyonephrosis.

7. Respondent failed to maintain a medical record for Patient A which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

B. On or about April 18, 2005, Respondent treated Patient B in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to perform and document an adequate

history and physical examination, including orthostatic vital signs and rectal examination for occult blood.

2. Respondent failed to appreciate Patient B's emergent condition and failed to appropriately follow-up on clear signs that the Patient was in a state of shock.

3. Respondent failed to make a differential diagnosis of some form of shock.

4. Respondent failed to undertake basic clinical investigation to ascertain the cause of Patient B's distress, including blood cultures, arterial blood gas, cardiac enzymes, bedside echocardiogram and spiral chest CT.

5. Respondent failed to obtain indicated consultations.

6. Respondent failed to identify and follow-up abnormal findings on electrocardiogram.

7. Approximately seven hours after presentation to the emergency room Patient B became unresponsive with hypotension and cardiopulmonary arrest, after which she was resuscitated. Patient B arrested again the following morning. Resuscitative efforts were not successful. The probable cause of death was sepsis.

8. Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment he provided , including patient history and physical, diagnoses and follow-up of test results.

C. On or about July 21, 2004, Respondent treated Patient C, a seven-year-old girl, in the emergency room at Long Island College Hospital in Brooklyn, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

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

2. Respondent failed to include the differential diagnosis of acute appendicitis in his evaluation of Patient C.

3. Respondent failed to order a CT scan of the abdomen or a surgical consultation.

4. Respondent made a diagnosis of urinary tract infection which was not warranted.

5. Respondent's discharge of the Patient was not indicated.

6. Respondent prescribed oral antibiotics which was not indicated.

7. Two days following her discharge from the emergency room Patient C returned. After reviewing an abdominal sonogram which showed a walled off appendicle abscess, an exploratory laparotomy was performed. The post-operative diagnosis was necrotizing ruptured appendicitis with pelvic abscess. Surgery was followed by twelve days of IV antibiotic treatment.

8. Respondent failed to maintain a medical record for Patient ~~B~~ C which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

5/12/06
MPZ

D. On or about March 30, 2001, Respondent treated Patient D at Franklin Hospital in Valley Stream, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to appropriately consider and rule out several likely differential diagnoses in his evaluation of Patient D, including myocardial ischemia, cardiogenic shock and obstructive shock.

2. Respondent's working diagnosis of anaphylaxis was not warranted.

3. Respondent failed to order H-1 and H-2 blockers, the routine indicated treatment for the alleged anaphylaxis.

4. Respondent failed to order a basic cardiac work up including an

electrocardiogram for Patient D, who was a known "cardiac" patient.

5. Respondent ordered the administration of magnesium sulfate, as a bolus, which was not indicated or was contraindicated.

6. Respondent, based on the results of an arterial blood gas test, inappropriately and unnecessarily ordered the intubation of Patient D who was otherwise breathing, alert and talking.

7. Respondent failed to evaluate and treat Patient D in accordance with basic principles of airway management. ~~For instance, prior to undertaking to intubate Patient D Respondent should have, but failed to, consult with anesthesia or ENT. Instead Respondent inappropriately administered a paralyzing agent, succinylcholine, and proceeded with intubation without proper preparation~~.

5-11-06 WITHDRAWN BY DOH. AMP

8. Despite multiple attempts at intubation, the airway was lost and the patient suffered severe brain anoxia and expired.

9. Respondent failed to maintain a medical record for Patient D which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, and follow-up of test results.

E. On or about July 16, 2005, Respondent treated Patient E at Peninsula Hospital Center in Far Rockaway, NY. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient E's primary complaints were severe abdominal pain and vomiting. Respondent failed to appropriately evaluate the abdominal pain and failed to re-examine the abdomen prior to discharge.

2. Respondent diagnosis of acute gastroenteritis was inappropriate and without clinical basis.

3. Respondent failed to properly interpret an abdominal x-ray. He missed unequivocal, characteristic findings indicative of small bowel obstruction.

4. Respondent failed to diagnose small bowel obstruction in Patient E.

5. Respondent inappropriately discharged Patient E without attempting to rule out the life threatening condition of small bowel obstruction.

6. Respondent failed to maintain a medical record for Patient E which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.

F. 1. On or about May 19, 2005, Respondent submitted an application for appointment to the medical staff of Queens Hospital Center in Flushing, N.Y. By answering "No" to the following questions Respondent, with intent to deceive, sought to mislead his prospective employer about the true nature of his professional work history and to conceal from them the fact that as a result of several departures from

6-26-06 AMZ

acceptable levels of patient care on Respondent's part, Respondent had been forced on May 11, 2005 to relinquish his clinical privileges and membership on the medical staff at Long Island College Hospital:

> "Have you ever been, or have Pending Challenges, or are you currently subject to denial, revocation, suspension, probation, non-renewal, voluntary/involuntary relinquishment/termination, reduction, limitation or diminution of:
>
> -Membership on any hospital staff?
> -Clinical privileges at any hospital/medical facility?"

2. In the same Queens Hospital Center application Respondent, with intent to deceive, falsely answered "No" to the following question in order to conceal from his prospective employer the fact that a complaint had been filed, or would imminently be filed, with the New York State Office of Professional Medical Conduct by Long Island College Hospital regarding the several instances of substandard patient care which were the basis for his forced resignation:

> "To the best of your knowledge, have you ever been or are you the subject of a focused review or under investigation by New York State or one of its designated agencies, e.g., DOH, DSS, etc?"

3. On or about May 30, 2005, Respondent submitted an application for appointment to the medical staff of Peninsula Hospital Center, Far

Rockaway, N.Y. In filling out a portion of this application dealing with the issue of whether the applicant is certified by any American Board and the date of any such certification Respondent, with intent to deceive, entered the following false information:

"American Board of Emergency Medicine (pending)"

In fact Respondent had failed the first part of the American Board of Emergency Medicine test three times and had never taken the second part at all. In no truthful sense could his status be described as "pending".

G. On or about April 25, 2001, Respondent submitted a license registration renewal form for the period July 1, 2001 through March 31, 2003. The form contains several questions which must be answered under penalties of perjury. Respondent falsely answered "Yes" to each of the following questions:

"2. Since you last filed a registration application:

a. Have you been convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal?

b. Has any other state or country instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence, or revoked, suspended, or

accepted surrender of a professional license held by you?

c. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

3. a. Are you under an obligation to pay child support?

b. If you are under such an obligation, do you meet one of the requirements listed in the Child Support Law section below".

H. Physicians in New York State are required to complete and return to the Department of Health a Profile Summary which contains, *inter alia*, information about the physician and the nature of his or her practice. This information is then made available for review by members of the public. On numerous occasions between 2001 and 2005 Respondent, willfully and/or grossly negligently, failed to submit a Profile Summary despite written requests for him to do so.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH 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 paragraphs:

1. A and A(1) - A(6).
2. B and B(1)-B(7).
3. C and C(1)-C(7).
4. D and D(1)-D(8).
5. E and E(1)-E(5).

SIXTH 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 paragraphs:

6. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

SEVENTH 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 paragraphs:

7. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

EIGHTH 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 paragraphs:

8. A and A(1)-A(6), B and B(1)-B(7), C and C(1)-C(7), D and D(1)-D(8) and E and E(1)-E(5).

NINTH TO THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

9. A and A(7).
10. B and B(1), B(7).
11. C and C(1), C(8).
12. D and D(9).
13. E and E(6).

FOURTEENTH AND FIFTEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following paragraphs:

14. F(1) - F(3).
15. G.

SIXTEENTH TO EIGHTEENTH SPECIFICATION

FALSE REPORT AND FAILING TO FILE A REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department or by Public Health Law § 2995-a, as alleged in the facts of the following paragraphs:

16. F(1) - F(3)
17. G.
18. H.

NINETEENTH SPECIFICATION

VIOLATION OF PUBLIC HEALTH LAW § 2805-K

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(14) by violating Public Health Law § 2805-k, as alleged in the facts of the following paragraphs:

19. F(1) - F(3).

DATED: March 21, 2006
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

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

June 12, 2006

CERTIFIED MAIL/RETURN RECEIPT & FEDERAL EXPRESS

Tyrone Walker, M.D.
1197 East 91st Street
Brooklyn, New York 11236

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP
757 Third Avenue
New York, New York 10017

Terrence J. Sheehan, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street – 4th Floor
New York, New York 10007-2919

RE: In the Matter of Tyrone Walker, M.D.

Dear Parties:

Enclosed please find the Interim Order in the above referenced matter.

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm

Enclosure

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

COPY

IN THE MATTER

OF

TYRONE WALKER, M.D.

INTERIM ORDER
UNDER §230(12) OF THE
PUBLIC HEALTH LAW

On reviewing the attached Hearing Committee's Recommendation to the Commissioner on the issue of Imminent Danger, wherein the Committee found that TYRONE WALKER, M.D. presents an imminent danger to the health of the people of the State of New York, and;

On reviewing the Hearing Committee's recommendation that the Commissioner's Summary Order prohibiting TYRONE WALKER, M.D. from practicing medicine in the State of New York remain in effect;

NOW THEREFORE, I HEREBY ORDER THAT:

The Summary Order, dated March 22, 2006, imposed on TYRONE WALKER, M.D., shall remain in effect until the Hearing Committee issues its final Determination and Order after hearing the evidence on the remaining charges set forth in the Statement of Charges served on Respondent (Department's Exhibit # 1).

DATED: Albany, New York
June 8, 2006

ANTONIA C. NOVELLO, M.D., M.P.H., Dr. P.H.
Commissioner of Health

Tyrone Walker, M.D.
1197 East 91st Street
Brooklyn, NY 11236

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein, &
Deutsch, LLP
757 Third Avenue
New York, NY 10017

Terrence J. Sheehan, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007-2919

Daniel W. Morrissey, O.P. – Chair
Hearing Committee Member

Fred S. Levinson, M.D.
Hearing Committee Member

Fernando A. Jara, M.D.
Hearing Committee Member

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

IN THE MATTER **OF** **TYRONE WALKER, M.D.**	**HEARING COMMITTEE'S RECOMMENDATION TO THE COMMISSIONER UNDER §230(12) OF THE PUBLIC HEALTH LAW**

TO: The Honorable Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner of Health, State of New York:

DANIEL W. MORRISSEY, O.P. (Chair), **FRED S. LEVINSON, M.D.** and **FERNANDO A. JARA, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(12) of the Public Health Law ("**P.H.L.**").

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health ("**Department**") appeared by **TERRENCE J. SHEEHAN, ESQ.**, Associate Counsel.

TYRONE WALKER, M.D., ("**Respondent**") appeared personally and was represented by **AARONSON, RAPPAPORT, FEINSTEIN & DEUTSCH, LLP., BARBARA A. RYAN, ESQ.**, of Counsel.

Hearings were held on April 27, May 11, 12, 18, 24, and 31, 2006. Evidence was received and examined. Transcripts of the proceeding were made. The Hearing Committee, after hearing the testimony to date and reviewing the documentary evidence submitted, issues this Hearing Committee's Recommendation to the Commissioner of the New York State Department of Health ("**Commissioner**").

Dr. Walker is presently charged with professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (14), (21), and (32) of the Education Law of the State of New York. On March 22, 2006, the Commissioner issued an Order which summarily suspended Respondent from the practice of medicine in New York State. A copy of the Commissioner's Order and Notice of Hearing and a copy of the Statement of Charges are attached as Appendix I.

The Hearing Committee is charged with the threshold responsibility of determining "whether by a preponderance of the evidence the licensee (Respondent) is causing, engaging in or maintaining a condition or activity which constitutes an imminent danger to the health of the people" as set forth in P.H.L. §230(12). To date the Hearing Committee has only heard and received evidence regarding the Charges involving Patients A through E identified in the Statement of Charges.

Based on the evidence presented to date in this proceeding, it is the opinion of the Hearing Committee that Respondent is guilty of at least more than one instance of serious negligence and that by a preponderance of the evidence the Department has shown that Respondent's practice constitutes an imminent danger.

Because there is sufficient evidence to show that Respondent was engaging in or maintaining a hospital emergency room practice which constitutes an imminent danger, the Hearing Committee unanimously recommended on the record, on Wednesday, May 31, 2006, that the Commissioner's Order be continued until the Hearing Committee issues its final Determination and Order after hearing the remaining charges (a copy of the Hearing Committee's recommendation is attached and incorporated as Appendix 2).

Submitted June 5, 2006.

Tyrone Walker, M.D.
1197 East 91st Street
Brooklyn, NY 11236

Barbara A. Ryan, Esq.
Aaronson, Rappaport, Feinstein, &
Deutsch, LLP
757 Third Avenue
New York, NY 10017

Terrence J. Sheehan, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007-2919

Daniel W. Morrissey, O.P. – Chair
Hearing Committee Member

Fred S. Levinson, M.D.
Hearing Committee Member

Fernando A. Jara, M.D.
Hearing Committee Member

APPENDIX 2

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

----------x

In the Matter

of

TYRONE WALKER, M.D.

----------x

MINUTES OF DECISION, held at the offices of the New York State Department of Health, Bureau of Professional Medical Conduct, 90 Church Street, New York, New York 10007, on Wednesday, May 31, 2006, commencing at 1:20 o'clock a.m.

BEFORE:

HONORABLE MARC P. ZYLBERBERG, ESQ.
Administrative Law Judge as
Administrative Officer

PANEL:

DANIEL W. MORRISSEY, O.P.,
Chairperson

FRED S. LEVINSON, M.D.

FERNANDO A. JARA, M.D.

APPEARANCES:

TERRENCE SHEEHAN, ESQ.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007

AARONSON, RAPPAPORT, FEINSTEIN &
DEUTSCH, L.L.P.
Attorneys for Respondent
757 Third Avenue
New York, New York 10017

BY: BARBARA A. RYAN, ESQ.

ALSO PRESENT:

TYRONE WALKER, M.D.,
Respondent
HEDVA SHAMIR, M.D.,
DOH Medical Coordinator

...

* * *

JUDGE ZYLBERBERG: We are back on the record.

The Hearing Committee has had a chance to discuss the issue of imminent danger, and review Section 230, paragraph 12 of the Public Health Law. Currently, it is a unanimous decision that the suspension should continue because there has been shown, by a preponderance of the evidence, that there has been negligence on more than one incident, especially as it reflects to Patients A, B and C.

So when I receive the transcript of this part of the Decision, I'll attach that to a report and recommendation to the Commissioner to continue the summary suspension until the final Decision is

made by the Hearing Committee as to what penalty should be issued based on the entire case, if any penalty, which would be, obviously, in addition to the summary suspension.

So, therefore, the summary

suspension should continue until the issuance of the determination and order issued by the committee.

(Time noted: 4:10 o'clock p.m.)

* * *

APPENDIX 3

Terms of Probation For Tyrone Walker, M.D.

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

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct ("**OPMC**"), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) 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 Determination and Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

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

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

PRACTICE SUPERVISOR

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

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

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

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