STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

June 15, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey Ficano, D.O.
REDACTED ADDRESS

Robert H. Iseman, Esq.
Iseman, Cunningham, et al
9 Thurlow Terrace
Albany, New York 12203

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 Jeffrey Ficano, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-131) 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,

REDACTED SIGNATURE
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

JEFFREY FICANO, D.O.,

Respondent

DETERMINATION

AND

ORDER

BPMC NO. 06-131

A Notice of Hearing and Statement of Charges dated December 12, 2005, were served upon the Respondent, JEFFREY FICANO, D.O. Subsequently an Amended Statement of Charges was admitted in evidence on January 19, 2006. **ROBERT A. MENOTTI, M.D., (Chair), RICHARD F. KASULKE, M.D. and GAIL S. HOMICK** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. The Respondent appeared by Iseman, Cunningham, Riester & Hyde, Robert H. Iseman, Esq. of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing & Statement of Charges:	December 12, 2005
Date of Amended Statement Of Charges	January 19, 2006
Dates of Hearing:	January19, 2006 January 27, 2006 February 14, 2006 March 3, 2006
Date of Deliberations:	April 24, 2006

STATEMENT OF CASE

The Amended Statement of Charges alleged the Respondent violated the following four categories of professional misconduct: gross negligence; negligence on more than one occasion; gross incompetence and incompetence on more than one occasion. A copy of the Amended Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous

determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Jeffrey Ficano, D.O., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about July 14, 1998 by the issuance of license number 211216 by the New York State Education Department. (Exs. 1 & 1A)

PATIENT A:

2. On or about September 9, 2004, Patient A, an 82 year old female, went to the Oneida Health Care Center (hereinafter "Center") with a chief complaint of headache. She presented with a history of a headache on and off for a few days which is now gone, hypertension, diabetes, recent stress, osteoporosis, and confusion on date of the ER visit. Her vital signs were stable, respiration effort was normal, her blood pressure was slightly

elevated and her neurological indicators were normal. (T. 28-29, 80, 82-84, 405-406, 469-470; Ex. 2)

3. When a patient presents to an ER physician as Patient A did, she should be evaluated for headache and confusion, including an adequate physical examination and a neurological evaluation. The Respondent conducted such an evaluation of Patient A. (T. 410-411, 473-474; Ex. 2)

4. When examined by the Respondent, Patient A did not have a headache and was not confused. It is not medically necessary to order a CT scan and a coagulation profile on a patient who does not have a headache and whose neurological indicators are normal. (T. 417; Ex. 2)

5. When a patient such as Patient A presents with no respiratory symptoms, no abnormal cardiac symptoms and normal vital signs, the examining physician does not have to order an EKG test. (T. 476; Ex 2)

6. On or about September 9, 2004, Patient A had blood laboratory tests performed. The results of the blood tests showed the specimen was lipemic and had some abnormalities, but no severe electrolyte abnormalities. Any abnormalities were reasonably attributable to the specimen being lipemic. Patient A did not exhibit any signs of respiratory insufficiency. (T. 105, 476-477; Ex. 2)

7. When a patient presents as Patient A did, admission to the hospital should be considered, but was not required. The Respondent considered admission, but decided not to recommend admitting Patient A. (T. 423, 477-478; Ex. 2)

PATIENT B:

8. On or about September 6, 2004, Patient B, an 81 year old male, went to the Center with a chief complaint of fever and chills. He presented with a history of an indwelling central venous catheter, septic joint from a knee replacement and being treated with Rocephin for the past eight weeks. (T. 132, 495-496, 641; Ex. 3)

9. Although Patient B had a history of a joint infection, based on his symptoms he did not have sepsis, and therefore did not need to be admitted for an evaluation of sepsis. (T. 143, 497, 499-500; Ex. 3)

10. As part of the treatment of a patient who presents as Patient B did, an ED physician should consult with an infectious disease specialist or the patient's physician, who was monitoring the treatment of the patient's infected joint. The Respondent did consult with Patient B's orthopaedic surgeon who was providing the ongoing treatment of the patient's infected joint who was also the patient's primary care physician. The Respondent

also spoke to the covering primary care physician. (T. 148, 496-497, 644-645; Ex. 3)

PATIENT C:

11. On or about September 29, 2003, Patient C, a 75 year old woman, went to the Center with a chief complaint of rectal bleeding with black stools. She presented with a history of diverticulitis and with similar episodes of rectal bleeding in the past several years. She had no symptoms of fainting, fatigue or weakness. Her vital signs were stable. (T. 154, 507-510; Ex 4.)

12. When a patient presents as Patient C did to an ED physician, she should be evaluated and treated for blood in stool, laboratory work should be done on her blood; an anal examination should be performed, and her treating physician, if any, should be consulted. The Respondent did this. (T. 510-511; Ex. 4)

13. Based on the presentation of Patient C and her ongoing medical treatment, Patient C did not require to be admitted to the hospital. (T. 511-512; Ex. 4)

PATIENT D:

14. On or about June 14, 2004, Patient D, a 52 year old woman, went to the Center with a chief complaint of numbness on the right side of her face. She presented with a history of recent mental status change, some confusion, past TIA's, hypertension and diabetes. She was under the care of a neurologist and recently had a carotid Doppler study, the results of which were negative. (T. 186-187, 521-522; Ex. 5)

15. When a patient presents to an ED physician as Patient D did, the physician should do a complete neurological examination, including an assessment of the patient's gait, eye movement, testing reflexes from side-to-side and testing patient's recall ability, so that he can adequately diagnose and treat the patient. The Respondent did not perform such a neurological evaluation. (T. 187-189; Ex. 5)

16. When a patient presents as Patient D, the ED physician should analyze and interpret the patient's clinical data. The Respondent did analyze and correctly interpreted Patient D's clinical data. (T. 522-523, 528; Ex. 5)

17. A patient presenting as Patient D did to the Center, would not require admission to a hospital. (T. 201; 528-529; Ex. 5)

PATIENT E:

18. On or about October 31, 2003, Patient E, a 41 year old man, was brought to the Center by his caregiver with a chief complaint of aspiration.

He had a history of non-productive cough, gurgle-type throat sounds, history of aspirating food regularly, was a spastic quadriplegic and severely retarded. (T. 550, 557, 707; Ex. 6)

19. When Patient E was triaged at the Center, the triage nurse suctioned him, and the patient's condition improved. When the Respondent examined Patient E, he was not in acute respiratory distress, and therefore did not require admission to the Center. (T. 548-549, 553, 556, 561, 708-709; Ex. 6)

20. When a patient presents as Patient E did, clinical tests should be ordered. Given Patient E's physical presentation, the Respondent ordered the necessary clinical diagnostic tests for this patient. (T. 555, 707-709; Ex. 6)

21. A patient who presents to an ED with respiratory distress should be monitored and treated, including a thorough physical examination of the patient's respiratory function. The Respondent adequately monitored and treated Patient E. (T. 555-556, 559, 561, 708-710; Ex. 6)

22. Given Patient E's presentation, a diagnosis of bronchitis was medically justified. (T. 553, 555, 560, 711-712; Ex. 6)

PATIENT F:

23. On or about March 13, 2004, Patient F, a six year old boy, was brought to the Center by his parents with a chief complaint of vomiting. He had a history of a sudden onset of vomiting beginning the night before and diarrhea, had been recently treated for strep throat, had been exposed to mononucleosis, and complained of sinus congestion. (T. 230, 569-570; Ex. 7)

24. Given Patient F's presentation, an ER physician should be concerned about patient's dehydration, and should treat the patient for that. The Respondent did diagnose Patient E's dehydration and treated it appropriately. (T. 574, 578-581; Ex. 7)

25. When a patient presents as Patient F did, repeat vital signs should be ordered and obtained. The Respondent failed to order repeat vital signs. (T. 235-236, 579, 589-590; Ex. 7)

26. When a patient presents as Patient F presented, it is appropriate to order certain diagnostic laboratory tests, including stool sample examination, electrolyte values, SMA-6, and a CBC. The Respondent did not order these tests for Patient F. (T. 576, 586-587, 592; Ex. 7)

27. Based on Patient F's presentation of recent strep throat and exposure to mononucleosis, the Respondent ordered certain laboratory tests and correctly interpreted the results of those tests. (T. 591-592; Ex. 7)

28. Based on Patient F's presentation, an ED physician would be medically justified in prescribing antibiotics to the patient. The Repondent prescribed antibiotics for this patient. (T. 578; Ex. 7)

PATIENT G:

29. On or about March 11, 2004, Patient G, an 86 year old female, went to the Center with a chief complaint of being disoriented. She had a history of gradual onset of mental status change, with intermittent symptoms, bladder suspension surgery two days prior, with symptoms of hypotension that appeared to be relieved by IV fluids administered by EMS. (T. 285, 596; Ex. 8)

30. When a patient presents as Patient G did, the ED physician should have obtained a history including a differential for hypotension, any urinary symptoms and a full documentation of the recent surgery. The ED physician should perform a physical examination, including a review of the patient's cardiac condition, evaluation for dehydration, a rectal examination and an evaluation of the recent surgery incision site for infection. The Respondent did not obtain such a history nor did he perform such a physical on Patient G. (T. 285-291; Ex. 8)

31. Based on Patient G's presentation, the patient should have been monitored and treated while in the ER, including, but not limited to repeat

vital signs, ascertaining oxygen saturation levels, repeat temperature and a urinalysis. The Respondent did not monitor or treat this patient as such. (T. 291-295, 609; Ex. 8)

32. Patient G's blood test results indicated left shift bands. When a patient's blood test exhibits left shift bands, an ED physician should interpret and address this as a possible early sign of infection. The Respondent did not do this with respect to Patient G. (T. 504-505, 599-600; Ex. 8)

33. Based on Patient G's presentation and course of treatment and response in the ER, an ED physician treating such a patient would not have to admit her. (T. 601-603; Ex. 8)

34. When a patient presents as Patient G did, an ED physician should consult with the patient's surgeon. The Respondent did not do this. (T. 299-300, 603, 752; Ex. 8)

35. When a patient presents to an ED as Patient G did, the etiology of her hypotension should be appropriately evaluated and treated. The Respondent appropriately evaluated and treated Patient G's hypotension. (T. 597-602; Ex. 8)

PATIENT H:

36. On or about March 14, 2004, Patient H, a 26 year old female, whose chief complaint was vomiting and fainting presented at the Center. She had a history of sudden onset severe headache the day before, with sinus congestion, photosensitivity, blurred vision, nausea and facial pain. (T. 343, 618-619; Ex. 9)

37. When a patient presents as Patient H did to an ED, an ED physician should obtain and perform an adequate history, physical and neurological examination. The Respondent did not perform an adequate neurological examination on Patient H. (T. 347, 626-627, 767; Ex. 9)

38. When a patient presents as Patient H did, to an ED, the ED physician should evaluate the patient for a life-threatening central nervous system condition and order appropriate diagnostic tests. The Respondent did not do this. (T. 347, 351, 627, 629, 767; Ex. 9)

39. When a patient presents to an ED as Patient H did with severe headaches and episodes of vomiting, the ED physician should obtain a history, perform a physical and prescribe medication to relieve the patient's symptoms. The Respondent did this. (T. 367-368, 620-625; Ex. 9)

40. Based on Patient H's presentation, the Respondent made a diagnosis of migraine and sinusitis. The Respondent's diagnosis of sinusitis was not medically justified. (T. 367-368, 624-625, 765-767; Ex. 9)

41. Based on Patient H's presentation, the Respondent's prescribing of Augmentin was not medically justified. (T. 353; Ex. 9)

CONCLUSIONS

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

Paragraph D.1.: (14 & 15);
Paragraph D.2.: (14 & 15);
Paragraph F.2.: (23 & 25);
Paragraph F.3.: (23 & 26);
Paragraph G.1.: (29 & 30);
Paragraph G.2.: (29 & 31);
Paragraph G.3.: (32);
Paragraph G.5.: (29 & 34);
Paragraph H.1.: (36 & 37);
Paragraph H.2.: (36 & 38);
Paragraph H.5.: (36 & 41).

The Committee found that factual allegations A.71. – 7., B.1. – 4., C. 1.- 4, D.3. and 4., E.1. – 5., F.1., 4. and 5., G.4. and 6., and H.3. and 5. were not proven by a preponderance of the evidence.

Accordingly, the Committee found that the following Specification of Misconduct as set forth in the Statement of Charges were sustained. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

INCOMPETENCE
ON MORE THAN ONE OCCASION

Eleventh Specification: (Paragraphs D.1. - 2., F.2. - 3., G.1. - 3. and 5., H.1.-2. and 5.

The Committee also concluded that the following Specifications should **not be** sustained:

The First through Tenth Specifications.

DISCUSSION

Respondent was charged with four specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by 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, among other conduct, gross negligence, negligence, gross incompetence and incompetence in the practice of medicine.

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

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

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.

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.

Inexplicably, with one exception, the Department did not charge the Respondent with a failure to maintain records which accurately reflect the care provided to the patient.

Using the above referenced definitions as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the eleventh specification of professional misconduct, practicing the profession incompetently on more than one occasion, should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Dr. Maureen Gang as its expert witness. Dr. Gang is a board certified Emergency Medicine physician. The Respondent presented Dr. Bonnie Grossman as its expert witness. Dr. Grossman is also board certified in Emergency Medicine. The Committee found both physicians to be credible in part. The Committee did find that Dr. Gang's conclusions often represented an academic viewpoint that was unrealistically rigid. In those instances the opinion of Dr. Grossman was found to be more credible and convincing. She testified in a forthright manner and responded to questions by both counsel in a direct manner.

There also were instances wherein Dr. Gang would not answer Respondent counsel's questions.

PATIENT A

Patient A was an 82 year-old female who was brought to the emergency room by her daughter and other family members on September 9, 2004.

The patient's chief complaint was headache. The headache was described as on and off for a few days and was not present when the patient was seen in the emergency room. The triage nursing staff classified the patient's acuity level as "non-urgent."

Patient A presented with significant co-morbidities. Her medical history included hypertension, heart disease, breast cancer and diabetes. Among the medications she was taking were Digoxin (an antidysrhythmic cardiac drug), Coumadin (a blood thinner) and Lasix (a diuretic used to treat hypertension).

There was also a history of recent anxiety and stress. One of the patient's daughters had died from cancer within the last 30 days. The Petitioner's expert testified that the context or circumstances surrounding an

emergency room visit were significant and the stress created by the recent death of a child is important medical history that may be clinically relevant.

The family members who brought Patient A to the emergency room thought she had experienced an episode of confusion earlier that day, but the family described no pattern of confusion. Upon initial assessment by the nursing staff, there was no complaint of confusion and no clinical finding of confusion. During the time that Patient A was in the emergency room, she did not exhibit any signs of confusion either to the Respondent or the Center's nursing staff.

The nursing staff completed a neurological assessment. Patient A's gait was steady, with normal motor functions. She was alert to person, place and time, making eye contact and showing no signs of facial droop. Her speech was clear. The patient exhibited symmetrical strength and sensation to extremities, with no paresthesia. Her behavior was appropriate to the situation. The Petitioner's expert agreed that this constituted a normal neurological assessment.

The Respondent saw Patient A about 40 minutes after her arrival in the emergency room. He conducted a physical examination and found the patient appearing to be well, well-groomed and in no acute distress. A psychiatric evaluation found the patient appropriate and cooperative in

appearance, alert, exhibiting normal judgment, having intact memory, both recent and remote, normal speech and appropriately oriented to person, place and time. There was no sign of confusion. She was very clear and lucid. Her motor and sensory exams were non-focal. A chest x-ray was normal. The Respondent's cardiovascular examination revealed the heart to be in regular rate and rhythm. The patient has slightly elevated systolic blood pressure. The patient denied any chest pain. Her condition had not changed since being evaluated by the nursing staff. This constituted an appropriate evaluation of the patient's presenting condition.

Patient A's respiratory functions were found to be normal, although she had an oxygen saturation reading by pulse oximeter of 92. The Respondent said he considered this to be "low normal." The Respondent learned that the patient's pulse oximeter reading of 92 constituted an approximate baseline for her. From the same source, he also became aware that Patient A was on oxygen at home at night. The Petitioner's expert concurred that the patient could continue treatment with her primary care physician and at home if she knew that 92% constituted a baseline value.

The Committee concurred with the Respondent's expert that there were no indications of respiratory distress, that pulse oximetry readings of

92 to 96 are not uncommon among elderly patients and that the patient showed no symptoms of hypoxia.

The patient presented to the Respondent as a normal-appearing 82 year-old woman who had previously complained of a headache, had no present symptoms, shows no signs of confusion, and wanted to go home.

The Respondent ordered blood tests, which showed certain abnormal values, but the Respondent thought that the results of the blood tests were inconsistent with the results of his physical examination. The Respondent noted the high lipid content in the blood and was suspicious of an error in the laboratory testing, and learned that normal lab values had been obtained about one week earlier. The Petitioner's expert conceded that an elevated lipid content in the blood could be a basis to suspect erroneous results.

The Respondent also evaluated the need for other diagnostic tests and considered ordering a CT scan of the head, a coagulation profile, and a test for Digoxin, but ultimately decided that it was not required based upon his clinical findings. The Committee concurred with this judgment.

In light of the findings on physical examination and the lack of any complaint of chest pain, the Committee agreed with the Respondent's expert that an EKG was not necessary.

The Respondent concluded that Patient A was mildly dehydrated and in light of her age and medical history, elected to treat dehydration gradually by directing her to reduce her Lasix to 20mg daily for one week, and then return to 40mg and to drink plenty of fluids, especially electrolytes. The Respondent also advised her to follow-up with her family physician.

Patient A wanted to go home. Based on her normal physical examination; a finding that her pulse oximeter reading of 92 seemed to be a baseline for her; Dr. Ficano's suspicions about the accuracy of the lab test values; the opportunity to slowly rehydrate the patient at home by temporarily reducing her Lasix and increasing fluids; the hospital practice of making the results of the emergency room visit, including laboratory tests, available to the primary care physician within 24 hours for appropriate follow-up; the patient's supportive family and established relationship with her primary care physician, the Respondent, as an exercise of his professional judgment, found no basis to recommend that Patient A be admitted. The Committee found this to be within the standard of care.

PATIENT B

Patient B was an 81 year-old man who was brought to the emergency room by his daughter on September 6, 2004. He complained of fever and chills, with the most recent onset of fever the morning of the emergency

room visit. The patient presented with a temperature of 101.6 degrees, and triage classified him as urgent.

Patient B had a history of knee replacement surgery, but the prosthesis had been removed because of chronic infection, which continued to be a problem. The infection was being treated actively by the patient's orthopedist who performed the surgery, as well as Patient B's primary care physician. When Patient B came to the emergency room, he was being treated with the antibiotic Rocephin, through a Hickman catheter.

The Respondent conducted a physical examination which yielded essentially normal results, with the exception of an elevated temperature, a slightly elevated pulse rate, and a swollen left knee, which was warm to the touch, but with no redness. The patient's blood pressure and respiratory rate were normal.

The Committee found that the Respondent ordered a number of appropriate diagnostic tests, including blood cultures, WBC manual differential for CBC, complete blood count and basic panel and urinalysis. These tests were essentially normal, except for a slightly elevated band count. The patient's white blood cell count was normal. The two blood cultures drawn were negative.

Patient B was also given a chest x-ray, which proved negative. The Respondent explained that he ordered the chest x-ray as part of a fever workup to check for pneumonia.

The Statement of Charges alleged that the Respondent "failed to appropriately diagnose and treat sepsis." The Petitioner's expert conceded that the patient was not septic when he was in the emergency room.

The record indicates that after consulting with both the patient's orthopedist and the primary care physician, the Respondent recommended a follow-up with an infectious disease specialist and discharged the patient with instructions to contact his primary care physician the next day.

The Committee found that the record indicates the Respondent consulted both the patient's treating orthopedist who performed the knee replacement surgery, and the covering primary care physician.

The Respondent advised the patient's orthopedist of his findings, including the results of blood tests, that the patient had a fever, bacteremia, a swollen knee that was so tender that it could not be manipulated or moved, and that he suspected a septic knee joint. They discussed the possibility of changing the patient's antibiotic, but the orthopedist thought Rocephin was still appropriate. The orthopedist said that the infection described by the Respondent sounded like the same problem he had been treating for several

months. Both physicians were aware that the patient had negative blood cultures a week or two prior to the emergency room visit, as well as a negative echocardiogram. The orthopedist suggested to Dr. Ficano that the patient be discharged and instructed to see him immediately. The Committee agreed that this course of action was appropriate since the patient was not septic.

The Petitioner's expert implied that her negative opinion of the care rendered to Patient B might have been different if she knew Patient B was being seen by an orthopedist for a chronic infection and that, as an emergency room physician, the Respondent had a right to rely upon information given by the patient's treating physician.

PATIENT C

Patient C is a 75 year-old female with a history of diverticulitis and gastrointestinal bleeding. She came to the emergency room on September 29, 2003, at the suggestion of her surgeon, who was one of the physicians who had been treating her. In light of her report of new rectal bleeding, her surgeon told her to go to the emergency room for evaluation and to have her blood checked. Triage classified her acuity as "non-urgent".

The Committee found that the Respondent conducted an appropriate history and physical examination. He learned that the patient had a long history of diverticulitis and that episodes of rectal bleeding occurred approximately every six months. The records of prior emergency room visits were referenced on the computer screen as part of the patient's electronic medical record. Some of the prior visits involved gastrointestinal bleeding. The Respondent was told that the patient's stools were black, with possible dark clots. The patient's vital signs were normal. Gastrointestinal examination found a soft abdomen that was non-tender and non-distended, with bowel sounds present and normal. There were no fast bowel sounds that might indicate present bleeding. There was no guarding or rebound. The Respondent's anorectal exam was guaiac-positive, but disclosed no masses, tenderness, strictures or lesions.

The Respondent ordered a basic panel and a complete blood count, which suggested the presence of chronic anemia. In particular, Patient C had a hemoglobin of 10 and a hematocrit of 30.2, which the Respondent concluded were baseline for her. This was determined by reference to earlier emergency room visits. The Respondent compared these values to the results recorded a few months earlier. He noted that the patient's anemia had improved since May 2003 and her vital signs were normal.

The Committee found that the Respondent did confer with the patient's surgeon. The Respondent reported his findings to the patient's surgeon, who confirmed that Patient C's symptoms were not new and were consistent with the condition he had been treating for some time. He told the Respondent he would see Patient C in the hospital the following day and perform a colonoscopy to determine the precise nature of the most recent problem. Before Patient C left the emergency room, the Respondent determined that she was not actively bleeding.

The Committee concurred with the Respondent's conclusion that because of Patient C's medical history and normal vital signs, she fell within a group of low-risk patients who do not require inpatient admission.

The Committee agreed with the Respondent's expert that the care rendered and management provided to Patient C by the Respondent was appropriate.

The Committee concurred with the Respondent's expert's basis for that conclusion in that Respondent appropriately examined and screened the patient for any emergent condition. The Patient was stable at that time. Her surgeon was quite aware of her condition, her history, he was going to see her in the immediate future and repeat his colonoscopy, and he thought it was an appropriate management plan.

PATIENT D

Patient D was a 52 year-old female who came to the emergency room on June 14, 2004, complaining of numbness on the right side of her face. Triage classified her acuity as "urgent". The symptoms began the day before the emergency room visit. The patient reported that her family thought the right side of her face was drooping. Her medical history included previous transient ischemic accidents ("TIAs"), hypertension, myocardial infarction with catheterization, and diabetes. The patient told Dr. Ficano that she felt confused, was speaking in half sentences, losing her train of thought and that family members thought there was a possibility of right facial drooping. The night before, she had stayed in the hospital overnight with her grandson, who was an inpatient, and she did not sleep well. While no facial droop was noted upon the initial nursing assessment or during the Respondent's examination, the nurses did note what appeared to be signs of a facial droop. The patient was under the active care of a neurologist and was receiving aspirin therapy. She also had a prior negative carotid study. This patient had a number of potentially serious co-morbidities.

The Committee concurred with the Department's expert that Respondent needed to perform a thorough physical examination and although he performed an examination, it was not complete. He failed to perform a thorough cerebellar examination and he failed to describe the patient's reflexes, especially her gait. Nothing in Respondent's medical chart for Patient D reflected whether Patient D was able to ambulate. He failed to evaluate the patient's eyes to see whether or not there were any abnormal movements as far as nystagmus. He also failed to do a finger-to-nose test and check rapid movements of her hands. It was insufficient to determine that the patient was alert and oriented to person, time, and place. He needed to perform tests like serial 7's. Respondent failed to determine the level of reflexes on one side versus the other; a brain infarct would effect the patient's reflexes.

The Committee concluded that the Respondent correctly interpreted the various test results and appropriately discharged this patient.

The Respondent ordered a complete blood count and a basic panel, the results of which were normal. He also ordered a CT scan of Patient D's head and an EKG, which were also normal. The patient's vital signs were normal. He discharged Patient D with a final impression of depression and a

normal physician exam. He advised the patient to see her neurologist the next day.

The patient may have experienced symptoms of another TIA, which were resolved or resolving when she came to the emergency room. For patients who are already under active treatment for repeated TIAs, are receiving aspirin therapy, and who have had negative carotid studies, admission as an acute care patient is a matter of judgment and is not mandatory.

PATIENT E

Patient E was brought to the emergency room by his caregivers on October 31, 2003. The chief complaint was that the patient aspirated food during lunch. He was a 41 year-old male who suffers from mental retardation with cerebral palsy, multiple drug allergies, spastic quadriplegia, and contractures. He resides in a supervised facility with 24-hour care. His acuity classification upon triage was "urgent". The nurses found the patient to be congested, with his lungs showing scattered rhonchi. The nurses also found his respiratory rate to be labored and between 24 and 28. After the patient was suctioned, Respondent noted that he had no difficulty with respiration and that his lungs were clear. The change in the clinical

observations of the patient's respiratory functioning was due to the success of the suctioning performed by the nursing staff.

The patient had been seen in the emergency room for similar episodes of food and beverage aspiration in the past, and the Respondent was told that this happened quite regularly. The patient had been seen in the emergency room on about five prior occasions. The results of the prior emergency room visits were available to the Respondent on the computer screen as part of the patient's electronic record.

A pulse oximeter reading of 80 was reported by the patient's caregivers, and was attributed by them to the patient's poor circulation. The Respondent recognized this to be a "very abnormal value". The caregivers reported no change in the patient's activity level. Pulse oximetry readings in the low 80s were noted on prior emergency room visits. The Department's expert implied that if she knew this was a baseline, it might have made a difference in her opinion. The Respondent found no respiratory distress after suctioning.

The Committee concluded that the patient was not in respiratory distress when seen by the Respondent.

The Committee also found that the Respondent did order the necessary diagnostic tests. A chest x-ray was normal, and the patient's lungs were clear.

No vital signs were taken. Attempts were made to obtain vital signs, but all were unsuccessful because the patient was uncooperative, but there was no hospital policy that provided instructions to be followed when incompetent patients are uncooperative and refuse care. Additionally the Respondent ordered a pulse oximeter reading, but this could not be obtained.

The Committee found that the patient was appropriately discharged with a final impression of acute bronchitis and aspiration. The diagnosis of acute bronchitis resulted from the Respondent's observation that the patient coughed up phlegm and the nurse's report of hearing rhonchi.

PATIENT F

Patient F was a six year-old boy who was brought to the emergency room by his family on March 13, 2004, complaining of vomiting. On triage, his acuity classification was found to be "non-urgent". Relevant medical history included ten episodes of vomiting in the previous 24 hours,

with associated signs and symptoms including diarrhea. Before coming to the emergency room, the patient's parents had given him Phenergan for his nausea, with some improvement. During the two hours the patient was in the emergency room, he did not experience symptoms of vomiting or diarrhea. The patient had been treated with Cefzil for strep throat. Sinus congestion was also reported, and the patient's sister recently had mononucleosis. Patient F was under the active care of his pediatrician. The Respondent examined the patient's skin for evidence of dehydration. The Respondent noted a yellow discharge upon examination of the patient's nose.

After ordering various blood tests to evaluate the possibility of mononucleosis and strep throat, and noting a slightly elevated white blood cell count, he discharged the patient with the final impressions of gastroenteritis and sinusitis. The Department's expert agreed with the diagnosis of gastroenteritis and agreed that nasal discharge and sinus congestion are symptoms of sinusitis.

The Committee agreed with the Respondent's expert that the Respondent appropriately diagnosed and treated the patient's dehydration.

The Respondent was concerned about dehydration in this patient as a result of fluid loss from vomiting and diarrhea, and he gave the patient a popsicle as an oral trial of hydration. It is accepted practice for a pediatric patient who requires hydration to begin with an oral trial, and providing a popsicle is an appropriate way to proceed. The patient was discharged to the care of his parents, with specific instructions noting the risk of dehydration and directing them to make sure their son drank plenty of clear liquids.

The Department's expert admitted that the Respondent's assessment of the parents and their ability to follow instructions was an important factor in determining the treatment of and whether to discharge the patient.

Although the Respondent appropriately diagnosed and treated the patient's dehydration, he should have ordered an SMA-6, a urine analysis, orthostatic vital signs and a reading of the oxygenation level. However, those tests which were conducted were correctly interpreted.

The Committee agreed with the Respondent's expert that the patient's presentation supported the diagnosis of gastroenteritis, and in particular, the diagnosis of sinusitis.

The Committee found the rationale of the Respondent's expert quite convincing as stated, the patient:

....”had just had a recent strep infection, he had a full complement of antibiotics and yet he was still complaining of sinus congestion and he still had nasal discharge, yellow, on exam, which is not normal, and he also still had some findings of inflamed pharynx. And I think that you would normally expect, after treatment and after a couple of weeks, that those would be cleared up. Generally speaking, when you see someone with - - that continues to drain or complain of congestion, usually by definition, if we don't see that clear up spontaneous in about one to two weeks then you get concerned about a sinus infection developing.” (Tr. 577-578)

thus providing a medical justification for the Respondent's prescription of an antibiotic.

PATIENT G

Patient G is an 86 year-old female who was brought to the emergency room on March 11, 2004, by emergency medical services and accompanied by her sister. The chief complaint was disorientation. The patient's sister found her disoriented and called 911. When EMS arrived, they found the patient had a blood pressure of 80/30, which increased to 100/47 after two 250cc boluses were administered. The IV therapy improved the patient's blood pressure. The patient's sister reported that the patient appeared much better upon her arrival at the emergency room. Nursing staff classified the patient's acuity level to be “urgent”.

Relevant medical history included bladder suspension surgery which had been performed as an outpatient two days before the emergency room

visit. The patient was also taking a variety of medications to control her blood pressure.

The Committee agreed with the Department's expert that although the Respondent performed a history and physical, they were inadequate. He noted that patient had bladder surgery two days prior to his evaluation; however, he failed to inquire the location of the surgery and whether it was an incision or laparoscopy. If there had been an incision, Respondent had an obligation to examine the incision area. He also needed to perform a rectal exam looking for occult blood loss.

Additionally, the Committee concluded that Respondent failed to appropriately monitor Patient G while she was in the emergency room. The patient came in with a potentially life-threatening process. It was important to reassess her vital signs to determine whether the patient was responding to therapy. The patient required repeat vital signs, the patient needed to be placed on a monitor to ascertain her 02 status. Also her pulse rate and blood pressure needed to be checked on a regular basis and repeat blood tests obtained. Tests can initially be negative for myocardial infarction but then changes can occur. The patient also needed a repeat temperature to make sure that she was not infectious.

Patient G required blood tests (including SMA-6 and troponins or CKs) to determine whether she was losing blood intra-abdominally, had an infection, was dehydrated or suffered heart damage. She also needed a chest x-ray to determine whether she had pneumonia or whether there was free air due to a perforation from her recent surgery, an EKG and a urinalysis.

The Committee agreed with the Department's expert that the Respondent should have contacted the surgeon who performed the bladder surgery to inquire about the nature of the surgery and discuss the current problem. The failure to consult with the surgeon deviated from accepted medical standards.

However, the Committee concurred with Respondent's expert that the patient was observed in the emergency room for more than three hours and showed normal findings. The final blood pressure reading was 107/60, with a pulse of 77 and a respiratory rate of 18. There was no basis for admission.

The Committee found that the Respondent did appropriately evaluate and treat the patient for hypotension. Although there no record of hypotension while in the ED, the Respondent diagnosed and treated her for dehydration as the cause of her history of hypotension, based on her response to the introduction of fluids via EMS.

The Committee agreed with the Respondent's expert reasoning, as stated:

> Because her BUN was elevated, and the fact that she seemed to be volume-depleted, which is reflected in the low blood pressure, the episode that she had could be a sign of dehydration, so all of those things could suggest dehydration." ..... to a small amount of fluid challenge she responded very quickly and seemed to be quite stable through her emergency department stay." (Tr. 601-02).

PATIENT H

Patient H was a 26 year-old female who came to the emergency room on March 14, 2004, with a chief complaint of vomiting and fainting. Headache was not identified as the chief complaint. The patient also reported dizziness, headache and nausea to the nursing staff as associated signs and symptoms. Sinus congestion and headache were recorded by the Respondent as the "context" for the chief complaint of vomiting and fainting. On triage, the patient was classified as "non-urgent". The history also included complaints of blurred vision, facial pain, nausea, photosensitivity and vomiting.

Although the Respondent obtained an adequate history and performed an adequate physical, the Committee concurred with the Department's

expert that Respondent's neurological examination of Patient H did not meet accepted medical standards. The patient needed a complete neurological exam including an evaluation of her no deep tendon reflexes as well as documentation whether the patient had any neck pain and a cerebellar exam.

Additionally, based on patient's history of severe sudden headache, a CT scan of the head should have been obtained to look for a subarachnoid hemorrhage, a life-threatening condition. Respondent did not order a CT scan. The failure to order these tests deviated from accepted medical standards and indicated the Respondent failed to appropriately evaluate a patient for a life-threatening central nervous system condition. A subarachnoid hemorrhage had to have been ruled out. Respondent failed to rule it out. His conduct deviated from accepted medical standards.

The diagnosis of sinusitis required a finding of fever, sinus tenderness and a nasal discharge. There was no such finding for this patient thus the diagnosis of sinusitis was not medically justified.

In light of the diagnosis of sinusitis being found to be not medically justified, the Committee concluded that the prescribing of Augmentin had no medical justification.

However, the Respondent did appropriately treat this patient as evidenced by her being given intramuscular medications for pain,

subsequent to which the patient reported that her headache pain improved and then became absent.

The Committee agreed with Respondent's expert that Respondent's diagnosis of migraine was consistent with the patient's symptoms, and was medically justified, but found that there was no medical justification for the diagnosis of sinusitis. The diagnosis of sinusitis required a finding of fever, sinus tenderness and a nasal discharge and there was no such finding for this patient. However, that allegation was not proven because the charge stated "migraine and sinusitis". Since the diagnosis of migraine was found to be medically justified, the allegation was deemed as not proven.

PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent should be **censured and reprimanded, a limitation on his area of practice and a three (3) year probationary period should be imposed on his license to practice medicine.** The terms of said probationary period are set forth in Appendix II, attached to this Determination and Order and made a part thereof. This determination was reached upon due consideration by the Committee 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.

In reaching this determination The Committee took into consideration the Respondent's statements that he has no desire to ever practice again in the field of emergency medicine and his realization that he needs additional training as evidenced by his seeking out a fellowship at St. Elizabeth Medical Center, Utica, New York (a copy of the letter of understanding from St. Elizabeth Medical Center to the Respondent, dated February 13, 2006, is attached hereto as Appendix III and made a part of this Decision and Order).

The Committee concluded that the requirement that Respondent successfully complete his fellowship in conjunction with the limitation on the Respondent's license and a three year probationary period with a practice monitor will ensure that the public is adequately protected.

ORDER

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

1. The **Eleventh Specification** of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) is **SUSTAINED**;

2. The Respondent's is hereby **CENSURED and REPRIMANDED.**

3. The Respondent's license to practice medicine is hereby permanently limited in that he is permitted to practice medicine only in those areas of medical practice that he is board certified in by the appropriate certifying board.

4. The Respondent's license to practice medicine is placed on **probation for a period of Three (3) years** in accordance with the terms and conditions set forth in Appendix II which is attached to this Determination & Order and a made a part thereof, with such probationary period to commence upon his completion of a fellowship as noted in Appendix III, attached hereto and made a part of this Determination & Order.

DATED: Clinton, New York
June 14 **, 2006**

REDACTED SIGNATURE

ROBERT A. MENOTTI, M.D., (Chair)

RICHARD F. KASULKE, M.D.

GAIL S. HOMICK

Jeffrey Ficano, D.O.
REDACTED ADDRESS

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APPENDIX I

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

IN THE MATTER

OF

JEFFREY FICANO, D.O.

AMENDED STATEMENT OF CHARGES

JEFFREY FICANO, D.O., the Respondent, was authorized to practice medicine in New York State on or about July 14, 1998, by the issuance of license number 211216 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 9, 2004, Patient A,(the identity of the patients is contained in the attached Appendix), an 82 year old female, was brought by her daughter to Oneida Health Care Center (Oneida), Oneida, New York, emergency room with a complaint of headache. Respondent discharged the patient with instruction to follow up with her private medical doctor as needed and to drink fluids as directed by the private physician.

Respondent's care and treatment of Patient A deviated from accepted medical standards, in that he:

1. Failed to appropriately evaluate the patient for headache and confusion;
2. Failed to order a CT scan of the brain;
3. Failed to order a coagulation profile for a patient on Coumadin with confusion;
4. Failed to obtain and review the results of the patient's Digoxin level;
5. Failed to obtain and evaluate an EKG;
6. Failed to recognize, appropriately evaluate and treat the patient's

EXHIBIT 10
Department

severe electrolyte abnormalities and respiratory insufficiency.

7. Failed to admit a patient with altered mental status with undetermined etiology to the hospital for evaluation and treatment.

B. On or about September 6, 2004, Patient B, an 81 year old male, with a Hickman catheter, an indwelling central venous catheter, who was being treated with Ceftriaxone (Rocephin) for sepsis, went to Oneida emergency room with complaints of fever and chills. Respondent discharged Patient B from the emergency room with a diagnosis of febrile illness, possibly from bacteremia or a septic joint.

Respondent's care and treatment of Patient B deviated from accepted medical standards, in that he:

1. Failed to appropriately diagnose and treat sepsis;
2. Failed to order a consultation with an infectious disease specialist;
3. Failed to consult the patient's treating orthopedist and primary care physician;
4. Failed to admit the patient to the hospital for evaluation of sepsis of unknown etiology.

C. On or about September 29, 2003, Patient C, a 75 year old woman, went to the Oneida emergency room with complaints of sudden rectal bleeding with black tarry clots. Respondent discharged the patient with a diagnosis of diverticulosis and chronic anemia.

Respondent's care and treatment of Patient C deviated from accepted medical standards, in that he:

1. Failed to appropriately evaluate and treat Patient C;
2. Failed to order a surgical consultation;

3. Failed to consult with the patient's primary physician;
4. Failed to admit the patient to the hospital.

D. On or about June 14, 2004, Patient D, a 52 year old female, went to Oneida emergency room with a complaint of numbness to the right side of her face, left upper extremity weakness and difficulty speaking. The patient had a past medical history of transient ischemic attack (TIA), hypertension, coronary artery disease, diabetes mellitus, and acute myocardial infarction. Respondent examined the patient, diagnosed her with depression/normal exam and discharged her home.

Respondent's care and treatment of Patient D deviated from accepted medical standards, in that he:

1. Failed to appropriately diagnose and treat a patient with new onset of acute neurologic deficits;
2. Failed to obtain and document an adequate neurologic examination;
3. Failed to correctly interpret results of clinical data;
4. Failed to admit Patient D to the hospital for observation and treatment of an acute central nervous system event.

E. On or about October 31, 2003, Patient E , a 41 year old man, was brought to Oneida emergency room by his caregiver due to aspiration of food followed by a coughing spell. After examination Respondent discharged Patient E with a diagnosis of acute bronchitis and prescribed Zithromax.

Respondent's care deviated from accepted medical standards, in that he:

1. Failed to diagnose and treat acute respiratory distress;

2. Failed to order necessary clinical diagnostic tests;
3. Failed to appropriately monitor and treat a patient with respiratory distress;
4. Diagnosed Patient E with bronchitis without any medical justification;
5. Failed to admit a patient to the hospital with acute respiratory distress.

F. On or about March 13, 2004, Patient F, a six year old boy, was brought by his parents to the Oneida emergency room with complaints that the child had ten bouts of vomiting and also diarrhea in the past 24 hours. Respondent diagnosed the patient with gastroenteritis and prescribed Phergan and Augmentin and discharged the patient from the hospital.

Respondent's care and treatment of Patient F deviated from accepted medical standards, in that he:

1. Failed to appropriately diagnose and treat dehydration;
2. Failed to order repeat vital signs and orthostatics;
3. Failed to order appropriate laboratory diagnostic tests;
4. Failed to correctly interpret laboratory test results;
5. Prescribed antibiotics without medical justification.

G. On or about March 11, 2004, Patient G, an 86 year old female, accompanied by family members, went to the Oneida emergency room with complaints of being disoriented. Patient G had undergone a urologic surgical procedure 48 hours earlier. Respondent discharged the patient from the emergency room with a diagnosis of dehydration and a recommendation to follow up with her private medical doctor.

Respondent's care and treatment for Patient G deviated from accepted medical conduct, in that he:

1. Failed to obtain an adequate history and physical examination in a patient presenting with hypotension;
2. Failed to order and administer appropriate monitoring and treatment to Patient G while in the emergency department;
3. Failed to correctly interpret results of clinical diagnostic tests;
4. Failed to admit a patient with symptomatic hypotension and no clear etiology to the hospital for continued observation and evaluation.
5. Failed to consult with Patient G's surgeon prior to discharging Patient G from the emergency room.
6. Failed to appropriately evaluate and treat the cause of hypotension in a postoperative patient.

H. On or about March 14, 2004, Patient H went to the emergency room of Oneida, with complaints of headaches, vomiting and fainting for three days with six episodes of emesis within the past 24 hours. She also complained of blurred vision, dizziness and nausea. Respondent examined the patient and discharged her from the emergency room with a prescription for the antibiotic Augmentin.

Respondent's care and treatment of Patient H deviated from accepted medical standards, in that he:

1. Failed to perform an appropriate history, physical and/or neurological examination;
2. Failed to appropriately evaluate the patient for life threatening central nervous system conditions by failing to order appropriate diagnostic testing and neuroimaging;
3. Failed to appropriately treat a patient with severe headaches and multiple episodes of vomiting;

4. Incorrectly diagnosed Patient H with migraine and sinusitis without medical justification;
5. Prescribed the antibiotic Augmentin without medical justification.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH 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;
8. Paragraph H and its subparagraphs.

NINTH 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:

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; and/or Paragraph H and its subparagraphs.

TENTH 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:

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; Paragraph G and its subparagraphs; and/or Paragraph H and its subparagraphs.

ELEVENTH 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:

11. 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; and/or Paragraph H and its subparagraphs.

DATE: January 8, 2006
New York, New York

REDACTED SIGNATURE

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

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

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

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

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

or periodic visits with Respondent and his staff at practice locations or OPMC offices.

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

7. Within **thirty (30) days** of the completion of the fellowship as set forth in Appendix III the Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 10%) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

d. Respondent shall maintain or have maintained on his behalf medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

8. In the event that the Respondent leaves or does not successfully complete the fellowship as set forth in Appendix III, the Respondent shall notify the Director and shall cease the practice of medicine and shall only resume such practice if it is with the written approval of the Director.

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

APPENDIX III

FEB 14 2006

ST. ELIZABETH MEDICAL CENTER
Sponsored by The Sisters of St. Francis
2209 Genesee Street • Utica, New York 13501-5999
(315) 798-8100

February 13, 2006

Robert H. Iseman
Iseman, Cunningham, Riester & Hyde, LLP
9 Thurlow Terrace
Albany, N.Y. 12203

Re: Jeffrey Ficano, D.O.

Dear Mr. Iseman:

I am writing in response to inquiries made on behalf of Dr. Ficano regarding the possibility of employment in a supervised capacity by St. Elizabeth Medical Center. Dr. Ficano is known to St. Elizabeth in that he completed one year of his residency training in Family Medicine here from July, 1995 through June, 1996.

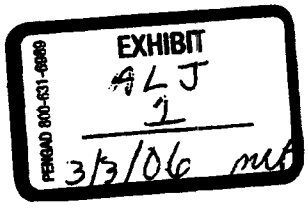
We have reviewed the material you have provided us regarding the cases from the Oneida Healthcare Center Emergency Department which have led to the current O.P.M.C. Hearing. We have also noted the apparent lack of serious quality concerns arising during Dr. Ficano's several previous Ambulatory Care and Urgent Care positions, as well as his certification by the American Osteopathic Board of Family Physicians. While acknowledging the concerns raised by the review of his Emergency Medicine Practice, my colleagues and I feel that Dr. Ficano has the potential to resume his career as a competent Primary Care Family Physician in an ambulatory care setting.

In light of the above considerations, St. Elizabeth Medical Center is prepared to offer Dr. Ficano a one-year Fellowship in Ambulatory Care Medicine subject to the conditions which will be described below. The Fellowship will be administered by the Medical Center's Family Medicine Residency Program and will be overseen by its Program Director, Dr. William Jorgensen. As a Fellow, Dr. Ficano will be a full time employee of the Medical Center receiving a salary and benefits, including malpractice insurance, which are standard for the position.

His responsibilities would be limited to providing primary care to patients at the Residency Program's Family Medicine Center on Hobart St. in Utica. He would not be involved in inpatient or Emergency Department care. His role would be primarily providing care to "walk-in" patients, patients whose primary care provider is not available and new patients requiring attention prior to their initial appointment with their primary care provider. He will not be assigned his own panel of continuity patients.

Supervision will be provided in two ways. During the hours of operation of the clinic there are always Attending Physicians present acting as preceptors supervising Family Medicine Residents. These preceptors will also be responsible for serving as preceptors for Dr. Ficano. They will be consulted for any difficult or complex patients in which the diagnosis or plan of management is unclear.

In addition to this concurrent supervision there will be a retrospective review of Dr. Ficano's charts. For the first 60 days, 100% of the charts will be reviewed. If the results are satisfactory the review will be reduced to 50% for the next 60 days and then to 25% for the duration of the Fellowship.



Dr. Ficano will also be assigned topics in ambulatory medicine to be researched and presented monthly at the Residency Program's Morning Report sessions. He will also participate in all of the Residency Program's didactic sessions (Morning Report, Grand Rounds, etc.).

The responsibility for evaluating Dr. Ficano's performance in this role will rest with the Program Director, Dr. Jorgensen. He will delegate some of the chart review and other supervisory functions to other members of the Residency Program's Faculty. If at any time during the one year Fellowship Dr. Ficano's performance is judged to be sub-standard, the Fellowship will be terminated and he will be dismissed from the Program.

This offer is conditioned upon the following factors:

- Dr. Ficano agrees to a complete and timely disclosure to SEMC of any information requested regarding his prior educational record and work history.
- Dr. Ficano qualifies for malpractice insurance coverage by SEMC's liability carrier, MLMIC
- The current O.P.M.C. Hearing concludes with Dr. Ficano's medical license intact.
- The O.P.M.C. approves of the above plan.
- The O.P.M.C. does not impose upon SEMC any additional monitoring or supervisory requirements which will require additional resources.
- Dr. Ficano agrees that his Fellowship can be terminated at the discretion of the Program Director without any hearing or appeal process, if his performance is judged sub-standard or if subsequent adverse action is taken by O.P.M.C. or other regulatory agencies.

Please contact me if you have any questions.

Sincerely,

REDACTED SIGNATURE

Albert D'Accurzio, M.D.
Vice-President, Medical Affairs

AD/bg
cc: J. Ficano, D.O.
W. Jorgensen, D.O.