STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

July 25, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Thomas Vincent Robb, D.O.
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Newburgh, New York 12550

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675 Third Avenue
New York, New York 10017

RE: In the Matter of Thomas Vincent Robb, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-176) 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, 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

THOMAS VINCENT ROBB, D.O.

DETERMINATION

AND

ORDER

BPMC NO. 06-176

A Notice of Hearing, dated December 16, 2005, and a Statement of Charges, dated December 16 2005, attached and annexed hereto as Exhibit A, were duly served upon **THOMAS VINCENT ROBB, D.O.** ("Respondent"). **LINDA PRESCOTT WILSON,** Chairperson, **RAMAN KAUL, M.D.** and **STEPHEN HORNYAK, M.D.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee ("the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **FREDERICK ZIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The **NEW YORK STATE DEPARTMENT OF HEALTH** ("Department" or "Petitioner") appeared by **DONALD P. BERENS, JR., ESQ.,** General Counsel, by **DIANNE ABELOFF, ESQ.,** of Counsel. Respondent appeared by **LIFSHUTZ & LIFSHUTZ, P.C., MARVIN L. LIFSHUTZ, ESQ.,** of Counsel, and by **SCHAUM & WIENER, MARTIN SCHAUM, 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

Answer Filed	January 18, 2006
Pre-Hearing Conference	February 1, 2006
Witnesses for Petitioner	Ronald N. Kaleya, M.D., Joseph Edwards, M.D.
Witnesses for Respondent	Thomas Vincent Robb, D.O., Burton I. Korelitz, M.D., Michael Shafir, M.D.
Hearing Dates	February 1 and April 28, 2006
Deliberation Date(s)	May 31, 2006

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the Petitioner, New York State Department of Health, Office of Professional Medical Conduct, pursuant to §230 of the P.H.L. Respondent, Thomas Vincent Robb, D.O., is charged with three specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). Specifically, Respondent is charged with one specification of practicing the profession of medicine with gross negligence on a particular occasion, one specification of practicing the profession of medicine with gross incompetence and one specification of failing to maintain a record for each patient which accurately reflected the care and treatment of the patient.

These charges concern, among other things, allegations that Respondent was grossly negligent and grossly incompetent with regard to Patient A's surgical care. Respondent, in his Answer, denied the allegations and specifications contained in the Statement of Charges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Committee hereby makes the following Findings of Fact:

1. **THOMAS VINCENT ROBB, D.O.** ("Respondent") was authorized to practice medicine in New York State on March 31, 1998 by the issuance of license number 209975 by the New York State Education Department (Pet. Exh. 2).
2. On August 28, 2003, Patient A , a 55 year old obese male, was admitted to St. Barnabas Hospital. Patient A had a history of left lower extremity thrombophlebitis, type II diabetes, hypertension, chronic renal insufficiency and a cerebral vascular event. At the time of admission, a large mass was detected on Patient A's anterior left thigh (T. 24-26, 240, 281; Pet.Exh.3).
3. Patient A was 5 foot 5 and weighed approximately 120.9 kilograms or 266 pounds (Pet. Exh. 3, pgs.115, 391).
4. After a CT scan and percutaneous aspiration, the thigh mass was determined to be a sarcoma

(T. 184-186; Pet. Exh.3).

5. On September 2, 2003, a repeat CT scan of the pelvis was performed which raised the suspicion of masses arising from the mid or lower left colonic segments. A colonoscopy was ordered to further evaluate the mass. The colonoscopy revealed a nearly obstructing colon cancer arising in the proximal ascending colon (Pet. Exh. 3, pg. 375 and 3B; T. 32).

6. Respondent testified that he felt Patient A should have been transferred to another hospital where the sarcoma could be resected concurrently with the colon cancer. However, the record does not support Respondent's testimony that he felt that the patient could not be safely treated at St. Barnabas Hospital, or that the patient would have been better served by being treated at only one facility (Pet. Exh. 3; T. 89, 121, 142, 153, 206-210).

7. Dr. Edwards, the Chief of Surgery, determined that the colon cancer needed to be treated and that the definitive therapy of the thigh sarcoma could be delayed (T.107-108, 127-130).

8. Since Respondent had begun the surgical care of this patient, Dr. Edwards felt that it was appropriate for him to continue the surgical care of the patient. He did not want to undermine one of his staff members whom he thought was capable of performing the surgery. Dr. Edwards consulted with Respondent and together they planned a right hemicolectomy (T. 107-108, 143-144, 155).

9. There was a discrepancy between the CT scan and the colonoscopy concerning the location of the obstructing lesion. A colonoscopy is usually correct about the location of a lesion, but at least .5 to 1% of the time, colonoscopies are incorrect. It is within the surgeon's knowledge that colonoscopies are sometimes incorrect (Pet. Exh. 3, pg. 375, Exh. 3B; T. 31-34, 63, 264- 267, 298).

10. It is the surgeon's responsibility to resolve the discrepancy (T. 34-35).

11. On September 22, 2003, Respondent performed a right hemicolectomy upon Patient A (T. 189-197; Pet. Exh. 3).

12. Prior to the September 22, 2003 hemicolectomy, Respondent could have resolved the discrepant test results by performing another diagnostic test such as a barium enema. This was not done. Alternatively, at the time of surgery, he could have resolved all of the preoperative issues. At the time of surgery, the surgeon needs to confirm the findings that are present on preoperative examinations. Especially where there is discordance between the preoperative examinations, the surgeon is obligated to confirm or negate the discordance (T. 35-44).

13. Respondent never confirmed or correlated his findings at surgery with the pre-operative examinations. This failure deviated from accepted medical standards (T. 52-53).

14. Even if the colonoscopist made in error in the location of the colon tumor, Respondent had the responsibility to explore the bowel completely during the surgery, and then to confirm after surgery that he had removed the tumor by opening the specimen in the operating room or sending it up to pathology for immediate analysis (T. 88).

15. Respondent testified that he was aware of the discrepancy in the CT scan and the colonoscopy reports regarding the location of the mass. However, there is nothing in Patient A's chart which indicates that Respondent was aware of the discrepancy nor were any actions taken on his part to indicate he was aware of the discrepancy (Pet. Exh. 3; T. 85, 188-189).

16. In the course of the September 22, 2003 surgery, Respondent failed to ensure that the tissue removed during the surgery contained the tumor which he intended to remove. Respondent needed to either open the specimen at the time of surgery and confirm the presence or

absence of the suspected tumor, or send it to pathology during the surgery to confirm that he had found the tumor (T.39-45, 53, 73, 296; Pet's Ex. 3, pg. 45).

17. Patient A was obese which could make exploring the bowel and palpating the tumor more difficult. Consequently, confirming the presence or absence of the tumor was even more crucial, particularly where there was a discrepancy between the CT scan and colonoscopy findings (T. 71-72, 281-282).

18. Patient A was a high risk surgical patient. In addition to his other problems, Patient A had serious cardiac issues and congestive heart failure (T. 190).

19. Opening a specimen and inspecting it in the operating room takes approximately two minutes and must be done before the patient is closed (T. 44, 47).

20. Dr. Edwards, the chief of surgery, was present at the September 22, 2003 surgery (T. 111).

21. Regardless of whether Dr. Edwards was present in the operating room, Respondent was the operating surgeon and was the physician in charge of the patient (T. 74, 88-90, 93, 223).

22. On September 22, 2003, Respondent removed tissue from the right side of the colon. The sarcoma was located on the left side of the colon. The presence of the sarcoma was irrelevant to considerations of whether Respondent failed to verify that the tissue he removed actually contained pathology. Regardless of the fact that Patient A had a concurrent colon cancer and sarcoma, Respondent still needed to verify that he had actually removed the colon tumor while the patient was still in the operating room (Pet. Exh.3, pg. 45; T. 88, 310).

23. Respondent failed to confirm the presence of the tumor and failed to remove the tumor during the September 22, 2003 surgery. The pathologist subsequently reported that the tissue removed from the right colon showed no diagnostic abnormality. Respondent's

conduct deviated from accepted medical standards and as a result, Patient A's tumor was not removed and a second resection was necessitated (Pet. Exh.3, pg. 45; T. 38, 45, 73).

24. The pathology report for the September 22, 2003 surgery did not mention the presence of enlarged lymph nodes or tumor. It referred to the presence of "nodules in pericolic fat" (Pet. Exh.3, pg. 45).

25. On September 23, 2003, Patient A returned to the operating room for further surgery because he still had a nearly obstructing mass in his colon. At that time, a large approximately three inch (7 centimeter) tumor was removed from Patient A's left colon. This tumor was located approximately 6 to 8 inches from the anastomosis performed as a result of the right hemicolectomy (T. 49-50,117-118, 145-147; Pet's Ex. 3, pg. 43).

26. Respondent and Dr. Edwards were the joint operating surgeons for the September 23, 2003 surgery. The operating surgeon has the responsibility to issue the operative report or to ensure that the resident writes an operative report (Pet. Exh. 3, pgs. 386, 405; T. 51, 67-68).

WITNESSES

In its deliberations, the Committee initially considered the credibility of the witnesses presented by the parties. Ronald Kaleya, M.D., testified as an expert witness for the Department. Burton Korelitz, M.D. and Michael Shafir, M.D. testified as expert witnesses for Respondent. Dr. Kaleya was regarded as credible. He spoke well, had command of the relevant case materials and answered questions directly and succinctly.

Dr. Korelitz, a gastro-enterologist gave brief testimony as to the gastro-enterological aspects of the case which the Committee found credible. However, the Committee concluded that Dr. Korelitz' brief testimony added little new information to the record which could assist the Committee in reaching its conclusions in this case.

Dr. Shafir, a surgical oncologist was viewed as generally credible although his experience was questioned. Dr. Shafir testified that he performed approximately ten to fifteen colon surgeries a year (T. 305-306). These numbers were less than would have been expected to be performed annually by an expert surgical witness.

The two physician members of the Committee questioned Dr. Shafir's statement that he did not always check the anastomic ends to ensure that they are negative for disease. Dr. Shafir testified "Only until very low, until sections of the rectum where the margins are neo and we want to make sure there is no microscopic disease at the margins, because to remain immobile intra-abdominal colon. I do not." (T.305). On this point, the Committee found Dr. Kaleya's testimony to be more persuasive. Dr. Kaleya testified that it would be below the standard of care not to ascertain that the margins were free of disease prior to making the anastomosis (T. 73). The Committee also questioned Dr. Shafir's testimony that he usually does not open the colon in the operating room (T. 305).

Following the submission of closing briefs, Respondent's counsel submitted two letters, dated May 24, 2006 (Resp. Ex. D) and May 25, 2006 (Resp. Ex. E) in which Respondent argued that Petitioner's counsel, in her closing brief, had totally misrepresented Dr. Shafir's testimony through her assertion that "Dr. Shafir's testimony basically supported Petitioner's position that it was incumbent upon the surgeon that he be sure that he removed the pathology when he performed the colon surgery..." (see third page from the end of Petitioner's closing brief). Respondent objected to Petitioner's statement and maintained that if such a statement had been made in an oral closing argument, it would have been objected to and a request would have been made to have the statement struck from the record. The Administrative Law Judge did not sustain Respondent's motion and found that based upon the record, Petitioner's statement was within the realm of

legitimate legal argument. Nevertheless, Respondent's letters were provided to the Committee at deliberations as Respondent's Exhibits D and E, and the Committee was instructed that it should examine the record and reach its own conclusions as to the meaning and import of Dr. Shafir's testimony.

The Committee found that there was indeed at least some support within the record for the proposition that Dr. Shafir's testimony basically supported the position that it was incumbent upon the surgeon to be sure that he removed the tumor when he performed the colon surgery (T. 296). More importantly, the Committee concluded that regardless of whether Dr. Shafir's testimony supported Petitioner's position, his testimony did not effectively counter Petitioner's case. Instead, Dr. Shafir was evasive as to whether the standard of care was met if the tumor was not removed. As further discussed below, the Committee believed that with regard to a patient such as Patient A who had multiple co-morbidities, the surgeon's goal is to make certain that the tumor is removed. Respondent should have opened the specimen to make sure that what he thought was a tumor upon palpation was substantiated. The Committee ultimately believed that Dr. Shafir did not persuasively counter Dr. Kaleka's testimony that the tumor needed to be removed.

Joseph Edwards, M.D., testified as a fact witness for Petitioner. Dr. Edwards was chief of surgery at St. Barnabas Hospital and was Respondent's supervisor at the time of the events in question. One Committee member believed that Dr. Edwards was not direct, definite or clear in his testimony. Another Committee member regarded Dr. Edwards' testimony as self serving and as an attempt to improve his own position vis-à-vis the events which occurred. Ultimately, while the Committee did not regard Dr. Edwards as a credible witness, two Committee members believed that at the September 22, 2003 surgery, Dr. Edwards did tell Respondent to "check to make sure he had the tumor" or words to that effect. In any event, the Committee did not regard Dr. Edwards

testimony as critical to their conclusions. They felt that as the operating surgeon, Respondent had the responsibility to operate in a manner that conformed with the standard of care.

With regard to the Respondent, Dr. Robb, the Committee observed that he was late for the first hearing date of February 1, 2006, and they did not believe that his attorneys were responsible for his late arrival by having advised him of the wrong hearing date (T. 225-226). The first paragraph of the Notice of Hearing set forth the date, time and place of the hearing. Contrary to Respondent's testimony, the first paragraph of the Notice of Hearing was not in legal jargon, and Respondent acknowledged having received the Notice of Hearing (T. 226). Respondent was regarded as bright and the Committee believed that it was extraordinary that he could not get to the hearing on time given the importance this proceeding had for his license to practice medicine, and that his coming late for the hearing was indicative of failure to take responsibility for his actions.

One Committee member questioned whether Respondent's arrests at the age of 22 for driving while intoxicated in the 1980s might have some bearing on the case (Pet's Ex. 2). The ALJ instructed that because the issue was not raised at the hearing and was remote in time, it was not a proper area for consideration. The two other Committee members felt that the arrests were remote in time and irrelevant in any event.

The Committee as a whole concluded that Respondent was not credible. He never offered a compelling reason for not having opened the specimen during the September 22, 2003 surgery, did not satisfactorily address questions posed to him, and did not admit his errors or take responsibility for his actions. The Committee noted that he attempted to shift responsibility for his mistakes to Dr. Edwards.

The Committee questioned Respondent's testimony that he did not feel it was appropriate to

operate on Patient A because he wanted Patient A to be transferred to a facility which could more effectively deal with his sarcoma. The Committee noted no notes in Patient A's medical record which corroborated Respondent's efforts to have Patient A transferred or which documented Respondent's thought processes regarding a possible transfer. Ultimately, Respondent operated upon Patient A regardless of whether he felt this was the correct course of care.

GENERAL CONCLUSIONS

Respondent was charged with three specifications alleging professional misconduct within the meaning of Education Law §6530. Specifically, Respondent was charged with one specification of practicing medicine with gross negligence, one specification of practicing medicine with gross incompetence, and one specification of failing to maintain a record for each patient which accurately reflected his care and treatment of the patient.

Education Law §6530 sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. This memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law", sets forth suggested definitions for, among other things, negligence, incompetence, gross negligence and gross incompetence. The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances, Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are

not essential elements in a medical disciplinary proceeding (Id.).

Gross negligence may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." (Rho, supra at 322). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion (Rho, supra at 322). No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad", articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient, Post v. State of New York Department of Health, 245 A.D. 2d 985, 986, 667 N.Y.S. 2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct, Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752, 634 N.Y.S. 2d 856 (3d Dept. 1995).

Incompetence is the lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d 249 (3d Dept. 1996).

Gross incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences, Post, Supra, at 986.

PATIENT A

Factual Allegation A.1 alleges that Respondent failed to identify a carcinoma of the colon at the time of surgery on September 22, 2003. Factual Allegation A.2 alleges that Respondent failed to remove the 7 cm. adenocarcinoma at the time of the right hemicolectomy performed on

September 22, 2003. Factual Allegation A.3 alleges that Respondent failed to confirm that he had removed the adenocarcinoma on September 22, 2003. The Committee sustains each of these allegations.

Respondent testified that he performed a right colon resection upon Patient A on September 22, 2003. He, also, acknowledged that another surgery became necessary when the pathologist did not find a colon cancer in the specimen of the colon obtained as a result of the September 22, 2003 surgery (T. 196-199). The absence of tumor in the September 22nd specimen was confirmed by Respondent who testified that instead of tumor, the specimen contained enlarged lymph nodes. The pathology report for the September 22nd specimen indicated that the specimen contained multiple nodules in pericolic fat (Pet's Ex. 3, pg. 45). The Committee accepted Dr. Kaleya's testimony that regardless of any discrepancies on the pre-operative tests, Respondent had the responsibility to explore the bowel completely during the surgery, and then to confirm after surgery that he had removed the tumor by opening the specimen in the operating room or sending it up to pathology for immediate analysis. Reliance on endoscopy or palpation was not sufficient in the case of Patient A who had multiple comorbidities and discrepant findings on his preoperative tests. The only way for Respondent to identify the carcinoma and ensure that it was removed was for Respondent to open the specimen and confirm the existence of tumor. Respondent failed to do this and ultimately it was confirmed that he failed to remove the adenocarcinoma.

The Committee sustained these allegations as gross negligence. It was essential that, during the September 22nd surgery, Respondent confirm the presence of the tumor. This was particularly the case in light of the discordant pre-operative test results. Patient A had multiple co-morbidities such as the tumor and sarcoma. He was, also, obese which could make exploring his bowel and palpating the tumor more difficult. A reasonable and prudent surgeon would have used every

reasonable means to ensure that the surgery was performed correctly and that the tumor was located. Not to use a simple procedure such as opening the specimen to definitively confirm the presence or absence of tumor, during the September 22, 2003 surgery, exposed Patient A to the grave risk of having his cancer missed during the surgery. This risk was exacerbated by the fact that, as a result of missing the cancer, Patient A needed a second surgery with the concomitant risks of anesthesia. As Respondent himself testified, Patient A was a high risk surgical patient with congestive heart failure and cardiac issues. Respondent did not want to leave Patient A open to obtain a frozen section given that Patient A was under anesthesia and undergoing a not insignificant procedure (T. 190). The Committee, however, believed that given Patient A's condition, the risk of exposing Patient A to a second surgery was also not insignificant. Respondent, himself, testified that he wished to avoid a second surgery by having the tumor and the sarcoma operated on at the same time (T. 217). The Committee concluded that the risk Patient A was subjected to was such that Respondent's conduct rose to the level of gross negligence.

FACTUAL ALLEGATION A.4

Factual Allegation A.4 alleges that Respondent failed to issue an operative report for the left hemicolectomy performed on September 23, 2003. The Committee does not sustain this allegation. Dr. Edwards testified that Respondent was the operating surgeon at the September 23, 2003 surgery and that he was there to assist Respondent (T. 117). Respondent testified that Dr. Edwards was the primary surgeon on that date (T. 203). Because neither Respondent or Dr. Edwards was believed to be credible, the Committee found that their testimony was not persuasive with regard to which of them was the lead surgeon. Patient A's medical record was not definitive as to the identity of the lead surgeon on September 23rd. but did contain entries listing both as the surgeon on the case (Pet. Exh. 3, pgs. 386, 405). The Committee determined, based upon its evaluation of the record, that

Respondent and Dr. Edwards were co-surgeons with respect to the September 23, 2003 surgery. The lead surgeon would have been responsible for ensuring that an operative report was issued. However, the Committee concluded that Petitioner did not meet its burden in establishing by a preponderance of the evidence who would have been responsible for issuing the operative report in the event that Respondent and Dr. Edwards shared responsibility for the surgery.

SPECIFICATIONS

FIRST SPECIFICATION

GROSS NEGLIGENCE

The First Specification which alleges that Respondent practiced the profession of medicine with gross negligence is sustained, on the basis of Factual Allegations A and A1, A.2 and A.3, as discussed above.

SECOND SPECIFICATION

GROSS INCOMPETENCE

The Second Specification is not sustained. There was nothing in the record which led the Committee to conclude that Respondent was lacking in the skill and knowledge necessary to practice medicine. The Committee, also, observed nothing in Respondent's testimony which would support this specification. In fact, Dr. Edwards who testified for Petitioner, indicated that Respondent was experienced with respect to the surgery in question, and was well equipped to handle the surgery (T. 139, 158).

THIRD SPECIFICATION

FAILING TO MAINTAIN A RECORD REFLECTING THE EVALUATION AND TREATMENT OF A PATIENT

The Third Specification is not sustained. The Committee believed that Factual Allegation A.3 was erroneously cited in support of this specification. Allegation A.3 charged that Respondent

failed to confirm that he removed the adenocarcinoma, and is not an allegation which charged poor record keeping. It appeared that Petitioner meant to cite Factual Allegation A.4 which charged that he failed to issue an operative report for the hemicolectomy performed on September 23, 2003. In any event, as noted above, the Committee did not sustain allegation A.4 and the record keeping specification is dismissed.

DETERMINATION AS TO PENALTY

The Committee unanimously concludes that Respondent's license to practice medicine should be suspended for two years with the final twenty one months of the suspension being stayed. In other words, Respondent's medical license shall actually be suspended for ninety days after which period the suspension would be stayed for the remainder of the two years. Following the ninety days, Respondent shall, also, be placed under probation for three years and will be required during that period to practice medicine in a supervised practice setting.

The Committee's 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 to a specified area or type of practice; (4) Revocation of the license; (5) Annulment of the license or registration; (6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service, and (10) Probation.

In reaching its determination as to penalty, the Committee noted that Respondent failed to take responsibility for his actions during the course of this hearing. The Committee concluded that a censure and reprimand was too lenient a penalty in this case. At the same time, based upon the entirety of the record, revocation was regarded as too severe a penalty for a case involving one patient. The Committee believed that a three month period of actual suspension with an additional twenty one months of suspension being stayed and

three years of probation requiring Respondent to practice in a supervised setting, was an appropriate penalty which would adequately protect the public.

ORDER

IT IS HEREBY ORDERED THAT:

1. The **FIRST SPECIFICATION** is hereby **SUSTAINED**;
2. The license to practice medicine of **RESPONDENT, THOMAS VINCENT ROBB, D.O.** is hereby **SUSPENDED FOR A PERIOD OF TWO YEARS WITH THE LAST TWENTY ONE MONTHS OF SAID SUSPENSION BEING STAYED** contingent upon **RESPONDENT'S** compliance with the **TERMS OF PROBATION** which are annexed and attached hereto as **EXHIBIT B**;
3. **RESPONDENT** shall remain on **PROBATION** for a total of **THREE YEARS** following the first ninety days of the suspension period; and
4. This **DETERMINATION AND ORDER** shall be effective upon service on **THOMAS VINCENT ROBB, D.O.** pursuant to Public Health Law § 230(10)(h).

DATED: New York, New York
24 July **, 2006**

LINDA PRESCOTT WILSON,
CHAIRPERSON

RAMAN KAUL, M.D.
STEPHEN HORNYAK, M.D

TO: Dianne Abeloff, Esq.
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Division of Legal Affairs
New York State Department of Health
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Thomas Vincent Robb, D.O.
460 Gidney Avenue
Newburgh, New York

EXHIBIT A

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

IN THE MATTER

OF

THOMAS VINCENT ROBB, D.O.

STATEMENT

OF

CHARGES

THOMAS VINCENT ROBB, D.O., the Respondent, was authorized to practice medicine in New York State on or about March 31, 1998, by the issuance of license number 209975 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 22 and 23, 2003, at St. Barnabas Hospital, The Bronx, New York, Respondent, failed to render appropriate care and treatment to Patient A, in that he:

1. Failed to identify a carcinoma of the colon at the time of surgery on September 22, 2003;
2. Failed to remove the 7 cm. adenocarcinoma at the time of the right hemicolectomy performed on September 22, 2003;
3. Failed to confirm that he had removed the adenocarcinoma on September 22, 2003;
4. Failed to issue an operative report for the left hemicolectomy performed on September 23, 2003.

SPECIFICATION OF CHARGES

FIRST 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.

SECOND 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:

2. Paragraph A and its subparagraphs.

THIRD 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:

3. Paragraph A and A3.

DATED: December 12, 2005
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT B

Standard Terms of Probation

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

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

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

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law Section 171(27); State Finance Law Section 18; CPLR Section 5001; Executive Law Section 32].

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

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

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

8. Respondent shall work only in a supervised setting, such as a facility licensed by New York State, where close practice oversight is available on a daily basis and where quality assurance and risk management protocols are in effect. Respondent shall not practice medicine until the supervised setting proposed by Respondent is approved, in writing, by the Director of OPMC.

   a. Respondent shall propose an appropriate supervisor or administrator in all practice settings, who shall be subject to the written approval of the Director of OPMC. Respondent shall cause the supervisor or administrator to submit reports, as requested (or quarterly), regarding Respondent's overall quality of medical practice.

   b. Respondent shall provide the supervisor/administrator in all settings with the Order and terms of probation and shall cause the supervisor/administrator, in writing, to comply with OPMC schedules and requests for information.

   c. Respondent shall submit semi-annually a signed Compliance Declaration to the Director of OPMC which truthfully attests whether Respondent has been in compliance with the employment setting and required supervision.

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