STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Public

Wendy E. Saunders
Chief of Staff

June 8, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gloria D. Sanders, M.D.
Redacted Address

Joseph H. Cahill, Esq.
NYS Department of Health
Div. Of Legal Affairs
Corning Tower, Room 2509
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Gloria D. Sanders, M.D.

Dear Parties:

Enclosed please find the **corrected** Determination and Order (BPMC No. 09-101) of the Hearing Committee in the above referenced matter. This **corrected** Determination and Order is in lieu of the previously served Determination and Order. Also note an " Errata Sheet" attached, which indicates the specific corrections made to the original Determination and Order. Additionally, in Appendix II, the first sentence under the heading of "Terms of Probation" has been rewritten.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:djh

Enclosure

ERRATA SHEET

Page References	Error	Correction
Page 3, Paragraph 1, line 2	"2008"	"2005"
Page 3, Paragraph 3, line 3	"endormetritis"	"endometritis"
Page 3, Paragraph 3, line 3	"atypica"	"atypical"
Page 4, Paragraph 5, line 5	"endrometrium"	"endometrium"
Page 4, Paragraph 9, line 2	"2008"	"2005"
Page 4, Paragraph 9, line 3	"endrometrial"	"endometrial"
Page 5, Paragraph 10, line 1	"2008"	"2005"
Page 5, Paragraph 12, line 2	"2000"	"2005"
Page 5, Paragraph 14, line 2	"puit"	"put"
Page 5, Paragraph 14, line 2	"hormonel"	"hormonal"
Page 5, Paragraph 14, line 2	"antibiolic"	"antibiotic"
Page 6, Paragraph 15, line 3	"endrometrial"	"endometrial"
Page 6, Paragraph 16, line 4	"endrometrial"	"endometrium"
Page 8, Paragraph 32, line 3	"endrometrial"	"endometrial"

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

IN THE MATTER OF GLORIA D. SANDERS, M.D.	DETERMINATION AND ORDER BPMC #09-101

COPY

A Notice of Hearing and Statement of Charges dated August 20, 2008, were served upon the Respondent, **GLORIA D. SANDERS, M. D. Peter S. Koenig, Sr., Chair, Carmelita V. Britton, M.D.** and **Robert J. Corona, Jr., D.O.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter "the Committee") in this matter pursuant to §230(10)(e) of the Public Health Law. **JEFFREY KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer for the Hearing Committee.

The Department of Health appeared by **JOSEPH H. CAHILL, ESQ.,** Associate Counsel. The Respondent appeared on the first day of the hearing by Hacker & Murphy, **JAMES E. HACKER, ESQ.**, of Counsel; thereafter the Respondent appeared *pro se*.

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:	August 20, 2008
Date of Hearing:	September 9, 2008 December 8, 2008 December 9, 2008 December 15, 2008
Date of Deliberations:	February 3, 2009

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated four categories of professional misconduct: gross negligence, negligence on more than one occasion, gross incompetence, and incompetence on more than one occasion.

All of the charges relate to the Respondent's reading of pathology slides from the period of October 2005 until February 2006, when she was employed at Arnot-Ogden Medical Center in Elmira, New York. (hereinafter the Med. Ctr).

A copy of the Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I. (NOTE: **The Department withdrew all the charges in the Statement of Charges relating to Patient F.**)

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 parenthesis 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. Gloria D. Sanders, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State on or about September 12, 2005 by the issuance of license number 237668 by the New York State Education Department (Ex,. 3).

PATIENT A:

2. Patient A was a 47 year old female, who had a pre-operative history of menorrhagia and abnormal uterine bleeding. On or about October 21, 2005 she underwent a dilation with curettage, hysteroscopy and endometrial ablation at the Med. Ctr. (T. 142; Ex. 7)

3. On or about October 24, 2005 the Respondent reviewed the pathology slides from Patient A's biopsy and issued a report based on those slides with a diagnosis of "acute and chronic endometritis with endometrial hyperplasia, focally atypical." (T.142-144; Ex. 7)

4. On or about December 12, 2005, Patient A underwent a total vaginal hysterectomy with bilateral salpingo-oophorectomy at the Med. Ctr. (Ex. 7)

5. On or about December 14, 2005, another physician at the Medical Center reviewed the pathology slides of Patient A's October 21, 2005 procedure and issued a pathology report finding "uterine serosa without pathological diagnosis." On or about January 24, 2006, the pathology slides for Patient A were sent to a third physician who reviewed them and issued a report finding "endometrial polyps and secretory endometrium with stromal breakdown." (Ex. 7)

6. On or about January 24, 2006, the Respondent issued an addendum to her pathology report of October 24, 2005 incorporating the finding of the January 24, 2006 pathology report. (Ex. 7)

7. The findings in the Respondent's pathology report of October 24, 2005 were not accurate. (T. 160, 164, 394-396, 416, 487, 501; Ex. 6)

8. Respondent's failure to accurately diagnose Patient A's pathology slides put Patient A at risk for inappropriate hormonal, antibiotic and surgical treatment, and was part of the basis for her physician recommending surgery and antibiotic treatment, and resulted in Patient A undergoing a total vaginal hysterectomy with bilateral salpingo-oophorectomy at the Med. Ctr. (T. 152, 156, 164, 165; Exs. 6, 7).

PATIENT B:

9. Patient B was a 56 year old female who had a pre-operative clinical history of post-menopausal bleeding. Ono r about December 19, 2005, Patient B underwent an endometrial biopsy (T. 211; Ex. 10)

10. On or about December 22, 2005 the Respondent reviewed the pathology slides from Patient B's biopsy and issued a report based on these slides with a diagnosis which included "complex endometrial hyperplasia with pseudo-deciducid stroma." (T. 214-215; Ex. 10)

11. On or about January 20, 2006, Patient B, as a result of the options presented to her by her treating physician, Patient B underwent a total vaginal hysterectomy and bilateral salpingo-oophorectomy at the Med. Ctr. (T. 218-219, 221-222; Ex. 10).

12. Subsequently, another physician at the Med. Ctr. reviewed the pathology slides of Patient B's December 19, 2005 procedure and issued an addendum pathology report dated April 5, 2006, finding among other things "areas suggestive of mildly disordered proliferation, not diagnostic, for hyperplasia, atypia or malignancy." (T. 216-217; Ex. 10)

13. The findings in the Respondent's pathology report of December 22, 2005 were not accurate. (T. 241-242, T-416; Exs. 10 & 31)

14. The Respondent's inaccurate diagnosis of the pathology slides from Patient B's December 19, 2005 biopsy put Patient B at risk for inappropriate, hormonal, antibiotic and/or surgical treatment, and resulted in the patient undergoing a total vaginal hysterectomy and bilateral salpingo-oophorectomy on January 20, 2006, at the Medical Center. (T.216-222, 229, 242, 525-526; Ex. 10).

PATIENT C:

15. Patient C was a 41 year old female, who had a pre-operative history of menorrhagia and abnormal uterine bleeding. On or about January 9, 2006 she underwent a dilation, with curettage, hysteroscopy and endometrial ablation at the Med. Ctr. (T. 251-254; Ex. 12)

16. On or about January 10, 2006, the Respondent reviewed the pathology slides from Patient C's biopsy and issued a report based on those slides with a diagnosis of, among other things, "acute proliferative endometrium with focal complex endometrial hyperplasia, with atypia." (T. 253; Ex. 12)

17. On or about January 24, 2006, another physician not affiliated with the Medical Center reviewed the pathology slides of Patient C's January 4, 2006 procedure, and issued a pathology report finding "Extensive stromal breakdown and fragments of endometrial polyps and no evidence of endometrial hyperplasia." (T. 253-254; Ex. 12)

18. On or about January 24, 2006, the Respondent issued an addendum to her pathology report of January 10, 2006 incorporating the finding of the January 24, 2006 pathology report. (T. 254; Ex. 12)

19. The findings in the Respondent's pathology report of January 10, 2006, were not accurate. (T. 254-256, 260, 262, 401-402, 427-428, 595; Exs. 12 & 32).

20. Respondent's failure to accurately diagnose Patient C's pathology slides, put Patient C at risk for inappropriate hormonal and/or surgical treatment. (T. 256, 262-263, 541; Ex. 12)

PATIENT D:

21. Patient was a 42 year old female, who had a pre-operative history of menorrhagia. On or about January 5, 2006, she underwent a dilation with curettage, hysteroscopy and endometrial ablation at the Medical Center. (T. 267-268; Ex. 14)

22. On or about January 6, 2006, the Respondent reviewed the pathology slides from Patient D's biopsy and issued a report based on those slides with a diagnosis of "disorder proliferative endometrium with focal complex endometrial hyperplasia with atypia." (T. 269)

23. On or about February 18, 2006, another physician at the Medical Center reviewed the pathology slides of Patient D's January 5, 2006 procedure and issued an addendum pathology report finding "fragments of benign proliferative endometrium. Not diagnostic for hyperplasia, atypia or malignancy." (T. 271' Ex. 14)

24. The findings in the Respondent's pathology report of January 5, 2006, were not accurate. (T. 278, 401, 417, 427; Ex. 14)

25. Respondent's failure to accurately diagnose Patient D's pathology slides put Patient D at risk for inappropriate hormonal and/or surgical treatment. (T. 278-279, 561-562; Ex. 14)

PATIENT E:

26. Patient E was a 51 year old male who had a preoperative history of an elevated PSA. On or about December 27, 2005, he underwent ultrasound-guided needle biopsy of the prostate, during which multiple specimens were obtained. (T. 323, 329; Ex. 16)

27. On or about December 29, 2005, the Respondent reviewed the slides from Patient E's December 27, 2005 needle biopsy of his prostate and issued a diagnosis signed off, and a pathology report which found all the biopsy specimens negative for malignancy. (Ex. 16)

28. On or about April 13, 2006, another physician reviewed the pathology slides of the December 27, 2005 needle biopsies of Patient E and issued an addendum report based on those slides which found there was prostatic adenocarcinoma in some of the biopsy specimens. On or about June 23, 2006, Patient E underwent a radical prostatectomy. (T. 338-343; Ex. 16).

29. The finding of the Respondent's December 29, 2005 pathology report were not accurate with respect of Blocks B, D, E, and F from the December 27, 2005, needle biopsies of Patient E's prostate.. (T. 349-350, 416, 437, 447; Ex. 16).

30. Respondent's failure to accurately diagnose Patient E's pathology slides from his prostate biopsies, specifically Blocks B, D, E and F, resulted in a delay in the correct diagnosis of Patient E's prostate malignancy and resulted in a risk of/or an actual delay in Patient E's timely and appropriate treatment and therapy. (T. 344, 351)

PATIENT G:

31. Patient G was a 58 year old female, who had a pre-operative history of menorrhagia and abnormal uterine bleeding. On or about November 7, 2005 she underwent a dilation with curettage, hysteroscopy and endometrial ablation at the Medical Center. (T. 288-289; Ex. 20)

32. On or about November 8, 2005 the Respondent reviewed the pathology slides from Patient G's biopsy and issued a report based on those slides with a diagnosis of "complex endometrial hyperplasia, focally atypical" (T. 142-144)

33. Subsequently, another physician not affiliated with the Medical Center, reviewed the pathology slides of Patient G's November 7, 2005 procedure, and on or about January 24, 2006 diagnosed, among other things, "endometrial polyp and dysynchronous endometrium. (Ex. 20).

34. On or about January 5, 2006, the Respondent issued an addendum to her pathology report of November 8, 2005, incorporating the finding of the January 24, 2006 pathology report. (T. 293-294; Ex. 20)

35. The findings in the Respondent's pathology report of November 7, 2005 were not accurate. (T. 296-300, 416; Ex. 20)

36. Respondent's failure to accurately diagnose Patient G's pathology slides put Patient G at risk for inappropriate hormonal, and/or surgical treatment. (T. 292-293; Exs. 20 & 35)

PATIENT H:

37. Patient H was a 39 year old female, who had a pre-operative history of menorrhagia and abnormal uterine bleeding. On or about December 28, 2005, she underwent a dilation with curettage and hysteroscopy at the Medical Center. (T. 303-304; Ex. 22)

38. On or about December 24, 2005, the Respondent reviewed the pathology slides from Patient H's procedure of December 28, 2005, and issued a report based on those slides with a diagnosis of "secretory type endometrium with complex hyperplasia without atypia; squamous mucosal fragments with koliocytocic change and chronic and acute inflammation". (T. 304-306; Ex. 22)

39. On or about December 14, 2005, another physician (not affiliated with the Medical Center) reviewed the pathology slides of Patient H's December 28, 2005 procedure, and issued a pathology report finding "secretory endometrium with stromal breakdown , fragments of endocervical mucosa and squamous epithelium with no diagnostic abnormality recognized".

40. On or about January 24, 2006, the Respondent issued an addendum to her pathology report of December 29, 2005 incorporating the finding of the January 24, 2006 pathology report. (Ex. 22)

41. The findings in the Respondent's pathology report of December 29, 2005 were not accurate. (T. 308-309, 312, 314, 400-401; Ex. 22)

42. Respondent's failure to accurate diagnose Patient H's pathology slides put Patient H at risk for inappropriate hormonal therapy. (T. 309-310, 315; Ex. 22)

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 A. **(2-6);**

Paragraph A.1: **(7);**

Paragraph A.2: **(8);**

Paragraph A.3: **(8);**

Paragraph B: **(9-12);**

Paragraph B.1: (13);

Paragraph B.2: (14);

Paragraph B.3: (14);

Paragraph C.: (15-18);

Paragraph C.1: (19);

Paragraph C.2: (20);

Paragraph D: (21-23);

Paragraph D.1: (24);

Paragraph D.2: (25);

Paragraph E: (26-28);

Paragraph E.1: (29);

Paragraph E.2.: (29);

Paragraph E.3.: (29);

Paragraph E.4.: (29);

Paragraph E.5.: (30);

Paragraph E.6.: (30);

Paragraph G.: (31-34):

Paragraph G.1.: (35);

Paragraph G.2.: (36);

Paragraph H.: (37-40);

Paragraph H.1.: (41);

Paragraph H.2.: (42 **however, the Petitioner did not prove the Patient was put at risk of unnecessary surgery or pap smears)**

As noted above Factual Allegations **F., F.1.,** and **F.2.** were **withdrawn** by the Petitioner.

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs A., A.l.-3.; B., B.1.-3.; D., D.1.-2.; E., E.1.-6.; G., G.1.-2.; H., and H.1.-2.

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Third through Eighth Specifications: (Paragraphs A., A.1.-3.; B., B.1.-3.; D., D.1.-2; E., E.1-6.; G. G.1-2; H. and H.1.-2.

The Committee found that the **Second and Ninth through Fourteenth Specifications** were not sustained.

DISCUSSION

Respondent was charged with **Fourteen** 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, negligence, gross negligence, incompetence, and gross incompetence.

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.

Using the above-referenced definitions where applicable as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the specifications of negligence on more than one occasion, and gross negligence should be sustained. The Committee also concluded that the specifications of incompetence and gross incompetence should not be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Linda Trapkin, D.O. as its sole expert witness. Dr. Trapkin is a board certified pathologist. There was no evidence of any bias on the part of Dr. Trapkin or her unsuitability as an expert witness. The Respondent presented James Terzian, M.D., who testified as an expert witness on her behalf. Dr. Terzian is a board certified pathologist and is also board certified in forensic pathology.

The Committee found the testimony of Dr. Trapkin quite credible. She testified directly, completely, in an informed fashion, and at length regarding the Respondent's substandard care of Patients A through E, and G and H. Her testimony was even-handed, and was given great weight.

The issues presented in this matter all involved the accurate review and diagnosis of pathology slides.

Although Dr. Terzian was deemed to be a qualified expert, his testimony was brief and viewed as less credible. Of particular significance was Dr. Terzian's testimony that he could not state there was an objective standard of care in the practice of pathology. (T. 471-472)

Additionally, in a number of the patients' cases at issue in this matter, Dr. Terzian disagreed in whole or in part with the Respondent's diagnosis. Dr. Terzian tended to downplay the Respondent's failure to accurately diagnose the slides in question. For example, in the case of Patient E, relating to the prostate biopsies, Dr. Terzian opined that the patient's cancer would eventually have been correctly diagnosed and tested. (T. 420)

Dr. Terzian also testified that he didn't feel that the Respondent's inaccurate diagnosis would result in harm to patients. However, in the case of Patients A and B, both patients had inappropriate surgeries, to wit, a total vaginal hysterectomy with bilateral salpingo-oophorectomy. In those cases where inappropriate surgery was not carried out, the patients still ran the risk of receiving inappropriate and unnecessary hormonal therapy.

Additionally, in many instances when questioned during an interview with representations of the OPMC, the Respondent disagreed with her own diagnosis made when she originally reviewed the slides, thus confirming the inaccuracy of that diagnosis.

Dr. Sanders showed no remorse or regret for the misdiagnoses of the patient cases presented at the hearing. There was no indication on the part of the Respondent that she needed to improve, nor was there any acknowledgement by her of the potential/real harm her misdiagnoses did or could result in. Her primary response to the charges was that she was overworked and got no support from the facility for obtaining help and was expected to get the job done with what she had. The Committee feels that this explanation might be valid in other settings, but it is not acceptable in the provision of medical care to patients.

The Respondent had a duty to accurately diagnose the laboratory slides she reviewed, a duty which she apparently lost sight of. This obligation to the patients and the correct course of conduct was succinctly stated in the hearing during Respondent's cross-examination of Dr. Dawn Riedy, a pathologist who participated in the OPMC interview of the Respondent, concerning the heavy caseload of the Respondent. The Respondent asked:

> Q. (By Dr. Sanders) "If you were told by your laboratory manager that they did not have the money to send out cases for screening, what would you have done in such a situation?"
>
> A. (By Dr. Riedy) "Well, I've taken an oath to do no harm, and if I felt that I was being asked to do something that I didn't think I was trained to do or could reasonably do, I simply would decline doing it. I wouldn't –" (T-409)

The Committee was troubled by the Respondent's lack of good judgment that this testimonial exchange exhibited.

In the case of Patient E's prostate biopsies, the Respondent testified that she did not issue the laboratory report and that someone else did, and electronically signed her name to it. The Committee did not find this scenario credible. The Committee did not believe that another physician would go to the Respondent's computer, access this particular lab report, and issue a diagnosis indicating a non-cancerous condition when the pathology showed a prostatic carcinoma.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be suspended until she fulfills the requirement of the Board as set forth in Appendix II. Subsequent to the suspension her license shall be on probation for a period of six (6) months. The terms of the probation are more specifically set forth in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee unanimously agreed that the Respondent's license should not be revoked. The record in this case established Respondent had a sufficient knowledge of the pathology, however the cases presented indicated a lack of judgment on her part. The Committee felt that the actions of the Respondent warranted a suspension of her license during which time she will have to complete continuing medical education courses in diagnostic pathology and ethics and judgment. Upon the lifting of the suspension of her license she will be on probation for six (6) months during which time her employment would be limited to a NY Public Health Law Article 28 facility or equivalent thereof and she will have to have a practice monitor.

ORDER

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

1. The First through Third through Eighth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED;**

2. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED**, the terms of the suspension are contained in Appendix II, attached hereto and made a part of this Determination and Order.

3. Subsequent to the Respondent's suspension the Respondent is placed on **PROBATION FOR 6 MONTHS**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: Dewitt, New York
05/28 **, 2009**

Redacted Signature

PETER S. KOENIG, SR., Chair

CARMELITA V. BRITON, M.D.
ROBERT J. CORONA, JR., D.O.

TO: Gloria D. Sanders, M.D.
Redacted Address

Joseph H. Cahill, Esq.
Associate Counsel
NYS-DOH
BPMC
Corning Tower - Rm. 2509
Albany, New York 12237-0032

APPENDIX I

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

IN THE MATTER OF GLORIA D. SANDERS, M.D.	STATEMENT OF CHARGES

Gloria D. Sanders, M.D., Respondent, was authorized to practice medicine in New York State on September 12, 2005, by the issuance of license number 237668 by the New York State Education Department. Respondent is currently registered with that Department. Respondent's registration address is P.O. Box 236, Wichita, Kansas, 67201.

FACTUAL ALLEGATIONS

A. Patient A (Patients are identified in the appendix) was a 47 year old female when she underwent a dilatation with curettage, hysteroscopy and endometrial ablation on October 21, 2005 at Arnot-Odgen Medical Center, Elmira, New York (hereafter referred to as "Arnot"). Her pre-operative clinical history was reported as menorrhagia and abnormal uterine bleeding. Respondent examined the pathology slides from the biopsy and signed out a pathology report on October 24, 2005. Respondent diagnosed, among other things, "Acute and chronic endometritis with endometrial hyperplasia, focally atypical." Patient A underwent a total vaginal hysterectomy with bilateral salpingo-oophorectomy at Arnot on December 12, 2005.

Following that surgery Dr. Terence Lenhardt reviewed the specimens. His pathology report, signed out on December 14, 2005, found, among other things "Uterine serosa without pathological diagnosis."

Subsequently, Dr. Esther Oliva was asked to review the pathology slides from the biopsy. Dr. Oliva diagnosed, among other things, "Endometrial polyp(s)" and secretary

endometrium with stromal breakdown"; She sent her report to Arnot on January 24, 2006.

Respondent signed out an Addendum Report on January 24, 2006 containing Dr. Oliva's diagnoses. Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about October 24, 2005 Respondent failed to make an accurate diagnosis of the pathology slides from the biopsy on Patient A.

2. Respondent's failure to make as accurate diagnosis of these pathology slides put Patient A at risk for inappropriate hormonal, antibiotic and/or surgical treatment.

3. Respondent's failure to make an accurate diagnosis of these pathology slides was one of the reasons Patient A's treating physician recommended surgery and antibiotic treatment to Patient A. Patient A, in fact, underwent a total vaginal hysterectomy with bilateral salpingo-oophorectomy at Arnot on December 12, 2005.

B. Patient B was a 56 year old female when she underwent an endometrial biopsy on December 19, 2005. Her pre-operative clinical history was reported as post-menopausal bleeding. Respondent examined the pathology slides from the biopsy and signed out a pathology report on December 22, 2005. Respondent diagnosed, among other things, "Complex endometrial hyperplasia with pseudo-deciduoid stroma." Patient B underwent a total vaginal hysterectomy and bilateral salpingo-oophorectomy on January 20, 2006 at Arnot.

Following that surgery Dr. Lenhardt reviewed the pathology slides. His pathology report, signed out on January 24, 2006 found, among other things, "Benign weakly proliferative endometrium with focal cystic change; not c(sic) atypia, or malignancy." Subsequently, Dr. Lenhardt examined the pathology slides related to Respondent's December 22, 2005 report. Dr. Lenhardt signed out an Addendum Report with a corrected diagnosis on April 25, 2006. His report found, among other things, "areas suggestive of mildly disordered proliferation, not diagnostic for hyperplasia, atypia, or malignancy."

Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about December 22, 2005 Respondent failed to make an accurate diagnosis of the pathology slides from Patient B's biopsy.

2. Respondent's failure to make an accurate diagnosis of these pathology slides put Patient B at risk for inappropriate hormonal, antibiotic, and/or surgical treatment.

3. Respondent's failure to make an accurate diagnosis of these pathology slides was one of the reasons Patient B's treating physician recommended a hysterectomy to Patient B. In fact, Patient B underwent a total vaginal hysterectomy and bilateral salpingo-oophorectomy on January 20, 2006 at Arnot.

C. Patient C was a 41 year old female when she underwent a dilatation and curettage, hysteroscopy and endometrial ablation on January 9, 2006 at Arnot. Patient C's pre-operative history was reported as abnormal uterine bleeding and menorrhagia.

Respondent examined the pathology slides from the biopsy and signed out a pathology

report on January 10, 2006. Respondent diagnosed, among other things, "Proliferative endometrium with focal complex endometrial hyperplasia with atypia."

Dr. Oliva was asked to review the pathology slides related to Respondent's January 10, 2006 report. Dr. Oliva examined the pathology slides and diagnosed "Extensive stromal breakdown and fragments of endometrial polyps" and "...no evidence of endometrial hyperplasia in the slide sent for evaluation"...She sent her report to Arnot on January 24, 2006.

Respondent then signed out an Addendum Report on January 24, 2006 containing Dr. Oliva's diagnosis. Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about January 10, 2006 Respondent failed to make an accurate diagnosis of the pathology slides from the biopsy performed on Patient C.

2. Respondent's failure to make an accurate diagnosis of the pathology slides put Patient C at the risk for inappropriate hormonal therapy and/or unnecessary surgery.

D. Patient D was a 42 year old female when she underwent a dilatation and curettage, endometrial ablation and hysteroscopy on January 5, 2006 at Arnot. Her pre-operative clinical history was reported as menorrhagia. Respondent examined the pathology slides from the biopsy and signed out a pathology report on January 6, 2006. Respondent diagnosed, among other things, "Disorder (sic) proliferative endometrium with complex endometrial hyperplasia with atypia."

Subsequently, Patient D's treating physician requested that Dr. Lenhardt evaluate the

same pathology slides. On February 18, 2006 Dr. Lenhardt signed out an Addendum Report containing the corrected diagnosis of "Fragments of benign proliferative endometrium, not diagnostic for hyperplasia, atypia, or malignancy."

Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about January 6, 2006 Respondent failed to make an accurate diagnosis of the pathology slides from the biopsy on Patient D.

2. Respondent's failure to make an accurate diagnosis of the pathology slides put Patient D at risk for inappropriate hormonal therapy and/or unnecessary surgery.

E. Patient E was a 51 year old male when he underwent ultrasound-guided needle biopsies of the prostate on December 27, 2005. Multiple specimens were obtained. His pre-operative clinical history was reported as an elevated PSA. Respondent examined the pathology slides from the biopsy and signed out a pathology report on December 29, 2005. Respondent diagnosed, among other things, that Blocks B, D, E, and F were "Negative for malignancy."

Subsequently, Dr. Lawrence Goldsmith evaluated these pathology slides . On April 13, 2006 Dr. Goldsmith signed out an Addendum Report with corrected diagnosis which found, among other things, the following:

"Block B (left mid)....

- Infiltrating prostatic carcinoma consistent with combined Gleason's score 6 (3+3) involving approximately 20% of the specimen."

"Block D (right base)...

- Invasive prostatic adenocarcinoma involving approximately 3% of one core."

"Block E (right mid)....

- Invasive prostatic adenocarcinoma consistent with combined Gleason's score 6 (3+3) involving 25% of the specimen."

"Block F (right apex)...

- Invasive prostatic carcinoma consistent with combined Gleason's score 6 (3+3) involving approximately 30% of the specimen."

On or about June 23, 2006 Patient E underwent a radical prostatectomy. Respondent's pathological diagnoses failed to meet accepted standards of medical care in the following respects:

1. On or about December 29, 2005 Respondent failed to make an accurate diagnosis of Block B (left midgland).

2. On or about December 29, 2005 Respondent failed to make an accurate diagnosis of Block D (right base).

3. On or about December 29, 2005 Respondent failed to make an accurate diagnosis of Block E (right mid).

4. On or about December 29, 2005 Respondent failed to make an accurate diagnosis of Block F (right apex).

5. Respondent's failure to make an accurate diagnosis of Blocks B, D, E and/or F of Patient E's prostate biopsy put Patient E at risk for failure to receive appropriate and/or timely treatment for prostate cancer.

6. Respondent's failure to make an accurate diagnosis of Blocks B, D, E and/or F of Patient E's prostate biopsy subjected Patient E to delay in the correct diagnosis of a prostate malignancy and/or delay in receiving appropriate therapy.

F. Patient F was a 67 year old female when she underwent a left thyroid lobectomy at Arnot on January 24, 2006. Her pre-operative clinical was reported as left thyroid goiter. Respondent examined the pathology slides from the lobectomy and signed out a pathology report on January 26, 2006. Respondent diagnosed, among other things:

- Follicular adenoma with recent hemorrhage fibrosis and retrogressive changes.
- Chronic thyroiditis.

Subsequently, the pathology slides were sent to Dr. Heffess at the Armed Forces Institute of Pathology for review and consultation. Dr. Heffess on, April 21, 2006, diagnosed "Follicular Carcinoma with cellular oxyphilia and Lymphocytic Thyroiditis", and sent a letter to Arnot. On April 25, 2006 Dr. Goldsmith signed out a Addendum Report reflecting the diagnosis made by Dr. Heffess.

Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to obtain an expert consultation in order to make an accurate diagnosis and/or failed to make an accurate diagnosis herself.
2. Respondent 's failure to make an accurate diagnosis subjected Patient F to delay in receiving the diagnosis of thyroid malignancy and/or receiving appropriate therapy.

G. Patient G was a 53 year old female when she underwent dilatation with curettage, hysteroscopy and endometrial ablation at Arnot on November 7, 2005. Her pre-operative clinical history was reported as abnormal uterine bleeding, and menorrhagia. Respondent examined the pathology slides from the biopsy and signed out a pathology report on November 8, 2006. Respondent diagnosed, among other things, "Complex endometrial hyperplasia."

Dr. Olvia was asked to review the pathology slides related to Respondent's November 8, 2005 report. Dr. Oliva examined the pathology slides and diagnosed, among other things:

"• Endometrail polyp
• Dysynchronous endometrium." (A note of explanation followed.)

Dr. Olvia reported theses findings to Arnot on January 24, 2006.
Respondent then signed out an Addendum Report on January 25, 2006, containing Dr. Oliva's diagnosis. Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about November 8, 2005 Respondent failed to make an accurate diagnosis of the pathology slides from the biopsy performed on Patient G.

2. Respondent's failure to make an accurate diagnosis of these pathology slides put Patient G at risk for inappropriate hormonal therapy and/or unnecessary surgery.

H. Patient H was a 39 year old female when she underwent a dilatation with curettage and hysteroscopy at Arnot on December 28, 2005. Her pre-operative clinical history was reported as abnormal uterine bleeding and menorrhagia. Respondent signed out a pathology report on December 29, 2005. Respondent diagnosed, among other things, "Secretory type endometrium with complex hyperplasia without atypia....Squamous mucosal fragments with koliocytocic(sic) changes and/or chronic and acute inflammation".

Dr. Oliva was asked to review the pathology slides related to Respondent's December 29, 2005 report. Dr. Olvia examined the slides and diagnosed, among other things, the following:

- "• Focal secretory endometrium with stromal breakdown.
- Fragments of endocervical mucosa and squamous epithelium with no diagnostic abnormality recognized..."

Dr. Oliva reported these findings to Arnot on January 24, 2006. Respondent then signed out an Addendum Report on January 24, 2006 containing Dr. Oliva's diagnoses. Respondent's pathological diagnosis failed to meet accepted standards of medical care in the following respects:

1. On or about December 29, 2006 Respondent failed to make an accurate diagnosis of the pathology slides from the biopsy.

2. Respondent's failure to make an accurate diagnosis of these pathology slides put Patient H at risk for receiving inappropriate hormonal therapy, unnecessary surgery and/or excessive Pap smears.

SPECIFICATION OF CHARGES

FIRST 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:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, G and G.1, G and G.2, and/or H and H.1, H and H.2.

SECOND 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:

2. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, G and G.1, G and G.2, and/or H and H.1, H and H.2.

THIRD THROUGH EIGHTH SPECIFICATIONS

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:

3. The facts in Paragraphs E and E.1
4. The facts in Paragraphs E and E.2
5. The facts in Paragraphs E and E.3
6. The facts in Paragraphs E and E.4
7. The facts in Paragraphs E and E.5
8. The facts in Paragraphs E and E.6

NINTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

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

9. The facts in Paragraphs E and E.1
10. The facts in Paragraphs E and E.2
11. The facts in Paragraphs E and E.3
12. The facts in Paragraphs E and E.4
13. The facts in Paragraphs E and E.5
14. The facts in Paragraphs E and E.6

Dated: August 20, 2008
Albany, New York

Redacted Signature

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

APPENDIX II

Terms of Suspension

1. The license to practice medicine of the Respondent, Gloria D. Sanders, is **suspended** until she complies with the following:

a. Respondent shall enroll in and complete 50 hours of continuing medical education in the area of diagnostic pathology and 10 hours of continuing medical education in the area of medical ethics and judgment. Said continuing medical education program shall be subject to the prior written approval of the Director of OPMC.

b. Respondent shall submit to a psychiatric examination by a psychiatrist approved by the Director of OPMC to assess the Respondent's medical judgment, assumption of responsibility and boundary issues and said psychiatrist attests in writing to the satisfaction of the Director of OPMC to the Respondent's mental status to practice medicine safely.

Terms of Probation

1. . Subsequent to the Respondent's compliance with the Terms of Suspension, **the Respondent is placed on *Probation* for a period of six months.** Respondent shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.

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. 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 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.

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/her 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. Upon the Respondent's license suspension ending Respondent shall practice medicine only at an N.Y. Pub. Health Law Article 28 facility or equivalent thereof and 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 monthly in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after she receives written notification from the Director of OPMC that the Suspension of her license is lifted.

8. 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.