Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 3, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ram Swaroop Makker, M.D.
Redacted Address

Ralph Erbaio, Esq.
Kern, Augustine, Conroy & Schoppman, P.C.
420 Lakeville Road
Lake Success, New York 11042

Terrence J. Sheehan, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Ram Swaroop Makker, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-166) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER

OF

RAM SWAROOP MAKKER, M.D.

DETERMINATION

AND

ORDER

BPMC #09-166

DIANE M. SIXSMITH, M.D., Chairperson, **GREGORY FRIED, M.D.** and **CONSTANCE DIAMOND, D.A.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) and Section 230(12) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **THOMAS CONWAY, ESQ.**, General Counsel, **TERRENCE J. SHEEHAN, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared by **KERN AUGUSTINE CONROY & SCHOPPMANN, P.C., RALPH A. ERBAIO, Jr., 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 Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged three (3) specifications of professional misconduct, including allegations of negligence, incompetence and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated April 23, 2009, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order. Respondent filed an Answer dated, April 24, 2009 and denied all allegations.

SUMMARY OF PROCEEDINGS

Commissioner's Order :	April 24, 2009
Notice of Hearing Date:	April 23, 2009
Answer	April 24, 2009
Pre-Hearing Conference	April 27, 2009
Hearing Dates:	April 30, 2009 May 5, 2009 June 2, 2009 June 11, 2009
Commissioner's Interim Order:	June 24, 2009
Deliberation Date:	July 23, 2009

WITNESSES

For the Petitioner:	Mark S. Silberman, M.D. Mother of Patient C
For the Respondent:	Ram Swaroop Makker, M.D.

FINDINGS OF FACT

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

1. Ram Swaroop Makker, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 2, 1993, by the issuance of license number 193129 by the New York State Education Department.

PATIENT A

2. Patient A, a 40 year-old woman with a history of sickle cell anemia, was brought to the Mary Immaculate Hospital Emergency Department by ambulance on 11/3/06. Both Basic Life Support ("BLS") and Advanced Life Support ("ALS") units responded to the call with a complaint of difficulty breathing. (T. 25-26)[1] The BLS report noted that she had been discharged from the ED the previous day with sickle cell anemia. She was found covered in diarrhea, with altered mental status, semi-responsive, with low blood pressure and difficulty breathing. Her vital signs were unstable, with a pulse of 110, blood pressure of 60/40, and a respiratory rate of 40. The ALS unit noted that Patient A was lethargic but

[1] Numbers in parentheses refer to Hearing transcript pages (T.)].

verbally responsive. They further noted shortness of breath with shallow, rapid breathing and abdominal breathing. Multiple IV placement attempts by the ALS unit were unsuccessful. (Pet. Ex. 2a, pgs. 13-16)[2].

3. The Emergency Department ("ED") triage notes were documented at 9:40 a.m. The chief complaint was unresponsiveness with difficulty breathing since 8:40 a.m. The ED triage vital signs revealed a pulse of 119, blood pressure of 119/91, respirations of 24, a temperature of 99.2, and an oxygen saturation of 90% despite supplemental oxygen. Past history of sickle cell disease was noted, as were the patient's home medications, methadone and albuterol. Further nursing notes indicate lethargy, fecal soiling all over, and that the patient was moaning at times in response to pain. (Pet. Ex. 2a, pgs. 20, 25-28).

4. Respondent documented his evaluation of the patient with a note timed at 9:55 a.m. He recorded chief complaints of unresponsiveness with shortness of breath, and that the patient had been found at home with a methadone bottle, lethargic, hypotensive, tacchypneic, and covered with diarrhea. On examination, Respondent notes no evidence of trauma, with neurological examination demonstrating unresponsiveness or mumbling. He further notes a supple neck and normal heart examination. Examinations of the pupils, the lungs and the abdomen were not documented. Respondent's clinical impression was recorded as gastroenteritis. (Pet. Ex. 2a, pgs. 21-23; (T. 34).

5. The nurses had difficulty placing an IV and obtaining blood for analysis, but Respondent obtained blood samples via arterial puncture at 10:30 a.m. The blood was sent for CBC, CMP, CK, troponin, amylase, lipase and coagulation testing. An IV line was established,

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[2] Refers to exhibits in evidence submitted by the New York State Department of Health (Pet. Ex.) or by Dr. Makker (Resp. Ex.).

and Respondent ordered a 500 ml IV, normal saline bolus, followed by a continuous infusion at 250 ml/hour. Supplemental oxygen, a chest x-ray, head CT and EKG were ordered. Cardiac and oxygen saturation monitoring were ordered, as well as hourly neurological status monitoring. (Pet. Ex. 2a)

6. Laboratory studies revealed hyperkalemia (5.6), renal insufficiency, and evidence of hemolysis typical for sickle cell anemia. The CBC demonstrated anemia (Hb of 7.5), leukocytosis (WBC of 18.9), and thrombocytosis. Arterial blood gas analysis was notable for significant, acute respiratory acidosis, with pH 7.22, pCO2 of 70.5, and a pO2 of 169.6. The laboratory called to notify the ED of these critical values. (Pet. Ex. 2a, pgs. 206-9).

7. Over the next few hours, Patient A remained tachycardic. At 2:00 p.m. her vital signs changed, with a blood pressure drop to 84/54 and an oxygen saturation drop to 92% on 100% oxygen. At 3:07 p.m. the patient became bradycardic and went into asystolic cardiac arrest. Respondent attempted endotracheal intubation twice without success. (Pet. Ex. 2a, pg. 24).

8. Orotracheal intubation was then successfully performed by anesthesia at 3:12 p.m. The patient was successfully resuscitated with intubation, epinephrine, atropine and dopamine. She had a return of spontaneous circulation with a blood pressure of 45/28 documented at 3:25 p.m. By 3:35 p.m., the blood pressure improved to 105/43 on the continuous dopamine infusion. (Pet. Ex. 2a. pgs. 27-29).

9. Post resuscitation, physicians from the critical care team became involved with the care of the Patient. They placed a central venous catheter in the right femoral vein and obtained an ABG at 3:45 p.m. revealing a pH of 6.97, pCO2 of 99, and pO2 of 419 on ventilator settings of CMV 12, tidal volume 500 ml, and 100% oxygen. They noted that the patient was found with an empty bottle of methadone in her home. The CCU team's clinical impression was

respiratory failure secondary to methadone overdose with encephalopathy. The patient was subsequently admitted to the critical care unit. (Pet. Ex. 2a).

10. In the ICU, the patient remained intubated and comatose. Her urine toxicology screen was positive for opiates and benzodiazepines. Subsequent CT of the brain showed diffuse cerebral edema consistent with anoxic encephalopathy. The Patient suffered generalized seizures and central fevers as high as 108 degrees. Patient A eventually suffered cardiovascular collapse and was pronounced dead on 11/9/06. An autopsy was performed, confirming the cause of death to be anoxic encephalopathy and drug overdose. (Pet. Ex. 2a, pg. 27; Pet. Ex. 2c).

11. The primary goal of an emergency room physician is to identify serious threats to life. Once an emergency room ("ER") physician rules out all life-threatening conditions, he or she may not have the goal of reaching a definitive conclusion. That job can be left to a primary care doctor or other specialist. (T. 23).

12. The critical issues to be addressed in this case were the alteration in mental status, the hypotension and tachycardia noted by EMS, and the respiratory distress. Initial considerations by the ER physician should have included methadone overdose that could cause abnormalities in blood pressure, respirations and depressed mental status. Other appropriate considerations would have included an acute ischemic stroke or hemorrhage, volume depletion, acute pneumonia and possible sepsis. (T. 39, 44, 48 and 95).

13. Respondent's assessment was extremely limited. He failed to examine the patient's pupils, a physical finding that could have supported overdose from methadone. (T. 47). He failed to examine this patient's lungs despite her respiratory distress, and he failed to examine her abdomen despite severe diarrhea. His clinical impression of gastroenteritis, while possibly

a secondary diagnosis, completely failed to address her critical and unstable neurological, respiratory, and cardiovascular condition. (T. 24-99).

14. Respondent failed to address Patient A's severely depressed mental status with a high likelihood of opiate overdose. (T. 47).

15. The blood gas analysis that was drawn by Respondent revealed hypoventilation and respiratory acidosis, critical signs of respiratory instability and impending respiratory failure due to opiate overdose. The blood gas results were called to the ED, but they were never recorded in Respondent's notes or addressed by Respondent. (T. 42-43).

16. The patient required either a trial of IV Narcan, or intubation with respiratory support, or both in an attempt to reverse the respiratory depression due to the opiate overdose. She received none of these critical treatments and instead was simply observed over the course of hours as her condition slowly deteriorated. No interventions were instituted for her critically unstable airway and poor respiratory status. (T. 89).

17. Patient A was documented to be hypotensive with desaturation at 2:00 p.m. This worsening of the patient's condition should have triggered Respondent to reevaluate the patient's clinical status. She was not reevaluated, and no further treatment or intervention was provided. At 3:07 p.m., Patient A suffered bardycardia, followed by cardiac arrest. At this point, Respondent undertook two failed attempts to secure the patient's airway with intubation. The nurse anesthetist was summoned and successfully secured the airway on the first attempt (T. 51-53).

18. Respondent failed to recognize just how sick Patient A was. The failure persisted "hour after hour after hour" when additional critical information came back indicating that Patient A was very ill and in a life-threatening circumstance. (T. 54)

19. Narcan and/or intubation would have reversed the respiratory acidosis that she was suffering had they been provided earlier in the course of Respondent's treatment. Patient A's cardiac arrest with the subsequent anoxic brain injury and death could have easily been prevented. (T. 57)

20. Patient A was not intubated until after she suffered a cardiac arrest. This occurred after the cardiac arrest team took over sometime between 3:00 pm and 4:00 pm. (T. 53)

21. There was enough time at Respondent's initial evaluation, even in the absence of other findings, to clearly indicate that Patient A was critically ill and at risk for very bad outcomes unless Respondent took aggressive action to manage the situation. (T. 98)

22. Respondent's medical record for Patient A did not meet minimally acceptable standards. (T. 58)

Patient B

23. On 3/4/02, at 9:02 a.m., Patient B, a 37 year-old woman, was brought to the Mary Immaculate Hospital ED by EMS. She reported acute onset of abdominal pain with nausea. EMS found her prone in the hallway and noted her to have pale conjunctiva, with sweating, weakness and near syncope. Upon sitting, the EMT was unable to palpate her blood pressure. Her lowest blood pressure recorded by EMS was 64 by palpation. They noted that her last menstrual period had been 6 weeks earlier, on ½0/02. (Pet. Ex. 3, pg. 15).

24. In triage, Patient B's vital signs had improved, with a pulse of 80 and a blood pressure of 114/94. The triage nurse noted abdominal pain with nausea but no vomiting and tenderness on the right side. (Pet. Ex. 3, pgs. 22-3). At 9:30 a.m., Respondent evaluated the patient, again noting the abdominal pain and nausea, as well as the last menstrual period 6 weeks earlier. He noted diffuse abdominal tenderness on examination. Respondent ordered blood,

urinalysis, urine pregnancy testing, as well as IV normal saline, Reglan and Pepcid. (Pet. Ex. 3, pgs. 16-17).

25. At 9:30 am, the nurse noted the urine pregnancy test to be positive, and the lab work was sent. At 1:00 p.m., nursing notes that the patient was awaiting a pelvic ultrasound. At 3:10 p.m., a serum HCG was run, with a result of 3,555. (Pet. Ex. 3,pg.78). Around 5:00 p.m., the GYN consult was notified. The initial hemoglobin drawn in the morning was 11.0 and a repeat done at 5:52 p.m. was 8.3. At 6:00 p.m. the patient went for pelvic ultrasound, which revealed an empty uterus and a right adnexal cyst. (Pet. Ex. 3, pg. 101).

26. The working diagnosis was ruptured ectopic pregnancy. The patient went to the OR where an exploratory laparotomy revealed a ruptured ectopic pregnancy in the right fallopian tube with active bleeding and hemoperitoneum. (T. 137).

27. Patient B underwent a partial right salpingectomy and evacuation of the hematoma. She was transfused two units of blood and made an uneventful recovery. She was discharged from the hospital on 3/7/02. (Pet. Ex. 3).

28. Given this constellation of findings of the late period, diffuse abdominal pain that came on suddenly and hypotension in the field by EMS, an ectopic pregnancy would have been at the top of the differential diagnosis. (T. 106- 108).

29. The standard of care in this situation calls for an immediate pelvic examination and urgent gynecological consultation. The patient with a ruptured ectopic pregnancy is at risk for ongoing bleeding or shock if diagnosis and treatment are delayed. (T. 107-108; 116-117).

Patient C

30. Patient C, a 15 year-old boy, came to the Lourdes Hospital ED on 5/13/07 with a complaint of abdominal pain after having his elbow stabbed into the left side of his abdomen while

playing soccer. His vital signs were normal; specifically, his blood pressure was 112/84 and his pulse was 72. He rated his pain 1/10. The triage nurse noted a soft abdomen with left sided tenderness. (Pet. Ex. 4a, pg. 5).

31. Respondent evaluated the patient, again noting that the patient's elbow struck his abdomen while playing soccer, resulting in abdominal pain. Respondent's history indicates that the pain initially resolved, so Patient C started playing soccer again. Later, the pain returned and his parents brought him to the ED. (Pet. Ex. 4a, pgs. 1,3,4).

32. Respondent's physical examination was unremarkable. Specifically, Respondent noted a soft abdomen without guarding or rebound. Respondent prescribed Toradol 60 mg IM. The Patient was discharged from the ED approximately one hour after presentation, with the nurse noting that the Patient was in good condition, without pain. (Pet. Ex. 4a, pg. 5).

33. At home, a few hours later, the abdominal pain increased with radiation to the left shoulder. Patient C developed dizziness and near syncope. He was taken to the Wilson Memorial Regional Medical Center, where he was found to have abdominal tenderness with rebound and guarding. He had a CT scan done, revealing a ruptured spleen with hemoperitoneum. He was given IV fluids and his vital signs remained stable. He was taken to the OR where he underwent a splenectomy. Patient C recovered uneventfully and later returned to full activities and sports. (Pet. Ex. 4b).

34. Given that Respondent evaluated the patient about three hours after his injury, it is likely that there would have been significant blood in the peritoneal cavity at the time of his examination. Due to the severity of the splenic injury that was identified at surgery, and given the amount of blood that was seen on CT scan at Wilson Memorial Hospital, it is highly likely that a proper abdominal examination would have demonstrated peritoneal

findings. (T. 148-150).

35. Patient C's mother stated that Respondent's entire examine was conducted while Patient C was fully clothed. (T. 772).

36. Respondent should have ordered a CT scan of the abdomen for trauma. (T. 157).

37. Respondent's administration of Toradol, a potent pain killer, was inconsistent with the absence of findings he made in his physical examination. (T.158).

38. Respondent's medical record for Patient C lacks internal consistency because his findings do not justify why he administered Toradol. (T. 159).

39. It was inappropriate for Respondent to discharge Patient C with a diagnosis of "abdominal pain status post hit with his own elbow." (T. 159).

Patient D

40. Patient D, a previously healthy 39 year-old man, presented to the St. John's Queens Hospital ED on 9/8/05 with a complaint of abdominal pain for one day, without vomiting or diarrhea. His triage temperature was 99.2 and his other vital signs were unremarkable. The triage nurse noted diffuse abdominal tenderness and pallor. (Pet. Ex. 5a. pg. 13).

41. Respondent evaluated the patient, noting a history of mid-abdominal pain for one day, getting worse over time. He further noted that this was the first time the patient had experienced abdominal pain, and that although Patient D felt nauseated, there had been no vomiting or diarrhea. On examination, Respondent found mid-abdominal peri-umbilical pain with voluntary guarding. (Pet. Ex. 5a, pg. 14).

42. Respondent ordered blood work including a CBC, chemistry, amylase, lipase, PT and urinalysis. He ordered chest and abdominal x-rays. The patient was given IV normal saline and was medicated with IV Pepcid, Reglan and Toradol. The x-rays were normal. The lab

work was notable for a WBC of 9.4 with a left shift, and was otherwise unremarkable. (Pet. Ex.5a, pgs. 15, 5, 6, 2-4).

43. Respondent reassessed Patient D and discharged him with a diagnosis of abdominal pain and gastroenteritis. He was given prescriptions for Reglan and Pepcid, was advised to follow up with his primary care physician in 3 to 4 days, and to return to the ED if needed. (Pet. Ex. 5a).

44. The following day, the patient continued to have ongoing pain and went to see his primary physician. The doctor referred him to the ED at Mt. Sinai Hospital of Queens to rule out acute appendicitis. On examination, he was found to have abdominal tenderness, including right lower quadrant tenderness, and he was sent for a CT scan. The CT demonstrated acute appendicitis and he was taken to the OR for an appendectomy. He recovered uneventfully and was discharged home the following day. (Pet. Ex. 5b)

45. Patient D had a presentation that was very strongly suggestive of acute appendicitis based on Respondent's initial history and physical exam. His pain was mid-abdominal, steady and worsening over time. He had not suffered this pain in the past and there was no vomiting or diarrhea. (T. 188).

46. It was a departure from the standard of care to discharge Patient D without doing a CT scan of the abdomen and pelvis to look for signs of acute appendicitis. (T. 190-191).

47. The characteristic of the pain exhibited by Patient D is not consistent with Respondent's diagnosis of gastroenteritis. (T. 200).

48. A surgical consultation should have been ordered for Patient D. (T. 190).

49. Patient D's record does not indicate that Respondent reassessed the patient before discharge. (T. 185).

Patient E

50. Patient E, a 35 year-old man, presented to the Lourdes Hospital ED triage nurse on 01/23/07 complaining of bilateral kidney pain of two days duration, right greater than left. He mentioned feeling burning on and off, as well as lethargy. Vital signs were a temperature of 99.7 and elevated blood pressure of 184/114, with normal pulse, respirations, and oxygen saturation. Pain was reported as mild, 1/10. (Pet. Ex. 6)

51. Respondent evaluated Patient E, again noting a report of bilateral kidney pain with burning, not related to urination. Review of systems was negative for nausea, vomiting, fever, and chills. The patient reported no significant past medical history, and social history was notable for alcohol abuse. (Pet. Ex. 6, pg. 1).

52. A physical examination by Respondent noted the elevated triage blood pressure, but was otherwise normal, including a normal abdominal and flank examination. Laboratory studies were ordered, including a CBC, comprehensive metabolic panel, coagulation studies, cardiac troponin, and urinalysis. Basic CBC results were normal, including a white blood cell count of 6.5, but there was a notable bandemia of 19%. Basic chemistries were normal, but liver functions studies were notable for albumin 5.0, AST 246, ALT 271, alkaline phosphatase of 97, and a bilirubin of 3.1. Amylase and lipase were normal. The coagulation studies were normal. Urinalysis demonstrated a specific gravity of 1.005, with 1+ ketones, but was otherwise normal. A 12-lead EKG tracing was normal, and cardiac troponin was also normal. A renal sonogram was performed, and the kidneys were noted to be normal. (Pet. Ex. 6) .

53. Repeat blood pressure prior to discharge was 158/84. Patient E was discharged with a diagnosis of bilateral flank pain and was advised to follow up with a urologist. (Pet. Ex. 6).

54. Respondent's history is very brief. There was no description of where the pain was or what is was like or its duration. (T. 218). There is no documentation in the record that Respondent formulated or considered a differential diagnosis of the patient's complaints. Respondent remained focused on the kidneys even after laboratory and imaging data indicated that there was no problem with the kidneys., In fact the patient had acute liver disease. (T.222).

55. Although Respondent ordered a full laboratory work-up, he failed to take note of significant results. His dictated report mentions a normal CBC, but he fails to note significant bands of 19%. He also mentions a normal metabolic panel, ignoring the significantly elevated liver transaminases and bilirubin that were reported on that metabolic panel. These laboratory abnormalities gave important information about the true nature of the Patient's acute illness being related to alcoholism and liver disease, and unrelated to the kidneys. (T.219-222).

56. Bandemia of 19% is a high number that suggests the possibility of a serious infection or inflammatory condition. (T. 220, 240).

57. The nurse notes that Respondent reviewed the lab data and ordered a renal sonogram. A renal sonogram is reasonable to perform in a patient with bilateral kidney pain. However, based on the abnormal liver function tests, a complete abdominal ultrasound should have been performed at the same time to rule out abnormalities of the liver, gallbladder, biliary ducts or other intra-abdominal organs. Respondent failed to appropriately order the correct ultrasound study. (T. 222-3).

58. Respondent discharged Patient E with a diagnosis of bilateral flank pain and referred him to a urologist, despite the fact that his urological work-up was normal and there was no indication of a need for further urological evaluation. However, it was important for Patient E to follow-up with a primary care physician to further evaluate the elevated liver function

tests and elevated blood pressure readings from the ED. Respondent failed to appropriately refer him for follow-up of these abnormal findings related to acute liver disease. Respondent also failed to give appropriate instructions about alcohol consumption. (T. 223-5).

Patient F

59. On 12/5/06 Patient F, a 9 year-old child, was brought to the Mary Immaculate Hospital ED for evaluation. The triage nurse spoke to a parent, and noted complaints of fever, back pain and a sore throat. The triage temperature was 99.6, blood pressure 140/69, pulse 159, respirations 22 and oxygen saturation 99%. (Pet. Ex. 7a, pg. 5).

60. Respondent evaluated the patient, noting a previously healthy child with a report of fever to 104 the prior night, with neck stiffness but no pain on movement and no headache. He noted that the patient had received Ibuprofen without relief. Physical examination was notable for pharyngeal erythema and good mobility of the neck without pain. The remainder of the examination was normal. (Pet. Ex. 7a, pg. 14-15).

61. Extensive ancillary studies were ordered, revealing a normal white blood cell count of 9.5 with 84% neutrophils. Chemistry studies were unremarkable. A chest x-ray was clear. A head CT scan was done and was normal. Repeat vital signs revealed a temperature of 100.2 and a pulse of 130. Respondent's clinical impression was fever and neck pain with tonsillitis. (Pet. Ex. 7a, pgs. 4, 14).

62. Respondent ordered D5 and 1/3 normal saline at 65 ml/hour. He also prescribed 1 gram of IV ceftriaxone. Respondent made further arrangements to transfer the patient to the specialty children's hospital by ambulance for further evaluation to rule out meningitis. (Pet. Ex. 7).

63. The patient was evaluated at the Schneider Children's Hospital. The pediatricians there

noted that he was not ill appearing. Upon taking a more detailed history, they noted that there was no headache, no photophobia and no neck stiffness. Physical examination was notable for an absence of meningismus or rash. Pharyngeal erythema was noted. The patient was diagnosed with a viral syndrome based on his history and physical examination. He was discharged home in good condition without further work-up. (Pet. Ex. 7-b)

64. Respondent documented no past history and his physical examination noted that the patient complained of a stiff neck but had no pain on movement. There was no headache under the review of systems and no examination of the eyes for photophobia. (T. 242, 266).

65. A 9 year old with acute meningitis would be highly febrile, with a toxic appearance. The patient would be holding his head with severe pain and exhibiting signs of stiffness of the neck and meningeal pain upon testing by the physician. (T. 245).

66. Patient F had no headache and had normal mobility of the neck without pain. His temperature had come down to 99.6 degrees and the patient was described by the nurse as a well appearing child. It was most likely that the patient had acute pharyngitis. (T. 245).

67. The proper test to confirm a diagnosis of meningitis is to do a spinal tap. A CAT scan of the brain has no utility in making a diagnosis of meningitis and is reserved for a child with an abnormal neurological finding or severe headache. It should not be used when not indicated because it can expose children to inappropriate doses of radiation. (T. 244).

68. Dehydration is a concern in a patient with an elevated hear rate and acute pharyngitis. While Respondent ordered maintenance fluids he did not order appropriate fluids for rehydration. An order for a normal saline bolus was required to restore volume. (T. 246-7).

69. Respondent's order to transfer Patient F to a pediatric hospital for an evaluation of acute meningitis was inappropriate. The patient did not exhibit signs of serious acute illness and

was inappropriately worked up with a CAT scan. (T. 247-248).

70. The standard of care for a child that presents with a concern for acute meningitis is to very quickly evaluate the patient with blood cultures and an immediate lumbar puncture. Antibiotics should be administered while awaiting these test results. (T. 261-262).

71. Respondent's records for Patient F were inadequate to support a working diagnosis of meningitis. (T. 264-265).

Patient G

72. Patient G, an 8-month old child, was brought to the ED at 8:30 p.m .on 3/27/07 with a history of vomiting and diarrhea for approximately 24 hours, with mucous in the stool and poor oral intake. She had no prior medical history. Vital signs were normal, with a temperature of 98.7, respirations of 22, pulse of 157 and oxygen saturation of 100%. (Pet. Ex. 8a, pg. 5).

73. Respondent evaluated the baby, again noting a history of vomiting with 4 episodes of vomiting in the ED, diarrhea, as well as a report of low-grade fever. His physical examination was normal. He ordered a chest x-ray, a CBC and a metabolic panel. Respondent also ordered Phenergan 12.5 mg as a rectal suppository, which was documented as given at 12:50 a.m. (Pet. Ex. 8a, pg. 1).

74. Fluid orders were also written by Respondent, with 160 ml specified as a saline bolus, followed by 5% dextrose with ¼ normal saline at 32 ml/hour. It was not written on the order sheet how this crystalloid fluid was to be given, by IV or otherwise. However, on his dictated report, Respondent specified that the intra-rectal route had been used to deliver this fluid. There is no notation in the record by a nurse that these orders for fluid were carried out. (Pet. Ex. 8a, pg. 1).

75. The chest x-ray was without infiltrates and the CBC was normal. The chemistry panel was hemolyzed, but was notable for a CO2 of 13, and an anion gap of 22. Although the BUN and creatinine were reported in the normal range, the BUN of 15 was high in relation to a creatinine of 0.3. Nursing follow-up notes indicate that Patient G's vital signs remained normal when checked 3 subsequent times. Other nursing notes indicate that there was no vomiting after pedialyte, and that the child was discharged alert, with age appropriate behavior and in good condition. (Pet. Ex. 8)

76. In 2004, an FDA black box warning was issued regarding the possibility of dangerous respiratory depression with Phenergan in children under the age of two. Despite this contraindication, Respondent ordered rectal Phenergan. This medication was contraindicated for this 8 month-old patient at the time that she was treated in 2007. Respondent did not order monitoring of the patient with pulse oximetry. Tigan, a safer alternative, was available in the ED on that date according to the hospital's Pyxis records. The Respondent also ordered a dose that was 50% too large. (Pet. Ex. 8b.); (T. 272-274).

77. Upon discharge, Respondent again prescribed Phenergan suppository 12.5 milligrams rectally every 12 hours as needed for nausea and vomiting. Subsequently the pharmacy called the ER regarding the black box warning not to administer this medication to an 8 month old child. (T. 278-281).

78. The standard of care for an infant with fluid losses from gastrointestinal illness is to assess for dehydration and to assure adequate volume replacement based on the patient's clinical status. This patient's serial vital signs, physical examination, and clinical status were most consistent with mild dehydration. There are notations that the patient took small amounts of Pedialyte orally. Respondent acknowledged that no blood tests were performed to

indicate that Patient G had been re-hydrated prior to discharge. (T. 269-271, 751).

79. Respondent's medical record does not meet the standard of care because it contains discrepancies that are unexplained and confusing. (T. 281).

Patient H

80. Patient H, an 88 year-old woman with moderate dementia and multiple medical problems, suffered a fall in her nursing home. She was transported by ambulance to the Lourdes Hospital ED on 12/26/06 for evaluation after the fall. She was noted to have an O2 saturation of 88% in triage. Respondent noted her complaint of right hip and rib pain. He performed a general physical examination and documented an irregular heartbeat with a murmur. On extremity examination he found good range of motion and no tenderness of the pelvis or hip joint. (Pet. Ex. 9a, pg. 2, 4).

81. Respondent ordered blood work, an EKG, and radiographs. The radiographs that Respondent specified on the order sheet were the left foot, pelvis, chest and right ribs. The radiographs that were done were different than the orders. The chest and right ribs studies were performed, as was a right hip series with 3 views. (Pet. Ex. 9a, pg. 2).

82. Respondent's record stated that "the left foot, pelvic bone, right rib series and chest" showed "no fracture, dislocation, or acute infiltration." (Pet. Ex. 9a, pg. 4). The Patient was discharged back to the nursing home on 12/26/06 at 9:10 p.m. The radiologist dictated his report of the right hip films at 9:29 p.m. that same day, noting an impacted right femoral neck fracture. (Pet. Ex. 9a).

83. It remains unclear when or how the discrepancy in the reading of the right hip films was discovered, but Patient H returned to the hospital ED the following day, approximately 21 hours later, for treatment of the right hip fracture. She was admitted to the hospital,

underwent right hip surgery, and was discharged back to the nursing home on 1/4/07. (T. 316).

84. An elderly patient who suffers a fall must be evaluated not only for possible trauma, but also for possible medical problems that may have contributed to the fall. Respondent did not mention possible medical problems that may have contributed to Patient H's fall. (T. 301-302).

85. Respondent never addressed the patient's low oxygen saturation or the abnormal EKG. Given the low oxygen saturation and the abnormal cardiac examination, Respondent should have considered the patient's pulmonary status and addressed whether or not there was a component of heart failure. (T. 302).

86. There was a discrepancy between the orders that Respondent wrote and the actual films that were performed. Respondent ordered a pelvic x-ray, but no x-ray of the patient's right hip. The x-ray technologist however performed a full right hip series. A pelvic x-ray only provides a single view of the hip in one plane and does not provide multiple views. It is a less sensitive test to look for a hip injury. (T. 300, 304).

87. The 3 views of the hip x-ray indicate a change of alignment. One can clearly see that the angle between the femoral neck and the femoral head is abnormal. (Pet. Ex. 9b); (T. 305-306).

88. Respondent discharged Patient H between 9:00 pm and 10:00 pm. Shortly, within minutes after the patient was discharged, the radiologist did an official final reading of the film and diagnosed an impacted femoral neck fracture. (Pet. Ex. 9b); (T. 307).

89. Any ED, where non-radiologists read x-rays, must have a system in place to identify discrepancies between the ED physician and the radiologist so that appropriate follow-up can

be arranged. (T. 315).

90. Despite the radiologist's reading that occurred within minutes of Patient H's discharge, it's highly likely that the radiologist was unaware of Respondent's negative reading of the film because the patient did not return to the ED for almost 21 or 22 hours later. (T. 316).

91. Respondent's reference in his report that he reviewed left foot and pelvic bone x-rays is inaccurate because there is no evidence that these tests were performed. (Pet. Ex. 9a, p.4); (T. 318).

92. Respondent's medical record for Patient H did not meet generally accepted standards of medical record keeping. (T. 319).

CONCLUSIONS OF LAW

Respondent is charged with three (3) specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

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

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

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that all three (3) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Mark S. Silberman, M.D., testified for the Department. Dr. Silberman is board certified in internal, pulmonary, critical care and emergency medicine. He is currently on the faculty at Columbia University Medical Center where he practices emergency medicine and teaches internal and pulmonary medicine. Dr. Silberman is a part-time director of emergency medicine at the Community Hospital in Dobbs Ferry. (Pet. Ex. 11); (T. 20-21). The Hearing Committee found Dr. Silberman to be an impressive and thorough witness. Although he was sometimes academic and rigid, they found his testimony to be very credible. The Department also offered the testimony of the mother of Patient C. The Hearing Committee found her testimony to be fairly measured and credible. They believe her statement that Respondent did not undress Patient C during his examination.

Respondent testified on his own behalf. The Hearing Committee found Respondent's testimony to be consistent with inconsistencies that he failed or refused to acknowledge. The Hearing Committee believes that Respondent lied to the Hearing Committee in several instances. The Hearing Committee does not believe that Respondent examined Patient C three different times and that the patient was undressed. The Hearing Committee also believes that Respondent lied about his review of the x-rays for Patient H. The Hearing

Committee found Respondent's overall testimony as not credible.

PATIENT A

Factual Allegations A, A.1, A.2, A.3, A.4, A.5 and A.6 : SUSTAINED

The Hearing Committee concurs with the opinion of Dr. Silberman and finds that Respondent's failure to properly diagnose and treat Patient A constitutes a serious deviation from the standard of care. None of the interventions that could have prevented Patient A's cardiac arrest were undertaken. The Hearing Committee rejects Respondent's explanation that he did not administer Narcan because of its side effects. (T. 384-385). The Hearing Committee concludes that there was no downside to using Narcan in this instance. Patient A's death was fully preventable had Respondent acted within the standard of care.

PATIENT B

Factual allegations B and B.1, B.2 B.4 B. 6 and B.7 : SUSTAINED

B. 3: Withdrawn by Department

B. 5: NOT SUSTAINED

The Hearing Committee rejects Respondent's explanation that he did not perform a pelvic exam because he did not want to cause unnecessary discomfort to Patient B. (T. 518). The Hearing Committee concurs with Dr. Silberman that at the time of Respondent's initial examination, it was urgent to establish the diagnosis of ectopic pregnancy and to treat the patient before further hemorrhage occurred. (T. 116). Respondent misplaced his focus on a GI problem, when the patient had obvious symptoms of an ectopic pregnancy. Respondent placed Patient B at grave risk during the many hours that she was under his care.

The Hearing Committee does not sustain Charge B.5 because Respondent cancelled the

abdominal x-rays after he received positive pregnancy results.

PATIENT C

Factual allegations C and C.1, C.2, C.3, C.4 and C.5: SUSTAINED

The Hearing Committee concurs with Dr. Silberman that if Respondent had performed an adequate physical examination, the seriousness of the injury would have been indicated. This is evident from the initial finding of tenderness by the triage nurse coupled with the subsequent findings at Wilson Hospital that Patient C's abdomen was full of blood with a spleen that was not a subcapsular hematoma but severely fractured. (T. 176). The Hearing Committee further believes the testimony of Patient C's mother that Respondent did not perform a head to toe examination despite his notations. The Hearing Committee concludes that Respondent never entertained a diagnosis of a fractured spleen and is responsible for delaying appropriate treatment to Patient C.

PATIENT D

Factual allegations D and D.1, D.2, D.3, D.4, D.5 and D.6: SUSTAINED

The Hearing Committee concurs with Dr. Silberman that Patient D presented with a classic case for early appendicitis. (T. 188). The patient's unexplained pain required at CT scan and surgical consult. The Hearing Committee finds that Respondent's testimony regarding the assessment of the patient demonstrates that his understanding of the disease process is deficient. (T. 550-560).

PATIENT E

Factual allegations E and E.1, E.2, E.3, E.4, E.5, E.7, E.8, E.9: SUSTAINED

E.6: NOT SUSTAINED

The Hearing Committee again concurs with the Department's expert. The Hearing

Committee notes that Respondent's "hands on examination" of the patient was inadequate and he seemed to let Patient E make his own diagnosis of kidney pain even when there was no evidence that the patient had trouble voiding. (T. 617, 622 - 625). The Hearing Committee also does not believe that Respondent advised the patient on seeking treatment for alcoholism and observes that it is not documented in the record. Charge E. 6 is not sustained because Dr. Silberman indicated that hospitalization would have been a judgment call. (T. 223).

PATIENT F

Factual allegations F and F.1, F.2, F.3, F.5, F.6 and F.7: SUSTAINED

F.4: NOT SUSTAINED

Charge F.4 is not sustained. The actual diagnosis was tonsilitis which can be bacterial or viral and the Hearing Committee finds it to be not relevant. The remaining allegations are sustained. The Hearing Committee is concerned that even if Respondent's working diagnosis of meningitis had been correct, Respondent wasted life saving time in ordering a CAT scan. Respondent initially saw this patient at 7:40 a.m and did not order the administration of antibiotics until 11:00 a.m. (T. 264).

PATIENT G

Factual allegation G.1 : Withdrawn by Department

Factual allegations G, G.2, G.3, G.4,G.5 and G. 7: SUSTAINED

Factual allegation G. 6 : NOT SUSTAINED

The Hearing Committee is deeply troubled by Respondent's answers concerning his administration of Phenergan. Respondent testified that the nurse told him that Tigan was not available when the hospital's Pyxis system clearly indicated that it was. (Pet. Ex. 8b);

(T.699). Respondent stated that he was aware of the Black Box warning for Phenergan but the Hearing Committee does not believe him. When Respondent gave the Phenergan, the dose was 50 per cent more than the appropriate dose. (T.273). The Hearing Committee is also disturbed about Respondent's explanation that having the nurse or the infant's mother keep an "eye on the patient" was sufficient to monitor for respiratory depression. (T. 704, 753-755). The Hearing Committee believes it was very fortunate that the error was caught by the pharmacy and that Patient G did not receive any further doses of Phenergan.

The Hearing Committee does not sustain Charge G.6 because once the fluids are ordered, the physician is not responsible for their administration.

PATIENT H

Factual allegations H and H.1, H.2, H.3, H.4, H.5 and H.7: SUSTAINED

Factual allegation H. 6: NOT SUSTAINED

The Hearing Committee has serious concerns about Respondent's credibility in this case. Respondent's record documents results from left foot and pelvic films when there is no evidence that these tests were ever performed. He testified that he saw the pelvic x-ray but the Hearing Committee does not believe him. The Hearing Committee further believes that the hip x-ray was available for Respondent's review but he never bothered to read it. The Hearing Committee concludes that it was a serious violation of the standard of care to discharge Patient H before all x-rays were reviewed.

Charge H.6 is not sustained because there is no evidence in the record to support it.

NEGLIGENCE ON MORE THAN ONE OCCASION

The Hearing Committee sustains all charges of negligence against Respondent and thus sustains the First Specification.

INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee sustains all charges of incompetence against Respondent and thus sustains the Second Specification.

FAILURE TO MAINTAIN RECORDS

The Hearing Committee finds that Respondent's records in all instances were inadequate and they sustain the Third Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be revoked. This determination was reached on due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for revocation of Respondent's license because Respondent failed to ensure patient safety in eight cases which represent a very clear cut presentation of the most common emergency room situations. Respondent's physical examinations and thought processes were sorely inadequate. Respondent consistently exhibited shotty diagnoses and practices, along with poor record keeping. Respondent also demonstrated a serious lack of engagement with his patients.

Most troubling to the Committee is that Respondent lied, expressed no remorse and blamed others for his mistakes. This is a personality trait which cannot be corrected by retraining. Even if allowed to practice in a supervised setting, the Hearing Committee is

concerned that Respondent could falsify records or state that he performed examinations when he did not. The Hearing Committee believes that Respondent creates a threat to patient safety and he cannot be allowed to return to practice medicine in this State. The Hearing Committee believes and concludes that revocation is the appropriate penalty and is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The First through Third Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. Respondent's license to practice medicine in New York State is **REVOKED;** and

3. This Order shall be effective on service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: **New York, New York**
September 2, **2009**

Redacted Signature

DIANE M. SIXSMITH, M.D. (Chairperson)
GREGORY FRIED, M.D.
CONSTANCE DIAMOND, D.A.

TO:

Ram Swaroop Makker, M.D.
52 Snapdragon Lane
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NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street- 4th Floor
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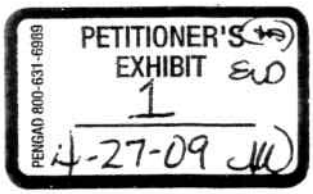
APPENDIX I



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

IN THE MATTER

OF

RAM SWAROOP MAKKER, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: RAM SWAROOP MAKKER, M.D.
Redacted Address

The undersigned, Wendy E. Saunders, Executive Deputy Commissioner, for Richard F. Daines, M.D., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by RAM SWAROOP MAKKER, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

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

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on April 30, 2009, at 10:00 a.m., at the offices of the New York State Health Department, 90 Church Street, 4th Floor, New York, NY 10007, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of

Charges with the below-named attorney for the Department of Health.

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

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

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

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

DATED: Albany, New York

April 24 ,2009

Redacted Signature

Wendy E. Saunders
Executive Deputy Commissioner
for:
Richard F. Daines, M.D.
Commissioner of Health
New York State Health Department

Inquiries should be directed to:

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

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

IN THE MATTER

OF

RAM SWAROOP MAKKER, M.D.

STATEMENT

OF

CHARGES

RAM SWAROOP MAKKER, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 2, 1993, by the issuance of license number 193129 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patient A's name is contained in the attached Appendix) on November 3, 2006, at Mary Immaculate Hospital, 152-11 89th Avenue, Jamaica, New York. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient A arrived at the Emergency Room via ambulance with the chief complaints of lethargy, respiratory distress and hypotension. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent failed to diagnose and treat a state of altered mental status, respiratory failure and shock.
3. Despite knowing that Patient A was on methadone, Respondent failed to consider and treat a diagnosis of methadone overdose.
4. Respondent inappropriately attributed Patient A's critical presentation to simple gastroenteritis.

5. Respondent failed to intubate and appropriately ventilate the patient.

6. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

B. Respondent treated Patient B in March, 2002, at Mary Immaculate Hospital, 152-11 89th Avenue, Jamaica, New York. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient B arrived at the Emergency Room via ambulance. She complained of abdominal pain, weakness and amenorrhea. Respondent failed to take and perform an adequate history and physical examination.

2. Respondent failed to diagnose and treat an ectopic pregnancy.

withdrawn by Department 4/30/09

~~3. Respondent failed to diagnose and treat a state of hemorrhagic shock.~~

4. Respondent made an incorrect working diagnosis of gastroenteritis.

5. Respondent inappropriately ordered two abdominal x-rays of Patient B, who was pregnant.

6. Respondent failed to timely obtain a gynecology consultation.

7. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and consultations.

C. Respondent treated Patient C on May 13, 2007, at Our Lady of Lourdes Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Patient C, accompanied by his parents, presented to the Emergency Room complaining of left abdominal pain following a sport injury. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent failed to order an abdominal CT scan to rule out splenic injury.
3. Respondent inappropriately ordered Toradol, a potent analgesic.
4. Respondent inappropriately discharged the patient with a diagnosis of "Abdominal pain s/p hit with his own elbow".
5. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

D. Respondent treated Patient D on September 8, 2005, at St. John's Hospital, Queens, New York. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent failed to order a CT scan of abdomen and pelvis.
3. Respondent failed to consider and make a diagnosis of acute appendicitis.
4. Respondent failed to obtain a surgical consultation.

5. Respondent inappropriately discharged the patient with a diagnosis of gastroenteritis.

6. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

E. Respondent treated Patient E on January 23, 2007, at Our Lady of Lourdes Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent ignored and failed to act upon important abnormal lab values.
3. Respondent failed to consider and make a diagnosis of acute liver disease.
4. Results of laboratory tests and a low grade fever suggested the presence if an infection. Respondent failed to address these findings.
5. Respondent made an incorrect diagnosis of bilateral flank pain.
6. Respondent failed to consider hospitalization of the patient for evaluation and treatment of acute alcoholic hepatitis and possible infection.
7. Respondent inappropriately referred Patient E to a urologist in the absence of any urological pathology.
8. Respondent failed to include in his discharge instructions to Patient E a warning against alcohol consumption.
9. Respondent failed to maintain a medical record for the patient which

accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

F. Respondent treated Patient F on December 5, 2006, at Mary Immaculate Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent inappropriately ordered a head CT scan.
3. Respondent made an inappropriate working diagnosis of meningitis which diagnosis he also failed to appropriately evaluate and treat.
4. Respondent failed to make a diagnosis of viral syndrome.
5. Respondent failed to order appropriate fluids to treat the patient's dehydration.
6. Respondent inappropriately ordered the transfer of Patient F to a tertiary pediatric referral hospital, Schneider Children's Hospital, for the performance of a lumbar puncture.
7. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

G. Respondent treated Patient G on March 27-28, 2007, at Our Lady of Lourdes Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and perform an adequate history and

physical examination.

2. Respondent ordered the administration of Phenergan which is contraindicated in children under the age of two.
3. Respondent failed to appropriately monitor the patient for respiratory depression, a known complication of Phenergan.
4. Respondent inappropriately discharged Patient G without confirming that she was adequately hydrated.
5. Upon discharge, Respondent improperly gave Patient G's mother a prescription for Phenergan.
6. Respondent prepared an emergency department report which contained inaccurate information concerning whether or not Patient G had received IV fluids while in the hospital.
7. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

H. Respondent treated Patient H on December 26, 20016 at Our Lady of Lourdes Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and perform an adequate history and physical examination.
2. Respondent failed to order an x-ray of the patient's right hip.
3. Respondent failed to correctly interpret x-rays of the patient's right hip, which x-rays a technician had independently performed. Respondent read them as negative, they actually showed a fracture.
4. Respondent failed to consult with a radiologist who was available at

the hospital, prior to discharging the patient.

5. EKG, pulse oximetry and other laboratory studies showed gross abnormalities, which Respondent failed to address.

6. Respondent failed to record his interpretation of the hip x-ray in the hospital's computerized radiology system. This failure prevented the radiology department from identifying a discrepancy and notifying the patient to return to the hospital once the radiology department had correctly read the x-rays.

7. Respondent failed to maintain a medical record for the patient which accurately reflects the evaluations he provided, including proper patient history, physical examination, diagnoses, rationales for testing, test follow-up and discharge notes.

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. Paragraph A and its subparagraphs, B and its subparagraphs, C and its subparagraphs, D and its subparagraphs, E and its subparagraphs, F and its subparagraphs, G and its subparagraphs, and/or H and its subparagraphs.

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. Paragraph A and its subparagraphs, B and its subparagraphs, C and its subparagraphs, D and its subparagraphs, E and its subparagraphs, F and its subparagraphs, G and its subparagraphs, and/or H 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 A6, B and B7, C and C5, D and D6, E and E9, F and F7, G and G7, and/or H and H7.

DATE: April 3, 2009
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct