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

Public

September 28, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jon Emerton, M.D.
262 Clinton Street
Watertown, New York 13601

Daniel J. Hurteau, Esq.
Nixon Peabody
677 Broadway, #10
Albany, New York 12207

Kevin C. Roe, Esq.
NYS Department of Health
ESP-Corning Tower – Room 2509
Albany, New York 12237

RE: In the Matter of Jon Emerton, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-177) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

JON EMERTON, M.D.

DETERMINATION

AND

ORDER

BPMC #10-177

COPY

A Notice of Hearing and Statement of Charges dated November 17, 2009, were served upon the Respondent, **JON EMERTON**, M.D. **MICHAEL GONZALEZ, RPA-C (Chair), ANDREW MERRITT, M.D.** and **RICHARD KASULKE, M.D.** 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 W. KIMMER, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer for the Hearing Committee.

The Department of Health appeared by **KEVIN C. ROE, ESQ.**, Associate Counsel. The Respondent appeared by **NIXON PEABODY, DANIEL J. HURTEAU, ESQ.**, of Counsel.

Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing & Statement of Charges:	November 17, 2009
Amended Statement of Charges:	January 11, 2010
Dates of Hearing:	January 21, 2009 April 21, 2010
Date of Deliberations:	June 30, 2010

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated five (5) categories of professional misconduct. The specifications included practicing with gross negligence, practicing with negligence on more than one occasion, practicing with gross incompetence, practicing with incompetence on more than one occasion and failure to maintain records which accurately reflect the patient's treatment. The charges arise from the Respondent's treatment of one patient at Samaritan Hospital Center (hereinafter Samaritan), Watertown, N.Y. A copy of the Amended Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in 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. **JON EMERTON, M.D.,** (hereinafter "Respondent"), was authorized to practice medicine in New York State on or about January 10, 2003 by the issuance of license number 227318 by the New York State Education Department. (Ex.1)
2. Respondent treated Patient A, a 52 year old male, at Samaritan from December 6 through 20, 2005. Patient A presented at the Samaritan Emergency Department on December 6, 2005, having been sent there by his rheumatologist, with a fever, chills, back and shoulder pain weakness and malaise. He had a history of rheumatoid arthritis and was on Remicade. About a week prior, he was lifting a tire and felt that he strained his back, and began to get mid thoracic back pain in the scapular area and some in the lower cervical area. This was fairly severe and he received trigger point injections for the pain. He continued to feel back pain and developed fevers and night sweats over the next several days. He went to his rheumatologist on December 6, 2005 for concern about a shoulder pain on the left and some tingling all over his body. His rheumatologist sent him to the emergency room due to some labs previously drawn. He had no cough or sputum production, fevers to 100.7 and some night sweats. No dysuria or abdominal pain. No hematuria, diarrhea, nausea or vomiting. His mid-back pain has been persistent since that episode. Patient A was seen by the emergency room physician at 4:11 p.m. Chief complaint was documented as fever for five days, increased liver function test, left

shoulder and neck pain, numbness all over. It was noted that the patient had strained his left shoulder and neck seven days ago and felt ill since. White blood count was 15.8 ALT 167 (high). AST –46(high), ALP-246(HIGH). Under range of symptoms the emergency physician documented fever for five days, chills, sore throat, decreased appetite, numbness for abdominal pain, no cough, left shoulder pain and knee pain. A history of thrush was noted. History of rheumatoid arthritis and treatment with Methotrexate and Remicade were noted. On physical examination, the emergency room physician documented right knee swollen but not hot and left shoulder tender. A chest x-ray and blood cultures were ordered. (Exhibit 2)

3. On December 6, 2005, the Respondent was the physician on call for Patient A's primary care provider. At or around the time Patient A arrived at the Emergency Room, the Respondent was admitting another patient from his practice and was already at the Emergency Room. The Emergency Room physician approached the Respondent to advise him that there was another admission from Respondent's practice and the Respondent assumed the treatment of Patient A. (T. 223, Ex. 2)
4. The Emergency Room physician advised the Respondent that Patient A had come from his Rheumatologist's office, that he had a fever, that the source of infection was not known, and that Patient A was on medication that probably had compromised his immune system. From approximately 5:30 p.m. to 6:00 p.m., Respondent evaluated Patient A in the Emergency Room (T. 223-224; Ex. 2).
5. When a physician treats a patient with a history and presentation such as Patient A, an adequate physical examination should include and document a complete neurological examination. The Respondent did not document such an examination. (T.246;Ex. 2)

6. The Respondent admitted Patient A to the hospital and issued admission orders which included: vital signs, every shift; blood cultures x 2; TEQUIN 400 I.V. daily; consult Dr. Turcotte regarding abscess mid back (already called); CT: Thoracic spine-fever, possible abscess, recent "trigger point injection")appears T6); CBC, CMP in a.m. 12/7

7. Patient A's presentation did not warrant admission to the ICU. The diagnostic tests and consult ordered by the Respondent in his admission orders were reasonable and adequate. (T. 208, 313-319; Ex. 2)

8. At 6:00 p.m., the Emergency Room physician documented "Pt too weak to ambulate." (Ex. 2)

9. At midnight, the R.N. on duty, who was caring for Patient A, documented that Patient A's was very concerned about the change in the patient's condition when she entered the room for assessment. Patient A complained of numbness in the lower extremities and stated he was unable to move his legs. Patient A also stated that he was unable to void since 2:00 p.m. that afternoon. A sensation assessment from the toes up was done. Patient A stated he had numbness and tingling sensation from the waist to the mid-sternal area and slight numbness to no sensation below the waist. Patient A was asked to try and move his legs bilaterally. The R.N. observed that Patient A was unable to move his legs. The R.N. contacted Respondent telephonically and notified him of this change in the patient's condition. (Ex. 2, T. 38, 61-64)

10. The Respondent was informed of a significant change in the patient's condition. Respondent should have come to the hospital to reevaluate the patient. (T. 149-151)

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);**

Paragraph A.1: **(2, 3, 4);**

Paragraph A.3: **(8, 9, 10)**

The Committee found that Factual Allegation A.2 was not proven by a preponderance of the evidence.

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

FAILURE TO MAINTAIN ACCURATE RECORDS

Third Specification: **(Paragraph A.1)**

DISCUSSION

Respondent was charged with five 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 the deliberations on these charges, the Committee consulted a memorandum prepared by General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law". Sets forth suggested definitions for, among other conduct, gross negligence, negligence, gross incompetence and incompetence in the practice of medicine.

The following definitions were utilized by the Committee during the 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 as a framework for the deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that only the Third

Specification of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below:

The Petitioner presented Dr. Haswell as its expert witness. Dr. Haswell is a board-certified Family Practice physician.

Although the Committee found him credible, they felt that his testimony and criticism regarding the tests that should have been done, and orders that should have been provided in this case upon admission, was unrealistic and would not have been met in a real life situation.

The Respondent presented as his expert witness, Dr. Carol Burgess. Dr. Burgess is board-certified in internal medicine. The Committee found her credible and concurred with her testimony regarding the tests and treatment that the Respondent ordered, and his decision to admit the patient to regular med-surgical floor as opposed to the ICU, was within the standards of practice.

Notwithstanding the lack of documentation, the Committee concluded that based on the Respondent's testimony regarding his past practice, he did conduct an adequate neurological exam in the course of admission, but failed to record it.

The patient presented with fever, pain in the shoulder area, and general malaise. The Respondent consulted with the Emergency Room doctor and reviewed what medical records he could before seeing this patient. He then performed a full assessment of the patient. The Respondent ordered a series of medical tests, all of which exhibits the appropriate level of care. He asked for a surgical consult to look at an area of concern on the patient's back and he ordered an x-ray and CT scan of the cervical spine. When the results of the consult and the CT scan were negative, he ordered a urinary analysis to rule

out a bladder infection. After properly medicating the patient to reduce the fever and relieve his aches and pains, the Respondent admitted the patient to the hospital to allow for additional testing and further observation.

The Committee concurred with the Respondent's witness that the Respondent provided adequate orders upon admission.

The Committee found that the testimony of the Petitioner's expert reflected an unrealistic standard of care and was not the applicable standard a physician given these facts would be held to.

With respect to the charge of adequately responding to the notification of the change in the patient's condition, the Committee found that the Respondent was informed of a neurological change. Based on the evidence, it is not clear how specific that notification was. The nurse in question was fairly new to her practice. She admitted to being less than assured of her role when notifying the Respondent a little after midnight. She also stated she informed her supervisor of the Respondent's response to her call about the change in the patient's condition and the supervisor did not follow-up. Yet given a notification of some sort of change in the patient's neurological condition the Respondent should have followed-up with a hands on evaluation of the patient. However, the Committee found that given the circumstances surrounding the RN's notification of the change in condition, this breach of the standard did not amount to gross negligence.

Additionally, of significance to the Committee was the fact that the Respondent received a letter of reprimand for his failure to respond appropriately on the night of December 6-7, 2005. The Committee found his response to the letter, specifically that he did not contest the letter as confirmation that there was some notification on the night in

question of a change in the patient's condition.

The Committee determined that the factual Allegations A.1 and A.3 as set forth in the Amended Statement of Charges were proven by a preponderance of the evidence. Since the allegation set forth in the charge A.3 was found to be negligence and not gross negligence, the Committee only found the Respondent committed negligence on one occasion. Therefore, the **Fourth Specification (negligence on more than one occasion)** was **not sustained.**

Based on the above, the Committee determined that only the **Third Specification (failure to maintain records which accurately reflect the care provided)** should be sustained.

Additionally, the Committee found mo evidence of incompetence on the part of the Respondent. As testified to by the Respondent's Expert Witness, this was an unusual case and the Respondent's steps taken to treat this patient were adequate and appropriate.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent should be censured and reprimanded. 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 believes this is the appropriate penalty in this case. The Respondent was found to be credible and appears to be a competent physician. There

was no evidence of a pattern of neglectful behavior by the Respondent.

The Committee is entrusted to carry out the duty, to the best of its ability, to ensure that the citizens of the State of New York are not provided unsafe medical care by a physician. The Committee unanimously determined that censure and reprimand of the Respondent would adequately protect the public.

ORDER

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

1. The **Third Specification** of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I, attached hereto, and made a part of this Determination and Order is **SUSTAINED**, and,
2. The Respondent is **CENSURED AND REPRIMANDED.**.
3. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt, or seven days after mailing, whichever is earlier), or by personal service (to be effective upon receipt).

DATED: Elmira, New York
9/25, **2010**

REDACTED

MICHAEL A. GONZÁLEZ, R.P.A.-C, Chair

RICHARD F. KASULKE, M.D.
ANDREW J. MERRITT, M.D.

TO: Jon Emerton, M.D.
262 Clinton Street
Watertown, New York 13601

Daniel J. Hurteau, Esq.
Nixon Peabody
677 Broadway, #10
Albany, New York 12207

Kevin C. Roe, Esq.
Associate Counsel
BPMC
ESP – Corning Tower
Rm. 2509
Albany, NY 12237

APPENDIX I

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

EXHIBIT 1A 11/10 P'd hcp

IN THE MATTER

OF

JON EMERTON, M.D.

AMENDED STATEMENT OF CHARGES

JON EMERTON, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 10, 2003, by the issuance of license number 227318 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A from December 6, 2005, to December 20, 2005, at Samaritan Medical Center, Watertown, NY. Respondent's care and treatment of Patient A failed to meet accepted standards, in that:

1. Respondent failed to perform and/or document an adequate physical examination at admission.
2. Respondent failed provide adequate orders at admission.
3. Respondent failed to adequately respond when notified of the patient's deteriorating condition at or about midnight on December 6, 2005.

SPECIFICATIONS

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4) in that, Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, and/or A.3.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(6) in that, Petitioner charges:

2. The facts in Paragraphs A and A.1, A.2, and/or A.3.

THIRD SPECIFICATION

RECORDKEEPING

Respondent is charged with failing to maintain records which accurately reflect evaluation and treatment in violation of New York Education Law §6530(32) in that, Petitioner charges:

3. The facts in Paragraphs A and A.1.

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with gross negligence in violation of New York Education Law §6530(3) in that, Petitioner charges:

4. The facts in Paragraphs A and A.1 and A.2 and/or A.3.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with gross negligence in violation of New York Education Law §6530(5) in that, Petitioner charges:

5. The facts in Paragraphs A and A.1 and A.2 and/or A.3.

DATED: June 11, 2010
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct