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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

March 2, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kimberly Godfrey, D.O.
Redacted Address

Philomena Basuk, Esq.
O'Connor, McGuinness, Conte
Doyle & Oleson, Esqs.
One Barker Avenue
White Plains, New York 10601

Dianne Abeloff, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Kimberly Godfrey, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-30) 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:nm

Enclosure

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

IN THE MATTER

OF

KIMBERLY GODFREY, D.O.

DETERMINATION

AND

ORDER

BPMC 09 - 30

Diane M. Sixsmith, M.D. (Chair), Zoraida Navarro, M.D., and Henry Sikorski, Ph.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

Marc P. Zylberberg, Esq., Administrative Law Judge, ("**ALJ**") served as the Administrative Officer. The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. Respondent, Kimberly A. Godfrey, D.O. (f/k/a Kimberly A. Wattoff), appeared personally and was represented by O'Connor, McGuinness, Conte, Doyle, & Oleson, Esqs., Philomena Basuk, Esq. of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	August 28, 2008
Date of Answer to Charges:	August 28, 2008
Hearings Held: - (First Hearing day):	September 8, 2008
October 2, 2008, November 7, 2008, November 13, 2008	

Pre-Hearing Conference Held:	August 28, 2008
Intra-Hearing Conferences Held:	November 7, 2008 November 13, 2008
Location of Hearings:	Offices of New York State Department of Health 90 Church Street, 4rth Floor New York, NY 10007
Witnesses called by the Department of Health:	Robert S. Hoffman, M.D. Patient G's mother[1] Patient H
Witnesses called by the Respondent:	Timothy G. Haydock, M.D. Kimberly A. Godfrey, D.O. John Joseph Sabia, M.D.
Department's Proposed Findings of Fact, Conclusions of Law, and Sanction:	Received December 19, 2008
Respondent's Proposed Findings of Fact, Arguments, and Conclusion:	Received December 30, 2008
Deliberations Held: (last day of Hearing)	Thursday, January 8, 2009

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of New York ["**P.H.L.**"]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" **or** "**Department**") pursuant to §230 of the P.H.L. Kimberly A. Godfrey, D.O. ("**Respondent**") is charged with twenty (20) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York ("**Education Law**").

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[1] The record and this Determination and Order refer to the patients by letter to protect patient privacy. All Patients are identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1).

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine with gross negligence on a particular occasion[2]; (2) practicing the profession of medicine with negligence on more than one occasion[3]; (3) practicing the profession of medicine with gross incompetence[4]; (4) practicing the profession of medicine with incompetence on more than one occasion[5]; (5) failing to maintain a record for each patient (eight patients) which accurately reflects the care and treatment of that patient[6]; and (6) abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care[7].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct and treatment towards eight (8) patients between 2001 and 2007. Respondent admits that she is licensed to practice medicine in the State of New York and is board certified in emergency medicine. Respondent denies all other factual allegations and all specifications of misconduct contained in the Statement of Charges.

Copies of the Statement of Charges and the Answer are attached to this Determination and Order as Appendices # 1 and # 2.

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[2] Education Law §6530(4) - (First through Eighth Specifications in the Statement of Charges [Department's Exhibit # 1]).

[3] Education Law §6530(3) - (Ninth Specification in the Statement of Charges [Department's Exhibit # 1]).

[4] Education Law §6530(6) - (Tenth Specification in the Statement of Charges [Department's Exhibit # 1]).

[5] Education Law §6530(5) - (Eleventh Specification in the Statement of Charges [Department's Exhibit # 1]).

[6] Education Law §6530(32) - (Twelfth through Nineteenth Specifications in the Statement of Charges [Department's Exhibit # 1]).

[7] Education Law §6530(30) - (Twentieth Specification in the Statement of Charges [Department's Exhibit # 1]).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. 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 Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence.

The Hearing Committee unanimously agreed with all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Dr. Godfrey (Respondent) was authorized to practice medicine in New York State on October 16, 1997 by the issuance of license number 208659 by the New York State Education Department - uncontested - (Department's Exhibit # 1); Respondent's Exhibit # A, # D, # G)[8].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on her); (P.H.L. §230[10][d]); [P.H.T-6-7][9].

3. Dr. Godfrey graduated from New York College of Osteopathic Medicine in June 1996. Dr. Godfrey completed a residency in emergency medicine at North Shore University Hospital (Manhasset, NY) from July 1996 to June 1999 (Respondent's Exhibit # G); [T- 520].

4. Dr. Godfrey became board certified in emergency medicine in May 2000 (Respondent's Exhibit # G); [T-521].

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[8] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Godfrey (Respondent's Exhibit #).

[9] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing transcripts or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

Patient A

5. Patient A, a 74 year old female in 2001, presented to the Emergency Department of St. Catherine of Siena Medical Center (Smithtown, New York) on October 30, 2001 at approximately 2:25 AM. Her chief complaint was "my stomach hurts" (Department's Exhibit # 2); [T-248-249, 481-482, 653-654].

6. Dr. Godfrey obtained a history of the patient's present illness which included abdominal pain radiating to groin for the past 12 hours (since 3:30 PM), no obstructive symptoms, no nausea, no vomiting, no constipation. The patient had no diarrhea, no fever, no chills and no urinary symptoms. The patient stated that the pain increased more with movement of her leg (Department's Exhibit # 2); [T-248-249, 481-482, 653-654].

7. Dr. Godfrey also learned that the patient had become the primary care giver that previous week for her husband who had suffered a stroke. Patient A's husband had been home for a week and she was doing a lot of assisted lifting of him because of his decreased mobility (Department's Exhibit # 2); [T-654-655].

8. After obtaining a history, Dr. Godfrey performed a physical examination on Patient A. Dr. Godfrey initially went through the ABCs, ("**Airway, Breathing, Circulation**"). The patient appeared comfortable. Patient A's HEENT ("**Head, Ears, Eyes, Nose, Throat**") examination was normal as were her lungs and her heart rate. The patient's abdomen was tender (right above the inguinal ligament) as indicated in the diagram contained at page 7 of Department's Exhibit # 2. Dr. Godfrey heard good bowel sounds in all quadrants of the patients's abdomen. Dr. Godfrey noted "no lumps" which she testified to mean no lymphadenopathy, no hernias, no masses, no organomegaly (Department's Exhibit # 2); [T-655-657, 483].

9. Dr. Godfrey testified that her differential diagnosis included; (a) infection, i.e., appendicitis or diverticulitis or colitis or mesenteric lymphadenitis; (b) a hernia, but she did not feel any lumps; or (c) possibly a GI bleed [T-656-657].

10. Dr. Godfrey checked the patient's urine and ordered a CBC (Complete Blood Count). Both tests came back normal (Department's Exhibit # 2); [T-657].

11. Dr. Godfrey did not consider ordering imaging studies (a CT scan) for this patient based on her evaluation, the normal laboratory results and her re-assessment of the patient before Patient A left the emergency room [T-658-659, 485].

12. Dr. Godfrey's re-assessment of Patient A revealed a soft, non-tender abdomen (Department's Exhibit # 2); [T-658-659].

13. Dr. Godfrey's discharge diagnosis was acute musculoskeletal pain (Department's Exhibit # 2); [T-661].

14. Patient A re-presented to the emergency department of St. Catherine of Siena Medical Center two days later, on November 1, 2001 at approximately 5:30 AM (Department's Exhibit # 2).

15. Patient A's presenting complaints on November 1, 2001 were significantly different than her complaints on October 30, 2001 (Department's Exhibit # 2); [T-489-491, 662].

Patient B

16. Patient B, a 48 year old male in 2003, was brought to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department by ambulance on August 7, 2003 at approximately 5:45 AM. The chief complaint indicates "Friends called 911 because pt was not acting right. Found very combative" (Department's Exhibit # 3); [T-182-183, 436, 589].

17. Patient B was non-verbal, combative and uncooperative with EMS and the staff at Saint Francis Hospital (Department's Exhibit # 3); (Respondent's Exhibit # F); [T-183, 439, 589].

18. Dr. Godfrey was able to obtain some history from EMS since Patient B was a poor historian. She learned that the patient had had a heart attack and that he had a recent stent. She also learned that Patient B was a smoker, a known heroin user, and possibly a multi-drug abuser (Department's Exhibit # 3); [T-591].

19. The medical record for Patient B as maintained by Dr. Godfrey (between 5:45 AM and 7:00 AM [August 7, 2003] when Dr. Godfrey went off shift) is incomplete in that it provides little information regarding Dr. Godfrey's plan of action, what is going on with the patient, or what future plan of action is contemplated for the patient (Department's Exhibit # 3); [T-200-203].

20. Dr. Godfrey did not perform an adequate physical examination of Patient B. She did not obtain adequate neurological information even given the fact that she sedated him with Ativan. She failed to obtain a rapid bedside glucose and ascertain electrolyte imbalances (Department's Exhibit # 3); [T-191, 197-198, 212, 450-452, 465, 606].

21. Even in a patient that is combative and uncooperative, minimum standard of care requires a physician to perform a thorough physical assessment including a complete set of vital signs and a thorough neurologic assessment. In addition to checking the ABC's and vital signs, Respondent should have obtained a rapid bedside glucose, and ordered a CT scan for Patient B [T-184-185, 188-189, 196-205, 211-212, 439, 450-452, 454-456, 459-460, 465, 467-468, 592].

22. Given Patient B's history of possible heroin use, Narcan, could have been considered; however, Patient B's presentation and behavior was not consistent with heroin overdose; he was breathing, his pupils were not small, and he was agitated (Department's Exhibit # 3); [T-212].

23. Given the patient's history of myocardial infarction, change in mental status, and, agitation, there are a number of possible life-threatening processes that could have been occurring to Patient B, including cerebral vascular accident, trauma, meningitis, electrolyte abnormalities, psychiatric illness or drug overdose [T-193, 450-468, 593-594].

24. Time is of essence for stroke patients in which thrombolytic intervention is appropriate. The thrombolytic agent must be administered within three hours [T-194].

25. Nothing in the medical records of Patient B indicates Dr. Godfrey thought of the possibility of a diagnosis of stroke. Dr. Godfrey did not initiate the stroke protocol, one of the first steps being a CT scan. An hour, which Dr. Godfrey had with the patient, was more than enough time to obtain a CT scan (Department's Exhibit # 3); [T-194-195, 214-215, 454-456, 459-460, 467-468].

26. Dr. Godfrey did not diagnose the cause of Patient B's altered mental status. Dr. Godfrey did not monitor and appropriately treat Patient B's condition. Dr. Godfrey sedated Patient B, incompletely evaluated him and turned him over to the next shift (Department's Exhibit # 3); [T-182-216, 436-468, 588-608].

27. Patient B died on August 8, 2008 at 21:10 hour. Patient B had suffered a large left middle cerebral artery stroke and a right basal ganglia stroke (Department's Exhibit # 3).

Patient C

28. Patient C, a 81 year old female in 2004, presented to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department on March 4, 2004 at approximately 5:00 PM. The chief complaint indicates "abd (abdominal) pain radiates to back. vomiting" (Department's Exhibit # 5); [T-277, 666].

29. Patient C was originally examined by a different physician who ordered a CT scan and blood tests. Dr. Godfrey assumed the care of Patient C on March 4, 2004, at 7:00 PM (Department's Exhibits # 5); [T-277-278, 667].

30. The receiving emergency department physician must know what tests were ordered, performed and their results. The receiving physician needs to review what is going on with the patient when she assumes patient care responsibilities [T-278-280, 298-299].

31. Patient C's blood tests results indicate an infection, hepatic inflammation or back-up of bile. The blood test and CT results require further work-up and admission to the hospital (Department's Exhibits # 5); [T-281-289, 670].

32. Dr. Godfrey discharged Patient C at approximately 21:20 hour with a diagnosis of abdominal pain, probable Gall Bladder. Her instructions were "return to the ER if pain returns, [if there was] persistent vomiting, yellowing of eyes or temperature [greater than] 101". Dr. Godfrey also instructed the patient not to eat any fried or fatty foods. Dr. Godfrey also made a referral to Dr. Asharaf, a gastroenterologist (Department's Exhibits # 5); [T-288].

33. Dr. Godfrey testified that she discharged Patient C without ever seeing laboratory results for this patient and without ordering laboratory tests [T-670, 672].

34. Patient C's condition prior to discharge required hospital admission. Patient C had cholecystitis or potentially cholangitis. Patient C was at risk of severe infection and death (Department's Exhibits # 5); [T-288-289].

35. The medical record for Patient C, as maintained by Dr. Godfrey, provides very little insight into Dr. Godfrey's medical thinking. The entries made by Dr. Godfrey provide no information regarding her review of the prior physician's notes, or the results of the blood tests (Department's Exhibits # 5).

Patient D

36. Patient D, a 62 year old male in 2005, presented to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department by ambulance on May 2, 2004 at approximately 21:40 hour. The chief complaint indicates "L (left) hip pain" (Department's Exhibit # 6); [T-106, 414, 569].

37. Dr. Godfrey determined that there was a dislocation of the hip that needed to be set by the orthopedic surgeon (Dr. Panos). Dr. Godfrey's role during the closed reduction of Patient D's left hip dislocation was to administer conscious sedation or procedural sedation and monitor the patient during the sedation (Department's Exhibit # 6); [T-110-117, 415-419, 570-572].

38. Dr. Godfrey obtained a past medical history from Patient D, evaluated him, obtained an initial x-ray of the patient's hip, and obtained the patient's consent for the sedation and the procedure (Department's Exhibit # 6); [T-110, 419].

39. The medications given to Patient D for sedation (Versed and Fentanyl) by Dr. Godfrey were appropriate and the total doses may have been appropriate (not excessive). The administration of the medications was too rapid or there was insufficient interval between doses (Department's Exhibit # 6); [T-130-131, 136, 420-421, 571].

40. During the closed reduction procedure and the sedation of Patient D, his oxygen saturation dropped to 69 and his respiration rate dropped to 9. When the patient's oxygen saturation dropped to 69 Dr. Godfrey began bagging Patient D to assist the patient to breathe (Department's Exhibit # 6); [T-120-122, 422-423, 572-573].

41. When Patient D stopped breathing, the appropriate and immediate focus was on the patient's breathing. The next step is to understand why Patient D stopped breathing (the rapid administration of Versed and Fentanyl) and to use drug reversal agents to get the patient breathing on his own again (Department's Exhibit # 6); [T-122-124, 573].

42. Dr. Godfrey elected to continue the post reduction x-rays prior to ordering the drug reversal agents (Department's Exhibit # 6); [T-125-128, 131, 424-425, 573-574].

43. Reviewing the Emergency Department medical records of Patient D, it was difficult to ascertain who actually performed the hip reduction procedure. There should have been a note from Dr. Godfrey describing the conscious sedation and the complication that occurred (Department's Exhibit # 6); [T-116, 129-130, 426-427, 574-575].

Patient E

44. Patient E, a 57 year old male in 2006, presented to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department on March 12, 2006 at approximately 1:30 AM. The chief complaint indicates chest pain for approximately the past 24 hours (Department's Exhibit # 7); [T-217, 469, 637].

45. Patient E had a history of diabetes, high blood pressure, pulmonary embolus and a cardiac catheterization a few years earlier. These conditions increased his risk for acute coronary syndrome. Patient E was on numerous medications meant to control his heart disease and he still had pain, making him a higher risk (Department's Exhibit # 7); [T- 217, 244, 469-470, 637-639, 650-651].

46. Myocardial ischemia or infarction is the immediate concern when a patient with Patient E's history and chest pain comes to the emergency department. Patient E presented with classic symptoms of acute coronary syndrome (Department's Exhibit # 7); [T-218-221, 639].

47. "The risk of sending him (Patient E) home is (that) he is going to have a myocardial infarction imminently and that translates into either death if it is bad enough or loss of ability to perform your function of life. ... as you lose myocardium, it becomes difficult to climb the stairs, it becomes difficult to walk to the bus, it becomes difficult not to have shortness of breath, and all the other things that go with it. And your subsequent risk is for lethal arrhythmias, presumably for a lot of the rest of your life." [T-244-245].

48. Dr. Godfrey originally recognized Patient E's symptoms as acute coronary syndrome and started to correctly treat this condition. She gave Patient D aspirin, nitroglycerin and oxygen (Department's Exhibit # 7); [T-220-221, 470-471, 640-641].

49. When the patient showed no response to Dr. Godfrey's treatment for acute coronary syndrome, Dr. Godfrey switched courses entirely, without medical indication, and started to treat Patient E as if he were experiencing gastric reflux (Department's Exhibit # 7); [T-221, 239-241, 471, 643].

50. Dr. Godfrey obtained a current presentation history from Patient E, obtained past medical history, obtained a list of medications that Patient E was taking, performed a physical examination, and reviewed the lab results (Department's Exhibit # 7).

51. Patient E was discharged by Dr. Godfrey on March 12, 2006 at approximately 4:10 AM with a diagnosis of "Atypical Chest Pain - most likely GI related" (Department's Exhibit # 7); [T-233-234, 478].

Patient F

52. Patient F, a 50 year old female in 2006, presented to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department on July 1, 2006 at approximately 23:25 hour. The chief complaint indicates numbness in her right leg (2 weeks) (Department's Exhibit # 9); [T-155, 578].

53. Dr. Godfrey obtained a medical history from Patient F which included high blood pressure, hypothyroidism and a recent diagnosis of sciatica. Dr. Godfrey performed a physical examination of Patient F with findings which included: foot was cool and purple; calf was tender; weakness and sensory loss in the patient's ability to move her leg (Department Exhibit # 9); [T-155-158; 578-582].

54. Dr. Godfrey testified that while doing a physical examination of Patient F she checked pulses but, as Dr. Godfrey admits, there is nothing in the medical record of Patient F that indicates that she did check or what her findings were (Department Exhibit # 9); [T-581].

55. Patient F presented with at least 3 of 5 classic symptoms of acute arterial occlusion, an emergent limb threatening condition. Patient F had pain, pallor, and paresthesia. A fourth classic symptom of pulselessness is not recorded as being present or absent. A fifth classic symptom of paralysis is absent (although the patient had difficulty moving her leg). Dr. Godfrey admits that she "completely missed the diagnosis" (Department Exhibit # 9); [T-160-161, 169-170, 584].

56. Given the patient's presentation and the recorded findings, Dr. Godfrey should have ordered an arterial study such as a Doppler or a CT scan or angiography. Dr. Godfrey ordered a venous duplex study which would tell about the patency of the venous system, which was not the problem with the patient's leg (Department Exhibit # 9); [T-162-163, 167-170, 583].

57. If the correct arterial study had been ordered by Dr. Godfrey and considering the patient's presentation and the recorded findings, Dr. Godfrey should have obtained a consultation with a vascular surgeon (Department Exhibit # 9); [T-164-165, 584].

58. After re-examining the patient and reviewing the venous study, Dr. Godfrey discharged Patient F with a diagnosis of "Neuropathic leg pain, Sciatica." Neither of these conditions would cause a leg to be purple (Department Exhibit # 9); [T-165-166, 584-585].

Patient G

59. Patient G, a 16 year old male in 2006, presented to Saint Francis Hospital (Poughkeepsie, New York) Emergency Department by ambulance on October 6, 2006 at approximately 20:55 hour. The chief complaint indicates a right ankle pain/injury. Patient G was 255 pounds and injured his ankle while playing high school football (Department's Exhibit # 10); [T-34, 47, 392, 394-395, 522-523].

60. Patient G was in tremendous pain. Dr. Godfrey ordered 5 milligrams ("**mg**") of Morphine to be administered intravenously to Patient G by EMS while on route to the hospital (Department Exhibit # 10); [T-35, 523].

61. When a patient presents at an emergency department with an injured ankle, a prudent emergency department physician (after checking the ABC's) needs to determine: whether the ankle and foot are neuro vascularly compromised, whether there is a pulse, whether there is sensation, whether the patient is able to move the foot to assess for underlying fractures, and then move down to determine if there is any underlying ligamentous injury. There is also a need to manage the patient's pain [T-34].

62. "Dislocation is a true limb-threatening emergency. ... There are two big reasons. The first is when the foot is not properly aligned, the vascular and nervous supply could be compromised, so that the ability for that foot to maintain its viability is in jeopardy. And the second reason it is an emergency is the longer it stays out, the greater the risk for arthritis and healing complications, so that leads to a long-term disability." [T-36-37, 559].

63. Dislocation of an ankle is almost always severely painful and Patient G was in considerable pain. Patient G continued to complain of severe pain and for reasons that are unclear Dr. Godfrey decided that she would not perform procedural sedation, but just continued to give pain medication to control the patient's pain (Department Exhibit # 10); [T-37, 412, 561].

64. Dr. Godfrey examined Patient G and sent him to radiology for an x-ray. The x-ray showed a dislocated ankle; Dr. Godfrey eventually relocated the ankle (closed reduction). Patient G's leg was immobilized and a post reduction x-ray was taken which demonstrated that the foot was properly aligned (Department Exhibit # 10); [T-42-44, 396-397, 527-529].

65. Dr. Godfrey first saw patient G at 21:05 and reduced his ankle at 22:35. It is unclear as to why it took Dr. Godfrey one hour and a half to perform this emergent, time critical, procedure of relocating Patient G's ankle (Department Exhibit # 10); [T-560-561, 397, 559].

66. Dr. Godfrey gave Patient G a total of 40 mg of Morphine (between 20:30 and 22:23) and 4 mg of Dilaudid (between 22:28 and 22:35). The 4 mg of Dilaudid would be the approximate equivalent of 20 mg of Morphine. Patient G received the equivalent of approximately 60 mg of Morphine in a two (2) hour period. This combination of Morphine and Dilaudid is a large amount (Department Exhibit # 10); [T-51-52, 57-58, 412-413, 532-534, 548].

67. Morphine causes central nervous system depression and respiratory depression. Dilaudid, artificial Morphine, also causes central nervous system depression and respiratory depression. At 22:15, Phenergan (12 ½ mg) was given to Patient G to help prevent nausea associated with Morphine. Phenergan is sedating. At 22:50, Benadryl (25 mg) was given to Patient G to counter the itchy allergic reaction Patient G experienced to the Morphine. Benadryl is also a sedating agent (Department Exhibit # 10); [T-39-40, 51-52, 57, 59-61, 532-535].

68. The medical records of Patient G, as maintained by Dr. Godfrey, lacks necessary information that would normally be documented by the emergency department physician. There is little or insufficient explanation of the problem, the plan to remedy it, permission to perform the procedure, description of the procedure (or procedure note of the closed reduction), the result of the procedure, plan for the future, and description of how the patient did. At the very least, there should have been two (2) well documented examinations of the patient's foot. The medical records contain one poorly documented examination. The medical records are silent about neuro vascular assessment (pulses, sensation, range of motion). The medical records have no explanation regarding the rationale for changing drugs, or for administering additional drugs, or the reactions to the drugs. There is no indication in the medical records that Dr. Godfrey ascertained Patient G's

ability to function prior his discharge. Dr. Godfrey's observations, if any, of Patient G's level of consciousness immediately before discharge were not noted in the record (Department Exhibit # 10); [T-34-80, 398, 403, 406, 529-531, 542].

69. Dr. Godfrey discharged Patient G from the hospital at approximately 23:45. The last dose of Dilaudid was given to Patient G at 22:35. Benadryl was given to Patient G at 22:50. Discharging Patient G from the hospital less than one hour after the last dose of the large amounts of medications he had been given was inappropriate (Department Exhibit # 10); [T-79-80, 408-409].

70. When Patient G tried to get into the car he indicated that he was nauseous and did not feel well. The nurse informed Dr. Godfrey who then prescribed more medication (30 mg of Toradol, commonly used as a pain medication). Dr. Godfrey did not re-evaluate Patient G prior to discharge and prior to her prescription for Toradol. Patient needed to be assessed and observed by Dr. Godfrey prior to his discharge (Department Exhibit # 10); [T-69-73, 79-80, 348-349, 540-541].

71. Patient G's mother called the hospital at approximately 1:30 AM (October 7) concerned that she was having trouble waking her son, she could not rouse him. Dr. Godfrey was in the hospital next to the nurse who was on the phone with Patient G's mother. Dr. Godfrey knew that the call was from Patient G's mother. Dr. Godfrey did not get on the phone with Patient G's mother (Department Exhibit # 10); [T-81-82, 359-360; 544-547].

72. Patient G was brought back to Saint Francis Hospital by ambulance at approximately 7:00 AM on October 7, 2006. Patient G could not be resuscitated and he died. The medical examiner ruled the cause of death as respiratory failure due to acute opiate, promethazine and diphenhydramine intoxication due to complication of treatment of right ankle dislocation (Department Exhibits # 10 and 11); [T-85-86].

Patient H

73. Patient H, a 76 year old female in 2007, presented to Northern Dutchess Hospital (Rhinebeck, New York) Emergency Department by ambulance on August 23, 2007 at approximately 14:28 hour. The chief complaint indicates leg pain, the patient fell at the Dutchess County Fair and was complaining of right upper leg pain (Department's Exhibit # 12); [T-302, 375-376, 496, 675].

74. Dr. Godfrey examined Patient H and found pain in the upper leg, decreased range of motion, especially with flexion of the hip, no obvious deformity, normal palpation, and normal circulation (Department's Exhibit # 12); [T-303, 376, 498, 506].

75. Dr. Godfrey ordered an x-ray of Patient H's femur. Dr. Godfrey did not order an x-ray of the hip of Patient H. A femur x-ray does not address the patient's complaint and clinical physical exam performed by Dr. Godfrey which indicates that the patient had pain in her upper leg and decreased range of motion, especially with flexion of the hip (Department's Exhibit # 12); [T-304-305, 499].

76. The x-ray taken of Patient H did show a fracture of the hip. The radiologist incorrectly interpreted the film (Department's Exhibits # 12 and # 15); [T-314-319, 500].

77. As Dr. Hoffman testified: [If] "you order an x-ray, you look at an x-ray" [T-315]. "You look at your own films, it doesn't matter whether you are responsible for ordering them, it doesn't matter if you are responsible for reading them. We (emergency physicians) know where it hurts and we know what is wrong with the patient." [T-314]. Dr. Godfrey did not look at or review the x-rays she ordered [T-679].

78. Patient H was a 76 year old woman who fell, had trouble walking, and had considerable pain in her hip and leg. She needed a hip x-ray. Depending on where the pain extended to, an x-ray of the femur would have been acceptable if performed <u>in addition</u> to the hip x-ray [T-304-305].

79. Dr. Godfrey received a negative x-ray reading and discharged Patient H at 16:17. This discharge was inappropriate and premature. The only information that Dr. Godfrey had available when she determined (at 16:02) the patient should be discharged was that the x-ray was negative but the patient was still in considerable pain with decreased range of motion and flexion in her hip and the patient limped. As far as Dr. Godfrey knew the pain had not decreased nor could Patient H walk. Dr. Godfrey never observed the patient get down from the examining table nor did she observe the patient walk. The nurse's comment that the patient is ambulatory with steady gait was made at 16:17, after Dr. Godfrey's determination to discharge Patient H (Department's Exhibit # 12); [T- 305-313, 378-379].

80. Patient H testified [T-378-379]:

> Question from Ms. Abeloff: Were you able to walk out of the hospital?
> Answer from Patient H: No.
> Question from Ms. Abeloff: How did you get out of the hospital?
> Answer from Patient H: Well, they told me that there was nothing wrong and they dismissed me. And they left me on the table. My husband got my clothes on and got me off the table. And I almost fell because I couldn't stand up. I had to grab a hold of something. He had to go through the hospital and try to find a nurse to get a wheelchair. He got a wheelchair. He came back into the room. I was there by myself. And he took me out to the car and got me in the car alone.
> Question from Ms. Abeloff: Did Dr. Godfrey at any point see you walk to the car?
> Answer from Patient H: No. Nobody did.

81. Dr. Godfrey did not obtain an orthopedic consultation. There was insufficient information, and an incorrect diagnosis, to make it necessary to obtain an orthopedic consultation [T-309-315].

82. Dr. Godfrey did not re-evaluate Patient H prior to discharging her. Dr. Godfrey did not observe whether Patient H could bear weight and function or walk before determining if discharge was appropriate (Department's Exhibit # 12); [T-378-380, 681-682, 686-687].

83. Dr. Godfrey claimed that the patient had some pain around her knee. This information is not documented in the medical records of Patient H, as maintained by Dr. Godfrey. Dr. Godfrey discharged Patient H with a diagnosis of "Contusion, Lower Leg". This diagnosis, other than being incorrect, has no foundation or basis as documented in the medical records of Patient H, as maintained by Dr. Godfrey. All prior findings concerned the upper leg. The medical records of Patient H is silent about the patient's pain at the time of discharge (Department's Exhibit # 12); [T-678, 684-685].

CONCLUSIONS OF LAW

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by unanimous vote, concludes that Respondent committed professional misconduct by: practicing the profession of medicine with Gross Negligence (Patients B through H); practicing the profession of medicine with Negligence on more than one occasion (Patients B through H); practicing the profession of medicine with Gross Incompetence (Patients E, F, and H); practicing the profession of medicine with Incompetence on more than one occasion (Patients E, F, and H); and failure to maintain a record for each patient (Patients B, C, D, F, G, and H) which accurately reflected the care and treatment for that patient.

The Specifications of Misconduct alleging Gross Negligence; Negligence on More than One Occasion; Gross Incompetence; Incompetence on More than One Occasion, and Failure to Maintain Records, contained in the Statement of Charges are **SUSTAINED**.

The Hearing Committee, by unanimous vote, concludes that as to Patient A Respondent did not commit professional misconduct (Gross Negligence, or Negligence, or Gross Incompetence, or Incompetence or failing to maintain records are not sustained). As to Patients B, C, D, and G: Respondent did not commit professional misconduct by practicing the profession of medicine with Gross Incompetence, or Incompetence. As to Patient E Respondent did not fail to maintain an adequate record. The Specification of Misconduct alleging Patient Abandonment (Patient G) contained in the Statement of Charges is **NOT SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with twenty (20) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled: Definitions of Professional Misconduct under the New York Education Law[10]. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Hearing Committee's determination is limited to the Charges set forth in the Statement of Charges.

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[10] A copy (ALJ Exhibit # 2) was made available to both parties at the Pre-Hearing conference [P.H.T-4-5]; [T-4-5].

Preponderance of the Evidence

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the Charges by a preponderance of the evidence.

Gross Negligence

3. 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. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his/her conduct.

Gross Incompetence

4. 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. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Negligence on More Than One Occasion

5. Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by Dr. Godfrey caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

Incompetence on More Than One Occasion

6. Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning. These factors may include the Hearing Committee's impression of Dr. Godfrey's technical knowledge and competence on the various issues and the charges under consideration.

The ALJ also instructed the Hearing Committee of the following commonly understood concepts:

Witness Testimony

7. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it

accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

With regard to the testimony presented, the Hearing Committee evaluated all witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, and demeanor.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony.

Credibility

Robert S. Hoffman, M.D. was called by the Department as its expert witness. Dr. Hoffman graduated from New York University School of Medicine in 1984. Among numerous current positions, Dr. Hoffman is a Senior Administrative Attending (since 1/1988) and Attending Physician (since 7/1987) at Bellevue and New York University Hospitals of Emergency Services. Dr. Hoffman is also an Associate Professor of Emergency Medicine and Medicine (Clinical Pharmacology) at New York University School of Medicine (since 7/2003). Dr. Hoffman is board certified in Internal Medicine (9/1987), Medical Toxicology (10/1989), Emergency Medicine (6/1995) and completed his recertification in Emergency Medicine in 2005 (Department Exhibit # 14).

The Hearing Committee found Dr. Hoffman to be a very credible witness. Both on direct and cross examination he answered questions knowledgeably, directly and without evasion. Dr. Hoffman was accurate, unbiased and fair. When Dr. Hoffman believed the care given or the amount of medicine ordered was appropriate he indicated so without hesitation even though his opinion did not necessarily support the Department's position.

Timothy G. Haydock, M.D. was called by the Respondent as her expert witness. Dr. Haydock graduated from Case Western Reserve University, School of Medicine in 1979. Dr. Haydock's current positions include Director of the Department of Emergency Medicine and Family Center at White Plains Hospital Center in White Plains, New York (since 4/2005); Emergency Room Physician at Northern Westchester Hospital in Mt. Kisko, New York (since 1983); and Attending Emergency Department Physician at St. Luke's Medical Center in New Bedford, Massachusetts (since 1996). Dr. Haydock is also an Associate Professor of Clinical Emergency Medicine at New York Medical College (since 9/2002). Dr. Haydock is board certified in Emergency Medicine (1/1985), Re-certified in December 1994, and Re-certified in December 2004 (Respondent's Exhibit # E).

The Hearing Committee found Dr. Haydock to be a credible witness. Both on direct and cross examination he answered questions knowledgeably, and mostly directly. Dr. Haydock was accurate and critical of Respondent's actions when pushed by the Hearing Committee. We found Dr. Haydock to be less willing to be forthcoming when his opinion would not necessarily support the Respondent's position. Although the Hearing Committee placed more weight on Dr. Hoffman's testimony than on Dr. Haydock's testimony, we did not sustain a number of the factual allegations based on the testimony of Dr. Haydock, not just Dr. Hoffman.

Kimberly A. Godfrey, D.O. testified on her own behalf. Dr. Godfrey's training is listed above (Findings of Fact # 3 and # 4). Dr. Godfrey's professional health care experience began in 1986, as a registered professional nurse. In 1992 Dr. Godfrey went back to school and obtained her degree in Osteopathic Medicine. Dr. Godfrey has been practicing as an emergency room physician since 1999. Dr. Godfrey's last employment as a physician was at Northern Dutchess Hospital. In August 2008 Dr. Godfrey voluntarily stopped practicing medicine, dependent on the outcome of the Department of Health investigation and this Hearing.

Respondent has the most at stake in this proceeding. The Hearing Committee found Dr. Godfrey's testimony to be mostly believable with some inconsistencies, some contradictions, and some unexplained lapses presented by the inadequate medical records she maintained. Where the records were silent, the Hearing Committee weighed the testimony versus the record and the likelihood of the claim or assertion made by Respondent. Where the testimony contradicted the information contained in the record, the Hearing Committee tended to believe the records.

The testimony provided by Patient G's mother and by Patient H was found to be credible. The testimony of Dr. Sabia was also found credible and was considered when we discussed penalty.

SUMMARY

PATIENT A

Respondent obtained an adequate history from Patient A and performed an adequate physical examination of Patient A. The likelihood, and justification in the medical records, that Patient A had acute musculoskeletal pain was small. The more common probabilities in this elderly patient was appendicitis or a hernia or an obstruction. However, Patient A's urinalysis, CBC, and physical examination by Respondent were negative. The Hearing Committee cannot conclude, by a preponderance of the evidence, that given the presentation of Patient A and the information available to Respondent on October 30, 2001 at approximately 5:35 AM a diagnosis of appendicitis or a hernia or an obstruction was required.

The Hearing Committee does not sustain the factual allegation that Respondent failed to appropriately evaluate the cause of right sided abdominal pain in Patient A. **Paragraph A.1. is not sustained**.

Considering the clinical picture of Patient A, including negative CBC and urinalysis results, Patient history, Respondent's initial physical examination, and Respondent's re-assessment examination prior to discharge, the Hearing Committee believes it was a judgment decision as to whether imaging studies should have been ordered [485-486].

The Hearing Committee does not sustain the factual allegation that Respondent failed to order necessary imaging studies for Patient A. **Paragraph A.2. is not sustained**.

The testimony of Dr. Godfrey presented additional information regarding her interaction with Patient A and her memory of the events of October 2001. The Hearing Committee recognizes that a medical record needs to be complete, accurate, and thorough; however, we also recognize that not every single discussion or impression can be included in the medical record. The medical record for Patient A, as maintained by Respondent, meets the minimum standards of care.

The Hearing Committee does not sustain the factual allegation that Respondent failed to maintain an adequate record. **Paragraph A.3. is not sustained**.

Given negative physical findings, no positive laboratory results, Respondent's belief of a diagnosis of acute musculoskeletal pain, and instructions to the patient to return if the pain gets worse, Patient A's discharge was not inappropriate.

The Hearing Committee does not sustain the factual allegation that Respondent inappropriately discharged Patient A from the hospital. **Paragraph A.4. is not sustained**.

We conclude that the Department has not shown, by a preponderance of the evidence, that Respondent's care of Patient A deviated from minimum accepted standards of medical care.

PATIENT B

Respondent's defense regarding the care provided to this patient was that she was unable to do much for him because the patient was too combative and uncooperative. This position is contradicted by the medical record in evidence. The nurses were able to obtain vital signs and place the patient on a cardiac monitor. Ativan was administered at 6:05 AM after which the patient was more cooperative. In one entry Respondent indicates that the patient is catatonic, another entry indicates that the patient is depressed while other indications in the medical records discuss the patient's agitation.

The Hearing Committee recognizes that with this type of patient it is difficult to obtain a past medical history. Given the patient's lack of cooperation the Hearing Committee does not sustain the factual allegation that Respondent failed to obtain an adequate history. **Paragraph B.1. is not sustained**.

The medical records of Patient B, as written by Respondent, do not contain sufficient information regarding the physical examination performed by Respondent on Patient B. There is a lack of neurological information which is critical given the patient's presentation.

The Hearing Committee sustains the factual allegation that Respondent failed to obtain an adequate physical examination. **Paragraph B.2. is sustained**.

When Respondent went off service her final impression was altered mental status and signed out to Dr. Neifeld. Respondent did not diagnose the cause of, or monitor, or appropriately treat Patient B's altered mental status. **Paragraph B.3. is sustained**.

Respondent should have ordered or ensured that a rapid bedside glucose test had been done and should have reviewed the results. Respondent should have ordered a CT scan. Both Dr. Hoffman and Dr. Haydock agreed that given the presentation of the patient, you control the patient and you get a CT scan. Although Respondent testified that she thought about the possibility of a stroke and discussed with Dr. Neifeld that a CT scan should be done, there is no documentation in the medical record of Patient B to support Respondent's position. In addition, a CT scan was not done until 9:35 AM, after the patient had a seizure.

The Hearing Committee sustains the factual allegations that Respondent failed to recognize and treat the clinical symptoms of a stroke, and, failed to perform appropriate diagnostic tests. **Paragraphs B.4. and B.6. are sustained**.

Since Respondent did not make the diagnosis of stroke, the Hearing Committee does not sustain the factual allegation that Respondent failed to follow stroke protocols. **Paragraph B.5. is not sustained**.

The medical record of Patient B has inconsistencies and provides little insight into Respondent's thoughts, plans or decisions. Respondent did not write an off-service note other than signed out to Dr. Neifeld. The entries of Respondent are wholly inadequate.

The Hearing Committee sustains the factual allegations that Respondent failed to maintain an adequate record. **Paragraph B.7. is sustained**.

The care provided by Respondent to Patient B was wholly inadequate and egregious. The proper work-up of Patient B was done approximately three (3) hours late. If done timely, the stroke protocols could have been initiated early on.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient B deviated from minimum accepted standards of medical care and constituted gross negligence and negligence but not gross incompetence or incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient B which accurately reflected the care and treatment of the patient.

PATIENT C

Respondent admitted to not seeing the blood test results prior to discharging Patient C. The medical records contain two (2) areas indicating that the blood tests were done. If Respondent was not aware that the blood test had been ordered, she should have ordered them prior to discharging this patient. The results of the blood tests indicate significant abnormal findings.

Respondent failed to correctly diagnose and manage Patient C's disease. It was not a difficult diagnosis to make. Respondent had before her an elderly woman with abdominal pain with a CT scan that hints there is something going on with her biliary tract and with abnormal laboratory results. All of this information indicated that the patient could not be discharged. Patient C needed to be NPO and IV hydrated with large doses of antibiotics in the emergency department. Patient C also needed a surgical consult.

The Hearing Committee does not sustain the factual allegations that Respondent failed to recognize that the patient suffered from an obstruction of the gallbladder because Respondent indicated in her discharge diagnosis that the pain was probably gallbladder. We do believe that Respondent failed to recognize Patient C's biliary problems. **Paragraph C.1. is not sustained**.

Since Respondent failed to check the laboratory results, she failed to recognize the significance of the abnormal results of Patient C's blood test. **Paragraph C.2. is sustained**.

Given the significant abnormal results of the blood test and the CT findings, the Hearing Committee does not find that an ultrasound of the gallbladder was required. **Paragraph C.3. is not sustained**.

The medical records maintained by Respondent were very poor. Respondent failed to maintain an adequate record. **Paragraph C.4. is sustained**.

This patient's diagnosis was not difficult to make [T-289]. Prior to discharge it was incumbent on Respondent to review the laboratory results. At the very least, if you are unsure, you provide the patient with some food and fluids and wait for results. Respondent failed to rule out the most life threatening diagnosis before moving down the ladder of differential diagnoses. By discharging Patient C, Respondent placed the patient at significant life threatening risk.

The Hearing Committee finds that Respondent inappropriately discharged Patient C from the hospital. **Paragraph C.5. is sustained**.

The Hearing Committee notes that Respondent's expert did not testify regarding Patient C and that the Department's expert was not cross-examined. Respondent admitted to her failure to see the lab results, failure to order labs, and failure to evaluate if the patient could eat or drink prior to discharging her.

The care provided by Respondent to Patient C was wholly inadequate and egregious. The failure to review the laboratory results prior to discharge was careless, sloppy, and negligent. Discharging the patient was gross negligence.

The Hearing Committee does not believe that Respondent lacks the medical understanding or knowledge required in this case. We find that Respondent just did not follow through.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient C deviated from minimum accepted standards of medical care and constituted gross negligence and negligence but not gross incompetence or incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient C which accurately reflected the care and treatment of the patient.

PATIENT D

Respondent obtained a past medical history from the patient and provided him medical clearance for the procedure. Although there is no consent form in the patient's medical records, there is a progress note which indicates "... Consents signed, procedure explained ...". **Paragraph D.1. is not sustained**.

Dr. Hoffman testified:

> While the use of drugs was entirely appropriate and the total dose of drugs might have turned out to be appropriate, I think the rapid escalating doses, the short interval between the doses would have allowed a prudent person or retrospectively, certainly to predict that over-sedation would have occurred, regardless when over-sedation and respiratory compromise did occur. Although, the initial response was completely correct, the delay in definitively addressing his respiratory depression, pending the evaluation of this x-ray -- obtaining and waiting of this x-ray is a clear departure from the standard. [T-130-131]. I don't think the doses were either inappropriate or excessive. I am a little critical of the interval between the doses. [T-136].

Dr. Haydock testified "... I believe they were given perhaps a little bit too rapidly, yes." [T-421]. Although the Hearing Committee observed over sedation in other cases presented and there seems to be a willingness by Respondent to provide sedation quickly, the Department's factual allegation is that Respondent administered inappropriate and excessive doses of medication during procedural sedation. **Paragraph D.2. is not sustained**.

Ordering x-rays without reversing the narcotic agents deviated from accepted medical standards. Respondent ordered x-rays to determine if the hip had been placed back in the socket; however, when the patient is not breathing, breathing becomes the priority, not whether the hip is in or out. It was fortuitous for Patient D and Respondent that he recovered without permanent complications. Respondent failed to reverse respiratory arrest prior to obtaining an imaging study. **Paragraph D.3. is sustained**.

Respondent admitted to her failure to document the severe incident of the patient's drop in oxygen saturation and her responses to that incident. Respondent admitted to her failure to do a procedure note regarding the procedural sedation she performed on Patient D. Respondent failed to maintain an adequate record for Patient D. **Paragraph D.4. is sustained**.

The care provided by Respondent to Patient D was inadequate and egregious. The failure to focus on the patient's respiratory arrest prior to obtaining x-ray evaluation lacks common sense and was gross negligence and negligence. The failure to produce an incident note and procedure notes has a potential impact on the patient's future medical care (it is difficult to know what occurred). Respondent's failure to maintain an adequate record constituted additional negligence.

The Hearing Committee does not believe that Respondent lacks the medical understanding or knowledge required in this case. We find that Respondent failed to use even first year medical training common sense.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient D deviated from minimum accepted standards of medical care and constituted gross negligence and negligence but not gross incompetence or incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient D which accurately reflected the care and treatment of the patient.

PATIENT E

Patient E, a 57 year old male with a history of diabetes, high blood pressure, pulmonary embolus and prior cardiac catheterization, presented to the emergency department with classic symptoms of acute coronary syndrome. Respondent began treating Patient E as if he had acute coronary syndrome but when the patient did not respond to her original treatment and for reasons that are unclear, Respondent switched course and started treating the patient as if he were experiencing gastric reflux.

Dr. Hoffman testified:

> The error here isn't in the discharge. The error is in the thought process that lead to the discharge. ...
>
> The man has a very, very high likelihood of having a cardiac event ongoing, based simply on who he is, made higher based on what he is complaining of.
>
> So high that most prudent physicians wouldn't even think twice about admitting him into the hospital with no further evaluation.
>
> 57-year-old -- 57-year-old diabetic with chest pain, that guy is keeping him in the hospital. There is not a lot of thought there.
>
> The error here is when he doesn't respond to the first dose of medication that would typically make this better, then he gets a different medication and the pain happens to go away. The thought is now trapped that this is no longer cardiac. Therefore, it is gastrointestinal. Therefore, it is okay to send him home.

> If this really were a gastrointestinal problem, it was entirely appropriate to send him home on the regimen that was recommended. It is just so unlikely that this was a gastrointestinal problem, there is an error of decision- making. ... [T-238-239].
>
> ... So there is really two failures here. There is a failure of decision-making, then there is a failure of evidence gathering that would have protected against the failed decision-making. [T-241].

Respondent failed to recognize signs and symptoms of acute coronary symptoms in a high risk patient. Respondent made a quick determination that it wasn't heart related and moved on to a less threatening disease without ruling out the more serious life threatening condition. **Paragraph E.1. is sustained**.

Respondent failed to appropriately diagnose and treat unstable angina. As indicated by Dr. Hoffman and to some extent by Dr. Haydock, there was nothing atypical about Patient E's chest pain. This was a classic text book emergency department presentation, first year. It is very fortuitous for Patient E and Respondent that he lived long enough to undergo an emergency heart catheterization (less than 48 hours after Respondent discharged him) (Department's Exhibit # 8). **Paragraph E.2. is sustained**.

Respondent inappropriately discharged Patient E from the hospital. Respondent's discharge of Patient E placed him at considerable risk and deviated from accepted medical standards. **Paragraph E.4. is sustained**.

There was testimony regarding Dr. Godfrey's interview and some inferences that she may have told the patient certain things that are not in the medical records. It is also unclear as to why Respondent went from initially treating Patient E for coronary syndrome to GI problems. The Hearing Committee does not sustain the charge that Respondent failed to maintain an adequate record because there was no clear testimony as to what was missing from the record or why the record maintained was inadequate. **Paragraph E.3. is not sustained**.

The care provided by Respondent to Patient E was inadequate and egregious. The failure to focus on the patient's life threatening condition and quickly proceed to a less acute GI condition is baffling. The care provided to Patient E was egregious. In this case the Hearing Committee does believe that Respondent lacks the medical understanding or knowledge required of an emergency department physician to treat patients who present with life threatening symptoms as Patient E. Respondent testified that she thought the patient was "... at the very least, a moderate risk." After further questioning Respondent seem to acknowledged that the patient was a very high risk, even more so with his current medication regimen.

Respondent acknowledged that her residency in emergency medicine taught her that there is a certain percentage (possibly a significant number) of patients who have chest pains, are admitted to the hospital but turn out not to really have coronary disease and had been admitted anyway. This is considered one of the tenets of emergency medicine and Respondent acknowledged that she did know that when she emerged from her residency program. It is not clear to the Hearing Committee when Respondent unlearned that principle, belief or doctrine. We find that Respondent failed to demonstrate comprehension of first year medical training and understanding.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient E deviated from minimum accepted standards of medical care and constituted gross negligence and negligence and gross incompetence and incompetence.

We conclude that the Department has not shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient E which accurately reflected the care and treatment of the patient.

PATIENT F

Patient F, a 50 year old female with a history of high blood pressure, hypothyroidism and a recent diagnosis of sciatica presented to the emergency department with classic symptoms of acute arterial occlusion. Instead of ordering an arterial study Respondent ordered a venous study. Respondent's reasoning is unclear as the medical record of Patient F does not contain sufficient information from Respondent. Respondent's discharge diagnosis of neuropathic leg pain and sciatica conflicts with her recorded physical examination findings and makes very little sense other than Respondent listened to the patient's diagnosis without making her own independent clinical assessment. Respondent testified that she checked pulses during her physical examination of Patient F, but it is undocumented. Respondent's physical examination of Patient F is clear otherwise. **Paragraph F.1. is not sustained**. **Paragraph F.7. is sustained**.

Respondent admitted to completely missing the diagnosis. Respondent failed to recognize the clinical symptoms of acute arterial occlusion. **Paragraph F.2. is sustained**. Respondent should have considered a vascular situation was occurring and ordered appropriate imaging studies of patient F's leg. **Paragraph F.3. is sustained**. There were sufficient abnormal physical findings of Patient F's leg to request a vascular surgical consultation. **Paragraph F.4. is sustained**.

It was inappropriate and poor management for Respondent to discharge Patient F given the documented physical findings. Patient F should have been seen by a vascular surgeon on an emergent basis. **Paragraph F.5 and Paragraph F.6. are sustained**.

Dr. Hoffman testified:

> Question from Ms. Abeloff: From your review of the record, did respondent's care of this patient meet accepted standards?
>
> Answer from Dr. Hoffman: Absolutely not.
>
> Question from Ms. Abeloff: Why not?

Answer from Dr. Hoffman: This was a complete failure of an understanding of the pathophysiology of a cold extremity.

There is -- there is -- the physical exam is lacking, regardless of the disease process. The documentation is -- if the physical examination was performed, the documentation is equally lacking. And the diagnosis that was pursued was not only unlikely, it was, frankly, probably impossible.

It is just a complete departure for how you would approach this problem. [T-173-174].

...

Essentially, if you want to focus in on the leg and you have a cold leg, you can't go past not saying, I felt the pulses and they are either there, present, diminished, some -- some marker.

And, you know, this is something that I would teach a medical student. Patient comes in with a painful leg or a cold leg, you better tell me what the pulses are before you come out of the room.

It is just such a fundamental departure that probably nothing else in the record matters. [T-175].

Patient F's discharge placed the patient at risk and probably resulted in the patient's above the knee amputation on July 20, 2006. Respondent inappropriately discharged Patient F from the hospital. Respondent's discharge of Patient F was a gross deviation from accepted medical standards. **Paragraph F.8. is sustained**.

The Hearing Committee notes, that similar to Patient C, Respondent's expert did not testify regarding Patient F and that the Department's expert was not cross-examined. Respondent admitted to her failure to document and failure to see the obvious diagnosis. Respondent did not explain how or why these failures occurred.

The care provided by Respondent to Patient F was inadequate and egregious. The failure to focus on the patient's limb threatening condition and quickly proceed to a less likely condition, probably based on the patient's reporting history of a prior recent diagnosis of sciatica (a probably incorrect diagnosis) is again baffling. The care provided to Patient F is even more egregious than the care provided to Patient E. Patient F's outcome was not as fortuitous or favorable as the results encountered by Patient D and Patient E.

In this case the Hearing Committee again believes that Respondent lacks the medical understanding or knowledge required of an emergency department physician to treat patients who present with limb threatening symptoms as Patient F. The testimony of Dr Hoffman quoted above is clear and unequivocal. We find that Respondent failed to use basic first year medical training and understanding.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient F deviated from minimum accepted standards of medical care and constituted gross negligence and negligence and gross incompetence and incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient F which accurately reflected the care and treatment of the patient.

PATIENT G

For reasons that remain unclear, Respondent continued to give Patient G pain medication (analgesia) for an hour and a half prior to reducing his ankle. Respondent did not administer conscious or procedural sedation. Neither Dr. Hoffman nor Dr. Haydock testified regarding the procedures and practices for the administration of conscious sedation versus providing analgesia. The Hearing Committee cannot sustain the first allegation that Respondent failed to follow appropriate procedures and practices for the administration of conscious sedation. **Paragraph G.1. is not sustained**.

Dr. Hoffman acknowledged that Patient G was appropriately monitored while he was in the hospital [T-79]. However, everyone agreed that Patient G should not have been discharged given the large doses of central nervous depressants, respiratory depressants, and other sedating agents he had received. Therefore the Hearing Committee concludes that Respondent failed to appropriately monitor Patient G, who had received a large dose of narcotics. **Paragraph G.2. is sustained**.

Respondent's discharge instructions direct the patient to call Orthopedic Associates to schedule an appointment. Dr. Haydock testified that once the injury is reduced, and assuming there is no neuro vascular problem, and the patient's ankle is immobilized and he is able to reliably go home, and follow-up the following day, that not obtaining an orthopedic consult that night was an acceptable way to manage this patient (with orthopedic follow-up the following day) [T-399]. Dr. Godfrey testified that the x-ray showed a simple, uncomplicated ankle and the reduction was a simple uncomplicated procedure. The post reduction x-rays showed a good reduction. Dr. Hoffman testified that accepted medical standards would require an orthopedist to see a patient with an ankle dislocation prior to discharge [T-46]. The date of the injury was a Friday and the Hearing Committee recognizes that the patient would not have been able to see an orthopedic specialist until Monday and that Respondent should have obtained an orthopedic consult. Nevertheless, we conclude, by a preponderance of the evidence, that not obtaining an orthopedic consultation was not below the minimum accepted medical standard of care. **Paragraph G.3. is not sustained**.

Patient G was in a lot of pain. The Hearing Committee agrees with Dr. Hoffman and Dr. Haydock that it was appropriate to give him medication to treat his pain. By quickly relocating the ankle, a lot of the patient's pain would have been alleviated. Once the ankle was reduced, the stimulus that kept Patient G awake was largely gone. A prudent emergency department physician would understand that drugs linger in the patient's system. It was not safe for the patient to be allowed to leave the hospital until enough time had passed and an examination had confirmed that

the influence of the medications had sufficiently subsided for the safe discharge of the patient. The bare minimum of observation would have been approximately three to four hours after 22:30. Discharging Patient G less than one hour after the last dose of medication was a gross deviation from minimum accepted medical standards and egregious conduct. Respondent inappropriately discharged Patient G from the hospital. **Paragraph G.4. is sustained**.

The medical records of Patient G, as maintained by Respondent, are severely lacking in detail. There is no neuro vascular status. Reasons for administering certain drugs are not existent. A substantial, and medically important amount of testimony by Dr. Godfrey regarding the care and treatment provided to Patient G is not documented. The Hearing Committee concludes that Respondent failed to maintain an adequate record for Patient G. **Paragraph G.5. is sustained**.

Respondent did not converse with Patient G's mother. Not speaking to the patient's mother did not deviate from accepted medical standards [81-82]. **Paragraph G.6. is not sustained**.

Similar to Patient F, Patient G's premature discharge placed the patient at severe risk and resulted in a severe consequence for the patient.

Respondent admitted to some errors and hindsight review, including her failure to document and failure to quickly reduce the patient's ankle. Respondent did not explain how or why these failures occurred. Respondent's testimony in this case is more suspect as it is not supported by or, at times, contradictory to the documentary evidence.

The care provided by Respondent to Patient G was egregious. The failure to quickly perform the reduction of the patient's ankle and then to proceed to quickly discharge him without realizing or understanding the impacts of the large amounts of narcotics the patient received were gross deviations. Respondent's failure to observe and re-assess the viability of the patient's discharge was also a gross error. Rather than learning from her past errors (Patients A through F - 2001 through 2006), Respondent's deviation from minimally accepted standard of care seems to escalate. Patient G's outcome was unacceptable and preventable.

The Hearing Committee does not believe that this case shows that Respondent lacks the medical understanding or knowledge required of an emergency department physician. The care and treatment Respondent provided to Patient G was careless and sloppy. Regardless of how busy Respondent was, she was required to provide proper and minimally acceptable medical care.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient G deviated from minimum accepted standards of medical care and constituted gross negligence and negligence but not gross incompetence or incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient G which accurately reflected the care and treatment of the patient.

We conclude that the Department has not shown, by a preponderance of the evidence, that the Respondent abandoned the patient.

PATIENT H

Again, Dr. Hoffman's testimony was clear and unequivocal, on direct questioning and during cross examination:

> Older women who fall break their hips. ... I don't think you even need to be an emergency physician to know that. You fall on your hip and you have hip pain and you're old and you are a woman, you're presumably osteoporotic. It doesn't matter if you have trouble walking. It is abnormal on physical examination, it needs a film. [T305-306].
>
> But broken bones are broken bones. That is emergency medicine 101. In fact, it is medical student 101. You order an x-ray on somebody because you think they have a broken bone. You look at the x-ray. And if you don't see it and the radiologist don't see it, well, then it is neither not there or you both missed it.

But the reason we have two people taking care of this patient is so that they can protect each other. And when we give up our rights to care for the patient, we give up our ability to protect the patient.

So that, when you order an x-ray, you check it and you say, you know what, if I am incapable of reading it, I give up my rights to the radiologist. But emergency physicians are trained in reading bone films. They are expected to look at them and they are expected to be able to interpret them.

Radiologists miss things all the time. [T-318-319].

Respondent's decision to x-ray the patient's femur rather than the hip is unexplained in the medical records. It is clear that the first rule out diagnosis of Patient H should have been fracture of the hip. First Respondent ordered the wrong x-ray and then Respondent relies on the radiologist to give her information based on her incorrect request. Respondent examined the patient. There is no question that Respondent should have looked at the x-ray herself. Then Respondent can correlate her clinical findings with her review of the films. Respondent's claim that the clinical findings were consistent with the x-ray findings is not confirmed by the patient's medical record, as maintained by Respondent. Respondent failed to order the correct imaging studies. **Paragraph H.1. is sustained**.

Respondent failed to diagnose a hip fracture based on the mechanism of injury and Respondent's physical and clinical findings. **Paragraph H.2. is sustained**.

Even more troubling is Respondent's complete failure to observe the patient ambulate or re-evaluate why Patient H's pain is an 8 on a scale of 1 to 10. Respondent's reliance on the nurses is as misplaced in this patient as it was in Patient G's care. Respondent apparently did not learn from that prior experience of less than one year. Respondent failed to re-evaluate the patient prior to discharging her for ability to ambulate. **Paragraph H.4. is sustained**.

Respondent's failure to re-evaluate the patient, review her clinical condition, and Respondent's failure to observe the patient for ambulation resulted in an inappropriate discharge of Patient H from the hospital. **Paragraph H.6. is sustained**.

On August 24, 2007, the next morning after Patient H's discharge from Northern Dutchess Hospital, Patient H's husband took his wife, by ambulance, to Sharon Hospital because the patient was unable to bear weight on her leg or sit up since her fall. X-rays of the patient's hip/pelvis were ordered. Patient H had a right femoral neck fracture which was repaired by an orthopedic surgeon at Sharon Hospital. The consequences to Patient H could have been much worse.

Information contained in Patient H's medical records is conflicting and inconsistent with Patient H's testimony, Respondent's testimony and some of the clinical findings and diagnosis noted by Respondent. Respondent failed to maintain an adequate record. **Paragraph H.5. is sustained**.

There was insufficient information, and an incorrect diagnosis, to make it necessary to obtain an orthopedic consultation. **Paragraph H.3. is not sustained**.

The medical care that Respondent provided to Patient H seemed sloppy and uncaring. As in other patients we have reviewed, Respondent seems to opt for to the less serious condition rather than rule out the more serious life or limb threatening diagnosis first.

The care provided by Respondent to Patient H was inadequate and egregious. The failure to focus on the patient's limb threatening condition and to quickly proceed to a less likely condition, is again baffling. Respondent's explanation and attempted justification of her reasoning for ordering an x-ray of the femur rather than the hip is not supported by the medical record. Her failure to observe the patient ambulate and her failure to re-assess the patient to understand the pain level and the reasons for that pain shows a total disregard for patient care.

In this case the Hearing Committee again believes that Respondent lacks the medical understanding or knowledge required of an emergency department physician to treat patients who present with limb threatening symptoms as did Patient H. The testimony of Dr Hoffman quoted above is clear and unequivocal. We find that Respondent failed to use basic first year medical training and understanding.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient H deviated from minimum accepted standards of medical care and constituted gross negligence and negligence and gross incompetence and incompetence.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent failed to maintain a record for Patient H which accurately reflected the care and treatment of the patient.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee, by unanimous vote, determines that Respondent's license to practice medicine in New York State should be revoked.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including: (1) Censure and reprimand; (2) Suspension of the license, wholly, wholly with conditions, partially, or partially with conditions; (3) Limitation of the license to a specified area or type of practice; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitation on registration or issuance of any further license; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

In arriving at an appropriate penalty the Hearing Committee discussed the above possible choices to determine the appropriate action necessary to address Respondent's misconduct in this case.

The Hearing Committee considered the following mitigating factors: Respondent is relatively young yet has been providing health care services for a more than 20 years; Respondent appeared remorseful in some of the cases presented although some testimony appeared practiced; Respondent candidly admitted to errors to some of the cases presented; Respondent was not badly trained and is board certified; Dr Sabia (the director of the emergency department at Northern Dutchess Hospital), has know Dr. Godfrey since February 2007, and indicated that he would like to see Dr. Godfrey back in his emergency department; Respondent voluntarily stopped practicing medicine until the matter is resolved; Respondent wants to continue to practice medicine and has submitted a number of suggestions that she would be willing to undertake.

The Hearing Committee considered the following aggravating factors: Respondent has been found guilty of gross negligence on the care she provided to 7 patients; Respondent has been found guilty of gross incompetence on the care she provided to 3 patients; A number of patients have suffered serious outcomes and death as a result of the care provided by Respondent; A number of patients where lucky that their outcome was not more severe after they were inappropriately discharged by Respondent; A number of the medical errors made by Respondent were obvious, almost textbook, presentations that an emergency department physician should not miss; Respondent's deviations were clear and obvious.

The Hearing Committee saw a pattern of behavior from Respondent which emerged as deciding the easiest diagnosis to get the patient out of the emergency department. Respondent failed to follow the basic tenet of emergency medicine "Our primary role is to identify and exclude life and limb-threatening emergencies, to provide immediate care to stabilize those people and move

them towards forward care." [T-32]. This pattern occurred over a period of years subsequent to Respondent obtaining her board certification in emergency medicine.

The Hearing Committee concluded that the care that Respondent provided on a number of occasions were sloppy and sorely lacking. Respondent testified that "... If there is one thing that I have learned from these proceedings is that my documentation is sorely lacking ... " [T-574-575]. Nevertheless, Respondent's submitted a CV (Respondent's Exhibit # D) which is inaccurate, and sorely lacking.

The Hearing Committee was not persuaded that Respondent's knowledge, attitude, accuracy, or abilities will improve. Respondent did not aggressively pursue the more serious conditions, was hesitant to utilize consultants, and failed to contact the patient's private physicians.

Censure and reprimand, monetary penalties, and public service were all deemed to be inappropriate penalties under the circumstances presented. The Hearing Committee concluded that an emergency department monitor or supervisor for Respondent was not practical. As Respondent indicated, she was the sole physician on duty most of her shifts. The Hearing Committee concluded that limiting Respondent's practice to medicine outside of emergency department medicine was insufficient. Given our conclusions regarding Respondent's sloppy and careless actions, harm can occur in any setting.

Respondent obtained good training at New York College of Osteopathic Medicine. Respondent completed a three year residency in emergency department medicine at a good facility. Respondent is board certified in emergency department medicine. The Hearing Committee concluded that retraining was not a realistic option.

The Hearing Committee considered suspending Respondent's license for a specific period of time. Balancing our responsibility to protect the public with our responsibility to be fair to the Respondent and taking all of the mitigating factors versus all of the aggravating factors into consideration, we could not in good conscience allow Dr. Godfrey to continue to practice medicine in the State of New York.

We agree with Respondent that emergency medicine is a team effort. The emergency department physician is the captain of that team. She is responsible for leading the team and she is responsible for the results that occur. There are certain medical decisions that physicians do not delegate to other members of the team. Respondent lacks the ability, knowledge and understanding necessary to lead the team.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The second through eighth specifications of misconduct (Gross Negligence) contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and

2. The ninth specification of misconduct (Negligence On More Than One Occasion) contained in the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED**; and

3. The tenth specification of misconduct (Gross Incompetence) contained in the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED**; and

4. The eleventh specification of misconduct (Incompetence On More Than One Occasion) contained in the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED**; and

5. The thirteenth, fourteenth, fifteenth, seventeenth, eighteenth, and nineteenth specifications of misconduct (Failure To Maintain Records) contained in the Statement of Charges (Department's Exhibit # 1) are **SUSTAINED**; and

6. The first specification of misconduct (Gross Negligence) contained in the Statement of Charges (Department's Exhibit # 1) is **NOT SUSTAINED**; and

7. The twelfth and sixteenth specifications of misconduct (Failure To Maintain Records) contained in the Statement of Charges (Department's Exhibit # 1) are **NOT SUSTAINED**; and

8. The twentieth specification of misconduct (Patient Abandonment) contained in the Statement of Charges (Department's Exhibit # 1) is **NOT SUSTAINED**; and

9. **Respondent's license to practice medicine in the State of New York is hereby REVOKED**; and

10. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

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

Redacted Signature

Diane M. Sixsmith, M.D., (Chairperson)
Zoraida Navarro, M.D.
Henry Sikorski, Ph.D.

Kimberly Godfrey, D.O.
Redacted Address

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Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, NY 10007-2919

APPENDIX 1

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

IN THE MATTER

OF

KIMBERLY GODFREY, .D.O.

STATEMENT

OF

CHARGES

KIMBERLY GODFREY, D.O., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1997, by the issuance of license number 208659 New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about October 30, 2001, Patient A (the identity of the patients appears in the attached Appendix) went to the emergency department of St. Catherine of Siena Medical Center with a chief complaint of stomach pain for 12 hours. Respondent examined Patient A and discharged her from the hospital with a diagnosis of acute muscular skeletal pain. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to appropriately evaluate the cause of right sided abdominal pain in an elderly patient;
2. Failed to order necessary imaging studies;
3. Failed to maintain an adequate record;
4. Inappropriately discharged Patient A from the hospital.

7

B. On or about August 8, 2003, at or about 5:45 a.m., Patient B was brought by ambulance to St. Francis Hospital emergency department. The ambulance was called by Patient B's friends because "he was not acting

9-08-08
MPZ

right." Upon arrival at St. Francis Hospital, Patient B was found to be alert, combative, non-verbal. Patient B had a significant cardiac history. Respondent diagnosed Patient B with altered mental status, ordered a CBC, a biochemical screen, a blood alcohol screen and a drug screen. Respondent signed the patient out to the next emergency department physician on duty who determined that the patient had suffered a massive ischemic stroke within the past 8-10 hours. Respondent's care deviated from accepted medical standards, in that Respondent:

9-08-08
MJZ

1. Failed to obtain an adequate history;
2. Failed to obtain an adequate physical examination;
3. Failed to diagnose the cause of, monitor and appropriately treat Patient B's altered mental status;
4. Failed to recognize and treat the clinical symptoms of a stroke;
5. Failed to follow stroke protocol;
6. Failed to perform appropriate diagnostic tests;
7. Failed to maintain an adequate record.

C. On or about March 4, 2004, at or about 5:00 p.m., Patient C went to the emergency department of St. Francis Hospital with complaints of abdominal pain radiating to the back and associated with vomiting. Respondent assumed the care of Patient C on March 4, 2004, at or about 7:00 p.m. Respondent discharged the patient with a diagnosis of "abdominal pain probable gallbladder." Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to recognize that the patient suffered from an obstruction of the gallbladder;
2. Failed to recognize the significance of the abnormal results of

Patient C's blood test;

3. Failed to order an ultrasound of the gallbladder;
4. Failed to maintain an adequate record;
5. Inappropriately discharged Patient C from the hospital.

D. On or about May 2, 2005, Patient D was brought by ambulance to St. Francis Hospital complaining of left hip pain. A closed reduction of the left hip dislocation was performed in the emergency department by an orthopedic surgeon. Respondent provided the conscious sedation. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to perform and/or obtain appropriate medical clearance prior to giving procedural sedation;
2. Administered inappropriate and excessive doses of opioid and benzodiazepine medication during procedural sedation;
3. Failed to reverse respiratory arrest prior to obtaining an imaging study;
4. Failed to maintain an adequate record.

E. On or about March 12, 2006, Patient E went to the emergency department of St. Francis Hospital with complaints of chest pain for the past 24 hours. Patient E was discharged from the hospital by Respondent with a diagnosis of atypical chest pain, most likely GI related. Respondent's care deviated from accepted medical standards, in that, Respondent:

1. Failed to recognize signs and symptoms of acute coronary symptom in a high risk patient;
2. Failed to appropriately diagnose and treat unstable angina;

3. Failed to maintain an adequate record;
4. Inappropriately discharged Patient E from the hospital.

F. On or about July 1, 2006, Patient F went to St. Francis Hospital emergency department complaining of numbness in the right leg, associated with pain and purple color of the leg. Respondent examined the patient, made the diagnosis of neuropathic leg pain, sciatica and discharged the patient with instructions to see her physician and to obtain an MRI of her lower back. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to perform an adequate physical examination;
2. Failed to recognize the clinical symptoms of acute arterial occlusion;
3. Failed to order appropriate imaging study;
4. Failed to obtain a vascular surgical consultation;
5. Failed to appropriately treat acute arterial occlusion;
6. Incorrectly diagnosed the patient with neuropathic leg pain and sciatica;
7. Failed to maintain an adequate record;
8. Inappropriately discharged the patient from the hospital.

G. On or about October 6, 2006, at or about 8:00 p.m., Patient G was brought by EMS to St. Francis Hospital with the complaint of a painful ankle. Respondent directed EMS, while enroute to the hospital, to administer Morphine 5 mg intravenously. Respondent administered a total of 40 mg Morphine and 4 mg Dilaudid in approximately two hours. During that period of time Respondent reduced Patient G's dislocated ankle. Patient G

9-08-08

was discharged from the hospital on October 6, 2006 at 11:45p.m. Patient G died on or about October 7, 2006 from anoxic arrest. Respondent's care of Patient deviated from accepted medical standards, in that Respondent;

1. Failed to follow appropriate procedures and practices for the administration of conscious sedation;
2. Failed to appropriately monitor a patient who had received a large dose of narcotics;
3. Failed to obtain an orthopedic consult;
4. Inappropriately discharged Patient G from the hospital;
5. Failed to maintain an adequate record;
6. Failed to converse with the patient's mother who called with concerns that her son, Patient G, was non-responsive.

H. On or about August 23, 2007, Patient H was brought by ambulance to Northern Dutchess Hospital emergency department with the chief complaints of right leg pain following a fall. Respondent discharged Patient H with the diagnosis of "contusion lower leg." The following day, Patient H went to a different hospital and was found to have a displaced femoral neck fracture of the right hip. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to order the correct imaging studies;
2. Failed to diagnose a hip fracture based upon the mechanism of injury and Respondent's physical and clinical findings;
3. Failed to obtain an orthopedic consultation;
4. Failed to re-evaluate patient prior to discharge for her ability to ambulate;

5. Failed to maintain an adequate record;

6. Inappropriately discharged Patient H from the hospital.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraph A and its subparagraphs;
2. Paragraph B and its subparagraphs;
3. Paragraph C and its subparagraphs;
4. Paragraph D and its subparagraphs;
5. Paragraph E and its subparagraphs;
6. Paragraph F and its subparagraphs;
7. Paragraph G and its subparagraphs;
8. Paragraph H and its subparagraphs.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

9. Paragraph A and its subparagraphs; Paragraph B and its

subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs; and/or Paragraph H and its subparagraphs.

TENTH SPECIFICATION

GROSS INCOMPETENCE

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

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

ELEVENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

11. Paragraph A and its subparagraphs; Paragraph B and its

subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs; and/or Paragraph H and its subparagraphs.

TWELFTH THROUGH NINETEENTH SPECIFICATIONS

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:

12. Paragraph A and A (3);
13. Paragraph B and B(7);
14. Paragraph C and C (4);
15. Paragraph D and D (4);
16. Paragraph E and E (3);
17. Paragraph F and F (7);
18. Paragraph G and G (5);
19. Paragraph H and H (5).

TWENTIETH SPECIFICATION

PATIENT ABANDONMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(30) by abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements

for the continuation of such care, as alleged in the facts of:

20. Paragraph G (6).

DATE: August 28, 2008
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

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

IN THE MATTER
OF
KIMBERLY GODFREY, D.O.

ANSWER TO STATEMENT OF CHARGES

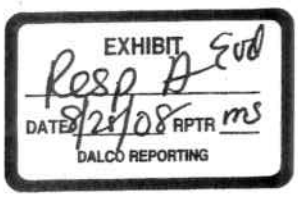
THE RESPONDENT, KIMBERLY GODFREY, D.O., BY HER ATTORNEYS, O'CONNOR, McGUINNESS, CONTE, DOYLE & OLESON, ANSWERING PETITIONER'S STATEMENT OF CHARGES:

Denies each and every factual allegation set forth in paragraphs A, B, C, D, E, F, G and H, except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

Denies each and every allegation contained in First through Eight Specifications claiming gross negligence except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

Denies each and every allegation contained in the Ninth Specification claiming negligence on more than one occasion except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

Denies each and every allegation contained in the Tenth Specification claiming gross incompetence except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.



Denies each and every allegation contained in the Eleventh Specification claiming incompetence on more than one occasion except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

Denies each and every allegation contained in Twelfth through Nineteenth Specifications claiming failure to maintain records except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

Denies each and every allegation contained in Twentieth Specification claiming patient abandonment except admits that KIMBERLY GODFREY, D.O. is licensed to practice medicine in the State of New York and is board certified in emergency medicine.

WHEREFORE, respondent, KIMBERLY GODFREY, D.O., demands judgment as follows:

Dismissing petitioner's statement of charges.

Dated: White Plains, New York
August 28, 2008

Yours, etc.

O'CONNOR, McGUINNESS, CONTE,
DOYLE & OLESON
By: Redacted Signature
PHILOMENA BASUK
Attorneys for Respondent
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