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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

Public

August 6, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Fitzgerald Hudson, M.D.
REDACTED

James H. Cosgriff, III, Esq.
Petrone & Petrone , P.C.
5500 Main Street – Suite 342
Williamsville, New York 14221

RE: In the Matter of Fitzgerald Hudson, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-70) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of

Fitzgerald Hudson, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 10-70

Before ARB Members D'Anna, Koenig, Wagle, Wilson and Milone
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Timothy J. Mahar, Esq.
For the Respondent: James H. Cosgriff, Esq.

In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2010), the parties ask the ARB to review and modify a Determination by a BPMC Committee. After a hearing below pursuant to PHL § 230(10(e), the Committee determined that the Respondent committed professional misconduct in both providing medical treatment and in submitting licensure and professional privileges applications. The Committee voted to revoke the Respondent's license to practice medicine in New York State (License). On review, the Respondent asks for a modification in the charges the Committee sustained and a reduction in the penalty. The Petitioner requests that the ARB sustain additional misconduct specifications. After reviewing the hearing record and the parties' review submissions, the ARB affirms the Committee's Determination in full.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(1-6), 6530(14), 6530(21) and 6530(32) (McKinney Supp. 2010) by committing professional misconduct under the following specifications:

- obtaining a license fraudulently,
- practicing medicine with fraud,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence,
- failing to disclose information required by PHL § 2805-k,
- willfully filing a false report, and,
- failing to maintain accurate patient records.

The negligence, incompetence and records charges related to the medical care that the Respondent provided to seven persons (Patients A to G) at the Emergency Department (ED) at Claxton-Hepburn Medical Center in Ogdensburg, between February and June 2008. The record refers to the Patients by initials to protect privacy. The remaining charges related to applications that the Respondent submitted for licensure to the New York State Education Department (SED) and for staff privileges at Jones Memorial Hospital in Jonesville (Jones) and Nicholas H. Noyes Memorial Hospital (Noyes) in Dansville. The Respondent conceded deficiencies in his record keeping, but the Respondent contested all the other charges at the hearing. Following the hearing, the Committee rendered the Determination now on review.

The evidence showed that the Respondent completed his medical training in 2007 and then submitted the SED Application. The Respondent received his License in October 2007. The Respondent testified at hearing that he took the job on the overnight shift at the Claxton-Hepburn ED because he was hoping for a light patient load and the opportunity to sleep [Hearing Transcript pages 830-834]. After leaving Claxton-Hepburn, the Respondent submitted the Jones and Noyes Applications in August 2008.

The Committee sustained the charges that the Respondent practiced with negligence and incompetence on more than one occasion and with gross negligence and incompetence. The Committee found that Patient A presented at the ED with severe abdominal pains, an elevated white blood cell count and recent gastric bypass surgery, with a high rate of complications. The

symptoms indicated a significant infectious or inflammatory process, with the need for intravenous antibiotic treatment and a surgical consultation. The Respondent discharged the patient with oral antibiotics, Prilosec and directions to see a physician in five days. Patient B presented at the ED with a recent history for chest pains and past history for myocardial infarction (MI), cardiac bypass surgery and stent placement. The Committee found that the Patient's symptoms showed the Patient at grave risk for death due to MI, but that the Respondent failed to obtain the information, to appreciate the information's significance and to admit the Patient. Patient C came to the ED from St. Lawrence Psychiatric Center, with a physician's written transfer summary that called for ruling out an intestinal blockage. The Committee determined that the Respondent failed to perform and document adequate abdominal and rectal examinations. The Respondent did order x-rays that showed a bowel obstruction, but the Respondent misdiagnosed the Patient, failed to admit the Patient and failed to obtain a surgical consultation. Patient D, a registered nurse, presented at the ED with a chief complaint of possible gall bladder attack. The Patient had experienced such an attack one month previously. The Respondent diagnosed the Patient with chest wall pain, although the Committee found that a lack of symptoms or examination findings to suggest such a diagnosis. The Respondent also prescribed two non-steroidal, anti-inflammatory medications (NSAID) for the Patient, despite a documented allergy to a different NSAID. The Respondent treated Patients E, F and G for fractures. The Committee found that the Respondent failed to obtain orthopedic consultations for Patients E and G and failed to arrange transfers to facilities where the Patients could receive orthopedic treatment. The Committee found that this failure placed the Patients at increased risk for complications from delay in reducing the fractures. Patient F presented with a slow heart rate. The Committee found that, at a minimum, the Respondent should have repeated a check on the Patient's pulse to determine whether the heart rate was still slow and whether a cardiac work-up was warranted. The Respondent failed to re-check the heart rate. In addition to finding repeated negligence and incompetence in these cases, the Committee ruled the Respondent practiced with gross negligence in treating Patients B and D, and with gross incompetence in treating Patients B, C and D.

As to the applications, the Committee found that the SED, Noyes and Jones Applications all asked a variation on the question: "Have you ever been dismissed from a hospital training program". The Respondent answered the question "no" on all three applications and at hearing the Respondent admitted that he was dismissed from a residency at Warren Hospital and that the residency was a training program. The Committee found further that the Respondent reported to Jones and Noyes that the Respondent graduated from York University and the Respondent reported to Noyes that he graduated from medical school in four years. The Respondent never earned a bachelor's degree and the Respondent took nine years to graduate from medical school. The Committee found further that the Respondent made the applications to Noyes and Jones after he left Claxton-Hepburn and the Respondent reported on those applications that he left Claxton-Hepburn due to either "a long commute" or "too far away". The Committee concluded that the Respondent left Claxton-Hepburn because the ED Director instructed the Respondent not to return to work, after a nurse's complaint that the Respondent failed to evaluate properly a patient with chest pains and EKG changes. The Committee held that the Respondent obtained his License fraudulently by making substantial false statements on the SED Application and the Committee sustained the charge that the Respondent obtained his License fraudulently. The Committee found further that the Respondent's answers on the three applications constituted willfully filing a false report. The Committee also held that the information that the Respondent withheld on the Noyes and Jones Applications amounted to practicing with fraud and failure to comply with the requirements for providing information in seeking professional privileges under PHL § 2805-k.

In making their findings, the Committee relied on testimony from the Petitioner's expert witness, Dan Mayer, M.D., a board certified emergency department physician, with 30 years experience. The Committee found that Dr. Mayer's experience and balanced testimony made him a credible witness. The Committee also credited testimony from Ruth Hart, M.D., a medical coordinator for the Office of Professional Medical Conduct (OPMC), who testified concerning statements the Respondent made in an interview that took place during the investigation in this case. The Committee also found the Respondent's medical expert, Joseph Takats, M.D., a

credible witness, but the Committee found that Dr. Takats' testimony did not necessarily support the Respondent's case. In some instances, Dr. Takats gave no testimony on the standard of care and thus left Dr. Mayer's testimony unchallenged. In other instances, Dr. Tataks agreed with Dr. Mayer, such as on cross-examination concerning Patient B. Dr. Tataks conceded the chest pain and cardiac history for Patient B were consistent with a risk for acute cardiac syndrome. The Committee found that the Respondent lacked credibility in his testimony. The Committee noted that the Respondent gave false answers on licensure and staff appointment applications and the Committee found the Respondent's attempts to explain those false answers unbelievable. The Committee noted further that the Respondent claimed that patients withheld information and that the Respondent obtained significant medical histories and relevant clinical findings that the Respondent failed to record. The Committee found those claims unbelievable as well and the Committee concluded that the Respondent failed to obtain relevant information or failed to recognize the information's significance.

The Committee voted to revoke the Respondent's License. The Committee described the Respondent as an incompetent diagnostician and an unreliable source of the facts. The Respondent completed his medical training in 2007 and the care at issue took place in February to June 2008. A supervising physician's written observation, from the Respondent's unsuccessful 2003 residency at Warren Hospital, found the Respondent:

- in a disjointed relationship between his knowledge of the facts and his ability to apply them,
- overwhelmed when he needed to address more than one thing at a time,
- often focused on the wrong thing, and,
- without insight into his own deficiencies.

The Committee found that the Respondent's training subsequent to the written observation failed to address the Respondent's deficiencies and that a disconnect existed between patients' presenting conditions and the Respondent's evaluation and treatment decisions. The Committee noted that during the four months at the ED in Claxton-Hepburn, the Respondent failed to diagnose life-threatening conditions in two patients and gave sub-standard care to all seven

patients at issue in this case. The Committee rejected the Respondent as a viable candidate for retraining and the Committee concluded that no amount of supervision would correct the Respondent's clinical deficiencies. The answers on the applications also demonstrated that the Respondent lacks integrity and no amount of training or supervision can correct a basic lack of integrity. The Committee noted that the Respondent's fraudulent conduct provided a separate and independent reason for revoking the Respondent's License.

Review History and Issues

The Committee rendered their Determination on May 4, 2010. This proceeding commenced on May 21, 2010, when the ARB received the Respondent's and Petitioner's Notices requesting Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's brief and reply brief. The record closed when the ARB received the reply brief on June 25, 2010.

The Respondent also submitted a letter, which the Administrative Officer for the ARB received on July 19, 2010. The ARB did not review the Respondent's letter because: the letter arrived past the time for filing briefs, there was no evidence that the Respondent provided a copy of the letter to the Petitioner and because the ARB had already conducted deliberations in the case when the letter arrived.

The Respondent argued that the evidence at hearing failed to support the Committee's findings on the charges. The Respondent argued further that the alleged deficiencies in the care for each Patient A to G failed to rise to the level of severe deviations from the standards of care and failed to warrant the penalty the Committee imposed. As to the applications, the Respondent contended that he provided SED, Jones and Noyes with sufficient information and/or releases to demonstrate that he held no intent to deceive in his answers on the applications. The Respondent

argued that any omissions on the applications failed to warrant the penalty the Committee imposed. The Respondent claimed that the problems at Claxton-Hepburn occurred over a short period of time and that the Respondent has since left emergency medicine and entered family practice. The Respondent requested that the ARB reconsider and reduce the penalty the Committee imposed.

The Petitioner requested that the ARB modify the Committee's Determination and sustain the charges that the Respondent practiced with gross negligence in treating Patients A and C. The Petitioner argued that the findings and conclusions for each Patient showed that the Respondent made a serious or significant deviation from the standard of care, which created a risk for grave consequences to each Patient.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even

without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. The ARB affirms the Committee's Determination in full.

The Committee found that omissions on the SED, Jones and Noyes Application amounted to fraud by the Respondent in practice and in obtaining his License, willfully filing a false report and violating PHL § 2805-k. In order to sustain a charge that a licensee practiced medicine fraudulently, a hearing committee must find that (1) a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have

disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation, Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (Third Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). A committee may infer the licensee's knowledge and intent properly from facts that such committee finds, but the committee must state specifically the inferences it draws regarding knowledge and intent, Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (Third Dept. 1991). To prove willfully filing a false report, a committee must establish that a licensee made or filed a false statement willfully, which requires a knowing or deliberate act, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986). Merely making or filing a false report, without intent or knowledge about the falsity fails to constitute professional misconduct, Matter of Brestin v. Comm. of Educ.,(supra). A committee may reject a licensee's explanation for erroneous reports (such as resulting from inadvertence or carelessness) and draw the inference that the licensee intended or was aware of the misrepresentation, with other evidence as the basis, Matter of Brestin v. Comm. of Educ.,(supra). Under EL § 6530(14), a physician commits professional misconduct by violating the provisions in PHL § 2805-k that require a physician to provide and verify information in seeking professional privileges at a medical facility. Nothing in 6530(14) requires a showing that the physician acted knowingly or with intent in violating that statute.

The Respondent argued that he held no intent to deceive in the answers he made on the Applications. The Committee found the Respondent lacked credibility as a witness and rejected the Respondent's explanations for the incorrect information in the Applications. The Committee inferred the intent from other evidence in the record. For example, the Committee found that the Respondent made the Jones and Noyes Applications soon after he was told not to return to the

Claxton-Hepburn ED. The Committee inferred the Respondent's intent to deceive on those Applications in order to improve his chances for future employment. The ARB sustains the charges that the Respondent obtained his License fraudulently and that the Respondent practiced fraudulently. The ARB also finds the evidence supports the Committee's conclusions that the Respondent willfully filed false reports and that the Respondent violated PHL § 2805-k. The ARB agrees further with the Committee that the Respondent's fraudulent conduct, standing alone, provided grounds to revoke the Respondent's License.

The ARB finds further that the evidence from the testimony by the Petitioner's expert, Dr. Mayer, and the medical records in evidence prove that the Respondent practiced with negligence and incompetence on more than one occasion, gross negligence and gross incompetence. The Respondent presented expert testimony by Dr. Takats, but the Committee found the testimony by Dr. Takats did not support the Respondent's position. In some instances, Dr. Takats failed to offer an opinion as to the standard of care and thus left Dr. Mayer's testimony unchallenged. In other instances, Dr. Takats agreed with Dr. Mayer. On cross-examination concerning Patient B, Dr. Takats acknowledged that a reasonably competent emergency room physician would recognize the Patient's chest pains and cardiac history were consistent with a risk for acute cardiac syndrome. In discussing Patient D, Dr. Takats described the Respondent's prescription of bowel compression by magnesium citrate as the wrong treatment. The Respondent also testified. The Respondent claimed that care problems resulted from patients withholding information and testified that he obtained histories or findings that he failed to record. The Committee rejected the Respondent's explanations. The ARB defers to the Committee, as the fact-finder, in the Committee's determination on credibility.

The ARB finds it sad that a person who tried for so long to become a physician would lose his License so soon after commencing practice, but the ARB also finds the revocation of the Respondent's License appropriate and consistent with the Committee's findings. The Respondent displayed cognitive problems from early in his training. The ARB agrees with the Committee that the Respondent presents as an unlikely candidate for retraining because the treatment to the patients at the ED occurred so soon after the Respondent completed his medical training. In the time the Respondent practiced at Claxton-Hepburn, he placed two patients at risk by incorrect diagnoses and the Respondent provided sub-standard care to five other patients. The ARB concludes that pattern that emerged from the evidence in this case shows profound deficiencies in the care the Respondent provided and demonstrated the Respondent's unfitness to practice medicine in New York State.

The Petitioner requested that the ARB modify the Committee's Determination by sustaining additional misconduct charges. The ARB sees no reason to make any changes to the Committee's Determination.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB affirms the Committee's Determination to revoke the Respondent's License.

Peter S. Koenig, Sr.
Datta G. Wagle, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Fitzgerald Hudson, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Hudson.

Dated 21 July, 2010

REDACTED

Linda Prescott Wilson

In the Matter of Fitzgerald Hudson, M.D.

Peter S. Koenig, Sr., an ARB Member concurs in the Determination and Order in the Matter of Dr. Hudson.

Dated: 7/20/2010, 2010

REDACTED

Peter S. Koenig, Sr.

In the Matter of Fitzgerald Hudson, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Hudson.

Dated: 7/20/, 2010

REDACTED

Datta G. Wagle, M.D.

In the Matter of Fitzgerald Hudson, M.D.

Richard D. Milone, an ARB Member concurs in the Determination and Order in the Matter of Dr. Hudson.

Dated: July 20, 2010

REDACTED

Richard D. Milone, M.D.

In the Matter of Fitzgerald Hudson, M.D.

John A. D'Anna, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Hudson.

Dated: 7-20, 2010

REDACTED

John A. D'Anna, M.D.