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

May 4, 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 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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

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

COPY

IN THE MATTER OF FITZGERALD HUDSON, M.D.	DETERMINATION AND ORDER

BPMC #10-70

A Notice of Hearing AND Statement of Charges, both dated August 20, 2009, were served upon the Respondent, Fitzgerald Hudson, M.D. **WALTER T. GILSDORF, M.D. (CHAIR), THERESE G. LYNCH, M.D., AND VIRGINIA R. MARTY,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Timothy J. Mahar, Esq., Associate Counsel. The Respondent appeared by Petrone & Petrone, P.C., James H. Cosgriff, III, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	August 29, 2009
Answer Filed:	September 24, 2009
Pre-Hearing Conference:	September 24, 2009
Hearing Dates:	October 2, 2009 November 23, 2009 December 4, 2009 December 11, 2009 January 21, 2010 January 22, 2010 February 2, 2010
Witnesses for Petitioner:	Dan A. Mayer, M.D. Ruth Hart, M.D.
Witnesses for Respondent:	Fitzgerald Hudson, M.D. Joseph R. Takats, III, D.O.
Deliberations Held:	March 17, 2010

STATEMENT OF CASE

Petitioner has charged Respondent, a family practitioner, with twenty-two specifications of professional misconduct. Thirteen of the specifications relate to Respondent's medical care and treatment of seven patients in the Emergency Department of Claxton-Hepburn Medical Center, in Ogdensburg, New York. The charges include allegations of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, and failing to maintain accurate medical records. The remaining

nine specifications relate to statements made by Respondent on his application for his New York medical license, as well as statements made on applications for appointment to the medical staff at two hospitals.[1] Respondent denied the allegations.

A copy of the Second Amended Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Fitzgerald Hudson, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 246593 on or about October 24, 2007. (Ex. #2).

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1 The Department twice amended the Statement of Charges. The First Amended Statement of Charges (Ex. #1A) was received on September 25, 2009. The Second Amended Statement of Charges (Ex. #1B) was received on January 21, 2010. The Hearing Committee's deliberations were based upon the Second Amended Statement of Charges.

Patient A

2. Respondent treated Patient A, a 46 year-old male, in the Claxton-Hepburn Medical Center (CHMC) emergency department on May 29, 2008 for complaints of abdominal pain, nausea and belching. He was triaged in the emergency department at 9:24 p.m. He had experienced sudden, "quite severe" pain in his umbilical area while driving his car that evening. The pain was persistent and severe by the time he had arrived home. (Ex. #3, pp, 2,9; Ex. #5, p. 6).

3. Patient A rated his abdominal pain as an 8 to 9 on a scale of 10 while in the emergency department. (Ex. #3, p. 9).

4. Recorded in the triage nurse's record was that Patient A had undergone gastric bypass surgery less than six months earlier, on December 4, 2007. Patient A's history of gastric bypass placed him at risk for complications of the surgery. (T. 31; Ex. #3, p.9).

5. Respondent assessed Patient A starting at 9:50 P.M. Respondent noted that Patient A's abdominal pain was "constant" and "still present". The pain was described as "cramping" with a severity rating of 6 out of 10. The pain was located in the upper mid-abdomen or the epigastrium. Patient A's pain was relieved by nothing and exacerbated by

nothing. The patient had not previously experienced similar symptoms, which would indicate both an acute condition and a potentially serious condition. (T. 35, 38; Ex. #3, p. 18).

6. The medical history which Respondent obtained from Patient A failed to document the patient's history of Type II diabetes. Patient A had in the past undergone an appendectomy, hernia repair and a tonsillectomy. Respondents' medical history inaccurately records that Patient A had a negative history for these surgeries. (T. 113; Ex. #3, p. 18; Ex. #5, p. 7).

7. It is the standard of care for a physician to obtain a medical history from the patient of any past surgeries related to the organ system which is the focus of the patient's chief complaint. Respondent failed to document any history of Patient A's gastric bypass surgery, which had been performed approximately six months earlier. Respondent's failure to obtain and document this history was a deviation from accepted standards of care. (T. 39-41).

8. Accepted standards of care in evaluating Patient A's abdomen by physical examination required Respondent to listen to Patient A's abdomen for bowel sounds. The type of bowel sounds heard may suggest that the bowel is not working (an ileus) or is obstructed. (T. 42).

9. Respondent failed to document that he listened for bowel sounds and what he observed. (Ex. #3).

10. Accepted standards of care required Respondent to palpate the four quadrants of the patient's abdomen to determine the presence and location of any tenderness. The physician must also evaluate the abdominal muscles for evidence of guarding, or the patient tensing the muscles when they are palpated. The abdomen must be assessed for rebound tenderness. The physician presses and quickly releases the abdominal muscle. A positive response indicates inflammation of the lining of the peritoneum. The appendix (McBurney's point) and the gallbladder (Murphy's sign) must be palpated for signs of tenderness. The abdomen must then be further assessed for localized tenderness with specific movement (Psoas sign, Rovsing signs and obturator sign), or in specific organs such as the spleen and liver. (T.43-44)

11. Respondent noted only tenderness in the middle of the abdomen. (Ex. #3, p. 19).

12. Respondent's failure to evaluate Patient A's bowel sounds and to perform a full abdominal examination to localize Patient A's tenderness were deviations from accepted standards of care. (T. 45).

13. Respondent ordered a CT study of Patient A's abdomen and pelvis with contrast. The radiologist called Respondent with the results which Respondent documented as "small bowel disease - thickening loops of small bowel - may be related to Crohn's disease. (Ex. #3, pp. 16, 19).

14. The CT findings would explain the patient's abdominal pain. The report of thickening loops of small bowel could be an infection of the bowel - colitis, or ileitis. It could be a sign of inflammation, Crohn's disease or cancer. (T. 47-48).

15. A complete blood count (CBC) obtained prior to Patient A's discharge from the emergency department showed an elevated white blood cell count of 21,890 and an elevated percentage of neutrophils of 87.2%. The elevated white blood cell count could indicate an infection, or the patient's response to an inflammatory process. The elevation of the percentage of neutrophils, or left shift, indicated that the elevated white blood cell count was most likely a response to a bacterial infection. (T. 48-49; Ex. #3, p. 12).

16. Patient A's clinical findings, along with the CT findings and elevated white blood cell count, would suggest to a reasonably prudent emergency physician a serious abdominal condition, including a newly acquired Crohn's disease or a

bacterial infection of the intestinal wall. For either condition, the indicated management was to admit the patient to the hospital, administer intravenous fluids and intravenous antibiotics, rest the bowel, and obtain a surgical or gastroenterology consult. (T. 52-53).

17. Patient A was at risk for a worsening infection, leading to bowel perforation. He was also dehydrated when evaluated by Respondent, as indicated by a urinalysis showing an elevated specific gravity. (T. 54-55; Ex. #3, p.13).

18. Respondent's clinical impression was that Patient A had abdominal pain of uncertain etiology. This diagnosis is used when the evaluation does not produce a possible diagnosis or diagnoses. It is not a specific diagnosis, but a description of abdominal pain of unknown cause. (T. 60, 111; Ex. #3, p. 19).

19. Respondent's diagnosis of abdominal pain of unknown etiology deviated from accepted standards of care. The CT results and laboratory findings explain the abdominal pain as a possible Crohn's disease or infection of the small bowel. (T. 59-60).

20. Patient A's discharge instructions refer to a diagnosis of GERD or gastro-esophageal reflux disease. Respondent prescribed Prilosec, an acid blocker, for Patient

A, even though the patient was already on the same medication (Omeprazole). The usual presentation with GERD is intermittent pain beginning in the abdomen going into the patient's chest with an acid-like taste in the back of the mouth. The condition is worsened by eating a large meal or when lying down. It is improved with sitting up and taking antacids. (T. 58, 1037-1038; Ex. #3, p. 4).

21. Nothing in Patient A's medical record supported the diagnosis of GERD. (T. 58).

22. Respondent discharged Patient A with prescriptions for oral Cipro, Flagyl, and Prilosec. The patient was instructed to follow up with his primary care physician in five days regarding the abdominal pain, and in seven days for the GERD. (Ex. #3, pp. 5-7).

23. Oral antibiotics are not absorbed at the same levels at which intravenous antibiotics are absorbed when there is an abnormality in the patient's gastrointestinal tract. (T. 97).

24. Respondent's failure to seek the admission of Patient A to the hospital was a serious deviation from accepted standards of care. Patient A had clinical, laboratory and radiology findings consistent with a serious underlying infection that was newly diagnosed. If the

infection was not treated appropriately, it could cause death. (T. 60-63).

25. Following the end of Respondent's shift in the emergency department, Patient A was called back into the emergency department to be reassessed. He was admitted to the hospital and started on IV antibiotics. He was discharged following a three-day admission with a diagnosis of probable acute distal ileitis. (Ex. #5, pp. 8-11).

Patient B

26. Patient B, a 65 year-old female, was treated by Respondent in the CHMC emergency department at approximately 9:40 P.M. on April 14, 2008 for complaints of chest pain radiating to her back. Patient B reported that her symptoms had started at 11:30 P.M. on April 13, 2008. She further reported that since 6:00 P.M. on April 14, 2008, Patient B took four sublingual nitroglycerin tablets at home. (Ex. #6, pp. 2, 6-7).

27. Patient B's past cardiac history included myocardial infarction, coronary artery bypass graft, and the placement of cardiac stents within the last month. (Ex. #6, pp. 6-7; Ex. #7, p. 7).

28. Patient B also had a history of diabetes, hypertension and high cholesterol. (Ex. #6, p. 6).

29. The initial nursing assessment noted that Patient B was having "chest pain now" that was radiating to the back. The severity of the radiating pain was reported as a 7 out of 10. (Ex. #6, pp. 6-7).

30. Respondent's evaluation documented that Patient B had chest pain and discomfort that night which was still present in the emergency department. She reported her pain as a 6 out of 10 to Respondent. (Ex. #6, p. 15).

31. Respondent documented that the onset of Patient B's pain occurred at rest. (Ex. #6, p. 15).

32. Chest pain at rest usually indicates a critical narrowing of a coronary artery. (T. 129).

33. Given Patient B's presenting complaint, accepted standards of care require the examining physician to obtain a history of the patient's prior cardiac procedures. Respondent recorded none of Patient B's past history of heart disease, her cardiac bypass surgery, or her stent procedure. Respondent incorrectly documented that Patient B had a negative history for cardiac bypass. (T. 133-134; Ex. #6, p. 15).

34. Respondent failed to obtain Patient B's cardiac history either from the patient or the nursing notes. This

was a deviation from accepted standards of practice. (T. 134).

35. An electrocardiogram (EKG) was performed on Patient B while in the emergency department. An EKG measures the electrical activity of the heart. In a heart with muscle damage, an EKG can show the type of damage sustained and location of the damage. (T. 138; Ex. #6, p.14).

36. Patient B's EKG has a number of abnormalities. Lead I and Lead aVL show gross inversions of the T wave. The inversion is likely due to ischemia, or lack of blood supply, to the left side of Patient B's heart. (T. 138, 140-141).

37. Leads V4, V5 and V6 show depression of the ST segment. The ST segment is between the QRS and T waves. On Patient B's EKG, the ST segments are depressed from the base line, suggestive of abnormal blood flow to the lateral wall of the heart. (T. 143-144).

38. Ischemia poses a risk of heart attack to the patient. (T. 145).

39. Patient B's EKG included a computer-generated description of the abnormalities shown on the graph. The description would have been available to Respondent at the time he treated the patient. (T. 146).

40. The computer-generated description of the EKG findings noted RSR consistent with right ventricular conduction delay, ST & T wave abnormality, with possible lateral ischemia. These are abnormal findings. (T. T. 145-147; Ex. #6, p. 14).

41. Respondent's only documented description of his interpretation of Patient B's EKG is of a normal sinus rhythm. The EKG does show a normal sinus rhythm; however, this finding fails to adequately describe the full findings on the EKG. (T. 148; Ex. #6, p. 16).

42. At interview, Respondent described the EKG as normal and stated that it did not show signs of ischemic change. Respondent's interpretation of the EKG is incorrect. (T. 149, 468).

43. Respondent's interpretation of the Patient B's EKG inadequately describes the study. It fails to address the inverted T waves, the ST segment depressions and the computer description of the conduction delay. (T. 150-151).

44. The failure to interpret and note the obvious abnormalities of the EKG were a severe deviation from accepted standards of care. (T. 151-152).

45. Given Patient B's prior cardiac history, her chest pain while at rest on and off for a day, and her

abnormal EKG, a reasonably prudent emergency physician would have diagnosed Patient B as having unstable angina. (T. 152).

46. A reasonably prudent physician would immediately admit Patient B to the hospital to rule out a myocardial infarction and refer the patient to a cardiologist for further evaluation. (T. 152-153).

47. Respondent's clinical impression of Patient B was that she was suffering from GERD. He prescribed Nexium for a 10 day period, and instructed the patient to follow-up with her physician in 5 to 7 days. (Ex. #6, pp. 4, 16).

48. Respondent's diagnosis of GERD was a severe deviation from accepted standards of medical care. There are no symptoms of GERD in the medical record, nor was Patient B's history consistent with GERD. (T. 154).

49. Respondent's diagnosis failed to recognize that Patient B was in the highest risk group for a cardiac event by virtue of her cardiac history, her complaints of chest pain, and her abnormal EKG. (T. 155).

50. Respondent's failure to seek the admission of Patient B to the hospital was a severe deviation from accepted standards of medical care. The patient was at risk for sudden death, or for suffering damage to a large area of the heart muscle. (T. 155).

51. Patient B was discharged from the emergency department at 1:25 A.M. on April 15, 2008. She returned to the emergency department approximately four hours later, at 5:28 A.M., complaining of chest pain. (Ex. #6, p.7; Ex. #7, p. 13).

52. Patient B was again evaluated in the emergency department by Respondent, and was admitted with a diagnosis of unstable angina. The patient was subsequently transferred to St. Joseph Hospital's cardiac catheterization unit in Syracuse, New York. (Ex. #7, pp.7, 25).

Patient C

53. Patient C, a 62 year-old female, was treated by Respondent in the CHMC emergency department at approximately 2:45 A.M. on February 26, 2008 for complaints of abdominal pain. Patient C was a resident of the St. Lawrence Psychiatric Center ("St. Lawrence"). (Ex. #8, pp. 2,6).

54. The written Emergency & Transfer Summary from St. Lawrence, written by Dr. Malika Ismaily reported a medical diagnosis of "rule out intestinal obstruction". (Ex. #8, pp. 15-16).

55. Respondent noted that Patient C had abdominal pain for one week. The pain was cramping in nature; it waxed and waned; and it was still present. Respondent documented

the pain as mild and almost gone. Respondent wrote that Patient C had neither been seen nor treated recently by a physician, even though Patient C had been discharged from the CHMC the previous day, after a sixteen day admission. (Ex. #8, pp. 17, 22).

56. The standard of care for performing Patient C's abdominal examination required Respondent to obtain bowel sounds, evaluate all four abdominal quadrants for tenderness, rebounding and guarding, assess the appendix and gall bladder for tenderness, and assess the spleen and liver for enlargement. (T. 197).

57. Respondent's medical record for Patient C noted tenderness and bowel sounds, but made no findings concerning guarding, rebound tenderness, or tenderness at the gall bladder or appendix. (Ex. #8, p.23).

58. Respondent's failure to perform and document a complete abdominal examination was a deviation from accepted standards of medical care and standards for documentation. (T. 199-200).

59. Respondent ordered both flat and upright abdominal x-rays of Patient C ("KUB"). Five views of Patient C's abdomen were produced and sent to the computer in the

emergency department for Respondent to review. (T. 799-800, 813-814; Ex. #8, p.5).

60. Respondent interpreted Patient C's x-rays as showing stool impaction. (Ex. #8, p. 23).

61. Given a diagnosis of stool impaction, a rectal examination was indicated both to confirm the presence of stool, and to obtain a specimen to be tested for the presence of occult blood. (T. 198).

62. There is no record of Respondent having performed a rectal examination on Patient C. Respondent's failure to perform and document a rectal examination was a deviation from accepted standards of medical care. (T. 198-200).

63. Respondent failed to adequately interpret Patient C's abdominal x-rays. In x-ray Se: 4, the segment of intestine shown in the upper right side of the abdomen measures 104 mm in diameter. The normal diameter of the intestine is approximately 50 to 60 mm. This illustrates distension of the intestine. (T. 202; Ex. #12, Se: 4).

64. In the upper left abdominal quadrant of Se: 4, the loop of bowel measures approximately 165 mm in diameter and is markedly distended. The structure appears to be large intestine with segments that are approximately two to three times the normal width. (T. 202-203).

65. Respondent's expert, Dr. Takats, testified that Se:4 showed marked dilation of Patient C's bowel which could be consistent with obstruction. He noted that the view in Se: 5 showed marked dilation of the bowel consistent with bowel obstruction. (T. 1092).

66. View Se: 3 is a supine view which, among other things, shows the rectum. There is no fecal impaction shown in the rectum or on any part of Se: 3. Some fecal matter is found in the upper right side of the ascending colon. (T. 204-206).

67. View Se: 2 of the abdominal x-ray shows two segments of dilated bowel which are side by side. The left side wall of one segment of bowel overlays the spine. Both segments of bowel measure more than 100 mm, approximately twice the bowel's normal width. (T. 207-208).

68. View Se: 2 also shows air-fluid levels, which are indications that the bowel is not functioning well with respect to movement within the bowel. A non-functioning colon is an ileus. (T. 207-208).

69. The view in Se: 1 shows bowel distended to almost three times its normal size. Air fluid levels are also present. (T. 208-209).

70. The condition of Patient C's colon on x-ray indicated that it was obstructed. The obstruction could be the result of scar tissue from a prior surgery pressing on the colon. It may also be the result of the colon having become twisted on itself (a "volvulus"). (T. 208).

71. Due to the massive dilation of Patient C's bowel, there was a risk of bowel perforation. If a perforation occurs, the bowel contents spill into the abdomen, leading to infection, sepsis and death. (T. 210).

72. Respondent's interpretation of the x-rays as showing stool impaction fails to accurately describe the abnormalities present. This failure represents a severe deviation from accepted standards of medical practice. (T. 212).

73. A reasonably prudent emergency physician reviewing Patient C's x-rays would diagnose the patient with a bowel obstruction which posed a life-threatening risk to the patient. (T. 212, 214).

74. The appropriate management for Patient C would have been to admit her under the care of a surgeon or gastroenterologist who would perform a colonoscopy to decompress the colon. (T. 213).

75. Respondent's clinical impression was constipation or stool impaction. He did not plan to admit the patient after reviewing the x-rays. (T. 802-803, 808-809).

76. A clinical impression of constipation represents a severe deviation from accepted standards of medical practice. Constipation is a minor condition, while bowel obstruction is potentially life-threatening. A reasonably competent physician would consider Patient C to be critically ill after reviewing her abdominal x-rays. There was sufficient information in the abdominal x-rays for a reasonably competent emergency department physician to admit Patient C to the hospital without other clinical findings. (T.215, 217-218, 265-267, 269; Ex. #11).

77. Respondent's failure to seek the admission of Patient C to the hospital was a severe deviation from accepted standards of medical care. (T. 215-216).

78. While Patient C was in the emergency department, Respondent ordered magnesium citrate. Magnesium citrate causes the bowel to contract against a fixed volume of gas, placing additional stress on the bowel wall. (T. 217; Ex. #8, p.5).

79. Given Patient C's degree of obstruction, Respondent should not have ordered magnesium citrate for

Patient C, as stimulation of the bowel can lead to bowel perforation. (T. 217).

80. The nursing record documented that Patient C vomited the magnesium citrate approximately ten minutes after it was administered. Her inability to keep the medicine down was another indication of an obstruction. (T. 217-218; Ex. #8, p.6).

81. Respondent also ordered an oil-based enema for Patient C. The enema failed to produce a bowel movement. If Patient C had stool low in her colon, it would be expected that the enema would have caused the stool to move. (T. 218-219; Ex. #8, p.6).

82. After Patient C returned to the St. Lawrence Psychiatric Center, she developed a low-grade fever, persistent vomiting and abdominal pain. She was transferred to the emergency department of Crouse Hospital, Syracuse, New York for treatment of a bowel obstruction. On the same day Patient C was released from the CHMC emergency department, she was operated on at Crouse Hospital for a perforation found in her sigmoid colon. The post-operative diagnosis was a perforated sigmoid volvulus. (Ex. #10, pp.338, 449-450).

Patient D

83. Patient D, a 66 year-old female, presented in the CHMC emergency department on May 22, 2008 at 10:13 p.m. with complaints of abdominal pain. She was reported to have abdominal pain in all four quadrants, as well as in her back and shoulder blade, starting at approximately 5:00 p.m. (T. 275-276; Ex. #12, p.2).

84. Patient D was a retired registered nurse from CHMC. Patient D, or someone accompanying her to the emergency department, reported to the triage staff that Patient D was having a "poss[ible] gallbladder attack". Further, Patient D telephoned a surgeon sometime during the evening of May 22, 2008, reporting abdominal pain which the surgeon found to be suggestive of gallbladder disease. Patient D reported to the surgeon that she had a similar attack a month earlier, and that she had been eating heavy Spanish rice over the last two to three days. (Ex. #14, pp. 6, 8; #38, p.33).

85. Patient D's pain was assessed as 8 out of 10 in the triage record. (Ex. #12, p. 2).

86. The initial nursing assessment found abdominal pain in all four quadrants, in addition to back, flank and shoulder pain. Patient D had pain for the entire day, which

had become worse since 5:00 p.m. Patient D reported nausea and one episode of vomiting. (T. 270, 275; Ex. #12, p. 8).

87. Respondent documented that Patient D had cramping and abdominal pain since that morning which waxed and waned. The pain was in the right upper quadrant of the abdomen and it was rated by Patient D as a 10 out of 10, although it was also documented by Respondent as "moderate". (T. 279-281; Ex. #12, p.16).

88. Respondent noted that Patient D had no history of chest pain. (T. 282; Ex. #12, p.16).

89. Respondent's abdominal examination of Patient D consisted of a finding of tenderness which was not localized to a particular abdominal quadrant, and a finding of abnormal bowel sounds. (T. 282, 287-288; Ex. #12, p.17).

90. Respondent failed to perform and record a standard abdominal examination, as set forth in Paragraph 10, above. (T. 283-290).

91. Although Respondent noted abdominal tenderness, he did not identify the location of the tenderness on the diagram provided in the record. If Patient D was having diffuse or generalized tenderness throughout her abdomen, it would have indicated a process such as infection or perforation. (T. 288-289; Ex. #12, p.17).

92. A reasonably competent emergency department physician would have understood the necessity of performing a standard abdominal examination in assessing a Patient such as Patient D. (T. 290-291).

93. An ultrasound of the gallbladder was negative. (Ex. #12, p.13).

94. Patient D's white blood cell count was elevated at 12.74 and the percentage of neutrophils (ANE) at 89 was above the normal limit of 64. While only slightly elevated, Patient D's white blood cell count would indicate an abnormality possibly due to infection or some other type of stress. (T. 294; Ex. #12, p.10).

95. The standard of care for a patient with complaints of abdominal pain includes performing a urinalysis. Pain within the abdomen can be an indication of a kidney infection or an abnormality of the kidney or bladder. A reasonably competent emergency department physician would have ordered a urinalysis for Patient D. (T. 296-297).

96. Respondent did not order a urinalysis for Patient D. This was a deviation from the accepted standard of care. (T. 296-297).

97. After having received 30 milligrams IV of Toradol, an anti-inflammatory medication, at 10:50 p.m.,

Patient D reported at 11:30 p.m. that her pain was better, but not gone. She rated her pain as 2 or 3 on the 10 point scale. Although she had a clinically significant reduction in pain, her remaining pain required further investigation. (T. 299-300; Ex. #12, p.8).

98. The standard of care for a patient complaining of abdominal pain is to re-evaluate the abdomen prior to discharge to determine if there has been any change in the findings. The same elements of the standard abdominal examination described above must be performed before a determination to discharge the patient can be made. (T. 301).

99. Respondent recorded that Patient D was examined and was improved on re-examination. There is no record as to how Patient D had improved, what Respondent's re-examination consisted of, or the findings from the repeat examination. It cannot be determined by reviewing the medical record whether Patient D continued to have either tenderness or abnormal bowel sounds. (T. 302-303; Ex. #12, p.17).

100. Based upon an examination and the diagnostic findings, a reasonably prudent emergency department physician would conclude that Patient D had some type of intra-abdominal process. If the physician concluded that there was a significant intra-abdominal process ongoing, urgent

consultation with a surgeon or gastroenterologist would be the standard of care. If upon re-examination, all of the findings had completely disappeared, Patient D could be discharged for follow-up with her primary care physician with instructions to seek re-evaluation if certain symptoms reappeared in the interim. (T. 304-305).

101. Respondent diagnosed Patient D as having chest wall pain. She was given discharge instructions for costochondritis, included a prescription for Mobic and instructions to follow-up with her regular physician in two days. (Ex. #12, pp. 5, 17).

102. Costochondritis is inflammation of the cartilage that connects the ribs to the breast bone. There is nothing in Patient D's emergency department record which supports the diagnosis of chest wall pain or costochondritis. (T. 306).

103. Respondent's diagnosis of chest wall pain had no relationship to Patient D's complaints or Respondent's findings on physical examination and represented a deviation from the accepted standard of care. (T. 306).

104. Patient D reported an allergy to Motrin which was documented in the nursing triage record. Respondent reviewed the nursing note. (Ex. #12, pp. 7, 17).

105. Motrin is a non-steroidal anti-inflammatory drug "NSAID"). Respondent ordered both Toradol and Mobic for Patient D. Both drugs are also NSAIDs. (T. 311, 314; Ex. #12, pp. 5, 7).

106. There was a risk in ordering Toradol and Mobic for Patient D in the presence of an allergy to Motrin. Allergies to one drug can result in allergies to other drugs in the same class. (T. 312).

107. Before prescribing NSAIDs for Patient D, a reasonably prudent emergency department physician would obtain a history of the specific allergic reaction she has to Motrin, give a test dose of Toradol and observe her reaction to the drug, if any. Respondent failed to take these steps. (T. 312-315).

Patient E

108. Respondent treated Patient E, a 29 year-old male, in the CHMC emergency department on April 29, 2008 for fractures he sustained to his left leg after flipping his dirt bike over backwards. (Ex. #15, p.2).

109. During the nursing triage, Patient E described pressure in his left knee. (Ex. #15, p. 6).

110. X-rays were taken of Patient E's left leg while in the emergency department. A fracture of the medial portion

of the tibia extended six to eight inches below the top of the tibia down towards the lateral wall. The lateral side of the tibia also showed a fracture near the center of the tibia. The fracture was also visible in joint space and extended to the top or plateau of the tibia. (T. 346; Ex. #16).

111. In the Se: 3 oblique view, the fracture can be seen going the center of the tibia and is widely displaced. (T. 352-353).

112. In the Se: 4 lateral knee complete view, blood is seen in the soft tissues and in the joint. Blood in the joint indicates significant trauma to the knee. (T. 353-354).

113. A reasonably prudent emergency physician viewing the x-rays of Patient E's left leg would recognize that the patient had sustained a bad fracture that would need to be treated by an orthopedic surgeon. (T. 347).

114. Given the x-ray findings, the physical examination of Patient E's left knee should assess the presence of tenderness, blood circulation in the lower leg and foot, and nerve function in the lower leg and foot. No attempt to move or stress the left knee to determine the integrity of the ligaments was indicated. (T. 357)).

115. Respondent documented an assessment of tenderness, blood circulation and nerve function. He also

performed an anterior drawer test of the ligaments of the left knee. (T. 358-359; Ex. #15, p.12).

116. In the anterior drawer test, the examiner grasps the lower part of the leg with one hand and the upper part with the other hand. The examiner attempts to move the lower part of the leg forward relative to the upper part. If one of the ligaments were torn or disrupted, there would be some movement when the lower part of the leg was moved. (T. 359).

117. It was a deviation from the standard of care to perform an anterior drawer test on Patient E. The test would have been extremely painful given the degree of Patient E's fractures, and would not provide any additional information. (T. 359-360).

118. The standard of care for an emergency department physician in treating a patient with Patient E's fractures would require the physician to obtain an orthopedic surgical consultation at the time the patient is seen in the emergency department. Patient E's fractures created a risk of swelling that could compromise the blood supply and the nerve function of the foot. Further, given the risk of the development of arthritis in the left knee due to the injury, the earlier the surgical intervention, the less likely the arthritis would be severe. (T. 361-363, 367).

119. Respondent documented that he "Referred" Patient E to a physician prior to discharge. The discharge instructions directed Patient E to follow-up with James McLoughlin, M.D., an orthopedic surgeon, in one day. (Ex. #15, p.13).

120. A referral to a specialist is an instruction to the patient to see a particular physician in the future. It is not a consultation whereby the emergency department physician discussed a patient's status with a specialist prior to discharge. (T. 364).

121. Respondent's failure to consult with an orthopedic surgeon regarding Patient E's fractures was a deviation from the standard of care. (T. 365).

122. Swelling is a known complication of fractures such as that suffered by Patient E. The swelling causes compression of the arteries feeding the leg and the nerves leading into the lower leg and foot. The effects of swelling can be minimized by admitting the patient, elevating the leg and, at the discretion of the orthopedic surgeon, operating early in the patient's treatment. A reasonably prudent emergency department physician would not take any of these steps without first consulting with an orthopedic surgeon. (T. 318, 367-368).

123. James McLoughlin, M.D., an orthopedic surgeon, examined Patient E on April 30, 3008 in his office. According to Dr. McLoughlin, Patient E had suffered a significant fracture with intra-articular comminution and the likelihood of developing post-traumatic arthritis. (Ex. #30, p.18).

124. Dr. McLoughlin testified that Patient E's surgery to repair and reduce his fractures was delayed due to soft tissue swelling. According to Dr. McLoughlin, the swelling was not only a consequence of the injury, but of the initial management of the injury. Patient E did not have a compression dressing on his left leg when he was initially seen in his office on April 30, 2008. (Ex. #30, pp. 30-32, 83-84).

125. The purpose of a compression dressing would have been to minimize the soft tissue swelling. Injuries such as Patient E's typically swell for three days. One objective after this type of fracture is to minimize swelling, as surgery to reconstruct the joint will be required. (Ex. #30, pp.28-29).

126. Respondent did not apply a compression dressing to Patient E's injury while in the emergency department. (T. 93).

127. Dr. McLoughlin testified that he had no recollection of being called about Patient E from the emergency department or being consulted about a tibial plateau fracture. (Ex. #30, pp. 23-25, 49-50).

128. During the four months Respondent practiced at CHMC, Dr. McLoughlin was the only practicing orthopedic surgeon at the hospital. Dr. McLoughlin was on-call seven days per month, including one weekend a month and one day a week. However, he responded to calls to consult on 20 to 22 days per month, even if he was not formally on-call. (Ex. #30, p.9).

129. Patients at CHMC requiring urgent orthopedic services when Dr. McLoughlin was not available were to be transferred to hospitals where the services were available. (Ex. #30, pp. 11-13).

Patient F

130. Respondent provided medical care to Patient F, a 38 year-old male, on June 5, 2008 for injuries he sustained when he fell from a ladder. He fell from the ladder at approximately 6:00 p.m., and presented at the emergency department at CHMC at 6:05 p.m. on June 5, 2008. (T. 383-385; Ex. #18, p.2).

131. Patient F was triaged as a Level II patient which denotes a patient with a possibly critical condition. (T.385).

132. Patient F's pulse rate was measured during triage at 46. A pulse rate of 46 is abnormally slow. In a 38 year-old male, a normal pulse rate would be in the range of 60-100 beats per minute. The patient's diastolic blood pressure (37) was also abnormally low. (T. 386).

133. As Patient F was not on any medications which could affect the heart rate, a reasonably prudent emergency department physician should consider whether the slow pulse rate was due to an irregular cardiac rhythm which had caused Patient F to lose consciousness and fall of the ladder. (T. 384-387).

134. The standard of care for evaluating Patient F's abnormal pulse rate required Respondent to obtain a repeat pulse rate, obtain an EKG and place the patient on a cardiac monitor. This would determine whether the low pulse rate was an artifact or the result of an irregular heart beat. (T. 393-394).

135. Respondent failed to obtain a repeat pulse rate, or order an EKG to assess the patient's cardiac condition. (T. 399-400).

Patient G

136. Respondent provided medical care to Patient G, an 11 year-old male, at the CHMC emergency department on May 5, 2008 at approximately 8:45 p.m. Patient G had fallen off his roller blades approximately 15 minutes earlier. (Ex. #22, p.2).

137. X-rays of Patient G's right wrist showed a 100% displaced fracture of the distal radial and ulnar bones with severe angulation of both bones and an override of the radial fracture. (T. 425-428; Ex. #22, p.13).

138. Patient G had sustained a severe fracture. The standard of care required Respondent to consult with an orthopedic surgeon prior to the patient's discharge from the emergency department. (T. 428-429).

139. Respondent failed to consult with an orthopedic surgeon prior to Patient G's discharge. (T. 430; Ex.#30, pp. 111-112).

140. If Respondent had consulted with an orthopedic surgeon, the standards of record-keeping required Respondent to document that consultation, including the surgeon's recommendation for treatment. (T. 431).

141. No documentation of a consultation with an orthopedic surgeon is documented in the medical record. (Ex. #22).

142. The triage nursing notes record that Patient G rated his pain as a "10" on a 0 to 10 pain scale at approximately 20:45. At 21:00 Patient G received two teaspoons of Tylenol with codeine. At 22:08 Patient G received 2 mg. Of morphine. Approximately one hour after receiving the morphine, the patient reported his pain as a "5" on the pain scale. (Ex. #22, pp. 6-7).

143. At Patient G's discharge from the emergency department, Respondent ordered Motrin, 200 mg every 4 to 6 hours as needed for pain. (Ex. #22, p.4).

New York State License Application

144. On September 12, 2007, Respondent's application for a New York State medical license was received by the Professional Licensing Bureau of the State Education Department. Respondent was licensed to practice medicine in New York on October 24, 2007. (Ex. #2, p.2).

145. Question #14, on page 2 of the license application provides as follows: *Has any hospital or licensed facility restricted or terminated your professional training, employment or privileges or have you ever voluntarily or*

involuntarily resigned or withdrawn from such association to avoid imposition of such measures? (Ex. #2, p.2).

146. Respondent answered "No" to Question #14. (Ex. #2, p.2).

147. On or about April 9, 2002, Respondent had been accepted into the Warren Hospital family practice residency program. The program provided three years of training in family medicine. (Ex. #27, p.3).

148. On June 16, 2003, Raymond S. Buch, M.D., the director of the Warren Hospital family practice residency program, advised Respondent that the faculty had determined that Respondent could not advance to the second year of residency as of July 1, 2003. He would remain a first year resident for at least three additional months to determine whether his performance improved to the point where he could undertake the responsibilities of a second year resident. (Ex. #27, p.9).

149. On July 29, 2003, Respondent was notified by Dr. Buch that the residency program faculty was dismissing Respondent from the program due to his on-going performance problems, as well as his failure of the pediatric rotation for a second time. (Ex. #27, p.5).

150. Respondent falsely answered "No" to Question #14 on the New York license application. At the time he completed the application, Respondent knew that Warren Hospital had terminated his professional training. (Ex. #2, p.2; Ex. #27, p.5).

151. Respondent used the Federation Credential Verification Service (FVCS) to provide many of his credentials to the New York State Education Department in connection with his license application. In the "Physician Information Report" section of the application, the FCVS reported that the following information concerning Respondent's premedical education was "reported by physician and was not verified by FCVS": *York University (Faculty of Science) North York, Ontario, M3J 1P3 Canada. Dates of Attendance: 08/1987-08/1990 Degree Conferred/Issued: Bachelor of Science.* (Ex. #2, p.14).

152. York University neither issued nor conferred any degree upon Respondent. Respondent did not meet the University's credit requirements for a Bachelor's Degree. (T. 608-609).

153. Respondent falsely reported to FCVS that he earned a Bachelor of Science degree from York University when he had known that he had not earned that degree. Respondent also knew that the credentials service would be providing his

credentials to the New York State Education Department as part of his license application. (T. 590, 608-609; Ex. #2, p.14).

Jones Memorial Hospital Application

154. On or about August 22, 2008, Respondent applied for a staff appointment and clinical privileges at Jones memorial Hospital (Jones Hospital) in Wellsville, New York. He was subsequently granted privileges at the hospital. (T. 632-633; Ex. #25, p.6).

155. Respondent's personal information was provided by Respondent to a third party who entered the information on the application form. (T. 593).

156. Respondent, through his agent, reported on the application that his undergraduate school was York University. He further reported that he earned a "BS" or Bachelor of Science degree on the application. (Ex. #25, p. 2).

157. Respondent falsely reported to Jones Hospital through his agent that he had earned a bachelor of science degree from York University. (*See*, Paragraph 152).

158. In the section of the Jones Hospital application entitled "Professional History", Respondent, acting through his agent, answered "No" to Question #6. Question #6 asked, *Have you ever been denied or had suspended or restricted*

completion of training or certification of completion of training by any healthcare facility? (Ex. #25, p.3).

159. Respondent, through his agent, falsely reported that he had not been denied, suspended or restricted from completion of his training when he knew that the Warren Hospital family practice residency program had terminated his training in July, 2003. (*See*, Paragraphs 147-149).

160. Respondent falsely asserted that *All information submitted by me in this application is true to the best of my knowledge and belief*, when he signed and dated the Jones Hospital application on August 22, 2008. (Ex. #25, p.6).

Nicholas Noyes Application

161. On August 25, 2008, Respondent made a written application to Nicholas H. Noyes Memorial Hospital (Noyes Hospital) for appointment to the hospital's medical staff and for clinical privileges. He was subsequently granted clinical privileges at the hospital. (T. 632-633; Ex. #26).

162. Respondent reported on the Noyes Hospital application that he had received the degree of Bachelor of Science from York University in August, 1990. (Ex. #26, p.2).

163. Respondent knew that he had not graduated from York University, nor had he earned or received a Bachelor of Science degree. (*See*, Paragraph 152).

164. Under a section of the Noyes Hospital application entitled "Corrective Action", Respondent answered "No" to the following question: *Have you ever been denied or had suspended or restricted completion of training or certification of completion of training by any health care facility?* (Ex. #26,p.7).

165. Respondent falsely reported that he had not been denied, suspended or restricted from completion of any training by any health care facility when he knew that he had been dismissed from the Warren Hospital family practice residency program in July, 2003. (*See*, Paragraphs 147-149).

CONCLUSIONS OF LAW

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

negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). A finding of gross

negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave consequences to the patient. Post, *supra*, at 986; Minielly, *supra*, at 751.

Fraudulent Practice

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (3rd Dept. 1991), citing Brestin v. Commissioner of Education, 116 A.D.2d 357, 501 N.Y.S.2d 923 (3rd Dept. 1986). In order to sustain a charge that a licensee was engaged in the fraudulent practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been 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 (3rd Dept. 1966), aff'd 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must specifically state the inferences it is drawing regarding knowledge and intent. Choudhry, at 894 citing Brestin.

The other charged specifications of misconduct allege the failure to maintain records which accurately reflect the care and treatment of the patient, in violation of N.Y. Education Law §6530(32), filing false reports, in violation of N.Y. Education Law §6530(21), violations of N.Y. Education Law §6530(14) by failing to disclose his termination from the Warren Hospital residency program, as required by Public Health Law §2805-k(1)(b), and obtaining his medical license fraudulently, in violation of N.Y. Education Law §6530(1) . The Hearing Committee interpreted these statutes in light of the usual and commonly understood meaning of the underlying language. (*See*, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed

above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented testimony from two witnesses. Dan Mayer, M.D. is a board-certified emergency department physician with over 30 years of experience. Dr. Mayer practices at Albany Medical Center, where his responsibilities include shifts in the emergency department and teaching at the Albany Medical College. Dr. Mayer also has experience practicing in the emergency departments of small rural hospitals. (T. 20-26). Based upon his experience and balanced testimony, the Committee found Dr. Mayer to be a very credible witness.

Ruth Hart, M.D. is a part time medical coordinator for the Office of Professional Medical Conduct (OPMC). She is also board-certified in emergency medicine. Dr. Hart testified regarding certain statements made by Respondent during his interview with her as part of the investigation of this case. (T. 451-453). The Hearing Committee found Dr. Hart to be a credible witness.

Respondent presented one witness, and testified on his own behalf. Joseph Takats, III, D.O. testified as an expert

witness on Respondent's behalf. Dr. Takats has practiced emergency medicine since 1971. He was board-certified for the period between 1991 and 2001. (T. 975-976, 1005-1006). The Hearing Committee found Dr. Takats to be a credible expert. However, his testimony did not necessarily support Respondent's care of the patients. There were instances where he did not offer any opinion as to the standard of care, leaving Dr. Mayer's opinions unchallenged. There were other instances where he essentially agreed with Dr. Mayer. For example, Dr. Takats acknowledged on cross-examination, that a reasonably competent emergency department physician would recognize Patient B's chest pain and extensive cardiac history as consistent with a risk of an acute cardiac syndrome. (T. 1065-1066).

Lastly, Respondent testified on his own behalf. He obviously has the most at stake in these proceedings, and the Hearing Committee evaluated his testimony accordingly. Respondent repeatedly made false statements on his applications for licensure and for appointment to the medical staffs of the two hospitals at issue in this case. He claimed that he had received an undergraduate degree from York University, when he knew that he had failed to complete the requirements for the degree. He ignored the plain language of the various applications when he falsely stated that he had never been

terminated from a training program, when he knew that he had been terminated by the Warren Hospital residency program. His attempts to explain those false statements were simply not believable.

Compounding his problems, Respondent claimed to have obtained significant medical histories or made clinical findings relevant to his diagnoses which he then inexplicably failed to record. Moreover, he claimed that his patients withheld vital information from him. For example, Respondent claimed that Patient A failed to disclose an appendectomy, and a hernia repair, as well as a gastric bypass performed just six months earlier. Patient B, a woman with an extensive cardiac history, supposedly failed to report a history of myocardial infarction, cardiac bypass surgery, and the cardiac stents placed only one month prior to presenting in the emergency department. The Hearing Committee found it far more likely that Respondent either did not obtain the relevant history, or failed to recognize its significance. Either way, the Committee concluded that Respondent's testimony was not credible.

Fraud

Respondent's professional career in New York is built on a series of false statements and deceptions. The three applications at issue - the New York State license application

and the Jones Hospital and Noyes Hospital applications- each ask the applicant a variation of the same question. "*Have you ever been dismissed from a hospital training program?*"

Respondent admitted that he was dismissed from the Warren Hospital residency program and that the residency was in fact a training program. (T. 572-574). Respondent claimed that he interpreted the questions to apply only to licensed physicians, and therefore did not apply to his pre-licensure training. (T. 556). However, this time-limiting qualification of the questions is not found anywhere in either the application's instructions or in the questions themselves. There is simply no basis for this claim.

Respondent claimed that he did not intend to deceive the application recipients by his false answers because he disclosed the residency termination to the FCVS. However, Respondent admitted that this disclosure did not excuse him from answering the questions on the applications truthfully. (T. 591). Respondent had an obligation to truthfully answer all of the questions on the applications. Further, the FCVS only reported information to the Education Department. It would not provide any information to Noyes or Jones Hospitals.

Respondent's intent to deceive the Education Department and the two hospitals regarding his dismissal from

his first residency program is inferred from the additional false statements which he made on these same applications. Respondent falsely reported to the FCVS and to the Jones and Noyes Hospitals that he had earned a Bachelor's of Science degree from York University. In fact, Respondent never earned a bachelor's degree because he failed to meet the requirements for the degree. In addition, Respondent falsely reported to Noyes Hospital that he had completed medical school in four years, when he had actually taken nine years to complete medical school. (T. 618; Ex. #26, p.2).

Respondent's false statements to Jones and Noyes Hospitals were made after his tenure at Claxton-Hepburn Medical Center. In the applications, Respondent claimed that his separation from CHMC was due to either a "long commute" or "too far away". (Ex. #25, p.3; Ex. #26, p.5). In fact, his separation from CHMC occurred after he was instructed not to return to work after a nurse reported to the emergency department director that Respondent had failed to properly evaluate a patient with chest pain and EKG changes. (T. 620-621).

Given Respondent's short and controversial tenure at CHMC, his misrepresentations on the subsequent applications to both Jones and Noyes Hospitals represent a clear intent to hide

the problems in his credentials, in order to improve his chances of future employment.

The evidence clearly established that Respondent made substantial false statements on his New York State medical license application. These false statements were made to induce the Education Department to issue a medical license to Respondent. In fact, the Education Department issued license #246593 on October 24, 2007. The Committee unanimously concluded that Respondent obtained his medical license fraudulently, in violation of New York Education Law §6530(1), and voted to sustain the Twenty-Second Specification of professional misconduct set forth in the Second Amended Statement of Charges (Ex. #1B).

The Hearing Committee unanimously concluded that the evidence established that Respondent made false statements on his applications for initial licensure and for staff membership regarding Jones and Noyes Hospitals, that he knew the statements were false, and that he intended to mislead the Education Department, and the two hospitals regarding his background. Accordingly, the Committee concluded that Respondent engaged in the fraudulent practice of medicine, in violation of New York Education Law §6530 (2), and sustained the Fourteenth through Sixteenth Specifications of professional misconduct.

The Committee further concluded that Respondent's submission of the three applications constituted the filing of false reports, as set forth in New York Education Law §6530(21), and voted to sustain the Seventeenth through Nineteenth Specifications of professional misconduct.

Public Health Law §2805(k) sets forth the requirements for investigations prior to the granting or renewing of clinical privileges by hospitals. The statute provides, in pertinent part "Prior to granting or renewing professional privileges or association of any physician,…a hospital or facility approved pursuant to this article shall request from the physician… and ***the physician… shall be required*** to provide the following information… (b) where such association, employment, privilege or practice was discontinued, the reasons for its discontinuation". [Emphasis supplied].

The evidence has established that Respondent failed to disclose the fact that he had been dismissed from the Warren Hospital residency on applications for clinical staff membership submitted to both Jones Hospital and Noyes Hospital. Therefore, he violated the provisions of Public Health Law §2805-k(b). As a result, the Committee voted to sustain the Twentieth through Twenty-First Specifications of professional misconduct.

Patient A

Patient A had a past surgical history of an appendectomy, bilateral hernia repair, tonsillectomy, and a gastric bypass. Nevertheless, Respondent testified that the patient made no mention of these surgeries, and documented that he had a negative history for appendectomy and hernia repair. We find this testimony unbelievable, given that Patient A accurately reported his surgical history to subsequent treating physicians only eight hours following Respondent's discharge of the patient from the emergency department. (T. 694-696, 739; Ex. #5, pp. 6,8).

Respondent's documentation of his physical examination of patients is equally unreliable. He testified that it was not his practice to bring the "T" sheet for the patient into the examination room, and that he might not fill out the examination form until after the patient's discharge, or at the end of the shift. (T. 688-689). Moreover, he stated that there were three possible reasons why a listed finding or symptom on the T form is not checked off; the exam was negative; the exam was not applicable, or he forgot to check the box. (T. 657). This renders the form of little value in delivering patient care. For example, he could not recall whether he examined Patient A,

who presented with severe abdominal pain, for guarding or rebound pain, nor did he listen for and record bowel sounds.

Curiously, Respondent recorded negative examinations for a number of Patient A's other body systems (Ex. #3. p. 19). However, the abdominal examination should have been the focal point of Respondent's examination, given the patient's abdominal complaints. He failed to record the findings of a basic abdominal examination. We therefore conclude that he failed to perform an adequate abdominal examination for Patient A.

Patient A was seriously ill. His elevated white blood cell count, with a left shift, indicated a significant infectious or inflammatory process. Patient A had recently undergone gastric bypass surgery, a procedure with a high rate of complications. Respondent should have sought to admit Patient A for treatment with IV antibiotics and a possible surgical consultation. Instead, he diagnosed the patient with acute abdominal pain of unknown etiology. He discharged the patient with oral antibiotics and Prilosec with directions to follow-up with his physician in five days.

A reasonably prudent and competent physician would have obtained an adequate history and physical examination, and diagnosed Patient A with a serious condition warranting admission to the hospital. Respondent's failure to do so

demonstrated both negligence and incompetence, as defined above. The Committee further concluded that Respondent's actions did not rise to the level of either gross negligence or gross incompetence with regard to Patient A, and thus did not sustain the Third and Eighth specifications of professional misconduct.

Patient B

Patient B presented to the emergency department at grave risk of sudden death due to a myocardial infarction ("MI"). She had a history of past MI, cardiac bypass surgery, and recent placement of stents. She also had a recent history of chest pains at rest. This indicated that she was at risk of suffering from acute coronary syndrome ("ACS").

Respondent failed to obtain any of this information, or to appreciate its' significance. In fact, he recorded none of the patient's past cardiac history. Respondent claimed that he asked all of his patients about a surgical history. (T. 767). He claimed that he documented a negative history for both the bypass surgery and cardiac stents based on the patient's statements. (T. 767-768). We find this testimony to be incredible.

Both experts agreed that Patient B's symptoms were consistent with ACS and that Respondent should have sought the admission of the patient to the hospital. Instead, Respondent

diagnosed the patient as having GERD. He prescribed Nexium, discharged the patient, and told her to follow-up with her private physician in 5 to 7 days. This was wholly inappropriate, and placed the patient in grave danger of sudden death.

The Committee sustained all factual allegations concerning Patient B. The Committee concluded that Respondent's departures from the standards of care were so egregious as to demonstrate both gross negligence and gross incompetence. Accordingly, the Hearing Committee voted to sustain the Fourth and Ninth specifications of professional misconduct.

Patient C

Patient C, a resident at the St. Lawrence Psychiatric Center, had just been discharged from CHMC following a sixteen day admission. The transfer summary from St. Lawrence expressly stated that the reason for the transfer was to rule out an intestinal obstruction.

Respondent claimed that he had no knowledge of these facts, despite the fact that the nursing notes recorded that the patient had just been released from the hospital. Moreover, the transferring physician at St. Lawrence documented that she had contacted the emergency department physician (Respondent) directly. (Ex. #8, p.15).

Respondent failed to perform and document an adequate abdominal and rectal examination consistent with the patient's complaints. He did order a series of flat and upright abdominal x-rays. He then claimed, without a credible explanation, that he received and reviewed only two of the films. Respondent testified that in SE: 3 he saw stool in the rectal vault, and saw some bowel dilation in SE: 4. (T. 99).

Respondent diagnosed the patient with stool impaction. He ordered magnesium citrate, which the patient vomited. Magnesium citrate contracts the bowel. He also ordered an enema which failed to produce a bowel movement.

The negative results of these treatments demonstrate that the patient did not have impacted stool in the rectum. Even if one were to assume that Respondent only saw the two films, there is no basis for his diagnosis of stool impaction. The films showed no sign of stool in the rectal vault, and bowel dilation consistent with an obstruction. In fact, the complete set of x-rays provides dramatic proof of the patient's bowel obstruction. His own expert, Dr. Takats, acknowledged that bowel compression by magnesium citrate was the wrong treatment for Patient C. (T. 1093).

The objective evidence available to Respondent clearly indicated that the patient should have been admitted, and a

surgical consultation obtained. Respondent failed to appreciate the significance of the evidence, and discharged the patient back to St. Lawrence. The same day, she was admitted to Crouse Hospital in Syracuse and was operated on for a perforated sigmoid volvulus.

The Hearing Committee unanimously concluded that all of the factual allegations raised regarding Patient C had been sustained, and that the medical treatment rendered by Respondent demonstrated both negligence and incompetence. The Committee further concluded that Respondent's mishandling of the case demonstrate gross incompetence, although not gross negligence. They voted to sustain the Tenth specification and dismiss the Fifth specification.

Patient D

Patient D was a registered nurse who had previously worked at CHMC. She gave a chief complaint of possible gallbladder attack to the triage nurse. The evening that she presented to the emergency department, Patient D called Dr. Yitta, a general surgeon, and reported her abdominal symptoms. She also told him that she had experienced a gallbladder attack one month earlier and that for the past two or three days she had been eating heavy Spanish rice.

Nevertheless, Respondent claimed that Patient D ***denied*** that food exacerbated her condition and denied having similar symptoms previously. Respondent made no record of the location of Patient D's pain on physical examination, even though she described it as a 10 out of 10. He did not document any assessment of guarding, rebounding, organ enlargement or McBurney's point tenderness. He also failed to order a urinalysis.

Respondent diagnosed Patient D as having chest wall pain, despite a complete lack of symptoms or examination findings suggestive of such a diagnosis. Dr. Takats acknowledged that Patient D's clinical findings and history indicated an abdominal pathology. Respondent then prescribed two NSAIDs for Patient D - Toradol and Mobic. The patient had reported an allergy to Motrin, another NSAID. Before prescribing these drugs, Respondent should have, at minimum, obtained further history about the allergy from the patient.

The Hearing Committee sustained all of the factual allegations raised regarding Patient D. Respondent's deviations from the standards of care where so egregious that the Committee concluded that they demonstrated both gross negligence (Sixth specification) and gross incompetence (Eleventh specification).

Patients E, F and G

These three patients all presented with various fractures. Patients E and G both required orthopedic consultations before discharge. Respondent acknowledged this but claimed that he did contact an attending orthopedic surgeon. There are no records of any such consultations in the hospital records. Dr. McLoughlin, the orthopedic surgeon on staff at CHMC, testified that he had no recollection of being contacted by Respondent regarding Patient E. He further testified that he was certain that he was not contacted regarding Patient G, a young boy with a serious fracture. Again, there was no consultation noted in the chart.

The Hearing Committee concluded that Respondent failed to obtain the necessary orthopedic consultations, or to arrange for a timely transfer to a facility where the patients could receive orthopedic treatment. This failure placed the patients at increased risk of complications due to the delay in reducing their fractures. The Committee concluded that these deviations demonstrated both negligence and incompetence, but did not rise to the level of either gross negligence or gross incompetence.

Patient F sustained a fracture following a fall from a ladder. His pulse, as taken by the nurse in triage, was 46 beats per minute. This was a significantly slow heart rate. At

a minimum, Respondent should have repeated the pulse rate, to determine whether it was indeed so slow. If so, then a cardiac work-up would have been warranted. Respondent's failure to at least re-check the heart rate was a deviation from the standard of care, and demonstrated both negligence and incompetence. Again, the Committee concluded that this deviation did not rise to the level of either gross negligence or gross incompetence.

Negligence/Incompetence on More Than One Occasion

The evidence clearly established that Respondent was both negligent and incompetent in his treatment of each of the seven patients. In several instances, his care rose to the level of gross negligence and gross incompetence. Thus, it is clear that he is also guilty of negligence on more than one occasion, in violation of New York Education Law §6530(3), and incompetence on more than one occasion, in violation of New York Education Law §6530(5). Accordingly, the Hearing Committee voted to sustain the First and Second specifications of professional misconduct.

Failure to Maintain Records

Respondent's medical records were woefully inadequate. He failed to document appropriate medical histories and physical examinations for each of the seven named patients. Critical pieces of information were missing. He failed to document any

appropriate consultations with specialists, although he claimed to have received them. The Hearing Committee concluded that in each instance Respondent failed to maintain records which accurately reflected the care and treatment provided to the patients. Accordingly, the Committee voted to sustain the Thirteenth specification of professional misconduct.

DETERMINATION AS TO PENALTY

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

The evidence established that Respondent is both an incompetent diagnostician and an unreliable source of facts. He demonstrated both gross negligence and gross incompetence with regard to some of the patients. Patients B and C were seriously ill, with potentially life-threatening conditions. They should have been admitted to the hospital, yet Respondent discharged them with incorrect diagnoses. The remaining cases all illustrate poor care, as well.

Respondent had only recently completed his residency training. One would reasonably expect that his knowledge and skills would be at their peak. Nevertheless, there is an obvious disconnect between the patients' presenting conditions and Respondent's evaluation and treatment decisions.

"There seems to be a disjointed relationship between Dr. Hudson's knowledge of facts and his ability to apply them clinically… He seems to get overwhelmed when there is more than one thing to be attended to. As a result, he is often focused on the wrong thing… Dr. Hudson has not developed any insight into his deficiencies…." (Ex. #27, p.24).

The observation quoted above was made in 2003 by one of Respondent's supervising physicians during his unsuccessful year in the Warren Hospital residency program. It is apparent that the deficiencies noted back then have not been addressed by his subsequent training, which was completed in 2007. During a four month period at Claxton-Hepburn Medical Center, Respondent failed to diagnose life-threatening conditions in two patients and gave substandard care to all seven of the patients named in this case. He failed, on numerous occasions, to obtain necessary medical histories, perform indicated physical examinations, and to consult with appropriate specialists for timely care.

Respondent claimed that he was simply overwhelmed by the volume of patients he had to treat in the emergency department. In a rare moment of candor, Respondent admitted that he took the position in the emergency department at Claxton-Hepburn Medical Center (an overnight shift) because he was hoping for a light patient load, and the opportunity to sleep (while being paid). (*See*, T. 830-834). He placed his own concerns above the needs of his patients.

Under the circumstances, we unanimously concluded that Respondent is not a viable candidate for any further re-training. Similarly, no amount of supervision would correct the deficiencies in Respondent's clinical abilities. Therefore, revocation of his medical license is the only sanction which will adequately protect the public.

Respondent also demonstrated a fundamental lack of integrity. Respondent obtained his New York medical license by fraud, and fraudulently misrepresented his background to both the State Education Department and two hospitals. He repeatedly claimed that patients essentially gave him false information, despite overwhelming evidence to the contrary. No amount of retraining or supervision can correct a basic lack of honesty. Again, this led the Hearing Committee to the conclusion that Respondent's fraud provides a separate and independent basis for

the revocation of Respondent's license to practice medicine in New York State.

ORDER

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

1. The First through Second, Fourth, Sixth, Ninth through Eleventh, and Thirteenth through Twenty-Second Specifications of professional misconduct, as set forth in the Second Amended Statement of Charges, (Exhibit #1B) are **SUSTAINED**;

2. The Third, Fifth, Seventh, Eighth, and Twelfth Specifications of professional misconduct, as set forth in the Second Amended Statement of Charges are **DISMISSED;**

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED**;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: **Lafayette, New York**
5/1/ **,2010**

REDACTED

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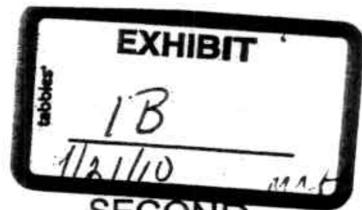
APPENDIX I



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

IN THE MATTER

OF

FITZGERALD HUDSON, M.D.

SECOND AMENDED STATEMENT OF CHARGES

Fitzgerald Hudson, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 24, 2007, by the issuance of license number 246593 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (Patients are identified by name in Appendix A) in the Emergency Department of Claxton-Hepburn Medical Center, in Ogdensburg, New York on May 29, 2008 through May 30, 2008 for complaints of abdominal pain and nausea, among other conditions. Respondent's care of Patient A deviated from accepted standards of medical care as follows:

1. Respondent failed to perform an adequate physical examination of Patient A.
2. Respondent failed to obtain and /or document an adequate surgical history from Patient A.
3. Respondent failed to appropriately and /or adequately diagnose Patient A's condition.
4. Respondent failed to seek the admission of Patient A to the hospital and/or obtain an appropriate consultation.
5. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B in the Emergency Department of Claxton-Hepburn Medical Center on April 14, 2008 through April 15, 2008 (April 14, 2008 Emergency Department care), and on a second occasion on April 15, 2008 for complaints of chest pain. Following her discharge from the Emergency Department by Respondent at approximately 1:25 A.M. on April 15, 2008, Patient B was admitted to Claxton-Hepburn Hospital approximately six hours later (7:06 A.M.) to be evaluated for acute coronary syndrome after further complaints of chest pressure. Respondent deviated from accepted standards of care in his care of Patient B as follows:

1. Respondent failed to take an adequate cardiac history from Patient B at the time of her April 14, 2008 Emergency Department care.
2. Respondent failed to adequately rule out a cardiac cause for Patient B's chest pain and/or failed to adequately diagnose her condition at the time of her April 14, 2008 Emergency Department care.
3. Respondent failed to appropriately interpret Patient B's ECG study at the time of her April 14, 2008 Emergency Department care.
4. Respondent failed to seek the admission of Patient B to the hospital at the time of the April 14, 2008 Emergency Department care and/or failed to obtain a timely consultation with a cardiologist.
5. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C for abdominal pain, among other conditions, in the Emergency Department of Claxton-Hepburn Medical Center on February 26, 2008. Respondent's medical care of Patient C

deviated from accepted standards of medical care as follows:

1. Respondent failed to perform an adequate physical exam on Patient C.
2. Respondent failed to adequately interpret Patient C's abdominal x-rays.
3. Respondent failed to appropriately and/or adequately diagnose Patient C's condition.
4. Respondent failed to obtain a timely surgical consultation for Patient C and/or failed to seek the admission of Patient C to the hospital.
5. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided medical care to Patient D for complaints of abdominal pain, among other conditions, in the Emergency Department of Claxton-Hepburn Medical Center on May 22, 2008. Respondent's medical care of Patient D deviated from accepted standards of medical care as follows:

1. Respondent failed to perform an adequate physical examination on Patient D.
2. Respondent failed to order indicated diagnostic testing of Patient D and/or obtain an appropriate consultation.
3. Respondent failed to appropriately and/or adequately diagnose Patient D's condition.
4. Respondent failed to take an adequate history of the side effects of Motrin for Patient D before prescribing Toradol and/or Mobic.
5. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent provided medical care to Patient E in the Emergency Department of Claxton-Hepburn Medical Center on April 29, 2008 for a left knee fracture. Patient E was evaluated by an orthopedic surgeon on April 30, 2008 who determined that an open reduction and internal fixation of the knee fracture was necessary. Respondent deviated from accepted standards of medical care in his care of Patient E as follows:

1. Respondent failed to obtain an adequate history from Patient E.
2. Respondent failed to perform an adequate physical examination on Patient E.
3. Respondent failed to obtain a timely and/or adequate consultation with an orthopedic surgeon regarding Patient E's fracture.
4. Respondent failed to maintain an adequate medical record for Patient E.

F. Respondent provided medical care to Patient F for a left wrist fracture and head laceration in the Emergency Department of Claxton-Hepburn Medical Center on June 5, 2008. Respondent's care of Patient F deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain an adequate history from Patient F.
2. Respondent failed to adequately evaluate Patient F by physical examination and/or neurological examination and/or diagnostic testing.
3. Respondent failed to adequately evaluate Patient F's bradycardia, and/or failed to seek the admission of Patient F to the hospital.
4. Respondent failed to maintain an adequate medical record for Patient F.

G. Respondent provided medical care to Patient G for angulated fractures of his right wrist, among other conditions, in the Emergency Department of the Claxton-Hepburn Medical Center on May 5, 2008. Respondent's medical care of Patient G deviated from accepted standards of care as follows:

1. Respondent failed to obtain a timely and/or adequate orthopedic consultation concerning Patient G's bone fracture.
2. Respondent failed to adequately treat Patient G's pain and/or expected pain.
3. Respondent failed to maintain an adequate medical record of Patient G's care.

H. Respondent, on or about August 22, 2008, completed an application for his appointment to the medical staff of Jones Memorial Hospital, Wellsville, New York (Jones application). Respondent answered "No" to the following question on the Jones application:

> 6. Have you ever been denied or had suspended or restricted completion of training or certification of completion of training by any healthcare facility?

Respondent was dismissed from the Warren Hospital Family Medicine Residency Program on or about July 27, 2003 after completing only one year or a part of one year of a three year training program due to performance issues. The Jones application included the following oath by Respondent:

> I fully understand that any significant false statement or omissions from the application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge.

Respondent's conduct in completing the Jones application deviated from accepted standards of care as follows:

1. Respondent failed to answer "Yes" to question no. 6 on page 3 of 9 of the Jones application and/or disclose that he was denied or restricted from completing training in a family practice residency at Warren Hospital in July 2003.
2. Respondent represented on his Jones application that the information submitted on the application was true to the best of his knowledge, when Respondent knew or should have known that certain information submitted on the application was not true or that he omitted requested information from the application.
3. Respondent represented on his Jones application or represented to third parties who completed his Jones application on his behalf that he had earned a Bachelor of Science degree from York University when Respondent knew that York University had not conferred any Bachelor's degree upon him.

I. Respondent on or about August 25, 2008 submitted an application for admission to the medical staff of Nicholas H. Noyes Memorial Hospital, Dansville, New York (Noyes application). On page 7 of the Noyes application, Respondent answered the following question "No".

> Have you ever been denied or had suspended or restricted completion of training or certification of training by any healthcare facility?

Respondent's conduct in completing his Noyes application deviated from accepted standards of care as follows:

1. Respondent failed to answer "Yes" to the above question on page 7 of the Noyes application and/or failed to disclose that he had been denied or restricted from completing training in the Warren Hospital Family Medicine Training Program on or about July 27, 2003 due to his performance issues in the training program.
2. Respondent represented on his Noyes application that he had earned a Bachelor of Science degree from York University, Toronto Canada, and/or that he had graduated from York University in "08/1990", when Respondent knew that York University had not conferred any Bachelor's degree upon him and/or that he had not graduated from York University.
3. Respondent represented on his curriculum vitae that he earned a Bachelor of Science degree from York University, Ontario, Canada in 1990, when Respondent knew that York University had not conferred a degree upon him.

J. Respondent filed an application for a New York State Medical License on or about September 6, 2007. Respondent answered "No" to question no. 14 of the application which reads as follows:

> Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures.

The license application included the following affirmation by Respondent.

> I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I

understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Respondent's conduct in completing the application for his New York State Medical License deviated from the accepted standards of care as follows:

1. Respondent failed to answer "Yes" to question no. 14 of the New York State application for a medical license and/or disclose that he had been restricted or terminated from his professional medical training at Warren Hospital on or about July 27, 2003.
2. Respondent represented on his New York State medical license application that the information submitted on the application was true, complete and correct, when Respondent knew or should have known that certain information submitted on the application was not true or that he omitted requested information from the application.
3. Respondent represented to the Federation Credentials Verification Service (FCVS) that he had earned a Bachelor of Science degree from York University, Toronto, Canada when Respondent knew he had not earned a Bachelor's degree from York University and/or with the further knowledge that the FCVS would report his academic credentials to the New York State Education Department in connection with Respondent's application for a New York State Medical license.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts alleged in the following Allegations: A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, G and G.1 and/or G and G.2.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts alleged in the following Allegations: A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, F and F.1, F and F.2, F and F.3, G and G.1 and/or G and G.2.

THIRD THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. The facts as set forth in Factual Allegations: A and A.1 and/or A and A.4.
4. The facts as set forth in Factual Allegations: B and B.1, and/or B and B.2, and/or B and B.3, and/or B and B.4.
5. The facts as set forth in Factual Allegations: C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4.
6. The facts as set forth in Factual Allegations: D and D.1, and/or D and D.2, and/or D and D.3.
7. The facts as set forth in Factual Allegations: F and F.1.

EIGHTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

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

8. The facts as set forth in Factual Allegations: A and A.1 and/or A and A.4.
9. The facts as set forth in Factual Allegations: B and B.1, and/or B and B.2, and/or B and B.3, and/or B and B.4.
10. The facts as set forth in Factual Allegations: C and C.1, and/or C and C.2, and/or C and C.3, and/or C and C.4.
11. The facts as set forth in Factual Allegations: D and D.1, and/or D and D.2, and/or D and D.3.

12. The facts as set forth in Factual Allegations: F and F.1.

THIRTEENTH SPECIFICATION

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in the Petitioner charges the following:

13. The facts set forth in Factual Allegations: A and A.5, and/or B and B.5, and/or C and C.5, and/or D. and D.5, and/or E and E.4, and/or F and F.4, and/or G and G.3 .

FOURTEENTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) by reason of his having practiced the profession of medicine fraudulently in that Petitioner charges the following:

14. The facts set forth in Factual Allegations: H and H.1, and/or H and H.2, and/or H and H.3.
15. The facts set forth in Factual Allegations: I and I.1, I and I.2, and/or I and I.3.
16. The facts set forth in Factual Allegations: J and J.1, and/or J and J.2, and/or J and J.3.

SEVENTEENTH THROUGH NINETEENTH SPECIFICATIONS

FILING A FALSE REPORT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(21) by reason of his having made or filed a false report, in that Petitioner charges the following:

17. The facts as set forth in Factual Allegations: H and H.1, and/or H and H.2, and/or H and H.3.
18. The facts as set forth in Factual Allegations: I and I.1, I and I.2, and/or I and I.3.
19. The facts as set forth in Factual Allegations: J and J.1, and/or J and J.2, and/or J and J.3.

TWENTY THROUGH TWENTY-FIRST SPECIFICATIONS

VIOLATION OF EDUCATION LAW §2805-k(1)(b)

Respondent is charged with having violated N.Y. Educ.Law §6530(14) in that Respondent failed to disclose on applications for hospital privileges the discontinuance and/or the reason for the discontinuance of Respondent's association, employment or privileges with the Warren Hospital in violation of N.Y.Educ.Law §2805-k(1)(b) in that Petitioner alleges the following:

20. The facts as set forth in Factual Allegations: H and H.1.
21. The facts as set forth in Factual Allegations: I and I.1.

TWENTY-SECOND SPECIFICATION

OBTAINING LICENSE FRAUDULENTLY

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530 (1) by reason of his having obtained his New York State medical license fraudulently, in that Petitioner charges the following:

22. The facts as set forth in Factual Allegations: J and J.1 and/or J and J.2, and/or J and J.3.

DATE: January 20, 2010
Albany, New York

REDACTED

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