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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

Public

August 3, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert J. Switzer, II, R.P.A.
c/o Stephen Pusatier, Esq.

REDACTED

Stephen F. Pusatier, Esq.
Pusatier, Sherman, Abbott & Sugarman
2464 Elmwood Avenue
Kenmore, New York 14217

Joel Abelove, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237-0032

RE: In the Matter of Robert J. Switzer, II, R.P.A.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-140) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

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

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

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

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

ROBERT J. SWITZER, II, R.P.A.

DETERMINATION

AND

ORDER

BPMC #10-140

Charles J. Vacanti, M.D. (Chair), Jagdish M. Trivedi, M.D., and William W. Walence, Ph.D, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

Christine C. Traskos, Esq., Administrative Law Judge, ("**ALJ**") served as the Administrative Officer. The Department of Health appeared by Joel E. Abelove, Esq., Associate Counsel. Respondent, Robert J. Switzer, II, R.P.A, appeared personally and was represented by Pusatier, Sherman, Abbott & Sugarman, Stephen Pusatier, Esq. and Jennifer Hemming Esq. of Counsel.

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

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	January 21, 2010
Date of Answer to Charges:	February 1, 2010
Hearings Dates:	March 3-4, 2010 May 5 -7, 2010

Pre-Hearing Conference Held:	February 18, 2010
Location of Hearing:	Alliance Court Reporting, Inc. 183 E. Main St. -Suite 1500 Rochester, NY 14604
Witnesses called by the Department of Health:	Patient A Wife of Patient A Patient B Wife of Patient B Mother of Patient B Patient C Girlfriend of Patient C Patient D Wife of Patient D Catherine J. Flannery, M.D. Suzanne Beamish, N.P. Rachel Trombley Rebecca Kane,R.P.A. Deirdre Flynn, Esq.
Witnesses called by the Respondent:	Robert J. Miller Donald Hotaling, R.N. Mary Olmstead, R.N. Andrew Reese, M.D. Tamara J. Jones, R.N. Shannon Spaulding, R.N. Bonnie Ann Lupo, N.P. Warren Weinstein, R.P.A. Robert Switzer II, R.P.A.
Department's Proposed Findings of Fact, Conclusions of Law, and Sanction:	Received June 17, 2010
Respondent's Proposed Findings of Fact, Arguments, and Conclusion:	Received June 17, 2010
Deliberations Held:	June 29, 2010

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 *et seq.* of the Public Health Law of the State of

New York ["**P.H.L.**"]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner" or "Department**") pursuant to §230 of the P.H.L. Robert J. Switzer II, R.P.A., ("**Respondent**") is charged with seven (7) specifications of professional misconduct pursuant to §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: willfully harassing, abusing or intimidating a patient either physically or verbally; practicing the profession with gross negligence on a particular occasion; practicing the profession with negligence on more than one occasion, practicing the profession with gross incompetence, practicing the profession with incompetence on more than one occasion, conduct in the practice of medicine which evidences moral unfitness to practice medicine and failing to maintain a record for each patient which accurately reflects the care and treatment of that patient. The charges are more specifically set forth in the Statement of Charges, dated January 21, 2010, a copy of which is attached as Appendix 1 and made a part of this Determination and Order. Respondent denies the factual allegations and specifications of misconduct contained in the Statement of Charges.

FINDINGS OF FACT

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

All Findings of Fact made by the Hearing Committee were established by at least a

preponderance of the evidence.[1]

1. Respondent was authorized to practice medicine as a physician assistant in New York State on or about September 13, 2002 by the issuance of license number 008952 by the New York State Education Department (Pet.'s Ex. 1).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (P.H.L. §230[10][d]). (Pre-hearing transcript 2/18/10, p.12)

Patient A

3. Patient A was a 52 year-old man who presented to the Emergency Room (ER) at Strong Memorial Hospital, Rochester, New York, on June 24, 2009, with a chief complaint of back pain and pain to the head.(Pet. Ex.4; T.284)

4. Patient A was initially evaluated by the nursing staff, and then by Respondent. (Pet. Ex. 4, pp. 5-7, 11-15, 18, 21-22; T.815).

5. Patient A made no complaint of genitourinary nature or testicular pain upon admission, (Ex.4, pp.5-6; T.286, 288-289) however, Respondent notes such a complaint in the record. (Pet. Ex. 4, pp.18-19, T. 816, 820-821, 823-824)

6. Respondent admits, through his answer, that he performed a genitourinary exam which elicited pain to Patient A's testicles, but failed to order a urine test or any radiological imaging, and failed to examine for rectal tone. (Resp. Ex. A)

7. Patient A testified that Respondent never checked his back(T. 285), but the patient's record indicates that Respondent performed a range of motion test on Patient A's back and charted that there were well healed scars on the mid-line of his back. (Pet. Ex. 4, p.19, T. 822)

8. Patient A was examined in bed #47 which is located in an exam room with two other

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[1] Numbers in parentheses refer to Hearing transcript page numbers (T.). "Ex." refers to exhibits admitted into evidence by Petitioner (Pet.) or Respondent (Resp.).

beds. (T. 283,671) The beds are separated only by a curtain. (T.348, 688, 813)

9. Respondent's record notes that Patient A complained of "some low back discomfort with some mild radiation down both legs." (Pet. Ex. 4. p.21) Respondent palpated Patient A's abdomen as well as his testicles based on these complaints. Patient A's wife was in the room for this part of the examination. (T. 349-350)

10. Respondent did not violate the standard of care by failing to examine the patient for rectal tone. Respondent testified that he perceived Patient A's testicle pain as being referred or radiating pain from his back. (T. 826) There was no clinical reason to do an ultrasound as Patient A did not present with symptoms of testicular torsion. (T. 827)

11. Respondent's expert, Warren Weinstein, R.P.A. stated that the instrument to take the sonogram would have increased Patient A's pain and that the diagnosis of testicular torsion is made clinically rather than by sonogram. (T. 737)

12. The ER record does record an explanation for Patient A's testicular pain and the clinical decision-making or the diagnosis. (Pet. Ex. 4, p.19) Mr. Weinstein concurs with Respondent that he accurately diagnosed Patient A with back pain as a result of Patient A's multiple back operations and history of back problems. (T. 721)

13. Patient A testified that Respondent wore gloves during the examination. (T. 291)

14. Patient A testified that he received a shot of Toradol at the VA that morning but it did not ease his pain. (T. 302) The first medication Respondent administered to Patient A was Dilaudid, based on the medications that Patient A was already prescribed. It was administered at 7:25 p.m. The nurse informed Respondent that the Dilaudid was ineffective, so Respondent prescribed two Percocet because that is what Patient A normally takes at home and he had not taken any Percocet that day. (Pet. Ex. 4, p.22; T. 832-833) The nurse administered the Percocet at 8:00p.m. (T. 833) Patient A informed the nurse that the Percocet was not working. He requested another shot and then wanted to leave. (T. 326, 833-843) Respondent went back in to see Patient A who reported

he was feeling better but thought another shot of Dilaudid would help him. He was administered the third medication at 9:20 p.m. and was discharged 25 minutes later. (T. 834-835)

15. The narcotics prescribed to Patient A were not excessive. (T.713-714)

16. Respondent asked the appropriate questions to rule out Cauda Equina Syndrome. The symptoms included pain, saddle numbness in the butt area, thigh area and perineal area along with a definite neurovascular decrease. (T. 715-716)

17. Respondent appropriately charted that there was no nausea, vomiting, abdominal pain and no bowel or bladder problems. Patient A was also neurovascularly intact with deep tendon reflexes in both lower extremities that were 2+ (Pet. Ex. 4,p. 18-19; T. 824-825).

18. Patient A had imaging done at the VA prior to his visit to Strong Memorial Hospital and there was no need for Respondent to repeat the process. (T. 466-467, 825)

19. It was not necessary for Respondent to examine Patient A's rectal tone/perineal sensation because Respondent already knew the patient had back problems and multiple surgeries. (T. 718-719)

20. Respondent's records for Patient A accurately reflect the evaluation and treatment of the patient.(Pet. Ex. 4;T. 721,843)

Patient B

21. Patient B was a 46-year-old man who presented to the ER at Strong Memorial Hospital on June 20, 2009, with a complaint of right posterior hip pain "through hip and down into thigh" for two weeks with no known injury, and right inguinal hernia pain. (Pet. Ex. 5, T.23, 66).

22. Patient B was initially evaluated by nursing staff and subsequently his care was assumed by Respondent. (Pet. Ex. 5, pp. 5-6, 10, 12-15, 17-21; T.881-883).

23. Respondent identified himself when he took Patient B back to the exam room. Patient B's wife first testified that Respondent identified himself as "Bob" and then on cross examination stated that he identified himself as "Dr. Switzer."(T. 134,138) Suzanne Beamish, a

nurse practitioner, who also had administrative duties testified that all providers at Strong Memorial are required to wear an identification badge. (T. 420) Respondent testified that he always wears a badge and has a lab coat with his name embroidered on it. (T. 903, 911)

24. Patient B did not present to the ER on June 20, 2009 with symptoms of testicular torsion. (T. 741, 893). Testicular torsion usually presents in younger males and the patient would have excruciating pain, most likely from trauma. Furthermore, Respondent did document his justification in not considering torsion. (T. 747-748, 750, 754-755)

25. An ultrasound of Patient B's testicle to rule out torsion was not medically justified. (T. 741, 748)

26. Respondent did not refer Patient B to a urologist or surgeon for a follow up because he has never referred a hernia patient to a urologist. Respondent did not obtain a surgical consult because the hernias were easily reducible.(T. 913) Respondent appropriately advised Patient B to follow up with his primary care physician. (T. 743, 756, 902-903)

27. Patient B was examined in Room #52 which was a revolving room at the hospital. (T.879) It is a swing room where exams are performed and then patients are brought right back out to the waiting room. (T. 681-682)

28. Respondent's records for Patient B accurately reflect the evaluation and treatment of the patient. (Pet. Ex.5 pp. 17-20; T.914)

Patient C

29. Patient C was a 43-year-old man who presented to Strong Memorial Hospital on April 24, 2008, with complaints of left upper quadrant pain which occurred after eating, past medical history of GERD and non-compliance with Zantac for two days.(Pet. Ex.6)

30. Patient C registered in the ER at 8:10 pm. (Pet. Ex. 6, p. 4; Resp. Ex. V; T. 148)

31. Patient C complained to Respondent that his urine was dark and that he had stomach pain. (T. 146, 148-149)

32. Patient C was seen in Bed #47 which is in a room that has three-stretchers. (T. 598)

33. Respondent ordered a urine test on Patient C, but no other laboratory or radiological tests. (Pet. Ex. 9)

34. An EKG was performed on Patient C and was read by Fred Ling, M.D., the head of interventional cardiology. Dr. Ling interpreted the EKG as non-specific T wave abnormalities. (Pet. Ex. 6, pp. 19, 21)

35. Patient C's record did not indicate that there were complaints of shortness of breath or chest pain and it supports the diagnosis of GERD. (T. 762)

36. Respondent's records for Patient C accurately reflect the evaluation and treatment of the patient. (Pet. Ex. 6, T. 764)

Patient D

37. Patient D was a 36- year- old man who presented to Strong Memorial Hospital on May 3, 2007, with complaints of inability to urinate and left flank pain. (Pet. Ex. 7)

38. Patient D was seen in a single room with one bed. (T. 191)

39. Robert J. Miller, is a medical technologist at Strong Memorial Hospital.(T.589) He was requested by Strong's Office of Counsel to review a urinalysis sample for Patient D from May 3, 2007. Mr. Miller reviewed the test for accuracy. He found that the lab report was accurate and that he did not see any presence of spermatozoa in the urine. (T. 590-593)

40. Patient D's history and physical exam support the diagnosis of prostatitis.(T. 782) Respondent diagnosed prostatitis in Patient D based upon his history of prostatitis, his inability to urinate, and the fact that he has taken Flomax and regularly sees a urologist. (T. 1074)

41. Conducting a prostate exam when you suspect prostatitis would potentially cause the patient to become septic and is contraindicated. (T. 781)

42. Patient D was properly referred back to his urologist. (T. 782)

43. Respondent's records for Patient D accurately reflect the evaluation and treatment

of the patient. (Pet. Ex. 7, T. 784)

CONCLUSIONS OF LAW

Respondent is charged with seven (7) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter. During the course of their 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:

Gross Negligence

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his/her conduct.

Negligence on More Than One Occasion

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

considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

Gross Incompetence

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. The Hearing Committee was advised that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Incompetence on More Than One Occasion

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

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by preponderance of the evidence, that all seven (7) specifications of professional misconduct should not be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of all witnesses presented by the parties. The Committee must determine the credibility of the witnesses in weighing each witness's testimony. First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When

the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's testimony and, at the same time, reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

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

Witnesses called by Petitioner:

Patient A

The Hearing Committee found Patient A's testimony full of inconsistencies. There was confusion about when he actually fell at the VA prior to coming to Strong Memorial. He testified that Respondent never checked his back and mainly focused on his genital area, yet the record shows that Respondent conducted a full range of motion exam and noted scars on Patient A's back. On cross- examination, Patient A acknowledged having these scars.(T. 310) The Hearing Committee found that Patient A's testimony regarding the first examination was not corroborated by his wife's testimony. His account of three additional sexual manipulations are not persuasive due his own admission of that after receiving a second shot of Dilaudid he said he was "feeling different in his mind." (T. 292) Patient A also testified that he left the ER without being discharged, but the medical record shows that he signed the discharge instructions. The Hearing Committee did not find Patient A's testimony persuasive enough to sustain the charges of sexual abuse.

Wife of Patient A

The Hearing Committee found the wife of Patient A to be a more credible witness but her testimony does not corroborate the testimony of her husband.

Patient B

The Hearing Committee does not believe Patient B because his testimony produced numerous inconsistencies that calls his overall credibility into doubt. He was inconsistent about what occurred during the course of Respondent's examination of him. The Hearing Committee further found it significant that Patient B lied under oath about his past drug use. He lied about prior LSD use and testified that he had not used cocaine in approximately one to two months. This was contradicted by his wife who acknowledged that he had used both marijuana and cocaine around 2:00 a.m. on the day of his appearance before the Hearing Committee.(T. 77, 135)

Wife of Patient B

The Hearing Committee also found the testimony of Patient B's wife to contain inconsistencies and she was not able to totally corroborate the testimony of her husband. This includes inconsistency about when she had the conversation with her husband about Respondent's sexuality and the degree of her husband's actual drug use.

Mother of Patient B

After Patient B testified that he informed his mother and his aunt about his concerns about his examination in the ER during a three way phone call. (T. 45) His mother testified that she was not aware of this particular phone call when the aunt was informed. The Hearing Committee finds that this testimony did not help corroborate Patient B's testimony.

Patient C

The Hearing Committee found the testimony of Patient C to be inconsistent regarding the conduct of Respondent's examination. He was uneasy relating information and specific details had to be drawn out of him. The Hearing Committee did not find his testimony persuasive enough to support the charges.

Girlfriend of Patient C

The Hearing Committee found that the testimony of Patient C's girlfriend did not corroborate

the testimony of Patient C. The Hearing Committee believes that she was outside of the curtain during the only examination conducted by Respondent and that she did not hear anything that was inappropriate.

Patient D

The Hearing Committee found Patient D's testimony highly inconsistent. There are significant contradictions between what he told the Rochester Police Department in 2007 (Pet. Ex.9) and his testimony at the hearing. More importantly, the lab results, which had been reviewed at the request of Strong Memorial Hospital showed there was no sperm in Patient D's urine sample. Also the Hearing Committee notes Patient D denied at the hearing that he had ever been diagnosed with a prostate problem or acute prostatitis which directly contradicts his medical history. As a result, the Hearing Committee found Patient D's testimony highly incredible.

Wife of Patient D

The Hearing Committee found that Patient D's wife had a poor memory for details and her testimony was not helpful to them.

Rebecca Kane, R.P.A.

Rebecca Kane, R.P.A. received her physician assistant certification from SUNY Stony Brook in 1994.(Pet. Ex. 8) She presently works as a physician assistant in the Emergency Department at Glens Falls Hospital. The Hearing Committee found her medical knowledge to be spotty. In particular, they reject her analysis of Patient C's alleged ischemia issues as his EKG showed non-specific findings and there were no clinical findings to justify additional testing. The Hearing Committee found her standard of care to be overreaching and not the standard of care that is applied to emergency room practice. As a result, the Hearing Committee gave her testimony little weight.

Catherine J. Flannery, M.D.

Dr. Flannery is a psychiatrist who diagnosed Patient B with posttraumatic stress disorder and continues to treat him. (T.253-255) The Hearing Committee believes that because Patient B withheld

information from her about his past and current drug use, she may not know Patient B as well as she may have thought. The Hearing Committee did not find her testimony helpful.

Suzanne Beamish, N.P.

Ms. Beamish is a long time employee of the Strong Memorial ER. She is the lead midlevel provider whose duties include orientation, scheduling and evaluation of employees. The Hearing Committee found her to be a credible witness and notes that she testified that Respondent received excellent evaluations from her. (T. 396)

Rachel Trombley

Ms. Trombley is an investigator for the Office of Professional Medical Conduct (OPMC). The Hearing Committee did not find her testimony helpful in resolving the charges.

Deirdre Flynn, Esq.

Ms. Flynn is the Senior Counsel in the Office of Counsel to Strong Memorial Hospital. The Hearing Committee found her testimony credible but not helpful in resolving the charges.

Witnesses called by Respondent:

Respondent, Robert Switzer, R.P.A

The Hearing Committee found Respondent's testimony to be credible. There were no inconsistencies in his testimony and he answered all questions posed to him to the satisfaction of the Hearing Committee.

Warren Weinstein, R.P.A.

Warren Weinstein, R.P.A. testified as Respondent's expert witness. Mr. Weinstein graduated from the physician's assistant program at Brooklyn Cumberland Medical Center, Long Island University in 1978. He has been employed in the Emergency Department at Montefiore Medical Center since 1981. (Resp. Ex. C) The Hearing Committee found Mr. Weinstein to be a very knowledgeable and credible witness who effectively testified to emergency room practices and treatments. The Hearing Committee gave his testimony great weight.

Robert J. Miller

Robert J. Miller, is a medical technologist at Strong Memorial Hospital and supervisor of the automated laboratory which routinely performs urinalysis testing. He has worked there for 29 years. (T.589) The Hearing Committee found him to be a credible witness.

Donald Hotaling, R.N.

Mr. Hotaling was at in the room with Patient C for part of the time and testified that the patient made no complaints to him about Respondent's care. The Hearing Committee found him to be a credible witness.

Mary Olmstead , R.N.

Ms. Olmstead is the Director of Nursing at Lifecare Medical Associates in Seneca Falls where Respondent worked in 2005 and is now presently employed there. She testified that she is not aware of any complaints of inappropriate behavior by the Respondent. The Hearing Committee had no reason to disbelieve her testimony.

Tamara J. Jones, R.N.

This nurse was working in the ER during Patient A's visit. Patient A was in bed #47. Ms. Jones testified that there was a prisoner accompanied by two guards in bed #49 at some point during Patient A's stay in the ER. The Hearing Committee had no reason to disbelieve this witness.

Shannon Spaulding, R.N.

This nurse testified about the care she provided to Patient D, and that he made no complaints about Respondent's care to her. The Hearing Committee had no reason to disbelieve this witness.

Bonnie Lupo, N.P. and Andrew Reese, M.D.

These were both character witnesses for Respondent. The Hearing Committee had no reason to disbelieve their testimony even though it is not helpful in resolving the charges.

PATIENT A

Factual Allegation A.1: Not Sustained

Factual Allegation A.2: Not Sustained

Factual Allegation A.3: Sustained

Factual Allegation A.4: Not Sustained

Factual Allegation A.5: Not Sustained

Factual Allegation A.6 : Not Sustained

Factual Allegation A.7: Not Sustained

Factual Allegation A.8: Not Sustained

Factual Allegation A.9: Not Sustained

Factual Allegation A.10: Not Sustained

Charge A.1

The Hearing Committee finds no proof whatsoever that Patient A presented to the Strong Memorial Emergency Room (ER) with complaints of face and finger injuries. The Triage note clearly states that the Patient A's chief complaint was "Back pain, fell last week at the VA."

Charge A.2

The Hearing Committee finds that while Patient A testified that Respondent never checked his back, the medical record contradicts his testimony because Respondent noted "some well healing scars midline in his low back" during a full range of motion exam. On cross-examination, Patient A confirmed the location of the scars on his back. (T. 310) The medical record indicates that Patient A complained to Respondent that he had "low back discomfort with some mild radiation down both legs." The record further states, "He said the pain does radiate into both testicles but he denies any pain or burning with urination...." The Hearing Committee concludes that Patient A's bilateral leg pain is consistent with the complaint of bilateral testicle pain and they do not sustain this charge.

Charge A.3

Respondent admits to this allegation.

Charge A.4

The Hearing Committee finds that Patient A's record does note an explanation for his testicular pain and Respondent's clinical decision making process. They concur with Respondent's expert witness, Mr. Weinstein who testified that the most likely source of Patient A's referred testicular pain was from Patient A's multiple operations and back problems. (T. 721)

Charge A.5

The Hearing Committee finds Patient A's testimony regarding the examination of his genitals to be quite confusing. Patient's A description of the first examination of his genital area was not corroborated by the testimony of his wife who was sitting at his bedside. The Hearing Committee is further concerned with Patient A's ability to recollect the incident due to the amount of medication he was on.

Patient A testified that after the effects of the second shot kicked in he started to feel "like I was having an-out-of body experience." (T. 289) Finally, the Hearing Committee has difficulty believing that these sexual events occurred on four separate occasions in a busy ER setting with numerous patients in nearby beds. The Hearing Committee finds there is insufficient evidence to sustain this charge.

Charges A.6 and A.7

Respondent testified that he always takes universal precautions when conducting patient examinations. Even Patient A acknowledged that Respondent was wearing gloves during his exam. (T. 291) The Hearing Committee finds that there is no evidence in the record to sustain these charges.

Charge A.8

The Hearing Committee concurs with Mr. Weinstein that since Patient A was still in pain

after the first and second medications were administered, the amount of narcotics prescribed by Respondent were not excessive.

Charge A.9

The Hearing Committee concurs with Respondent that Cauda Equina Syndrome is a very rare problem and that he adequately questioned the patient to rule it out. They also find that there was no medical justification to examine Patient A's rectal tone/perineal sensation.

Charge A.10

The Hearing Committee finds that Respondent's records for Patient A accurately reflect the evaluation and treatment of the patient.

PATIENT B

Factual Allegation B.1: Sustained

Factual Allegation B.2: Not Sustained

Factual Allegation B.3: Not Sustained

Factual Allegation B.4: Not Sustained

Factual Allegation B.5: Not Sustained

Factual Allegation B.6 : Not Sustained

Factual Allegation B.7: Not Sustained

Factual Allegation B.8: Not Sustained

Factual Allegation B.9: Not Sustained

Factual Allegation B.10: Not Sustained

Charge B.1

The facts in the medical record sustain this charge. (Pet. Ex. 5)

Charge B.2

Due to the inconsistencies in the testimony of Patient B, the Hearing Committee finds insufficient evidence to sustain this charge.

Charge B.3

According to the testimony of the wife of Patient B, the Hearing Committee finds that Respondent appropriately identified himself to Respondent before the start of the examination.

Charge B.4

The Hearing Committee finds that Patient B's testimony does not support this charge because Patient B testified that he does not remember Respondent trying to get him erect. (T. 48)

Charge B.5

Due to the inconsistencies in the testimony of Patient B, the Hearing Committee finds insufficient evidence to sustain this charge.

Charge B.6

Due to the inconsistencies in the testimony of Patient B regarding this allegation, (T. 48-49, 98-102), the Hearing Committee finds insufficient evidence to sustain this charge.

Charges B.7 and B.8

The Hearing Committee concurs with Mr. Weinstein that Patient B did not present to the ER with symptoms of testicular torsion, that no ultrasound was required and that Respondent's documentation supports that he ruled it out after an adequate examination .

Charge B.9

The Hearing Committee concurs with Mr. Weinstein, as well as Respondent, that referring Patient B back to his primary care physician was appropriate.

Charge B.10

The Hearing Committee finds that Respondent's records for Patient B accurately reflect the evaluation and treatment of the patient.

PATIENT C

Factual Allegation C.1: Sustained

Factual Allegation C.2: Withdrawn

Factual Allegation C.3: Sustained

Factual Allegation C.4: Not Sustained

Factual Allegation C.5: Not Sustained

Factual Allegation C.6 : Not Sustained

Factual Allegation C.7: Not Sustained

Charge C.1

The Hearing Committee notes that while the initial assessment in the ER noted the chief complaint as left upper quadrant pain, Patient C told Respondent that he had complaints of blood in his urine and semen. (Pet. Ex. 6,p.12)

Charge C. 2

Withdrawn by the Department

Charge C.3

Respondent admits that he ordered the urine test based on the patient's complaint's of blood in the urine and semen. When the test came back positive, that supported the patient's complaint and there was no need for a further work up for liver or kidney disease. (T. 760) The Hearing Committee concurs with Mr. Weinstein's opinion.

Charge C.4

The Hearing Committee concurs with Dr. Weinstein that no further evaluation after the patient's electrocardiogram was required since the patient had already been seen by a board certified ER physician who cleared Patient C to be treated in a non-monitored area. (T.761-762)

Charge C.5

The Respondent testified that his examination of Patient C was brief and the Hearing Committee believes that this is supported by the time line from the patient's chart. (Resp. Ex. V) The record indicates that Respondent examined the patient at 9:15 p.m. and wrote his orders at 9:30 p.m. The Hearing Committee finds that a genital examination and questions about his sexual history

were appropriate given his complaints of blood in both urine and semen. The Hearing Committee believes that it is quite possible that Patient C achieved an inadvertent erection during the examination and became embarrassed as per the Respondent's explanation. (T. 969) As a result, the Hearing Committee finds insufficient evidence to sustain this charge.

Charge C. 6

The Hearing Committee finds no evidence in the record to sustain this charge

Charge C.7

The Hearing Committee finds that Respondent's records for Patient C accurately reflect the evaluation and treatment of the patient.

PATIENT D

Factual Allegation D.1: Sustained

Factual Allegation D.2: Not Sustained

Factual Allegation D.3: Not Sustained

Factual Allegation D.4: Not Sustained

Factual Allegation D.5: Not Sustained

Factual Allegation D.6 : Not Sustained

Factual Allegation D.7: Not Sustained

Factual Allegation D.8: Not Sustained

Charge D. 1

The Hearing Committee finds that the Patient D's record supports his complaints of inability to urinate and left flank pain.

Charge D.2

The Hearing Committee finds there is insufficient evidence in the record to sustain this charge. This is due to the verified lack of semen in the urinalysis, the inconsistencies in the

testimony of Patient D and the police report, as well as the time line of events in the patient's chart. (Pet. Ex 9, Resp. Ex. V. T. 199, 212,219)

Charge D.3

The Hearing Committee finds that the inconsistencies in Patient D's testimony do not support this charge. The Hearing Committee further believes that Respondent did not conduct a rectal exam due to Patient D' s history of prostatitis.

Charge D.4

Due to the inconsistencies in Patient D's testimony, the Hearing Committee finds insufficient evidence to sustain this charge.

Charge D.5

Since Patient D testified that Respondent did not touch his penis a second time, the Hearing Committee finds insufficient evidence to sustain this charge. (T. 224-225)

Charge D.6

Due to the inconsistencies in Patient D's testimony, the Hearing Committee finds insufficient evidence to sustain this charge.

Charge D.7

The Hearing Committee strongly disagrees with Ms. Kane's opinion and agrees with Mr. Weinstein and Respondent that Patient D's history and physical exam support the diagnosis of prostatitis.

Charge D.8

The Hearing Committee finds that Respondent's records for Patient D accurately reflect the evaluation and treatment of the patient.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee, by unanimous vote, determines that no penalty can be assessed against Respondent's license to practice as a physician assistant in New York State.

The Hearing Committee did not sustain any of the Specifications of Misconduct alleged in the Statement of Charges. The Hearing Committee assessed each patient independently and concluded that each patient's testimony contained inconsistencies and lacked corroboration by the witnesses called on their behalf. The Hearing Committee is also concerned about the effects of drugs, whether prescribed or recreational, upon Patients A through D. The Hearing Committee believes that these patients may been under the influence of drugs during their ER examinations as well as at the time of their testimony.

Moreover, the Hearing Committee has difficulty believing that such unorthodox behavior could occur in a busy wing of the ER where Respondent would have little control over the environment. Finally, the Hearing Committee finds there is no evidence in the record to call into question Respondent's level of care and skill in the practice of his profession.

The Hearing Committee concludes that the Petitioner has not proven the charges by the preponderance of the evidence. As a result, no action is taken against Respondent's license.

ORDER

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

1. The First Specification through Seventh Specifications contained in the Statement of Charges (Petitioner's Exhibit # 1) are **NOT SUSTAINED**; and

2. No Penalty is assessed against **Respondent's license to practice as a physician assistant in the State of New York;** and

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

DATED: ~~Rochester~~ cv PITTSFORD
29 July **2010**

REDACTED

Charles J. Vacanti, M.D., (Chairperson)
Jagdish M. Trivedi, M.D.
William W. Walence, Ph.D

Robert J. Switzer, II, R.P.A.
c/o Stephen Pusatier, Esq.
REDACTED

Stephen F. Pusatier, Esq.
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Joel Abelove, Esq.
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APPENDIX 1

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

IN THE MATTER

OF

ROBERT J. SWITZER, II, RPA

NOTICE
OF
HEARING

TO: ROBERT J. SWITZER, II, c/o Stephen Pusatier, Esq.

REDACTED

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 3-4, 2010, at 10:00 a.m., at the Alliance Reporting Building, Suite 1500, 183 East Main Street, Rochester, New York, 14604, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES F. HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-

0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

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

DATED: Albany, New York
January 21, 2010

REDACTED

Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Joel E. Abelove
Associate Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2512
Albany, New York 12237-0032
(518) 473-4282

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

IN THE MATTER

OF

ROBERT J. SWITZER, II, RPA

STATEMENT

OF

CHARGES

ROBERT J. SWITZER, II, RPA, the Respondent, was authorized to practice medicine as a physician assistant in New York State on or about September 13, 2002, by the issuance of license number 008952 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A on June 24, 2009, in the Emergency Department at Strong Memorial Hospital, Rochester, New York 14627. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Patient A presented to Strong Memorial Hospital with a complaints of face, finger, and back pain.
2. Patient A made no complaint of a genitourinary nature or testicular pain; however, Respondent notes such a complaint.
3. Respondent notes that he performed a genitourinary exam which elicited pain to Patient A's testicles, but failed to order a urine test or any radiological imaging, and failed to examine for rectal tone.
4. Respondent failed to note an explanation for Patient A's testicular pain in the clinical decision making or the diagnosis.

5. Respondent conducted a genital examination of Patient A, which involved prolonged manual manipulation of Patient A's penis; requested a semen sample from Patient A; and offered to perform oral sex on Patient A.
6. Respondent's actions potentially exposed Patient A to sexually transmitted diseases.
7. Respondent failed to address Patient A's complaints of facial trauma and his finger injury.
8. Respondent ordered excessive narcotics for Patient A.
9. Respondent failed to consider the diagnosis of Cauda Equina Syndrome or fracture of the spine in Patient A, and as such failed to perform the examination documenting rectal tone/perineal sensation.
10. Respondent failed to adequately document his treatment of Patient A.

B. Respondent provided medical care to Patient B on June 20, 2009, at Strong Memorial Hospital, Rochester, New York 14627. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Patient B presented to Strong Memorial Hospital with a complaint of right posterior hip pain "through hip and down into thigh" for two weeks with no known injury, and right inguinal hernia pain.
2. Respondent spoke to Patient B in a sexually explicit and inappropriate manner and asked questions of a personal and

sexual nature that were not germane to establishing any differential diagnoses of Patient B's medical condition.

3. Respondent failed to identify himself to Patient B, wear a badge identifying himself, or have his name on the discharge papers for Patient B to identify him.
4. Respondent manually attempted to stimulate Patient B's penis, in order to achieve an erection.
5. Respondent performed oral sex on Patient B.
6. Respondent attempted to digitally stimulate Patient B's rectum.
7. Upon noting testicular tenderness in Patient B, Respondent failed to sufficiently exam the testicle, and failed to order an ultrasound of the testicle.
8. Respondent failed to consider the diagnosis of testicular torsion, and failed to document any justification in not considering torsion if an ultrasound was not performed.
9. Respondent failed to refer Patient B to a urologist or surgeon for follow-up of his hernias.
10. Respondent failed to adequately document his treatment of Patient B.

C. Respondent provided medical care to Patient C on April 24, 2008, in the Emergency Department at Strong Memorial Hospital, Rochester, New York 14627. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in that:

1. Patient C presented to Strong Memorial Hospital with complaints of left upper quadrant pain which occurred after

eating, and a past medical history of GERD and non-compliance with zantac for two days.

2. Patient C made no complaint regarding blood or semen in his urine, and such a note is absent from the triage note; however, Respondent notes such complaints.

3. Respondent ordered a urine test on Patient C, but no other laboratory or radiological tests.

4. An ECG was done on Patient C, which was suggestive of mild ischemia, yet no further evaluation or examination was done to explore this finding.

5. Respondent conducted a genital examination of Patient C, which involved prolonged manual manipulation of Patient C's penis; requested a semen sample from Patient C; asked inappropriate sexual questions of Patient C; had another unidentified person visualize Patient C's penis, the purpose for this not being explained to Patient C by Respondent; and made Patient C feel uncomfortable by Respondent's inappropriate behavior.

6. Respondent's actions potentially exposed Patient C to sexually transmitted diseases.

7. Respondent failed to adequately document his treatment of Patient C.

D. Respondent provided medical care to Patient D on May 3, 2007, in the Emergency Department at Strong Memorial Hospital, Rochester, New York 14627. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care in that:

1. Patient D presented to Strong Memorial Hospital with complaints of inability to urinate and left flank pain.
2. Respondent manually manipulated Patient D until Patient D ejaculated and urinated.
3. Respondent digitally manipulated Patient D's rectum with continual in and out motions; and told Patient D that he was performing a prostate exam.
4. Respondent was masturbating himself while digitally manipulating Patient D's rectum.
5. Following a CT scan of Patient D, Respondent told Patient D he would need another urine specimen and again started to manually manipulate Patient D's penis.
6. Respondent's actions potentially exposed Patient D to sexually transmitted diseases.
7. Respondent diagnosed prostatitis in Patient D despite the lack of documentation to justify it.
8. Respondent failed to adequately document his care and treatment of Patient D.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Respondent is charged with Willfully Harassing, Abusing or Intimidating a Patient Either Physically or Verbally, in violation of N.Y. Education Law Section 6530(31), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.5, A and A.6, B and B.4, B and B.5, B and B.6, C and C.5, C and C.6, D and D.2, D and D.3, D and D.4, D and D.5.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with Practicing the Profession with Gross Negligence on a Particular Occasion, in violation of N.Y. Education Law Section 6530(4), in that Petitioner Charges the Following:

1. The facts in Paragraphs A and A.1, A and A.3, A and A.5, A and A.7, A and A.8, B and B.4, B and B.5, B and B.6, C and C.5, C and C.6.

THIRD SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Negligence on More Than One Occasion, in violation of New York Education Law Section 6530(3), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.4, B and B.5, B and B.6, C and C.3, C and C.4, C and C.5, C and C.6, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7.

FOURTH SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with Practicing the Profession with Gross Incompetence, in violation of N.Y. Education Law Section 6530(6), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, A and A.4, A and A.5, A and A.7, A and A.8, B and B.1, B and B.7, B and B.8, B and B.9, C and C.5, C and C.6.

FIFTH SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing the Profession with Incompetence on More Than One Occasion, in violation of N.Y. Education Law Section 6530(5), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.3, C and C.4, C and C.5, C and C.6, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7.

SIXTH SPECIFICATION

CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

Respondent is charged with Conduct in the Practice of Medicine Which Evidences Moral Unfitness to Practice Medicine, in violation of N.Y. Education Law Section 6530(20), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.5, A and A.6, B and B.4, B and B.5, B and B.6, C and C.5, C and C.6, D and D.2, D and D.3, D and D.4, D and D.5.

SEVENTH SPECIFICATION

FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE PATIENT

Respondent is charged with Failing to Maintain a Record for Each Patient Which Accurately Reflects the Evaluation and Treatment of the Patient, in violation of N.Y. Education Law Section 6530(32), in that Petitioner charges the following:

1.The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.10, B and B.1, B and B.3, B and B.8, B and B.10, C and C.2, C and C.7, D and D.7, D and D.8.

DATE: January 21, 2010
Albany, New York

REDACTED

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct