Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 14, 2012

***CERTIFIED MAIL-RETURN RECEIPT REQUESTED***

Christopher G. Symenow, R.P.A.
REDACTED ADDRESS

Re: License No. 009611

Dear Mr. Symenow:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 12-22. This order and any penalty provided therein goes into effect February 21, 2012.

Please direct any questions to: Board for Professional Medical Conduct, 90 Church Street, 4th Floor, New York, NY 10007-2919, telephone # 212-417-4445.

Sincerely,

REDACTED SIGNATURE
Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Laura Spring, Esq.
Sugarman Law Firm, LLP
211 West Jefferson Street
Syracuse, NY 13202-2680

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT BPMC No. 12-22

**IN THE MATTER**

**OF**

**CHRISTOPHER SYMENOW, R.P.A.**

CONSENT
ORDER

Upon the application of (Respondent) CHRISTOPHER SYMENOW, R.P.A. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 2/14/2012

REDACTED SIGNATURE

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

**IN THE MATTER**
**OF**
**CHRISTOPHER SYMENOW, R.P.A.**

CONSENT AGREEMENT AND ORDER

CHRISTOPHER SYMENOW, R.P.A., represents that all of the following statements are true:

That on or about October 16, 2003, I was authorized to perform medical services as a physician assistant in the State of New York, and issued License No. 009611 by the New York State Education Department.

My current address is REDACTED ADDRESS, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with Ten specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit A, is attached to and part of this Consent Agreement.

I admit to the First Specification, Negligence On More Than One Occasion, and the Factual Allegations set forth therein, in full satisfaction of the charges against me, and agree to the following penalties:

1. My license shall be suspended for a period of three years, with the entire period of the suspension to be stayed.
2. Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for a period of five years, subject to the terms set forth in attached Exhibit B.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this

Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 19 Jan. 2012

REDACTED SIGNATURE

CHRISTOPHER SYMENOW, R.P.A.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: Jan. 19, 2012

REDACTED SIGNATURE
LAURA SPRING, ESQ.
Attorney for Respondent

DATE: January 26, 2012

REDACTED SIGNATURE
CINDY M. FASCIA
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 2/10/12

REDACTED SIGNATURE
KEITH W. SERVIS
Director
Office of Professional Medical Conduct

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

**IN THE MATTER**

**OF**

**CHRISTOPHER SYMENOW, RPA-C**

STATEMENT

OF

CHARGES

CHRISTOPHER SYMENOW, RPA-C, Respondent, was authorized to perform medical services as a physician assistant in New York State on or about October 16, 2003, by the issuance of license number 009611 by the New York State Education Department. Respondent is currently registered with the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (Patients are identified in the attached Appendix.) on or about May 11, 2007 in the Emergency Department of River Hospital, located at 4 Fuller Street, Alexandria Bay, New York. Respondent's medical care of Patient A did not meet accepted standards of care in that:

1. Respondent failed to obtain and/or document an adequate history for Patient A.
2. Respondent failed to perform and/or document adequate physical examination of Patient A.
3. Respondent failed to adequately evaluate Patient A's altered mental status.
4. Respondent discharged Patient A with a diagnosis of TIA without performing or documenting adequate evaluation pertinent to said diagnosis.
5. Respondent, despite his discharge diagnosis of "TIA" for Patient A, failed to adequately evaluate Patient A for embolic stroke risk and possible intervention prior to discharge.

6. Respondent failed to adequately evaluate Patient A for acute coronary syndrome.
7. Respondent misinterpreted Patient A's EKG and/or failed to adequately evaluate Patient A for ST elevation MI.
8. Respondent, after receiving the official reading of Patient A's EKG, again misinterpreted Patient A's EKG.
9. Respondent failed to respond appropriately to Patient A's abnormal EKG and/or failed to arrange for Patient A's admission.
10. Respondent failed to perform and/or document reassessment of Patient A after the patient's symptoms improved.

B. Respondent provided medical care to Patient B on or about October 9, 2007 in the Emergency Department of River Hospital. Respondent's medical care of Patient B failed to meet accepted standards of care in that:

1. Respondent failed to obtain and/or document an adequate history for Patient B.
2. Respondent failed to perform and/or document adequate physical examination of Patient B.
3. Respondent failed to adequately evaluate Patient B for recurrent and/or uncontrolled seizures.
4. Respondent failed to order or obtain or to transfer the patient to obtain adequate and/or timely neuro-imaging.
5. Respondent failed to order or obtain or to transfer the patient for the purpose of obtaining a neurology consultation.
6. Respondent discharged Patient B on new and/or additional antiepileptic medication without obtaining a neurology consultation.
7. Respondent failed to adequately evaluate Patient B's metabolic status.

8. Respondent failed to adequately evaluate and/or monitor Patient B's cardiac status.
9. Respondent failed to re-assess or to document reassessment of Patient B after any of his episodes of seizure activity in the Emergency Department.

C. Respondent provided medical care to Patient C on or about November 23, 2007 in the Emergency Department of River Hospital. Respondent's medical care of Patient C did not meet accepted standards of care in that:

1. Respondent failed to obtain and/or document an adequate history, including review of systems and/or associated review of systems for Patient C.
2. Respondent failed to perform and/or document adequate physical examination of Patient C initially and/or after Patient C's complaints of chest pain in the ED.
3. Respondent failed to order or obtain a cardiology consultation and/or failed to arrange for Patient C's admission.
4. Respondent, after obtaining a troponin level that was elevated outside the normal range, failed to appropriately respond to the elevated level and/or failed to order or obtain serial troponin measurements.
5. Respondent, despite Patient C's hypertension and headache on presentation to the ED, failed to determine and/or document whether Patient C's elevated creatinine was baseline or suggestive of target organ damage.
6. Respondent, despite Patient C's history of cardiac disease, chose to treat Patient C with hydralazine instead of other agents.

D. Respondent provided medical care to Patient D on or about February 25, 2008 in the Emergency Department of River Hospital. Respondent's medical care of Patient D failed to meet accepted standards of care in that:

1. Respondent failed to obtain and/or document an adequate history, including review of systems and/or associated symptoms for Patient D.
2. Respondent failed to perform and/or document adequate physical examination of Patient D.
3. Respondent failed to timely order aspirin and/or nitrates for Patient D.
4. Respondent failed to timely order a chest x-ray for Patient D.
5. Respondent failed to adequately monitor Patient D's vital signs.

E. Respondent provided medical care to Patient E on or about February 25, 2008 in the Emergency Department of River Hospital. Respondent's medical care of Patient E failed to meet accepted standards of care, in that:

1. Respondent failed to obtain and/or document an adequate history for Patient E.
2. Respondent failed to perform and/or document adequate physical examination of Patient E.
3. Respondent failed to order an EKG for Patient E.
4. Respondent failed to interpret and/or to document his interpretation of the chest x-ray he ordered for Patient E.
5. Respondent failed to adequately monitor Patient E's vital signs.
6. Respondent failed to adequately monitor Patient E's urine output.

F. Respondent provided medical care to Patient F on or about February 25, 2008 in the Emergency Department of River Hospital. Respondent's medical care of Patient F failed to meet accepted standards of care in that:

1. Respondent failed to adequately evaluate Patient F for acute coronary syndrome.
2. Respondent failed to obtain a cardiology consultation and/or failed to have Patient F evaluated for admission.
3. Respondent failed to obtain and/or document an adequate review of systems for Patient F.
4. Respondent failed to perform and/or document reassessment of Patient F and/or failed to document results of medications given to Patient F in the Emergency Department.

G. Respondent provided medical care to Patient G on or about February 19, 2007 in the Emergency Department of River Hospital. Respondent's medical care of Patient G failed to meet accepted standards of care in that:

1. Respondent failed to order an EKG for Patient G.
2. Respondent failed to obtain and/or document an adequate history and review of systems for Patient G.

H. Respondent provided medical care to Patient H on or about January 31, 2007 in the Emergency Department of River Hospital. Respondent's medical care of Patient H failed to meet accepted standards of care in that:

1. Respondent failed to obtain and/or document an adequate history, including an adequate review of systems, and/or failed to document inability to obtain a reliable history.
2. Respondent failed to perform and/or document adequate physical examination of Patient H.
3. Respondent failed to adequately evaluate Patient H for reported near-syncope.
4. Respondent made a diagnosis of UTI for Patient H without adequate

data and/or documentation to support this diagnosis.

5. Respondent failed to order appropriate lab work and/or diagnostic studies for Patient H.

## SPECIFICATION OF CHARGES

## FIRST SPECIFICATION

## PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion in violation of New York Education Law § 6530 (3), in that Petitioner charges two or more of the following:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6 and/or A.7 and/or A.8 and/or A.9 and/or A.10; B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6; D and D.1 and/or D.2 and/or D.3 and/or D.4 and/or D.5; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6; F and F.1 and/or F.2 and/or F.3 and/or F.4; G and G.1 and/or G.2; H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5.

## SECOND SPECIFICATION

## PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with incompetence on more than one occasion in violation of New York Education Law § 6530 (5), in that Petitioner charges two or more of the following:

2. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or A.6 and/or A.7 and/or A.8 and/or A.9 and/or A.10; B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or B.5 and/or B.6 and/or B.7 and/or B.8 and/or B.9; C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or C.5 and/or C.6; D and D.1 and/or D.2 and/or D.3 and/or D.4 and/or D.5; E and E.1 and/or E.2 and/or E.3 and/or E.4 and/or E.5 and/or E.6; F and F.1 and/or F.2 and/or F.3 and/or F.4; G and G.1 and/or G.2; H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5.

**THIRD THROUGH TENTH SPECIFICATIONS**

**FAILURE TO MAINTAIN ACCURATE RECORDS**

Respondent is charged with failing to maintain a record for each patient which accurately reflects the care and evaluation of the patient in violation of New York Education Law § 6530 (32), in that Petitioner charges:

3. The facts in Paragraphs A and A.1 and/or A.2 and/or A.4 and/or A.10.
4. The facts in Paragraphs B and B.1 and/or B.2 and/or B.3 and/or B.9.
5. The facts in Paragraphs C and C.1 and/or C.2 and/or C.5.
6. The facts in Paragraphs D and D.1 and/or D.2.
7. The facts in Paragraphs E and E.1 and/or E.2.
8. The facts in Paragraphs F and F.3 and/or F.4.
9. The facts in Paragraphs G and G.2.
10. The facts in Paragraphs H and H.1 and/or H.2 and/or H.4.

DATE: January 27, 2012
Albany, New York

REDACTED SIGNATURE

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

## EXHIBIT B

### Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 1000, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6. The probation period shall toll when Respondent is not engaged in actively performing medical services as a physician assistant in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active performance of medical services as a physician assistant ("active practice") in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit A or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall practice medicine only when supervised in his/her medical practice. The practice supervisor shall be on-site at all locations, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.

9. Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess Respondent's medical practice. Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

10. Respondent shall authorize the practice supervisor to have access to his/her patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review and other such on-duty conduct as the supervisor deems appropriate to report.

11. Within thirty days of the Consent Order's effective date, Respondent shall perform medical services as a physician assistant only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 30) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

    b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public

Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

12. Respondent shall obtain a clinical competency assessment performed by the Upstate Clinical Competency Center at Albany Medical College. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC within sixty (60) days of the effective date of this Order.

    a. Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This term of probation shall not be satisfied in the absence of actual receipt, by the Director, of such documentation, and any failure to satisfy shall provide a basis for a Violation of Probation proceeding.

13. At the direction of the Board and within 60 days following the completion of the clinical competency assessment (CCA) the Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC. The Respondent shall cause the Preceptor to:

    a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies /retraining recommendations identified in the CCA. Additionally, this proposal shall establish a timeframe for completion of the remediation program.

    b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

    c. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.

    d. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.

    Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program, or to the monitoring physician.

14. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

15. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

16. Respondent, during the period of probation, shall complete a total of one hundred fifty (150) hours of Category I Continuing Medical Education (CME). Said CME shall include courses in all of the following areas:

Emergency Medicine and medical records. All CME courses are subject to the prior written approval of OPMC. Said 150 hours of CME shall be in addition to any other CME that Respondent may be required to complete to satisfy the remediation plan set up by the Preceptor, or licensure in any jurisdiction, or privileges in any facility.

17. Upon my successful completion of three years of the period of probation, I may petition the Director for an early release therefrom and the Director shall exercise reasonable discretion in deciding whether to grant my petition.

18. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.