NEW YORK STATE OF OPPORTUNITY. Department of Health

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Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 19, 2015

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Funsho Busari-Alabi, M.D.
[redacted]

Adeshola Adeyemo, Esq.
90-79 Sutphin Boulevard
Jamaica, New York 11435

Jeffrey J. Conklin, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2517
Albany, New York 12237

RE: In the Matter of Funsho Busari-Alabi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.15-244) 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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER OF FUNSHO BUSARI-ALABI, M.D.	DETERMINATION AND ORDER BPMC #15-244

A Notice of Hearing and Statement of Charges were served on **Funsho Busari-Alabi, M.D.**, Respondent, on September 29, 2014. Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on December 16, 2014, continuing on March 17, June 16, 22, and 23, 2015. All hearings were held at the Offices of the New York State Department of Health, 150 Broadway, Riverview Center, Albany, New York ("the Petitioner"). **Jerry Waisman, M.D. CHAIR, William A. Tedesco, M.D., and David F. Irvine, DHSc, RPA-C**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **David A. Lenihan, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Petitioner appeared by **James E. Dering, Esq.**, General Counsel, by **Jeffrey J. Conklin, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with counsel, **Adeshola Adeyemo, Esq**. Evidence was received, witnesses were sworn or affirmed, 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 of Notice of Hearing and Statement of Charges:	September 29, 2014
Answer Filed:	November 23, 2014
Pre-Hearing Conference:	September 26, 2014
Hearing Dates:	December 16, 2014 March 17, 2015 June 16, 2015 June 22, 2015 June 23, 2015
Witnesses for Petitioner:	Siavash Okhravi, M.D. Patient "B" Patient "D" Deidre Fitzgerald, RN Peter Holtermann [redacted] David Wirtz, M.D.
Witnesses for Respondent	Funsho Busari-Alabi, M.D. Mrs. Olufunke Alabi
Deliberations Date:	August 24, 2015

It is noted that this matter was initially heard on September 29, 2014. Prior to the hearing, Respondent's motion to dismiss for lack of personal jurisdiction was granted. The basis for the decision was Department's Exhibit 2, which purported to represent personal service. The affidavit dated August 25, 2014 from Gary DiPaolo, however, averred that the Respondent was a black male, approximately 30 years old, six feet in height, weighing

approximately 230 pounds, when Respondent presented almost twice the age indicated, shorter, and weighing significantly less.

The motion to dismiss was granted and the Department's attorney was directed to re-serve the Respondent forthwith.[1] The Respondent was re-served and the matter was rescheduled for hearing in December, 2014.

STATEMENT OF THE CASE AND BACKGROUND

Petitioner charged Respondent, an emergency room physician, with thirteen (13) specifications of professional misconduct. The first through third specifications charged Respondent 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 for three of the four named patients.

In the fourth through sixth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence on a particular occasion for three of the four named patients.

In the seventh through tenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently with regard to two of the four named patients.

[1] See the transcript of the proceedings for September 29, 2014 at page 11.

In the eleventh specification Respondent was 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 in regard to patients A, B, C, and D.

In the twelfth specification Respondent was 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 with regard to patients A, B, C, and D.

In the thirteenth specification, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record which accurately reflects the evaluation and treatment of each of the four named patients.

EVALUATION OF TESTIMONY

With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence.

The central witnesses in this case were Patient B and Dr. Wirtz for the Department, and Doctor Busari-Alabi for himself. Each of these witnesses was evaluated separately.

David Wirtz, M.D.:

It is noted that this was a complex case with multiple issues ranging from cardiology to obstetrics to gastrointestinal concerns. While Dr. Wirtz is board certified in emergency medicine, the panel was not fully satisfied with his expertise in all the issues presented in this case.

Patient B:

The panel found that the testimony of Patient B was not persuasive. This witness testified that Dr. Busari-Alabi told her that her pregnancy was five or six **weeks** contradicting the testimony of Dr. Busari-Alabi that it was five or six **months.** The Hearing Committee did not give credence to this testimony about a 2008 conversation, noting that this witness was not clear about the date of her last menstrual period. This cast doubt on her ability to recall events.

Funsho Busari-Alabi, M.D.:

The Hearing Committee found the testimony of Dr. Busari-Alabi to be credible and persuasive. They saw him as a credible, competent physician working in a challenging environment. They concluded that Dr. Busari-Alabi was credible. The panel also recognized that his medical license was at stake. Nevertheless, the panel found his testimony believable.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to transcript page numbers or Exhibits, denoted by the prefixes "T." Or "Ex." These citations refer to 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. All Hearing Committee findings were unanimous.

1. Funsho Busari-Alabi, M.D., Respondent, was authorized to practice medicine in New York State on or about August 24, 2005 by the issuance of license number 237437 by the New York State Education Department. (Pet. Ex. 3)

PATIENT A

2. Respondent provided medical care and treatment for Patient A at Faxton-St. Luke's Hospital Emergency Room on or about September 15th and 16th, 2011. The Faxton Campus of Faxton-St. Luke's Hospital is located at 1676 Sunset Avenue, Utica, New York 13502. (Pet. Ex. 4)

3. Patient A, 77 years of age, presented to Faxton-St. Luke's Hospital with complaints of chest pain while carrying laundry upstairs, as well as nausea, vomiting, decreased appetite dizziness, lethargy and low blood pressure. (Pet. Ex. 4, pp. 20, 39, T. 155)

4. At the time of Patient A's triage, performed by Nurse Diedre Fitzgerald, his respiratory rate was 18 (normal); he was not experiencing shortness of breath, and his heart rate was 101 (slightly elevated – normal range 60 to 100), (Pet. Ex 4, p. 39, T. 95)

5. Patient A's history of exertional chest pain was an indication for an immediate 12-lead electrocardiogram (EKG). (T. 156, 158 and 159)

6. The purpose of the EKG was to determine whether Patient A had experienced an acute ST[2] segment elevation myocardial infarction (heart attack). (T. 158, 159)

7. If Patient A had suffered a heart attack, there would have been an indication for reperfusion therapy by cardiac catherization procedure whereby a catheter is inserted into the artery in the heart, dye is injected to confirm the blockage, the artery opened, and a stent inserted. (T. 168)

8. If a cardiac catherization procedure is not available, the alternative would be to administer thrombolytic medications to dissolve the clot. (T. 168)

9. The goal of reperfusion therapy, whether by catherization or by thrombolytics, is to open a blocked artery to restore the flow of blood and prevent the heart from dying. (T. 168)

10. Respondent saw Patient A at approximately 10:00 PM and after an EKG had been administered. (T. 395)

11. Respondent read the EKG report and made a diagnosis of a non-ST elevation myocardial infarction (heart attack). (T. 397)

12. This diagnosis did not call for an emergency catherization but rather called for a cardiac catherization after the patient stabilized. (T. 398)

13. The Respondent did not call for a cardiology consult at 10:00 PM, after seeing the EKG, because there was low blood pressure and vomiting which could have resulted from shock. (T. 403)

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[2] S-T segment is the part of an electrocardiogram immediately following the QRS complex and merging into the T wave.

14. Respondent determined to wait for the results of cardiac enzymes tests to confirm the diagnosis before calling the cardiologist. (T. 404)

15. According to the Respondent, patients with the above diagnosis do not usually require catherization. (T. 404)

16. The Respondent decided to wait for the cardiac enzyme results to come in. If they were positive, he planned to call cardiology and admit the patient. (T. 405)

16. At approximately 11:00 PM the cardiac enzyme results came back and the patient was already in shock. (T. 406)

17. At this time, Respondent called cardiology and administered dopamine to bring the patient's blood pressure back to normal. (T. 408)

18. Patient A had a cardiac arrest around 11:35 PM. He was given dopamine and was transferred to the ICU. (T. 410)

PATIENT B

19. Respondent provided medical care and treatment for Patient B at St. Mary's Hospital Emergency Room on November 13th and 14th, 2008. St. Mary's Hospital is located at 427 Guy Park Avenue, Amsterdam, New York, 12010 (Pet. Ex. 5A)

20. Patient B, age 30, presented to the Emergency Room with complaints of constipation, intense[3] rectal pressure, abdominal pain, cramping, burning pain with urination, and anxiety. (Pet. Ex. 5A, p. 5)

21. On examination at triage, Patient B's heart rate was elevated at 110 beats per minute. (Pet. Ex. 5A, p. 5)

[3] "Ten out of ten" on the pain scale in the record.

13. Respondent examined Patient B at 11:40 PM on November 13, 2008. (Pet. Ex. 5A, p. 8)

22. Respondent ordered diagnostic tests, including urinalysis, which confirmed Patient B was pregnant and had a BhCG level of 3,085. Such a level would be found in either the first or third trimester of pregnancy. (Pet. Ex. 5A, pp. 7, 9)

23. At the time of triage, Patient B did not know when her last menstrual period had occurred. (Pet. Ex. 5 A, p. 3, T. 73, 74)

24. Patient B was discharged from St. Mary's Hospital to her home[4] with a diagnosis of urinary tract infection, constipation and pregnancy. Patient B's abdominal pain on discharge was still ten out of ten. (Pet. Ex. 5A, p. 5)

25. After being discharged, Patient B delivered a full term baby, in the ambulance, at 6:22 AM on the 14th of November, 2008. (T. 256)

PATIENT C

26. Respondent provided medical care and treatment for Patient C at St. Mary's Hospital Emergency Room on November 1st, 2008. (Pet. Ex. 6A, pp. 1-16)

27. Patient C, 62 years of age, presented to St. Mary's Hospital with complaints of pain of the right and left patella and the right wrist. She also had an abrasion and bruising of her left upper chest. (Pet. Ex. 6A, pp. 5, 7 and 8)

28. Patient C, who was restrained by a shoulder seatbelt, had been involved in a one-vehicle rollover accident, which resulted in air bag deployment. (Pet. Ex. 6A, pp. 5 and 7)

29. Respondent examined Patient C and ordered x-rays of her knees, left hand and chest. (Pet. Ex. 6A, pp. 6 and 8)

30. Respondent noted in the chart that Patient C had suffered an abrasion to her left upper chest on the border of her left shoulder, and pain, swelling and abrasions to both knees. (Pet. Ex. 6A, p.8; T., 278)

31. Respondent interpreted Patient C's chest x-ray as being normal, with no acute disease, no infiltrates, and normal heart size and normal mediastinum. (Pet. Ex. 6A, p. 8; T., 278, 560)

32. Respondent's clinical impression of Patient C's condition was contusion to the knees and left hand. (Pet. Ex. 6A, p. 8; T. 279)

33. Patient C was discharged in improved and stable condition. (Pet. Ex. 6A, p. 8; T. 279)

34. Subsequently, a radiologist reviewed Patient C's chest x-ray and noted the impression of a moderate-sized pneumothorax. (Pet. Ex. 6A, p. 11; Pet. Ex. 6B1; T. 279, 560)

35. A pneumothorax is a pocket of air inside the lung cavity and outside the lung, which is abnormal. (T. 291, 292)

36. The Respondent failed to recognize and diagnose a pneumothorax in Patient C's chest X-rays and stated that he was not a radiologist. (T. 572)

37. The Department's expert witness, Dr. Wirtz, found Respondent's failure to interpret the existence of a moderate sized traumatic pneumothorax from Patient C's X-rays to be a mild deviation from the minimally accepted standard of care for emergency department physicians. The panel disagreed. (T. 295, 296)

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[4] The record is not clear as to the exact time, but an approximation of 1:40 AM was given. (T. 251)

38. The standard of review of X-rays is substantially higher for radiologist than for emergency room physicians. (T. 579)

39. Respondent initially noted that Patient C's chest x-ray was normal. Subsequently, the X-ray was read by a radiologist who found the pneumothorax. (T. 560)

40. Such errors are common in the Emergency Room which is why there is kept a log book for such errors – an X-ray discrepancy book. (T. 562)

41. Respondent was informed of the error by the radiologist and the patient was called back to the hospital. (T. 563)

42. After some convincing by the Respondent, the patient returned to the hospital and a chest tube was inserted to address the problem, (T. 564)

PATIENT D

43. Respondent provided medical care and treatment to Patient D on February 21st, 2008, at St. Mary's Hospital Emergency Room. (Pet. Ex. 7A).

44. Patient D, 21 years of age, presented to St. Mary's Hospital with complaints of right-sided pain for 3 weeks, difficulty urinating, vomiting and anxiousness. (Pet. Ex. 7A, p. 10, T. 589)

45. Patient D was 6 weeks post-partum at the time of her presentation to St. Mary's Hospital. Patient D assessed her pain as 7 on a scale of 1 to 10. (Pet. Ex. 7A, p. 10)

46. Respondent examined Patient D, who had a chief complaint of abdominal pain, which was associated with nausea, vomiting and loss of appetite. (Pet. Ex. 7, p. 13)

47. Respondent ordered laboratory tests which were positive for a urinary tract infection and elevated liver enzymes. (Pet. Ex. 7, pp. 14, 15, T. 589)

48. The laboratory results documented elevated alkaline phosphatase at 254, AST of 466 and ALT of 418. (Pet. Ex. 7, p. 15). An ultrasound was not ordered because the pattern of liver function was not specific for cholestasis. The Respondent testified that it was more specific for hepatocellular injury. (T. 591)

49. The laboratory results further documented a slightly elevated bilirubin of 1.7, which could have been an indication that there was an obstruction blocking the flow of Patient D's bile to her liver. (Pet. Ex. 7, p. 15; T., p. 304)

50. Respondent documented his clinical impression as acute abdominal pain and a urinary tract infection. (Pet. Ex. 7, p. 14; T., pp. 304, 305)

51. The standard of medical record keeping required that Respondent document Patient D's abnormal liver function test results. (T., p. 305)

52. Respondent documented Patient D's abnormal liver function test results in his clinical impression. (Pet. Ex. 7, p. 14)

53. Respondent discharged Patient D to home in an "improved and stable condition". (Pet. Ex. 7, p. 14)

54. The discharge instruction sheet for Patient D documented a diagnosis of a urinary tract infection, prescribed Levaquin and Tylenol, and directed the patient to follow-up with Dr. Ryan. (Pet. Ex. 7, p. 19)

55. Dr. Ryan was Patient D's obstetrician and gynecologist. (T., pp. 81, 82)

56. Respondent discussed with Patient D his diagnosis of a urinary tract infection. (Pet.

Ex. 7, p. 14; T. 80)

57. On February 22, 2008, Patient D returned to St. Mary's Hospital Emergency Room with complaints of abdominal pain and vomiting. (Pet. Ex. 7, p. 24). Laboratory tests documented that Patient D had pancreatitis secondary to gallstones. (Pet. Ex. 7, p. 24).

58. Patient D developed renal failure as a result of her condition. (Pet. Ex. 7, p. 24.)

59. When Respondent discharged Patient D on February 21, 2008 she was stable and safe to go home. There was no reason for an emergency intervention at that time. (T. 602)

CONCLUSIONS OF LAW

Pursuant to the Findings of Fact as set forth above, the Hearing Committee unanimously concludes that the Factual Allegations and Specifications as set forth in the Statement of Charges, are resolved as follows:

1. The First through Thirteenth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**

These specifications of professional misconduct are listed in New York 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. The definitions utilized herein are set forth in 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," dated January 9, 1996, sets forth suggested definitions for gross negligence, negligence, gross incompetence, and

incompetence.

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

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.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of skill or knowledge necessary to practice the profession.

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.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the above conclusions of law pursuant to the factual findings listed above. All of the above conclusions resulted from a unanimous vote of the Hearing Committee.

DISCUSSION

The Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the five (5) Hearing days, the Department's Proposed Findings of Fact, Conclusions of Law, and Sanction as well as the Respondent's Summation.[5] During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Allegations and Charges set forth in the Statement of Charges. (Appendix I)

2. The burden of proof in this proceeding rests on the Department. The Departrnent must establish by a preponderance of the evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegations presented are more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim.

3. The specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the charges by a preponderance of the evidence and, as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and to base its inference on what it accepts as the truth.

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[5] It is noted that the Respondent submitted a brief which the Department's attorney objected to as references were made to material not in evidence. A redacted version of this brief was submitted to the panel.

4. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness' testimony and, at the same time, reject another. The Hearing Committee understands that, as the trier of fact, they may accept so much of a witness' testimony as is deemed true and disregard what they find and determine to be false. In the alternative, the Hearing Committee may determine that if the testimony of a witness on a material issue is willfully false and given with an intention to deceive, then the Hearing Committee may disregard all of the witness' testimony.

5. The Hearing Committee followed ordinary English usage and vernacular for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence.

In evaluating the testimony of the expert witnesses, the panel gave credence to the testimony of Doctor Wirtz, but noted that he was board-certified in emergency medicine but was not an expert on complex cardiology, obstetrics or gastrointestinal matters that are pivotal to this case.

The panel also gave credence to the testimony of the Respondent, finding him knowledgeable on the issues germane to this case.

VOTE OF THE HEARING COMMITTEE

FIRST through THIRD SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

The first three specifications in this case charged Respondent 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 for each of the three named patients.

In its deliberations the panel reviewed the record and testimony as it pertained to each of the named patients and determined, unanimously, that the allegations of gross negligence, with regard to patients A, B and C as set forth in paragraphs A through C of the Statement of Charges were not sustained. As defined above, 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. The panel was unanimous in finding that the Department did not establish the case for gross negligence by a preponderance of the evidence for each of the three named patients.

Patient A

As for Patient A, the panel noted, in particular, that the record clearly establishes that the Respondent ordered all the tests appropriate to the situation. It is noted that an EKG was administered to Patient A upon admission to the Emergency Room. When Doctor

Busari-Alabi examined Patient A, he decided to wait for the results to be returned from the lab. In retrospect, it would have been ideal had the patient been given immediate catheterization upon his arrival at the emergency department. In this case, however, Dr. Busari-Alabi exercised his judgment and decided not to call for an immediate cardiac catheterization. According to the Panel, this decision was reasonable.

At the time of triage in the emergency department at 9:10 P.M., the patient was not in shock, short of breath, or with difficulty breathing. (T. 95, 96, 157, 158) At this time, the patient's respiratory rate was 18 (normal) and his heart rate was only slightly elevated at 101. (T. 95, 96,157, 158) The computerized results from an EKG performed at 9:32 P.M. showed sinus rhythm of the first degree AV block, non-specific intraventricular conduction block, and inferior infarct. Respondent, relying on the computerized results, which did not show a posterior wall myocardial infarction, did not order catheterization or thrombolytic medications. The Hearing Committee agreed with that decision and found that those treatments were not indicated here.

Although Respondent failed to appreciate a posterior wall myocardial infarction on the EKG until after the heart attack occurred, the panel noted that EKGs are frequently subject to multiple interpretations and in this case, the patient's clinical status was stable when the EKG was performed and he exhibited no signs of immediate distress. Moreover, the timeframe between triage in the emergency department and the patient coding was less than three hours. The panel felt that this patient was survivable for only the first hour upon his arrival at the emergency department and within that time frame, there was no way for Respondent to appreciate the severity of the patient's condition. The Hearing Committee opined that even if transfer to the catheterization lab, catheterization, or the administration

of thrombolytic medications occurred in this case, the heart attack could not have been prevented and the patient's outcome would have been the same.

The Panel felt similarly about a cardiac consult in that in addition to it not being indicated prior to the patient coding in this case, an earlier consult would not have changed the patient's outcome. The Respondent did not call for a cardiology consult at 10:00 PM after seeing the EKG, because there was low blood pressure and vomiting which could have resulted from shock. Respondent determined to wait for the results of cardiac enzymes tests to confirm the diagnosis before calling the cardiologist. If they were positive, he would then inform cardiology and admit the patient. By the time he received the enzyme results, the Patient coded and was sent to the ICU.

With regard to the administration of Atropine, the panel found that Respondent did not give an excessive dosage amount. In this case, Atropine was given twice, at two separate times, totaling four dosages. Since the protocols at that time stated that in two-time intervals, Atropine was appropriate, the fact that Respondent administered it correctly twice does not mean there was a deviation from the protocols. Dr. Wirtz was in agreement that the initial Atropine dosage amounts were appropriate. (T. 231-233) The panel noted that the protocols do not prohibit the administration of Atropine in a second two-step dosage should the patient re-arrest, which is what happened here. The panel concluded that the Atropine dosage was appropriate and not a deviation from the standard of care.

On review of the evidence in this case, the panel concluded that Dr. Busari-Alabi did all that he could for this patient. As such, the Hearing Committee was unanimous in finding that the Department did not establish its case for gross negligence by a preponderance of the credible evidence.

Patient B

As for the specification about Patient B, the panel was unanimous in concluding that gross negligence was not established by the Department's evidence. The patient presented to the emergency room with complaints of constipation, abdominal pain, and rectal pressure. (Ex. 5, p.5) A urine test revealed a pregnancy, of which the patient was unaware. Although the patient stated her last menstrual period was two or three months prior, Respondent determined the pregnancy was at five to six months, given his palpation of the fundus, which was felt above the umbilicus. There was thus a variance in the testimony of Doctor Busari-Alabi and the patient on this point of the gestational age of the pregnancy. According to Patient B, Dr. Busari-Alabi claimed it to be five or six weeks. (T. 64, 144) The Respondent, however, testified he told the patient that she was five or six months pregnant. (T. 334)

The time-frame discrepancy is important, according to the panel, since a pregnancy at six weeks or prior would have mandated certain testing, which was not performed here. The panel noted the patient's weight, which was obese, and Respondent's determination of the location of the fundus above the umbilicus, and found that his diagnosis of pregnancy at five to six months was reasonable.

The panel also considered Respondent's failure to diagnose labor. The panel found that Respondent's failure to diagnose labor was not a breach of the standard of care. Even though rectal pressure and abdominal pain are symptoms of labor, those same complaints are consistent with a urinary tract infection, which the Respondent diagnosed. Aside from

not realizing she was pregnant, the patient, according to the panel, did not present to the emergency department with characteristic labor pain complaints.

The panel agreed that although an ultrasound, internal exam, or pelvic exam may have assisted Respondent in diagnosing labor or a later stage of pregnancy, none of those tests were indicated. An ultrasound would only have been necessary had an ectopic pregnancy been suspected. In this case, Respondent determined the patient to be well past the stage of pregnancy when ectopic pregnancy concerns exist. Also, per hospital regulation, ultrasounds were only performed when ectopic pregnancy was suspected, which it was not in this case. (T.336)

An internal or pelvic exam was also not indicated. The panel reasoned that since such an examination can stimulate labor, vaginal or internal exams are not recommended in an emergency room setting for a case such as this one. Also, the panel felt that a pelvic exam would have been indicated had the patient complained of bleeding. In this particular case, since Respondent concluded, based on his examination of the patient, that the pregnancy had a gestational age of between five or six months, and in light of the patient's complaints, which did not include bleeding, there would have been no reason to perform an internal or pelvic exam.

The panel also felt that an obstetric consultation was not called for as this appeared to be an uncomplicated pregnancy. The panel felt that Respondent performed all necessary tests on this patient and that his instructions at discharge to follow-up with an OB/GYN for the pregnancy were appropriate. In sum, the panel found that the Department did not establish gross negligence by a preponderance of the evidence.

Patient C

As for Patient C, the panel was unanimous in concluding that gross negligence was not established by the Department's evidence. The hearing committee reviewed the testimony and record and found no negligence in the Respondent's actions with regard to Patient C.

This was a rollover automobile accident with bruising and lacerations. X-rays were done in the Emergency Room and the Respondent interpreted them to be normal. A subsequent review by the radiologist found a pneumothorax and the patient was called back to the hospital. The Respondent at this time inserted a tube and addressed the problem.

While it is true that the Respondent misread the initial x-ray, such a mistake is common as he did not have the ability to enlarge the x-ray as the radiologist had. The panel determined, unanimously, that such an oversight does not rise to the level of negligence and, *a fortiori*, gross negligence. Accordingly, the hearing committee concluded that the Department did not establish a case for gross negligence by a preponderance of the evidence.

FOURTH THROUGH SIXTH SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

The fourth through sixth specifications in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (4) by practicing

the profession of medicine with gross incompetence on a particular occasion for each of the named patients.

In its deliberations the panel reviewed the record and testimony as it pertained to each of the named patients and determined, unanimously, that the allegations of gross incompetence, with regard to patients A, B and C as set forth in paragraphs A through C of the Statement of Charges were not sustained. As defined above, 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. While gross negligence involves *not doing* what should have been done, gross incompetence involves *not knowing* what should have been done. In all three cases, the panel found the Respondent to be knowledgeable and competent in his medical skill and not grossly incompetent as alleged in the Department's case.

As for Patient A, the panel noted, in particular, that the record clearly establishes that the Respondent knew the appropriate steps to be taken in this case and called for a cardiology consult when the tests showed that it was warranted. Accordingly, the panel was unanimous in concluding that gross incompetence was not established by a preponderance of the evidence.

As for the specification about Patient B, the panel was unanimous in concluding that gross incompetence was not established by the Department's evidence. This case presented as one of constipation and was dealt with as such. It developed that this patient was pregnant and the Respondent addressed this situation by doing all the appropriate tests and directing the patient to follow up with her obstetrician. As with Patient A, the hearing committee determined that the Department did not prove its case by a

preponderance of the evidence.

As for Patient C, the panel was unanimous in concluding that gross incompetence was not established by the Department's case. True, an x-ray was misread, but this oversight was quickly corrected and the patient was called back to the hospital for the appropriate treatment. The hearing committee reviewed the record and determined, unanimously that gross incompetence was not established and determined to dismiss the charge.

SEVENTH THROUGH TENTH SPECIFICATIONS

VOTE: NOT SUSTAINED (3-0)

In the seventh through tenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently with respect to Patients A and B.

The Hearing Committee considered whether the evidence supported a finding that Respondent's conduct constituted practicing the profession of medicine fraudulently, pursuant to Education Law § 6530(2), and concluded that it did not. The intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine and with the intent to deceive, constitutes the fraudulent practice of medicine. Choudry v. Sobol, 170 AD2d 893, 894 (3rd Dept. 1991). To sustain a charge of fraudulent practice, the Department must show that there was a false representation made by the

licensee which should have been disclosed, that the licensee knew the representation was false, and that the licensee intended to mislead through the false representation.

As for Patient A, the Department based its case on an interview OPMC had with the Respondent in the year 2012. (Pet. Ex. 11A) It is noted that the Respondent claimed to be present except for the time he left to call for a cardiology consult. Nurse Fitzgerald testified that the Respondent left the room after the initial examination at 10:00 PM and did not return until the patient coded at 11:35 PM. The hearing committee recognized that this was an emergency room and that there were other patients that the Respondent had to attend to and noted that, for instance, there was an order issued for Dopamine at 11:09 PM, that would have needed the Respondent's presence. It is also noted that the record in this case shows when the Respondent entered Patient A's room but makes no clear documentation of when he left. The hearing committee concluded, unanimously, that the Department did not establish a case of fraudulent practice in the matter of Patient A.

As for Patient B, the Department based its charge of fraudulent practice on a statement made at an OPMC interview in which the Respondent is reported to have said that he could not get an ultrasound after 10:00 PM because he was of the opinion that the pregnancy was more than three months. The Respondent claimed that an ultrasound could be done only if the pregnancy was less than three months to rule out an ectopic pregnancy.

The Department responded that if the ultrasound were not available the Respondent should, in that case, have done an internal pelvic examination. (Departmental Brief, p, 57). The hearing committee credited the Respondent's version of what transpired back in 2008 and concluded that there was no sonogram administered because it was not available at the hospital except in cases of suspected ectopic pregnancy; this was ruled out because of

the Respondent's opinion that this pregnancy was between five and six months in gestational age. In addition, the panel again noted that a pelvic examination was not done because there was no pregnancy complaint and no bleeding and no obstetric consultation was called for as this appeared to be an uncomplicated pregnancy.

Thus the hearing committee concluded, unanimously, that the Respondent's statements to OPMC did not constitute fraudulent practice and the Department's charge was not proved by a preponderance of the evidence. Accordingly, the Hearing Committee found that Specifications Seven through Ten were not sustained and should, therefore be dismissed.

ELEVENTH SPECIFICATION

VOTE: NOT SUSTAINED (3-0)

The eleventh specification in this case charged Respondent 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 particular occasion for each of the four named patients.

For Patient A the Hearing Committee found no negligence as the Respondent ordered all the appropriate tests and called for a cardiology consultation when it became clear that the patient had suffered a heart attack. Unfortunately, by that time, the patient coded and it became necessary to stabilize the patient before other measures could be taken. The panel was of the opinion that Respondent did all that he could for this patient.

As for Patient B, as we have seen, this patient presented with complaints of constipation and tests were given. When it was discovered that she was pregnant she was discharged with a follow up with her obstetrician.

As for Patient C, the Respondent failed to see a pneumothorax on an x-ray. As noted above, this oversight was found by the radiologist and the patient was brought back to the hospital to address the problem.

As for Patient D, the Department charged the Respondent with failing to appropriately address this Patient's abnormal liver function tests. The Hearing Committee noted that on the first day tests were administered that did show elevated liver enzymes and signs of a UTI. The Respondent discharged the patient, but she came back the following day with an elevated white blood count, elevated liver enzymes, and, for the first time, markedly elevated amylase and lipase and, with this new information, she was admitted to the hospital and treated for acute pancreatitis.

The Department's expert witness testified that this failure of the Respondent to appreciate the abnormal liver function tests constituted a mild deviation from the minimally accepted standard of care. (T. 312) The Respondent agreed that the elevated liver enzymes on the first day are an early manifestation of pancreatitis, but this disease could only be diagnosed on the second day when the amylase and lipase values became abnormal. (Respondent's Brief, p. 20, T. 593-597) As we have noted above, negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. In this case, the panel determined that the Respondent's actions were reasonable and not negligent.

For each of the named patients, the Hearing Committee found that the Department

had not established a case for negligence by a preponderance of the evidence. Accordingly, the Committee concluded, unanimously, that these specifications should be dismissed.

TWELFTH SPECIFICATION

VOTE: NOT SUSTAINED (3-0)

The twelfth specification in this case charged Respondent 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 particular occasion for each of the four named patients.

Incompetence is a lack of skill or knowledge necessary to practice the profession. On review of this case, the Hearing Committed found that the Respondent did have the skill and knowledge to practice the profession of medicine, and thus they determined, unanimously, to dismiss this specification.

THIRTEENTH SPECIFICATION

VOTE: NOT SUSTAINED (3-0)

The thirteenth specification in this case charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (32) by failing to maintain a

record for each patient which accurately reflects the evaluation and treatment of the patient for each of the four named patients.

As for Patient A, the Department maintained that the standard of medical record keeping of an emergency department physician would be to document an appropriate plan of care. (T.183) The Department's expert testified that the Respondent made a slight deviation from the minimally accepted standard of medical record keeping in failing to document an appropriate plan of care for Patient A, including an evaluation of the patient's condition, recognition that Patient A suffered a heart attack, diagnosis of such condition, and an appropriate treatment plan. (T.183) The Hearing Committed determined that the Respondent did diagnose a myocardial infarction, cardiogenic shock, and cardiopulmonary arrest. The plan of care was a cardiology consult which was done and the further care was then left to the recommendation of the cardiologist.

As for Patient B, the Department maintained that, based upon Respondent determining Patient B was pregnant, the standard of medical record keeping required documentation of Patient B's pregnancy history, including the number of pregnancies and results of such pregnancies. While it is true that Respondent did not document Patient B's pregnancy history, including the number of pregnancies and results of such pregnancies, it must be noted that this patient presented in the emergency room with a complaint of constipation. When the pregnancy was established she was referred to her gynecologist to ascertain the gestational age of the fetus, and do history of Patient B's pregnancy history, including the number of pregnancies and results of such pregnancies.

On review the panel determined, unanimously, that the Department did not established the failure to maintain records in this case for Patient B by a preponderance of the evidence.

As for Patient C, the Department maintained that the standard of medical record keeping required an emergency department physician to document a moderate-sized traumatic pneumothorax, confirmed by a chest x-ray. Respondent failed to document a moderate-sized traumatic pneumothorax. According to the Department's expert, Respondent moderately deviated from the accepted standard of medical record keeping in failing to document the moderate-sized traumatic pneumothorax, confirmed by Patient C's chest x-rays.

As we have seen above, the Respondent did not recognize the pneumothorax on his initial exam and thus it would have been impossible for him to note this fact in the record. Thus, the Hearing Committee found that the Department did not prove this matter of record keeping for Patient C by a preponderance of the evidence.

As for Patient D, the Department maintained that the standard of medical record keeping for this 2008 case required an emergency department physician to document an appreciation that he recognized a patient's abnormal liver function test results and that an emergency department physician is required to document a clinical impression of a patient's elevated liver function enzymes.

Also, the Department's expert maintained that the standard of medical record keeping required an emergency department physician to document referral of a patient who had abnormal liver function test results to a primary care doctor or specialist. The Department's expert testified that the Respondent failed to document referral of Patient D

to a primary care doctor or specialist to address her abnormal liver function test results. The Department's expert maintained that the Respondent mildly deviated from the accepted standard of medical record keeping in failing to document that he recognized Patient D's abnormal liver function test results; failing to document a clinical impression of Patient D's abnormal liver function enzymes; failing to document Patient D's abnormal liver function test results in his physician notes and discharge instructions; and failing to document a referral of Patient D to a primary care doctor or specialist to address her abnormal liver function test results.

The Hearing Committee reviewed the evidence in this case and found that the Respondent did, in fact, note the abnormal liver function tests in the record. (Pet. Ex. 7, p. 14). A review of the record shows that the Respondent documented an AST level of 466 and an ALT level of 418. The Respondent testified that he discussed the liver tests with the patient and stated that he found a urinary tract infection and indicated that this could cause the abdominal pain.

The record shows that the patient was discharged home and referred to a Dr. Ryan for further treatment. The Department maintained that Dr. Ryan was not her primary care physician, but the patient's obstetrician. However, this is the name that patient indicated on intake. The Hearing Committee determined, unanimously that as for Patient D, the Department did not establish its case by a preponderance of the evidence.

Accordingly, as for Specification Thirteen, it was the unanimous conclusion of the panel, that it, too, should be dismissed.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, after due deliberation, unanimously determined that none of the charges and specifications raised against Respondent were sustained. Accordingly, the panel determined, again unanimously, that all charges should be dismissed and no penalty imposed.

ORDER

IT IS HEREBY ORDERED THAT:

1. All the Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**
2. The Charges herein are hereby **DISMISSED;**
3. This Determination and Order shall be effective upon service on the Respondent. Service shall be 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: Poughquag, New York
September 16, 2015

[redacted]

Jerry Waisman, M.D. CHAIR

William A. Tedesco, M.D.
David F. Irvine, DHSc, RPA-C

TO:

Funsho Busari-Alabi, M.D., Respondent

[redacted]

Adeshola Adeyemo, Esq.
Attorney for Respondent
90-79 Sutphin Blvd.
Jamaica, New York 11435

Jeffrey J. Conklin, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
Division of Legal Affairs
Corning Tower Building, Room 2517
Empire State Plaza
Albany, New York 12237

APPENDIX I

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

IN THE MATTER OF FUNSHO BUSARI-ALABI, M.D.	NOTICE OF HEARING

TO: Funsho Busari-Alabi, M.D.
[redacted]

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of New York Public Health Law §230 and New York State Administrative Procedure 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 the 29th day of September, 2014, at 10:00 a.m., at the Offices of the New York State Department of Health, Riverview Center, 150 Broadway, Menands, New York 12204-2719, 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 who shall be an attorney admitted to practice in New York state. 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.

EXHIBIT 1

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here [redacted]

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, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, 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.

[redacted]

DATED: August 20, 2014

Michael A. Hiser, Esq.
Deputy Counsel
Bureau of Professional Medical Conduct

Albany, New York

Inquiries should be directed to:
Jeffrey J. Conklin, Associate Counsel
Bureau of Professional Medical Conduct
(518) 473-4219

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

IN THE MATTER

OF

FUNSHO BUSARI-ALABI, M.D.

STATEMENT

OF

CHARGES

FUNSHO BUSARI-ALABI, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 24, 2005, by the issuance of license number 237437 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (hereinafter identified in the attached Appendix A) at the Emergency Department of Faxton-St. Luke's Healthcare, Utica, New York, from on or about September 15, 2011, through September 16, 2011. Patient A, who had experienced chest discomfort earlier in the day, presented with low blood pressure, and complaints of chest pain, dizziness, nausea, vomiting, and decreased appetite. Respondent's care of Patient A deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient A.
2. Respondent failed to appropriately appreciate the severity of Patient A's condition.
3. Respondent failed to appropriately interpret Patient A's electrocardiogram test.
4. Respondent failed to appropriately diagnose the condition of Patient, who had suffered a myocardial infarction.
5. Respondent failed to arrive at an appropriate plan of care for Patient A, and/or failed to document such plan of care.
6. Respondent administered an excessive dose of Atropine for Patient A.
7. Respondent failed to adequately treat Patient A, including:
   a. Administering appropriate and indicated thrombolytic medications for Patient A; and/or

(5)

b. Failing to request an indicated consultation with a cardiologist and referral for a heart catheterization procedure.

8. Respondent failed to maintain appropriate medical records for Patient A.

9. Respondent on two occasions made false representations to the New York State Department of Health, Office of Professional Medical Conduct (OPMC) relating to his care of Patient A.

   a. On or about the 23rd day of February, 2012, the Respondent was interviewed by representatives of OPMC. On such occasion, the Respondent was asked questions and gave information relating to the medical care and treatment rendered to Patient A at the Emergency Department of Faxton-St. Luke's Healthcare from on or about September 15 through September 16, 2011. The Respondent stated that he was at Patient A's bedside the entire time, except for a short period of time between the first code and second code. In fact, Respondent left Patient A's bedside from the time of the initial evaluation of said patient by Respondent until the first code. The representation made by Respondent was false; the Respondent knew the representation was false; and the Respondent intended to mislead OPMC by such false representation.

   b. By letter dated April 2, 2012, the Respondent, through his attorney, made a submission to OPMC regarding the medical care and treatment rendered to Patient A at the Emergency Department of Faxton-St. Luke's Healthcare from on or about September 15 through September 16, 2011. In such submission, the Respondent, among other things, stated that he first saw Patient A at approximately 10:00 p.m. [on September 15, 2011], and stayed by Patient MR's [Myron Rosenthal's] bedside monitoring the situation...and [Respondent] left for only a brief moment to call for a cardiology consult. In fact, Respondent left Patient A's bedside from the time of the initial evaluation of said patient until the first code. The representations made by Respondent were false; the Respondent knew the representations were false; and the Respondent intended to mislead OPMC by such false representations.

B. Respondent provided medical care and treatment to Patient B (hereinafter identified in the attached Appendix A) at the Emergency Department of St. Mary's Hospital, Amsterdam, New York, from on or about November 13, 2008, through November 14, 2008. Patient B presented with a history of constipation for three days, and a complaint of rectal pressure of 10 out of 10. Respondent's care of Patient B deviated from accepted standards of care as follows:

1. Respondent failed to adequately evaluate Patient B.
2. Respondent failed to appropriately diagnose Patient B's condition.
3. Respondent failed to order indicated diagnostic tests.
4. Respondent failed to conduct an indicated pelvic examination of Patient B.
5. Respondent failed to appropriately determine the gestational age of Patient B's fetus.
6. Respondent failed to request an indicated consultation with an obstetrician.
7. Respondent failed to adequately treat Patient B.
8. Respondent failed to maintain appropriate medical records for Patient B.
9. Respondent on two occasions made false representations to OPMC relating to his care of Patient B.
    a. Respondent was interviewed by representative of the OPMC on or about the 27th day of June, 2011. On such occasion, the Respondent was asked questions and gave information relating to the medical care and treatment rendered to Patient B at the Emergency Department of St. Mary's Hospital, Amsterdam, New York, from November 14th day through November 15, 2008. The Respondent stated that he could not get an ultrasound [of Patient B] after 10:00 p.m. because he thought the pregnancy was more than three months, and that ultrasound could only be done if the pregnancy was less than three months to rule out an ectopic pregnancy. In fact, Respondent did not think the pregnancy was more than three months, Respondent could have ordered an ultrasound examination of Patient B to rule out ectopic pregnancy and/or at Respondent's discretion, pursuant to the written policy of the St. Mary's Hospital Ultrasound Department, and Respondent advised Patient B that she was 5 and ½ weeks pregnant. The representations made by Respondent were false; the Respondent intended to mislead OPMC by

such false representations; and the Respondent knew the representations were false.

b. By letter dated September 8, 2011, the Respondent, through his attorney, made a submission to OPMC regarding the medical care and treatment he rendered to Patient B at Emergency Department of St. Mary's Hospital from November 13th through November 14th, 2008. In such submission, the Respondent, among other things, stated that Patient B was certain that:

1. Patient B was not pregnant and that said patient was adamant that there was no way she could be pregnant;

2. Patient B did not believe she was pregnant and refused to believe the Respondent;

3. Respondent could not get an ultrasound [of Patient B] after 10:00 p.m. because the hospital policy is that they will only perform ultrasounds after 10:00 p.m. to rule out ectopic pregnancy or DVT; and/or

4. Respondent did not perform an internal pelvic examination because [Patient B] would not have consented to an internal pelvic examination in light of the fact that she did not believe she was pregnant.

In fact, Patient B accepted that she was pregnant and believed Respondent, an ultrasound examination of Patient B could have been performed to rule out an ectopic pregnancy and/or, and Patient B did not refuse an internal pelvic examination by Respondent, and said patient would have submitted to such an examination. The representations made by Respondent were false; the Respondent knew the representations were false; and the Respondent intended to mislead OPMC by such false representations.

C. Respondent provided medical care and treatment to Patient C (hereinafter identified in the attached Appendix A) at the Emergency Department of St. Mary's Hospital, Amsterdam Hospital, Amsterdam, New York, on or about November 1, 2008. Patient C presented with

a history of having been involved in a one car rollover motor vehicle accident, and complaints of pain of the right and left patella, and right wrist, and an abrasion to the upper left chest and shoulder area. Respondent's care and treatment of Patient C deviated from the accepted standards of care as follows:

1. Respondent failed to appropriately interpret Patient C's chest x-ray, which was significant for a pneumothorax.
2. Respondent failed to maintain appropriate medical records for Patient C.

D. Respondent provided medical care and treatment to Patient D (hereinafter identified in the attached Appendix A) at the Emergency Department of St. Mary's Hospital, Amsterdam, New York, on or about February 21, 2008. Patient D presented with a history of right-sided pain for three weeks, and complaints of difficulty urinating and anxiousness. Respondent's care and treatment of Patient D deviated from accepted standards of care as follows:

1. Respondent failed to appropriately address Patient D's abnormal liver function test results.
2. Respondent failed to appreciate Patient D's abnormal liver function laboratory test results and/or failed to document such appreciation.
3. Respondent failed to arrive at an appropriate differential diagnosis based upon Patient D's abnormal liver function laboratory test results, and/or failed to document such differential diagnosis.
4. Respondent failed to appropriately instruct Patient D to follow-up on the abnormal liver function test results, and/or to document such instructions.
5. Respondent failed to prepare an appropriate patient instruction sheet for Patient D upon said patient's discharge from the hospital.
6. Respondent failed to maintain appropriate medical records for Patient D.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

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

1. The facts of Paragraphs A. and A.1, A. and A.2, A. and A. 3, A. and A.4, A. and A.5, A. and A.7(a), and A. and A.7(b);
2. The facts of Paragraphs B. and B.1, B. and B.2, B. and B.3, B. and B. 4, B. and B.5, B. and B.6, and B. and B.7; and
3. The facts of Paragraphs C. and C.1.

FOURTH THROUGH SIXTH 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:

4. The facts of Paragraphs A. and A.1, A. and A.2, A. and A. 3, A. and A.4, A. and A. 5, A. and A.7(a), A. and A.7(b);
5. The facts of Paragraphs B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, and B. and B.7; and
6. The facts of C. and C.1.

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

7. The facts of Paragraphs A. and A.9(a).
8. The facts of Paragraphs A. and A.9(b).
9. The facts of Paragraphs B. and B.9(a).
10. The facts of Paragraphs B. and B.9(b)

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of the following:

11. The facts of Paragraphs A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, A. and A.7(a), and A. and A.7(b); B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, and B. and B.7; C. and C.1; and/or D. and D.1, D. and D.2, D. and D.3, D. and D.4, and D. and D.5.

TWELVTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of the following:

12. The facts of Paragraphs A. and A.1, A. and A.2, A. and A.3, A. and A.4, A. and A.5, A. and A.6, A. and A.7(a), and A. and A.7(b); B. and B.1, B. and B.2, B. and B.3, B. and B.4, B. and B.5, B. and B.6, and B. and B.7; C. and C.1; and/or D. and D.1, D. and D.2, D. and D.3, D. and D.4, and D. and D.5.

THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of the following:

13. The facts of Paragraphs A. and A.5, and A. and A.8; B and B.8; C and C.2; and D. and D.2, D. and D.3, D. and D.4, D. and D.5, and D. and D.6.

DATE: August 20, 2014
Albany, New York

[redacted]

MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct

(12)