Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

NEW YORK
state department of
HEALTH

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Public

January 12, 2015

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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John Carey, M.D.
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RE: In the Matter of John Carey, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 15-006) 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. 2013) and §230-c subdivisions 1 through 5, (McKinney Supp. 2013), "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:

Enclosure

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

IN THE MATTER

OF

JOHN CAREY, M.D.

DETERMINATION

AND

ORDER

BPMC #15-006

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("the Department"). A Notice of Hearing ("NOH") and Statement of Charges ("SOC") both dated January 8, 2014 were served on John Carey, M.D. ("Respondent") and hearings were held pursuant to N.Y. Public Health Law ("PHL") §230 and New York State Admin. Proc. Act §§301-307 and 401 at the Department's offices at 90 Church Street, New York, New York. The Department's February 4, 2014 Amended Statement of Charges ("Amended SOC") replaced the original SOC, and a February 25, 2014 "Second Amended as to Paragraph A Only" Statement of Charges ("Second Amended SOC") replaced the Amended SOC. A copy of the NOH and Second Amended SOC is attached to this Determination and Order as Appendix 1. Gregory Fried, M.D., William M. Bisordi, M.D., and Michael N.J. Colon, Esq., duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Hearing Committee" "Committee" or "Panel") in this matter. Administrative Law Judge ("ALJ") Ann H. Gayle served as the Administrative Officer. The Department appeared by James E. Dering, Esq., General Counsel, by Claudia M. Bloch, Associate Counsel. The Respondent appeared by Robert R. Sappe, Esq., of Feldman, Kleidman, Coffey, Sappe & Regenbaum, LLP. Evidence was received, including witnesses who were sworn or affirmed, and a transcript of this proceeding was made.

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

PROCEDURAL HISTORY

Date of Service of NOH and SOC:	January 9, 2014
Answer Filed:	January 24, 2014
Pre-Hearing Conference:	February 10, 2014
Hearing Dates in 2014:	March 4 March 25 April 24 April 25 July 17 July 24
Witness for Petitioner:	David P. Haswell, M.D.
Witnesses for Respondent:	Respondent Richard Walker, M.D. Ringu Singh Patient D Patient E
Deliberations Dates:	October 2, 2014 October 27, 2014

STATEMENT OF THE CASE

The Department charged Respondent with thirteen specifications of professional misconduct under N.Y. Educ. Law §6530 which included practicing medicine with negligence on more than one occasion §6530(3), gross negligence §6530(4), incompetence on more than one occasion §6530(5), inadequate record keeping §6530(32), and a violation of any term of probation §6530(29). Respondent denied and/or objected to each of the factual allegations and denied each of the specifications.

FINDINGS OF FACT[1]

The following Findings of Fact ("FOF") were made after a review of the entire record in this matter. Citations in brackets, which refer to exhibits ["Ex"] that were accepted into evidence and transcript page numbers ["T"], represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Respondent was authorized to practice medicine in New York State on or about July 1, 1978, by the issuance of license number 134672 by the New York State Education Department. [Ex 1; Ex 2]
2. From the completion of his residency in June 1980 to September 12, 2008, Respondent was a sole practitioner and from September 13, 2008 to the present, Respondent has practiced medicine with one other family medicine physician and other health care providers at Horizon Family Medical Group ("Horizon"). From 1980 to September 12, 2008, Respondent's charts consisted of handwritten notes and notes typewritten by support staff from Respondent's dictated notes. Approximately 4-5 years ago, Respondent began using the Dragon software voice recognition system. Respondent's charts at Horizon from 2010 to 2011 were generated by PrognoCIS. Beginning in 2011, Respondent's charts were generated by the eClinicalWorks system. Both PrognoCIS and eClinicalWorks are electronic medical records ("EMR"). Respondent treated Patients A through E in Goshen, New York at his private offices and then at Horizon; their charts consist of handwritten, typed, and EMR. [Ex 4; Ex 4B; Ex 5; Ex 6; Ex 6A; Ex 7; Ex 8; Ex C; T 676-678, 689, 697-699, 728-729, 736, 773-777, 782-783, 875-877, 952-953, 1006-1008]

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[1] *All findings in this section are unanimous.*

3. The standard of care for recordkeeping requires that the chief complaint, history of present illness, physical examination, diagnosis and plan must be taken, done, and included in the patient's chart. The general purpose of a medical record, particularly in primary care, is to organize the patient's past, current, and family histories, surgeries, hospitalizations, medications, allergies, preventive health care, screening procedures, and immunizations in a manner or form that can be retrieved, modified, and updated on a regular basis. Maintaining a record for each patient is important for the practitioner to have this information available over the course of the patient's treatment and for any other practitioner who might treat the patient. [T 31-33, 183, 783-784, 791, 1246-1247]

4. Horizon has maintained a "paperless" EMR since 2010. The EMR creates alerts and contains much more information about the patient (such as whether a colonoscopy is needed, overdue, or has been completed) than what is reflected in the paper charts in evidence which the Department's expert criticized[2]. [Ex 4; Ex 4B; Ex 5; Ex 6; Ex 6A; Ex 7; Ex 8; Ex C; T 230- 233, 236, 239, 244, 245, 254, 257-258, 269, 279, 286-287, 291, 313, 332, 339, 366, 378, 383, 389, 393, 399, 482, 484-486, 493, 502-503, 511, 513, 515-516, 521-522, 526, 530, 539, 566, 578, 581, 588-589, 599-600, 1005-1006, 1017-1018, 1034-1037, 1058-1062]

Patient A

5. Respondent treated Patient A from April 1990 to January 2009. Patient A had a history of smoking one pack of cigarettes a day for 50 years, and he complained of persistent and worsening cough from December 2007 to December 2008. Patient A was diagnosed with metastatic Non-Small Cell Lung cancer in January 2009. [Ex 4, 4A, 4B]

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[2] *The Department's expert admitted that his opinions were based upon the paper charts he reviewed and further admitted that if information is maintained in a digital format in the EMR (but not in the paper chart) that would constitute an adequate medical record. [301-302, 304]*

6. Respondent failed to note a complete and appropriate physical examination of Patient A. [Ex 4, 4B; T 51, 54] [FOF # 3]

7. Respondent failed to order and/or obtain a chest x-ray on Patient A. [Ex 4, 4B; T 109, 111, 114, 1274-1277, 1290]

8. Respondent failed to appropriately evaluate Patient A's chronic cough and/or diagnose Patient A's chronic cough as a symptom of lung cancer. [Ex 4, 4B; T 114-120, 1274]

9. Respondent failed to maintain an office record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of Patient A. [Ex 4; Ex 4B; Ex C; T 1290] [FOF # 3]

Patient B

10. Respondent treated Patient B from February 1982 to August 2012. [Ex 5; Ex C]

11. Respondent inappropriately maintained Patient B on Xanax. [Ex 5, p 16-49, 92-96; Ex C, p 6-11; T 215-216]

12. Respondent inappropriately maintained Patient B on Vicodin. [Ex 5, p 16, 19, 22,32, 35, 38, 44, 96, 99, 101, 103-105; Ex C; T 255-256, 261-263]

13. From 2006-2008, Respondent failed to maintain an office record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of Patient B. [Ex 5; Ex C; T 274] [FOF # 3]

Patient C

14. Respondent treated Patient C from April 1994 to August 2012. [Ex 6; Ex 6A; Ex C]

Patient D

15. Respondent treated Patient D from August 1982 to March 2012. [Ex 7]

16. Respondent failed to maintain an office record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of Patient D. [Ex 7; T 492, 503-504, 521] [FOF # 3]

Patient E

17. Respondent treated Patient E from November 2007 to June 2012. [Ex 8]

Probation

18. Pursuant to Board Order No. BPMC #99-45 ("Board Order"), Respondent was placed on probation for five years from February 1999 to February 2004. A probation term imposed by the Board Order required, in part, that "Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients." [Ex 3]

19. Respondent violated a term of probation imposed by the Board Order in that he failed to maintain an office record for Patients A and D during the probationary period in accordance with accepted medical standards and in a manner which accurately reflected his care and treatment of those patients. [Ex 3; Ex 4; Ex 4B; Ex 5; Ex 7; Ex C] [FOF # 3]

FACTUAL ALLEGATIONS NOT SUSTAINED[3]

The Department charged Respondent with misconduct based on at least 10 factual allegations for Patient A, 11 for Patient B, 10 for Patient C, 8 for Patient D, and 5 for Patient E which is a total of at least 44 factual allegations for the five patients[4]. The vast majority of the 50+ factual allegations were not sustained, and of the remaining 9 factual allegations sustained, 5 were sustained as charged (A.6 and 10, B.11, D.8, and F.2) and the others were sustained only in part to the actual wording of the allegations.

[3] *All findings in this section are unanimous.*

Patient A

The Department charged Respondent with failing to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient A (A.1). Because the Department's Paragraph A sets the timeframe from "on or before April 11, 1990 through on or about January 12, 2009" and charge A.1 reads "failed to obtain and/or note **an** adequate and complete..." (emphasis supplied), the Committee did not sustain this charge because Respondent charted histories and complaints in various entries in the chart. [Ex 4, p 76-77, 88-89, 129, 133-135; T 822]

The Department charged Respondent with inappropriately treating Patient A with antibiotics (A.4), and inappropriately prescribing Robitussin AC to Patient A (A.5). The Committee did not sustain charges A.4 and A.5 because the Department's expert's testimony on these charges stated his opinions and not the standard of care therefore the Committee found that Respondent's treatment and prescriptions for antibiotics and Robitussin AC were judgment calls. [Ex 4, p 18; T 737-741, 766-767, 1210, 1212-1214]

The Department charged Respondent with failing to timely refer Patient A for a pulmonary consult (A.7), inappropriately failing to coordinate the care and treatment of Patient A with various medical specialists Respondent referred Patient A to (A.8), and failing to develop an appropriate treatment plan for Patient A's care (A.9). The Committee found that throughout the course of treatment Respondent did develop an appropriate treatment plan (A.9), he coordinated Patient A's care by sending him to various specialists (A.8), and the pulmonary consult was timely because the course of Patient A's condition was getting better and worse

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[4] *more than 50 when factual allegations subparagraphs B.3.a-c, B.6.a-d, and C.3.a-b and the factual allegations in F.1 and F.2 which relate back to Patients A-E are added in*

(A.7), therefore the Committee did not sustain allegations A.7, 8, and 9. [Ex 4, p 20-22, 73, 97-104, 108; 4B; T 758-759, 794-795]

With regard to charges A.2, 3, 6, and 10, A.6 and 10 were sustained as charged, but A.2 and 3 were sustained in part as follows. The Department charged Respondent with failing to perform and/or note a complete and appropriate physical examination of Patient A (A.2) and failing to order and/or obtain any diagnostic testing on Patient A, including a chest x-ray (A.3). Based on the totality of the testimony (to be discussed *infra* under Credibility heading) the Committee believes that Respondent did perform physical examinations on Patient A, and as such dismissed that part of A.2 which read "perform and/or" and then sustained charge A.2 (T 786-787). Because the Department's attorney stated, "We're not talking about CAT scans...the charge is chest x-ray" (T 1218, lines 13-14 and 21-22) the Committee did not consider that part of A.3 which read, "any diagnostic testing ... including" and then sustained charge A.3.

Patient B

The Department charged Respondent with failing to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient B (B.1), and with failing to perform and/or note a complete and appropriate physical examination of Patient B (B.2). Because the Department's Paragraph B sets the timeframe from "on or about February 2, 1982 through on or about August 6, 2012" (*i.e.*, a 30-year period) and charge B.1 reads "failed to obtain and/or note <u>an</u> adequate and complete..." (emphasis supplied), and B.2 reads "failed to perform and/or note <u>a</u> complete and appropriate ..." (emphasis supplied) the Committee did not sustain these charges because Respondent charted histories and complaints and physical examinations in various entries in the chart. [Ex 5, p 1-2, 84; Ex C, p 5]

The Department charged Respondent with failing to appropriately evaluate, diagnose and/or treat Patient B's chronic complaints of back pain, anxiety and depression, and fatigue and malaise by a. failing to order and/or timely obtain appropriate diagnostic testing, including x-ray, MRI and/or a sleep study, b. failing to treat and/or counsel Patient B on weight reduction, and c. failing to refer and/or timely refer Patient B for appropriate consultation with a psychiatrist, neurologist, orthopedist and/or cardiologist (B.3.a-c), with treating Patient B with antibiotics inappropriately (B.7), and with failing to order and/or note any discussion with Patient B regarding age related prostate cancer screening and the need for a colonoscopy (B.10). The Committee did not sustain charges B.3.a-c, B.7, and B.10 because the Department's expert's testimony on these charges stated his opinions and what he would like to see but he did not establish what the standard of care was, and with regard to at least some of these allegations, Respondent actually did what he was charged with not doing, *e.g.*, Respondent treated Patient B's back pain and anxiety, ordered imaging studies, and recommended a psychiatrist, and as to charge B.10, Patient B had screenings for prostate cancer and by the time Patient B was 50 years old, EMR (electronic medical records) was in place so colonoscopy is addressed. [Ex 5, p 62-64 109, 110; Ex C, p 10; Ex E; Ex F; T 300-304, 899-911, 912-914, 925-927, 952, 1032-1039, 1125-1129]

The Department charged Respondent with inappropriately treating Patient B's hypertension with HCTZ and/or failing to appropriately monitor this medical therapy (B.4), and with failing to appropriately evaluate and/or diagnose and treat abnormal laboratory results reported on or about November 17, 2001, to wit: blood sugar, LDL and creatinine (B.5). The Committee did not sustain charges B.4 and B.5 because Patient B's blood pressure fluctuated up and down so he did not always have high blood pressure, and the laboratory results were not

particularly elevated. [Ex 5, p 2, 5, 8, 11, 56, 58, 60, 62, 64, 66, 68, 70, 76, 81, 84, 92, 96, 118, 120; Ex C; T 899-904, 936-938, 954-955]

The Department charged Respondent with failing to develop an appropriate treatment plan for Patient B (B.8). The Committee found the Department's charge B.8 that Respondent failed to develop an appropriate treatment plan for Patient B too vague in part because once again the Department charged "an appropriate..." (emphasis supplied), therefore it could not be ascertained where in the 30 years of treatment the Department was charging that Respondent did not develop an appropriate treatment plan; as such the Committee did not sustain charge B.8. In addition, there were examples of Respondent's treatment plan for Patient B. [Ex 5, p 110; Ex C; T 897-898, 913-915]

The Department charged Respondent with inappropriately failing to coordinate the care and treatment of Patient B with various medical specialists Respondent referred Patient B to for complaints of severe and chronic abdominal pain from in or about July, 2001 through in or about November, 2001 (B.9). The Committee did not sustain charge B.9 because the Committee found that Respondent referred Patient B to Dr. Mobed on 7/16/01 and he ordered a HIDA scan in November 2001 (11/19/01); the Panel also found that this charge was too vague. [Ex 5, p 120, 126-127; Ex C, p 6; T 891-894]

The Committee sustained charge 6 in part and did not sustain it in part. The Department charged that Respondent "inappropriately and without accepted medical indication and justification prescribed and/or maintained Patient B on various medications, including a. Xanax, b. Vicodin, c. Hydrocodone, and d. Norco." The Committee found that the Department did not establish that Respondent prescribed any of these medications without accepted medical indication and justification but did find that Respondent inappropriately maintained (emphasis

supplied) Patient B on Xanax and Vicodin, therefore the Committee sustained that part of B.6.a-b which read that Respondent "inappropriately ... maintained Patient B on various medications, including ... Xanax [and] Vicodin..." but did not sustain the remainder of the charge. [FOF # 10 and 11]

Patient C

The Committee dismissed all charges regarding Patient C, in general because the Department's expert, Dr. Haswell, was "all over the place" with this patient; he often stated that this is what he would like to see, what he would want done, and what he would do in various instances of Respondent's care and treatment for Patient C, but more specifically because his testimony did not establish what the standard of care is, he retracted what he said, and at times admitted that he did not read the chart in certain instances, and because the evidence established that Respondent actually did do what the Department alleged he failed to do and/or appropriately did what the Department alleged he did inappropriately.

The Department charged Respondent with failing to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient C (C.1), and failing to perform and/or note a complete and appropriate physical examination of Patient C (C.2). The Committee did not sustain charge C.1 because histories appeared in several places in the chart and Dr. Haswell conceded at times that he did not read the chart, and the Committee did not sustain charge C.2 because there were various entries of physical examinations in the chart. Also, see discussion under headings Patient A and Patient B, *supra*, for further discussion. [Ex 6, p 1-2, 5, 8, 25, 154, 260, 262, 6A; Ex C, p 18; T 339]

The Department charged Respondent with inappropriately and without accepted medical indication and justification prescribing and/or maintaining Patient C on various medications, to

wi t: a. Xanax and b. Percocet (C.3.a and b), and with treating Patient C with antibiotics inappropriately (C.4). The Committee did not sustain charge C.3 because Xanax and Percocet were indicated and the Department's expert agreed with this, and the Committee did not sustain charge C.4 (*see discussion under charges A.4 and B.7, supra*) because the antibiotics were indicated and a judgment call. [Ex 6, p 24-26, 27-30, 32-33, 53-54, 56, 68-69, 78, 139, 151, 178-191, 251, 256; Ex 6A; Ex C; T 353, 408, 416, 420, 429, 450-452, 1093, 1096-1107, 1115-1116, 1129-1134, 1154-1156]

The Department charged Respondent with failing to evaluate and/or appropriately treat Patient C's obesity, hypertension, and/or hyperlipidemia (C.5). The Committee did not sustain charge C.5 because Patient C was not obese, his hypertension was on and off, and the treatment of all three (obesity, hypertension, and hyperlipidemia) were judgment calls. [Ex 6, p 2, 5, 8, 11, 14, 16, 19, 22, 30, 32, 109-111, 114, 120, 131-134,140, 143, 145-146, 148-153; T 355-356, 446-447, 1330, 1332]

The Department charged Respondent with failing to develop an appropriate treatment plan and/or follow-up plan to address Patient C's chronic pain and/or ongoing anxiety and depression (C.6). The Committee did not sustain charge C.6 because Respondent did this and the Department's expert's testimony on these charges stated his opinions and not the standard of care therefore the Committee found that Respondent's treatment and plans for these conditions were judgment calls. [Ex 6, p 10-11, 18-19, 21, 27-37, 41,-42, 53, 56-59, 130-133, 139, 183-191, 256, 6A; Ex C, p 17; T 1093-1099, 1104, 1106-1107, 1109-1114, 1130-1132, 1138, 1142, 1144-1145, 1148, 1153-1155]

The Department charged Respondent with inappropriately failing to coordinate the care and treatment of Patient C with various medical specialists Respondent referred the patient to,

including a pain specialist, orthopedist, neurosurgeon and psychologist (C.7), and with failing to appropriately follow-up and/or note a follow-up on laboratory results, MRI and x-rays performed on Patient C (C.8). The Committee did not sustain charges C.7 and 8 because Respondent sent Patient C to all these specialists and received reports, and he followed up on the imaging studies and results. [Ex 6, p 18-19, 21, 151; T 444-449, 794-795, 1139-1140, 1144-1146, 1330-1332]

The Department charged Respondent with failing to appropriately evaluate and/or diagnose and treat abnormal laboratory results reported throughout the period of Respondent's care and treatment of Patient C, to wit: high LDL and Triglycerides of greater than 407 (C.9). The Committee did not sustain charge C.9 because Respondent addressed these findings by telling Patient C to stop smoking and lose weight, and Dr. Haswell conceded that the best treatment for these abnormal results would be weight loss. [Ex 6; T 355-356, 1332]

The Department charged Respondent with failing to maintain an office record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient (C.10). The Committee did not sustain charge C.10 because a review of the record demonstrates what the care and treatment for this patient was. The Committee found that the care and treatment was clear and apparent in Patient C's chart. [Exhibits C, 6, and 6A as a Whole]

Patient D

The Department charged Respondent with failing to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient D (D.1). The Committee did not sustain charge D.1 because histories appeared in various places in the chart. Also, see discussion under headings Patient A and Patient B, *supra*, for further discussion. [Ex 7, p 53, 132-134, 136, 191, 222]

The Department charged Respondent with failing to perform and/or note a complete and appropriate physical examination of Patient D (D.2). The Committee did not sustain charge D.2 because Respondent's testimony that he always does a physical examination on his patients was confirmed by Patient D's very credible testimony that Respondent examined him. [Ex 7, p 7-10, 160, 193; T 1119-1120, 1354-1355, 1373]

The Department charged Respondent with inappropriately and without accepted medical indication and justification prescribing and/or maintaining Patient D on various medications, to wit: a. Ambien, b. Vicoden, c. Viagra, and d. Ativan (D.3.a-d). The Committee did not sustain these charges because the Department failed to meet its burden of proof in that Dr. Haswell, who really waivered in his testimony about these medications, did not convince the Panel that prescribing these medications was inappropriate. The Panel was instead persuaded that these were reasonable medications for this patient's conditions. [Ex 7, p 1-2, 33, 74; T 515-517, 521-523, 529, 534-535, 1122-1123, 1365-1371, 1379-1383]

The Department charged Respondent with treating Patient D with antibiotics inappropriately (D.4). The Committee did not sustain charge D.4 (*see discussion under charges A.4, B.7, and C.4 supra*) because the antibiotics were indicated and such prescribing constituted judgment calls. [Ex 7]

The Department charged Respondent with failing to appropriately evaluate and follow, and/or note an evaluation and follow-up of Patient D's ongoing medical problems and to lower Patient D's cardiac risk (D.5), and with failing to appropriately evaluate and/or diagnose and treat abnormal laboratory results, reported throughout the period of Respondent's care and treatment of Patient D, to wit: fasting blood sugar and LDL (D.6). The Committee did not sustain these charges because these results were not so far from normal to warrant follow-up, the

Department did not present sufficient evidence of how these were deviations and/or what Respondent should have done, and once again because Dr. Haswell's testimony on these charges stated his opinions and what he would like to see but he did not establish what the standard of care was. [Ex 7, p 22-30, 57, 88, 105-106, 137-140; 183; T 525-527, 545-554, 1119-1122, 1372-1379]

The Department charged Respondent with failing to develop an appropriate treatment plan for Patient D (D.7). The Committee did not sustain charge D.7 because the Committee found that Respondent had a treatment plan for Patient D and he addressed Patient D's issues as they arose and developed. Also, Patient D did not visit Respondent regularly, including periods where he would not visit Respondent's office for long stretches of time. [Ex 7; T 1119-1122, 1356, 1372-1379]

Patient E

The Committee dismissed all charges regarding Patient E because the evidence established that Respondent actually did do what the Department alleged he failed to do and/or appropriately did what the Department alleged he did inappropriately.

The Department charged Respondent with failing to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient E (E.1). The Committee did not sustain charge E.1 because as discussed under headings Patient A and Patient B, *supra*, histories were noted throughout Patient E's chart, and Patient E filled out his own questionnaire. [Ex 8, p 1-2, 88, 99-100]

The Department charged Respondent with failing to perform and/or note a complete and appropriate physical examination of Patient E (E.2). The Committee did not sustain charge E.2 because as discussed under heading Patient B, *supra*, there are entries for physical examinations

in the chart, and Patient E credibly testified that Respondent examined him. [Ex 8, p 8-9, 90-91, 104; T 991, 996, 1398-1399, 1404-1406, 1410-1414]

The Department charged Respondent with failing to appropriately evaluate and treat Patient E's hypertension and/or obesity (E.3) and with failing to develop an appropriate treatment plan for Patient E (E.4). The Committee did not sustain charges E.3 and E.4 because Respondent had a treatment plan and diagnosed and treated these conditions, and Patient E's credible testimony corroborated this. [Ex 8, p 1, 4-7, 19, 27, 32-33, 35, 40, 43-47, 77, 89-91, 104; T 583-584, 608, 612-617, 636-646, 652, 983-992, 996-999, 1397-1416, 1437]

The Department charged Respondent with failing to maintain an office record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of Patient E (E.5). The Committee did not sustain charge E.5 because Respondent's record for Patient E, who was a sick man, gives the picture of Respondent's care and treatment of Patient E; the record follows Patient E's issues in the course of his care and treatment. [Exhibit 8 as a Whole]

Violation of a Term of Probation

The Department charged Respondent with violating the probation term imposed by the Board Order that read "Respondent shall conduct [himself] in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by [his] profession" by failing to appropriately and within the minimally accepted standards of conduct care for and treat Patients A through E. The Committee felt that the language which read, "and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by [his] profession" did not relate to the charges in this case and therefore did not consider this language. As to the

remaining language, the Committee found that Respondent did conduct himself in a manner befitting his professional status. The Committee then dismissed allegation F.1 because the negligence findings the Committee did sustain do not rise to the level of not conducting himself in a manner befitting his professional status. [Record as a Whole]

CONCLUSIONS OF LAW[5]

Respondent is charged with thirteen Specification of Charges of professional misconduct under Educ. Law §6530. The Committee concludes that although the Committee sustained very few of the factual allegations, those findings constituted some negligence on more than one occasion, limited incompetence on more than one occasion, inadequate recordkeeping, and a violation of one of the terms of probation and as such sustained those aspects of the First, Seventh, Eighth, Ninth, Eleventh, and Thirteenth Specifications as described below, and did not sustain the Second, Third, Fourth, Fifth, Sixth, Tenth, and Twelfth Specifications.

Negligence on More Than One Occasion – Educ. Law §6530(3)

The first specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing medicine with negligence on more than one occasion with respect to Patients A through E.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S.2d 381 (3d Dept. 1993). Injury, damages, and proximate cause are not essential elements in a medical disciplinary proceeding (Id.)

[5] *All findings in this section are unanimous.*

The statutory definition of "negligence" for professional misconduct requires proof of negligence "on more than one occasion." N.Y. Educ. Law §6530(3). The Court of Appeals has interpreted "occasion" to mean "an event of some duration, occurring at a particular time and place, and not simply ...a discrete act of negligence which can occur in an instant." Rho, supra at 322. While several acts of negligence occurring during a single autopsy do not constitute professional misconduct (Rho), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct. Orosco v. Sobol, 162 A.D.2d 834, 557 N.Y.S.2d 738 (3d Dept. 1990).

While the Committee concluded that the majority of the factual allegations were not sustained, the sustained factual allegations identified in the Second Amended SOC as A.2 (in part), 3 (in part), 6, and 10, B.6 (in part) and 11, and D.8 represented failures by Respondent on multiple occasions to exercise the care that a reasonably prudent physician under the circumstances would exercise.

Accordingly, the first specification as to those findings only is sustained.

Gross Negligence – Educ. Law §6530(4)

The second to sixth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing medicine with gross negligence with respect to Patients A through E.

"Gross negligence," in the specific context of a professional misconduct proceeding, may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." (Rho, supra at 322). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach ("Rho"). 74 N.Y.2d 318, 322, 546 N.Y.S.2d 1005 (1989).

No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient. Post v. State of New York Department of Health, 245 A.D.2d 985, 986, 667 N.Y.S.2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct. See Minielly v. Commissioner of Health. 222 A.D.2d 750, 751, 634 N.Y.S.2d 856 (3d Dept. 1995).

With regard to the approximately 8 factual allegations the Committee sustained regarding Patients A, B, and D, the Panel concludes that none of the sustained allegations independently rose to the level of "a single act of negligence of egregious proportions," and that the sustained allegations taken together did not rise to the level of "multiple acts of negligence that cumulatively amount to egregious conduct."

Accordingly, the second through sixth specifications of gross negligence are not sustained.

Incompetence on More Than One Occasion – Educ. Law §6530(5)

The seventh specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing medicine with incompetence on more than one occasion with respect to Patients A through E.

Incompetence is a lack of the requisite skill or knowledge to practice medicine safely. (Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D. 2d 609, 651 N.Y.S. 2d

249 (3d Dept. 1996)). The statutory definition requires proof of practicing with incompetence "on more than one occasion." N.Y. Educ. Law §6530(5). "On more than one occasion" in relation to incompetence would presumably carry the same meaning as it does in relation to negligence on more than one occasion, discussed above.

Based on Respondent's testimony and the treatment he provided Patients A through E, in conjunction with Dr. Walker's, Patient D's, and Patient E's testimony, the Committee found Respondent to have the requisite *knowledge* to practice medicine safely. The Committee also found Respondent to have the requisite *skill* (except with regard to recordkeeping) to practice medicine safely. However, based on Patients A, B, and D's records and the totality of the testimony which were the basis for the sustained factual allegations identified in the Second Amended SOC as A.2 (in part) and 10, B 11, and D 8, the Committee concluded that Respondent lacked the requisite recordkeeping *skill*.

Accordingly, the seventh specification as to those findings only is sustained.

Record Keeping – Educ. Law §6530(32)

The eighth to twelfth specifications charged Respondent 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 the patient with respect to Patients A through E.

It should be noted from the outset that because Respondent was already disciplined for recordkeeping in Board Order #BPMC 99-45, the Committee considered Respondent's records for these patients from February 25, 1999 to the last day of treatment only. The Committee did not consider dates before February 25, 1999, the effective date of the Order, because this Committee believed that Respondent was already disciplined for recordkeeping up to February

24, 1999, therefore this Committee of the Board would not discipline him again for the same type of misconduct, albeit for different patients, in the time period prior to February 25, 1999.

The Committee accepts that the saying in medicine about record keeping that "if it's not written it wasn't done" is frequently the case, but finds that it does not apply here based on Respondent's and the two patients' testimony. The care and treatment provided by Respondent for Patients D and E as testified to by Respondent and corroborated by Patients D and E established that Respondent provided much more care and treatment for them than is reflected in their records. This, combined with Respondent's overall knowledge of medicine, convinced the Panel that this saying should not be applied to this case.

Based on FOF #3 that records should include the patient's past, current, and family histories, history of present illness, surgeries, hospitalizations, medications, allergies, preventive health care, screening procedures, immunizations, chief complaint, physical examination, diagnosis and plan, the Panel found enough of this information lacking in Patients A, B, and D's charts to accurately reflect those patients' course while under Respondent's care, and sustained this charge for those three patients. Respondent's record for Patient A was not focused which forced the Panel to go through the whole record to understand the treatment provided to Patient A. The Committee sustained charge B.11 for the years 2006-2008 because Patient B's records were very brief during this time period wherein many of the 2006-2008 entries read simply "refill" and many of those entries were not even visits; by 2009, Respondent's records were acceptable although the Panel did note that Respondent did not consistently include why Patient B was there. The Committee sustained charge D.8 because Patient D's records were inaccurate.

Accordingly, the eighth, ninth, and eleventh specifications (as to those parts of A.2 and 10, B.11, and D.8 that were sustained) are sustained, and the tenth and twelfth specifications are not sustained.

Violation of a Term of Probation – Educ. Law §6530(29)

The thirteenth specification charged Respondent with committing professional misconduct under N.Y. Educ. Law §6530(29) by violating any term of probation imposed on the licensee pursuant to PHL §230.

The Committee dismissed all the charges regarding Patients C and E and sustained some of the Department's recordkeeping charges regarding the three remaining patients. Respondent's probation ran from February 1999 to February 2004. Because the Panel found Respondent's recordkeeping in at least Patients A and D's charts to be inadequate during that timeframe, the Committee, after dismissing factual allegation F.1, found that Respondent violated the term of probation which read, in part, "Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients."

Accordingly, the Committee concludes that the thirteenth specification (as to F.2) is sustained.

DISCUSSION[6]

Credibility and Weight

The Department presented one witness, David P. Haswell, M.D., to testify as an expert witness. Respondent testified in his own behalf and presented four witnesses: Patient E, Rinku Singh, Patient D, and Richard Frank Walker, M.D. Both Dr. Haswell and Dr. Walker had the

[6] *All findings in this section are unanimous*

requisite experience and credentials to render expert opinions, however, Dr. Walker who treated Patient A gave factual and expert testimony about Patient A only. The Committee found Dr. Walker to be credible; he conceded some points and did not support Respondent fully. The Panel gave Dr. Walker's testimony great weight. The Committee found Dr. Haswell's testimony to be credible at times but he lost some credibility in circumstances that will be described below.

Department's Expert

The Panel believes the Department's expert saw his role as a prosecutor who had to "nail" this Respondent. The most blatant example of this was where Dr. Haswell testified on direct examination that in his opinion Responded did not coordinate his care and treatment with other physicians and/or therapists that Patient C saw (T 398-399) but retracted this upon Panel questions when Dr. Haswell responded that he thinks Respondent did coordinate the care when the Chair asked him about the serious charges of not 'coordinating his care' (T 445). Upon another Panel member's question, Dr. Haswell testified that he did not agree with the allegation that Respondent failed to coordinate the care (T 448-449) but then on redirect questions by the Department's attorney, Dr. Haswell flip-flopped again by answering the question that coordination of care means there's communication or an understanding of what's going on but he did not see that in Respondent's chart for Patient C (T 454-455). This led the Panel to believe that Dr. Haswell saw himself more as an agent of the Department and less as an expert witness whose role it is to educate the Panel about the standard of care.

The Panel found that Dr. Haswell and the Department did not really address the standard of care until the Panel started asking questions about standard of care; before the Panel directed Dr. Haswell to standard of care he was testifying primarily about what he would do, what he would like, what would be nice, and what he would like to see. Subsequent to the Panel directing

Dr. Haswell to standard of care, he reverted again to testifying about what he would do, what he would like, etc.

Dr. Haswell lost credibility at several junctures but especially when he would not concede gross negligence (T 187) and incompetence particularly in his testimony about the use of Robitussin; Dr. Haswell lost credibility in the Panel's view this early in his testimony. The Panel was also especially concerned about Dr. Haswell's testimony on colonoscopies and all the times there was something in the record that he said wasn't there. The Panel found Dr. Haswell also lacked credibility when he would say in a sweeping way that things weren't there but when Respondent's attorney would point to examples in the chart, Dr. Haswell would concede that he didn't read that. Although the Panel gave credit and weight to some of his testimony, the aforesaid observations/remarks/comments gave the Panel a very difficult time finding his testimony credible and giving his testimony much weight in many circumstances.

Other Witnesses

The Committee finds Patients D and E to be credible. The Committee further finds the testimony of Rinku Singh, Horizon's HIPAA compliance officer and head of IT, to be credible. The Committee found Mr. Singh to be a valuable witness; he educated the Panel on what Respondent's practice entailed as well as about problems with PrognoCIS and how Horizon's present EMR system addresses any concerns the Department had about Respondent's recordkeeping. The deficiencies articulated by the Department's expert particularly his primary concern that Respondent "does a very poor job of updating the patient's history, documenting preventative health care ... medication ... hospitalizations ... [and providing] a whole picture of the patient" [T 564] are addressed with the Dragon software, a user friendly EMR, numerous quality assurance measures and continued physician training and monitoring that is in place at

Horizon. The Panel was persuaded by Mr. Singh's testimony that with Horizon's "fail safe" and quality assurance measures it is nearly impossible to not keep a good record, and Mr. Singh gave insight as to Respondent's ability to keep appropriate records going forward. [T 563-564, 1080-1086]

HEARING COMMITTEE DETERMINATION AS TO PENALTY[7]

Respondent's attorney argued that the Department has not carried its burden of proof for any of the charges and therefore the Committee should not sustain the charges. The Department argued that the factual allegations and specification of charges should be sustained and Respondent's license to practice medicine in NYS should be revoked. Having dismissed some specifications and the majority of the allegations, the Committee unanimously concludes that the allegations and specifications that were sustained do not warrant a revocation of Respondent's license. In fact the Committee, most cognizant of its duty to protect the public, strongly believes that removing Respondent from practice would be a disservice to, and not a protection of, the public. The Committee strongly believes the charges were out of proportion to Respondent's performance, and although the Panel believes Respondent was overcharged, the Panel is concerned about Respondent's obstinacy in not conceding a single allegation including Patient B's Xanax addiction or any of Respondent's recordkeeping. The Panel believes this case is predominantly one of poor documentation with a few instances of negligence in addition to negligent recordkeeping, and while Respondent seemed to think that it didn't matter what he wrote in his record as long as his care and treatment of the patient was appropriate, the Panel did find Respondent to be very sincere in his desire to continue to improve his recordkeeping.

[7] *All findings in this section are unanimous.*

Regardless of what "fail safe" and quality assurance measures are in place and what is prepopulated in the EMR system, the records are adequate and complete only if the physician properly inputs his/her observations, findings, assessments, and treatment plans into the system; this is an area where Respondent requires additional improvement.

The Committee, having considered the full range of penalties available pursuant to PHL §230-a, determined the appropriate penalty to be (1) a limitation on the license to not practice as a sole practitioner; Respondent must practice within a group similar to his current group practice that has EMR, and (2) probation for three (3) years. Probation will include a practice monitor for chart review of Respondent's recordkeeping of patients. Probation will also include a requirement for Respondent to complete an in-person CME course in recordkeeping (such as the WILM course, attached) within the first year of Probation.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Educ. Law §6530 are sustained:

   Educ. Law §6530(3) – practicing with negligence on more than one occasion
   Educ. Law §6530(5) – practicing with incompetence on more than one occasion
   Educ. Law §6530(32) – failure to maintain an accurate record
   Educ. Law §6530(29) – violation of a term of probation

2. The misconduct charge under Educ. Law §6530(4) of practicing with gross negligence is not sustained.

3. Pursuant to PHL §230-a(3) there shall be a permanent limitation on Respondent's license to practice medicine in a medical office practice that has at least two physicians and which utilizes EMR. Respondent shall not practice medicine in a medical practice as a sole practitioner[8].

[8] *It is noted that Board Order #BPMC 99-43 imposed a "permanent limitation on [Respondent's] medical license that except in emergencies or where previously authorized in writing by the Director of OPMC, [his] medical practice shall be limited to [his]*

4. Pursuant to PHL §230-a(9) Respondent shall be placed on Probation for a period of three (3) years. Terms of Probation are attached to this Determination and Order as Appendix 2. Probation will include a practice monitor for chart review of Respondent's recordkeeping of patients. Probation will also include a requirement for Respondent to complete an in-person CME course in recordkeeping within the first year of Probation.

5. This order shall be effective upon service on the Respondent by personal service or by certified mail as required under PHL §230(10)(h)

DATED: New York, New York
January 9, 2015

[redacted]

GREGORY FRIED, M.D., Chair
WILLIAM M. BISORDI, M.D.
RAYMOND N.J. COLON, ESQ.

registered address and to hospitals in which [he] may now or in the future hold medical privileges." The permanent limitation imposed by this Committee's Order is in addition to the BPMC 99-45 permanent limitation.

APPENDIX 1

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

IN THE MATTER

OF

JOHN CAREY, M.D.

NOTICE

OF

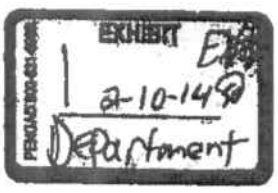
HEARING

TO: JOHN CAREY, MD
30 Hatfield Lane, Suite 101
Goshen, N.Y. 10924

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on March 3, 2014, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, NY 10007, 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.

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.

DATE Jan 8, 2014
New York, New York

[redacted]
ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:
Claudia Morales Bloch, Associate Counsel
Bureau of Professional Medical Conduct
145 Huguenot Street, Rm. 601
New Rochelle, NY 10801
Tel: 914-654-7047
Fax: 914-654-7050

in Evid 3/4/14 AG

SECOND AMENDMENT AS TO PARAGRAPH A ONLY

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

IN THE MATTER OF JOHN CAREY, M.D.	AMENDED STATEMENT OF CHARGES

JOHN CAREY, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1 1978, by the issuance of license number 134672 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A (the identity of all patients herein charged is set forth in Appendix "A") from on or before April 11, 1990 through on or about January 12, 2009, at his offices located at Harriman Drive, Goshen, NY; I Hatfield Lane, Goshen, NY; and/or 30 Hatfield Lane, Goshen, NY (hereinafter referred to as Respondent's "offices"). Patient A had a history of smoking one (1) pack of cigarettes a day for 50 years and presented to Respondent, from on or about December 3, 2007 through on or about December 23, 2008, with complaints of persistent and worsening cough. In or about January, 2009, Patient A was diagnosed with metastatic Non Small Cell Lung cancer. Respondent's care and treatment of Patient A deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient A.
2. Failed to perform and/or note a complete and appropriate physical examination of Patient A.

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

IN THE MATTER

OF

JOHN CAREY, M.D.

AMENDED STATEMENT OF CHARGES

JOHN CAREY, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1 1978, by the issuance of license number 134672 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A (the identity of all patients herein charged is set forth in Appendix "A") from on or about September 7, 1995 through on or about January 12, 2009, at his offices located at Harriman Drive, Goshen, NY; I Hatfield Lane, Goshen, NY; and/or 30 Hatfield Lane, Goshen, NY (hereinafter referred to as Respondent's "offices"). Patient A had a history of smoking one (1) pack of cigarettes a day for 50 years and presented to Respondent, from on or about December 3, 2007 through on or about December 23, 2008, with complaints of persistent and worsening cough. In or about January, 2009, Patient A was diagnosed with metastatic Non Small Cell Lung cancer. Respondent's care and treatment of Patient A deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient A.
2. Failed to perform and/or note a complete and appropriate physical examination of Patient A.

3. Failed to order and/or obtain any diagnostic testing on Patient A, including a chest x-ray.
4. Inappropriately treated Patient A with antiblotics.
5. Inappropriately prescribed Robitussin AC to Patient A.
6. Failed to appropriately evaluate Patient A's chronic cough and/or diagnosis Patient A's chronic cough as a symptom of lung cancer.
7. Failed to timely refer Patient A for a pulmonary consult.
8. Inappropriately failed to coordinate the care and treatment of Patient A with various medical specialists Respondent referred Patient A to.
9. Failed to develop an appropriate treatment plan for Patient A's care.
10. Respondent failed to maintain an office record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Respondent undertook the care and treatment of Patient B, at his offices, from on or about February, 2, 1982 through on or about August 6, 2012. During this period of time, Patient B continued to gain weight from 176 lbs in 1982 to 268 lbs in 2012. Respondent's care and treatment of Patient B deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient B.
2. Failed to perform and/or note a complete and appropriate physical examination of Patient B.
3. Failed to appropriately evaluate, diagnose and/or treat Patient B's chronic complaints of back pain, anxiety and depression, and fatigue and malaise. Respondent:

   a. Failed to order and/or timely obtain appropriate diagnostic testing, including x-ray, MRI and/or a sleep study.

   b. Failed to treat and/or counsel Patient B on weight reduction.

   c. Failed to refer and/or timely refer Patient B for appropriate consultation with a psychiatrist, neurologist, orthopedist and/or cardiologist.

4. Inappropriately treated Patient B's hypertension with HCTZ and/or failed to appropriately monitor this medical therapy.
5. Failed to appropriately evaluate and/or diagnose and treat abnormal laboratory results reported on or about November 17, 2001, to wit: blood sugar, LDL and creatinine.
6. Inappropriately and without accepted medical indication and justification prescribed and/or maintained Patient B on various medications, to wit:
   a. Xanax
   b. Vicodin
   c. Hydrocodone
   d. Norco
7. Treated Patient B with antibiotics inappropriately.
8. Failed to develop an appropriate treatment plan for Patient B.
9. In or about July, 2001 through in or about November, 2001, Respondent inappropriately failed to coordinate the care and treatment of Patient B with a medical specialists Respondent referred Patient B to for complaints of severe and chronic abdominal pain.
10. Failed to order and/or note any discussion with Patient B regarding age related prostate cancer screening and the need for a colonoscopy.
11. Respondent failed to maintain an office record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

C. Respondent undertook the care and treatment of Patient C at his offices from on or about April 22, 1994 through on or about August 10, 2012. During this period of time, Patient B presented with various ailments, including anxiety and depression, chronic pain and stiffness from a fall, fatigue and malaise and hypertension. Respondent's care and treatment of Patient C deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient C.

2. Failed to perform and/or note a complete and appropriate physical examination of Patient C.
3. Inappropriately and without accepted medical indication and justification prescribed and/or maintained Patient C on various medications, to wit:
   a. Xanax
   b. Percocet
4. Treated Patient C with antibiotics inappropriately.
5. Failed to evaluate and/or appropriately treat Patient C's obesity, hypertension, and/or hyperlipidemia.
6. Failed to develop an appropriate treatment plan and/or follow-up plan to address Patient C's chronic pain and/or ongoing anxiety and depression.
7. Inappropriately failed to coordinate the care and treatment of Patient C with various medical specialists Respondent referred the patient to, including a pain specialist, orthopedist, neurosurgeon and psychologist.
8. Failed to appropriately follow-up and/or note a follow-up on laboratory results, MRI and x-rays performed on Patient C.
9. Respondent failed to appropriately evaluate and/or diagnose and treat abnormal laboratory results, reported throughout the period of Respondent's care and treatment of Patient C, to wit: high LDL and Triglycerides of greater than 407.
10. Respondent failed to maintain an office record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Respondent undertook the care and treatment of Patient D, at his offices, from on or about August 20, 1982 through on or about March 27, 2012. Patient D presented with a number of medical issues, including: pneumonia associated with Bullous lung changes, extensive pleural densities, early stage syphilis, prostate cancer, back pain and rapid atrial fibrillation. Respondent 's care and treatment of Patient D deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient D.
2. Failed to perform and/or note a complete and appropriate physical examination of Patient D.
3. Inappropriately and without accepted medical indication and justification prescribed and/or maintained Patient D on various medications, to wit:
   a. Ambien
   b. Vicoden
   c. Viagra
   d. Ativan
4. Treated Patient D with antibiotics inappropriately.
5. Failed to appropriately evaluate and follow, and/or note an evaluation and follow-up of Patient D's ongoing medical problems and to lower Patient D's cardiac risk.
6. Failed to appropriately evaluate and/or diagnose and treat abnormal laboratory results, reported throughout the period of Respondent's care and treatment of Patient D, to wit: fasting blood sugar and LDL.
7. Failed to develop an appropriate treatment plan for Patient D.
8. Respondent failed to maintain an office record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

E. Respondent undertook the care and treatment of Patient E, at his offices, from on or about November 30, 2007 to on or about June 28, 2012. Patient E presented with a number of medical issues, including: hypertension, obesity and weeping venous insufficiency sores. Respondent 's care and treatment of Patient E deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, family history and/or history of current complaint(s) from Patient E.
2. Failed to perform and/or note a complete and appropriate physical examination of Patient E.

3. Failed to appropriately evaluate and treat Patient E's hypertension and/or obesity.
4. Failed to develop an appropriate treatment plan for Patient E.
5. Respondent failed to maintain an office record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

F. Pursuant to New York State Board of Professional Medical Conduct Order No. BPMC #99-45, Respondent was placed on probation from on or about February 25, 1999 through on or about February 24, 2004. A probation term imposed pursuant to the Board Order provided that "Respondent shall conduct [himself] in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by [his] profession." Another probation term imposed required, in part, that: "Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients." Respondent violated the terms of probation imposed by the Board Order in that he:

1. Failed to appropriately and within the minimally accepted standards of conduct care for and treat Patients A through E, as set forth in paragraphs A through E and the respective subparagraphs, supra.
2. Failed to maintain an office record for Patients A through E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patients.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. Paragraphs A., A.1 – A.10, B., B.1, B.2, B.3, B.3.a – B.3.c, B.4, B.5, B.6, B.6.a – B.6.d, B.7 – B.11, C., C.1, C.2, C.3, C.3.a, C.3.b, C.4 – C.10, D., D.1, D.2, D.3, D.3.a – D.3.d, D.4 – D.8, E, E.1 – E.5.

SECOND THROUGH SIXTH SPECIFICATION

GROSS NEGLIGENCE

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

2. Paragraphs A., A.1 – A.10
3. Paragraphs B., B.1, B.2, B.3, B.3.a – B.3.c, B.4, B.5, B.6, B.6.a – B.6.d, B.7 – B.11.
4. Paragraphs C., C.1, C.2, C.3, C.3.a, C.3.b, C.4 – C.10.
5. Paragraphs D., D.1, D.2, D.3, D.3.a – D.3.d, D.4 – D.8
6. Paragraphs E, E.1 – E.5.

SEVENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

7. Paragraphs A., A.1 – A.10, B., B.1, B.2, B.3, B.3.a – B.3.c, B.4, B.5, B.6, B.6.a – B.6.d, B.7 – B.11, C., C.1, C.2, C.3, C.3.a, C.3.b, C.4 – C.10, D., D.1, D.2, D.3, D.3.a – D.3.d, D.4 – D.8, E, E.1 – E.5.

EIGHTH THROUGH TWELFTH SPECIFICATION

FAILURE TO MAINTAIN RECORD

Respondent is charged 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 care and treatment of the patient, as alleged in the facts of the following:

8. Paragraphs A., A.1, A.2, A.9, A.10.

9. Paragraphs B., B.1, B.2, B.3.a, B.10, B.11.

10. Paragraphs C., C.1, C.2, C.6, C.8, C.10..

11. Paragraphs D, D.1, D.2, D.5, D.8.

12. Paragraphs E, E.1, E.2, E.5.

THIRTEENTH SPECIFICATION

VIOLATION OF A TERM OF PROBATION

Respondent is charged with committing professional misconduct as defined in N.Y. Law §6530(29) by violating any term of probation imposed pursuant to N.Y. Pub. Health Law Sec. 230, as alleged in the facts of the following:

13. Paragraphs F, F.1, F.2

DATE: February 4, 2014
New York, New York

[redacted]

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

TERMS OF PROBATION

1. Respondent's conduct shall conform to moral and professional standards of conduct and to governing law. Any act of professional misconduct by Respondent as defined by New York Education Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York Public Health Law § 230 (10) or (19), or both.
2. Respondent shall remain in continuous compliance with all requirements of New York Education 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 New York Education Law § 6502(4) to avoid registration and payment of fees.
3. Respondent shall provide to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, Suite 355, 150 Broadway, Albany, New York, 12204, at least every six months and as otherwise requested, or within thirty days of any change in the information, the following information in writing:
    a. a full description of the Respondent's employment and practice;
    b. all professional and residential addresses and telephone numbers within and outside of New York State;
    c. any and all information concerning investigations, arrests, charges, convictions or disciplinary actions by any local, state, or federal agency;
    d. any and all information concerning investigations, terminations, or disciplinary matters by any institution or facility.
4. Respondent shall provide to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, Suite 355, 150 Broadway, Albany, New York, 12204, copies of all applications relating to the practice of medicine, including but not limited to, privileges, insurance, and licensure, in any jurisdiction, concurrent with their submission.
5. Respondent shall cooperate fully with, and will respond within two weeks to, OPMC requests to provide written periodic verification of Respondent's compliance with these

terms of probation. Upon the Director of OPMC's request, Respondent shall meet personally with a person designated by the Director.

6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty 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 medical practice in New York State for a consecutive thirty-day period. Respondent shall then notify the Director again at least fourteen 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 the Determination and Order or as are necessary to protect the public health.
7. The Director of OPMC, or his/her designee, may review Respondent's professional performance. This review may include but shall not be limited to:
    a. A review of office records, patient records, hospital charts, and/or electronic records;
    b. Interviews with or periodic visits with Respondent and/or staff at practice locations or at OPMC offices.
8. 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.
9. Respondent shall practice only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to written approval of the Director of OPMC.
    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 on a random unannounced basis at least monthly and shall examine a selection (no less than 20) of records maintained by Respondent. The review will determine whether Respondent's charting 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 within 30 days after the effective date of this Determination and Order.

10. Respondent shall enroll in and successfully complete an in-person CME course in recordkeeping within the first year of Probation; such course is subject to the prior written approval of the Director of OPMC.

11. Respondent shall comply with these Terms of Probation, 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 for Professional Medical Conduct may initiate a violation of probation proceeding, and/or any other proceeding authorized by law, against the Respondent.

To: Claudia M. Bloch
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
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Medical Record Keeping

Home > Medical Record Keeping

Medical Record Keeping Course Overview (PACE equivalent):

This Medical Record Keeping Course is accepted by the California Medical Board as CME designed for clinicians who would like to improve their medical record keeping skills (**PACE equivalent**). Attendees will learn best practices which will ensure that their medical records meet standards, laws and regulations applicable to medical documentation. These skills will help improve medical care and help ensure accurate communications between care providers. This intensive two day long course is critical for prescribers who have been found deficient in medical documentation either by hospitals or by regulatory agencies and has been accepted by the California Medical Board as meeting the coursework requirements of physician probation.

[illegible] Registration Required

19 CME Hours – 2 Day Program

Program Content:

1. Purposes of patient record documentation.
2. Documentation and the law of evidence.
3. Deficient records.
4. Content of the patient records, including support of diagnosis and treatment plans.
5. Other information that should be documented.
6. Technical issues in documentation.
7. Electronic health records.
8. Documenting discussions with patient and/or family: including warnings, consent, informed consent and patient education.
9. Records that show fulfillment of legal obligations, including review of prior and concurrent care records.
10. Record keeping errors that increase liability risk
11. Documentation in situations requiring increased caution, including patient non-compliance.
12. Documenting frequently litigated conditions.
13. Undermining the credibility of the records.

Mailing Address

Address: 1700 S. El Camino Real, Suite 204, San Mateo, CA 94402

Phone: (650) 212-4904

Fax: (650) 212-4905

Email: Administrator@WILM-Ed.org

Business Hours:
Monday-Friday: 9:00-6:00

Conference Location

1700 South El Camino Real, San Mateo, CA 94402

14. Undermining the credibility of the record keeper.
15. Maximizing reimbursement while minimizing risk of fraud and abuse accusations.
16. Medical record confidentiality.
17. Confidentiality when contacting the patient.
18. Release of medical records with authorization.
19. Release of medical records without authorization.
20. Patients' access to their own records.
21. Medical record workshops with analysis of records.

Scheduled dates:

- **March 16 - 17, 2015:** Add course to your schedule: ical | Outlook 2003
- **June 22 - 23, 2015:** Add course to your schedule: ical | Outlook 2003

WILM's Conference room is located on the 1st floor.

Daily times:

8:00 AM - 12:30 PM and 1:30 PM - 6:00 PM.

Location:

Courses are held in the San Francisco Bay Area, typically nearby the San Francisco International Airport or within downtown San Francisco, depending on the number of registrants. Call for details and for help booking nearby hotels.

Follow WILM!

Tuition:

$949. Organizations sponsoring multiple registrants should call (650) 212-4904 to discuss reduced tuition fees that may apply.

Registration for Record Integrity

CME Accreditation:

COURSE OBJECTIVES

At the conclusion of the course, attendees should be able to:

1. Apply medical record keeping skills which will improve patient safety and continuity of patient care.

2. Integrate satisfaction of patients and their families with health care by improving the quality of their medical records.

3. Recognize and protect patients' legal rights relating to their medical records.

4. Recognize and comply with physicians' legal responsibilities relating to documentation and information disclosure.

5. Integrate cooperation among members of the health care team.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Legal Medicine and the Western Institute of Legal Medicine. The American College of Legal Medicine is accredited by the ACCME to sponsor continuing medical education for physicians.

The American College of Legal Medicine designates this live and enduring materials activity for a maximum of 19.00 *AMA PRA Category 1 Credit(s)* ™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

The American College of Legal Medicine, Continuing Medical Education Department has reviewed this activity's speaker and planner disclosures and resolved all identified conflicts of interest, if applicable.

For completion of this course, medical record workshops with analysis of submitted patient records are required. For information on submission of records, CLICK HERE.

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We welcome and educate medical professionals from all specialty areas and provide what we believe to be the best value for your money in an interactive and interesting classroom format. Call us today for more information or proceed to the registration page to sign up now.

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