NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

Public

June 3, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christine M. Radman, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Georges Ramalanjaona, M.D.
REDACTED

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates, PC
1123 Broadway – Suite 1117
New York, New York 10010

RE: In the Matter of Georges Ramalanjaona, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-144) 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., 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

COPY

IN THE MATTER OF GEORGES RAMALANJAONA, M.D.	DETERMINATION AND ORDER BPMC #14-144

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 December 13, 2012 were served on Georges Ramalanjaona, 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 on twelve dates from February to November 2013 at the Department's offices at 90 Church Street, New York, New York. Minor amendments to the SOC were made on April 9, 2013 and May 29, 2013. A Second Amended SOC dated July 25, 2013 was served on Respondent; minor amendments to the Second Amended SOC were made on November 26, 2013. A copy of the NOH and Second Amended SOC (which includes all the amendments) is attached to this Determination and Order as Appendix 1. Joan Martinez-McNicholas, Jill Rabin, M.D., and David Harris, M.D., 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. Ann H. Gayle, Administrative Law Judge ("ALJ"), served as the Administrative Officer. The Department appeared by James E. Dering, Esq., General Counsel, by Christine M. Radman, Associate Counsel. The Respondent appeared by Nathan L. Dembin, Esq., of

Nathan L. Dembin and Associates, P.C. 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 Notice of Hearing and Statement of Charges:	December 13, 2012
Answer Filed:	January 7, 2013
Pre-Hearing Conference:	January 11, 2013
Hearing Dates in 2013:	February 12 April 9 and 23 May 7 and 28 June 25 July 9 and 25 August 26 October 8 November 13 and 26
Witness for Petitioner:	Joseph Garber, MD
Witnesses for Respondent:	Respondent Timothy Haydock, MD
Deliberations Dates:	February 27, 2014 April 10, 2014

STATEMENT OF THE CASE

The Department charged the Respondent with thirteen specifications of professional misconduct under N.Y. Educ. Law §6530 which included practicing medicine with gross negligence §6530(4), negligence on more than one occasion §6530(3), gross incompetence §6530(6), and incompetence on more than one occasion §6530(5); failing to maintain accurate patient records §6530(32); and practicing

medicine fraudulently §6530(2). The Respondent denied each of the factual allegations and 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 transcript page numbers ["T"] and exhibits ["Ex"] that were accepted into evidence, 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. All Hearing Committee findings are unanimous unless otherwise stated.

1. Respondent was authorized to practice medicine in New York State on or about October 11, 1991, by the issuance of license number 187371 by the New York State Education Department ("Licensing Board"). [Ex 1]
2. Respondent was responsible for the care and treatment of Patients A-F in his capacity as an attending Emergency Medicine ("EM") physician for the North Shore-Long Island Jewish Health System at Plainview Hospital ("NSLIJ Plainview") on the following dates in 2009: April 8–Patient B, April 26–Patient C, July 5–Patient A, July 14–Patients E and F, and July 27–Patient D. [Ex 3A, 4A, 5A, 6, 7A and 8A]
3. EM physicians are responsible for taking care of patients that present to an Emergency Department ("ED" or "ER") 24 hours a day, 7 days a week, 365 days a year. EM physicians work in assigned shifts and are trained to focus on recognizing and expeditiously treating life and limb threatening diseases, illnesses and trauma

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

before moving on to consider other disease states that are less emergent. [T 31-32, 1628, 1868-1869]

4. The standard of care for the appropriate management of an ED patient includes a history and physical examination. The medical history must include presenting symptoms, past medical/surgical diagnoses and interventions, current medications, and a review of systems. The physical examination must include the taking of vital signs (blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation) and a more focused physical exam related to the nature of the current complaint as well as the patient's other medical circumstances. [T 32-35]
5. In addition to the history and physical ("H&P"), the ED physician may order laboratory tests/consultations/medications and/or perform or order procedures. The ED physician formulates a differential or definitive diagnosis, and determines if the patient should be discharged with instructions or admitted to that hospital or transferred to another hospital for further care. [T 35-36]
6. Documentation in the patient's record is the means by which physicians communicate with other physicians and caregivers. It provides continuity of care and understanding of the disease process afflicting a patient from one caretaker to the next. Documentation is vital and it must be complete. The chief complaint, history of present illness, past medical, social and surgical history, allergies including medication allergies, current medications, review of systems, physical examinations, orders for medications and laboratory and radiology tests, and diagnoses and dispositions must be written in the chart which should be dated, timed, and signed. For a history of the patient's current medications and medication allergies, the ED

physician must note them or note that s/he reviewed the medication reconciliation form filled out by another caregiver. There is an axiom in medicine that if something wasn't documented it wasn't done. [T 40-42, 209, 296-299, 1945-1946, 2283-2284]

7. It is the responsibility of the EM physician, during his/her shift, to follow-up on any tests ordered, procedures and treatments performed/given, and to re-evaluate the patient following the interventions to gauge response to intervention. To assure continuity of care when an EM physician goes off shift before the patient's ED work-up is completed, there is a hand-off from the signing-out EM physician to the oncoming EM physician. It is the responsibility of the signing-out EM physician to apprise the oncoming EM physician via a conversation between the two physicians of the patient's current status by giving a brief description of the patient and any tests, procedures or treatments undertaken, results received or still pending, and to discuss a possible plan, and then note in the chart the name of the oncoming physician. [T44-46, 211-212]

Patient A

8. Patient A was a 70 year old woman when she presented to the NSLIJ Plainview ED on July 5, 2009 at approximately 9:15 am, complaining of a 7 out of 10 severity epigastric pain going to the chest area and a fainting episode 2 days before. Her past medical history was significant for a pacemaker (for sick sinus syndrome), colon cancer with a colostomy and reversal, appendectomy, hernia, gastroesophageal reflux disease (GERD), tonsillectomy, and arthritis of the right hip. Her Medication Reconciliation sheet was completed by the triage nurse and revealed that she had no known allergies and was currently taking prescribed doses of Diazide, Welchol,

Prilosec and Celebrex daily. Patient A was triaged as a priority 1, indicating that she needed to be evaluated by a physician emergently. Respondent was responsible for Patient A's care in the NSLIJ Plainview ED from the time he began his evaluation of her at 10:00 am until at least 2 pm. [Ex 3A, p 4, 8; T 50-55, 1727]

9. Respondent diagnosed a STEMI (ST-segment elevation myocardial infarction, commonly known as a heart attack) but he failed to appropriately treat Patient A's STEMI by not timely administrating Aspirin and Heparin, and instead ordering Zantac and Zofran. [Ex 3A, p 7, 10; T 70-73, 93-96; 98-99] [FOF # 3]
10. Respondent failed to obtain an adequate history, including information regarding Patient A's cardiac risk factors such as a history of the medical conditions for which Patient A was taking Diazide and Welchol and whether or not Patient A's epigastric pain going to the chest was relieved or exacerbated by any factors, as Patient A's complaints together with her history were suggestive of acute coronary syndrome (especially as it presents in women) and that she was at risk for coronary artery occlusion. [Ex 3A, p 4-5; T 57-60; 61-65] [FOF # 4]
11. Respondent failed to perform an adequate physical examination of Patient A most notably by failing to examine her heart. [Ex 3A, p 6; T 150-153 –] [FOF # 4]
12. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient A. [Ex 3A; T 40-42, 62, 150-151, 200, 201, 209, 210-211, 1470-1472] [FOF #6]

Patient B

13. Patient B was a 58 year old woman when she presented to the NSLIJ Plainview ED at approximately 9:40 am on April 8, 2009 complaining of abdominal pain, vomiting,

severe right flank pain, and chest heaviness. Her past medical history was significant for myocardial infarction followed by stenting in 2002, hypertension, hypercholesterolemia and renal colic. Her Medication Reconciliation sheet was completed by the triage nurse and revealed that she was allergic to Aspirin, Penicillin, Motrin, Niacin and Plavix. Patient B was currently taking prescribed doses of Ticlopidine, Prednisone, Lopressor, Zantac, Enalapril and SMZ-TMP daily. Patient B's vital signs exhibited hypotension (low blood pressure), tachycardia (fast heart rate), tachypnea (rapid breathing), and elevated temperature. Patient B was triaged as a priority 1, indicating that she needed to be evaluated by a physician emergently and Respondent evaluated her at approximately 10:00 am. [Ex 4A, p 7-8, 11; T 283-290, 293-296]

14. Sepsis describes an illness in which the body has a severe response to infection, triggering a systemic inflammatory response that can become increasingly dangerous without intervention. Clinical signs of this condition include hypotension, an inability to regulate body temperature, and fast heart rate/respirations. A low bicarbonate level in the blood and bandemia (immature white blood cells recruited to fight the infection) are suggestive of sepsis as well. Shock is a state in which the body is unable to provide adequate blood supply to the vital organs of the body, usually represented clinically by severe hypotension, and may be neurogenic, cardiogenic, hemorrhagic or septic in nature. The process by which an infection may lead to a systemic inflammatory response to incipient sepsis to sepsis to severe sepsis to septic shock exists on a continuum with characteristic clinical signs of each

that a trained EM physician should be able to recognize. [T 38-40, 389, 392, 1590-1592]

15. An EM physician must review medications noted in a patient's chart and elicit that information from the patient to ensure that the list is complete and to ascertain why particular medications are being taken especially when the prior medical history does not reveal a condition for which a specific medication is typically prescribed, and allergies and medication interactions must be considered to prevent patient harm, but Respondent testified that knowing what medications Patient B was taking when he assessed her would not have influenced his assessment. [T 296-299, 1549]

16. Respondent failed to assess and address Patient B's complaint of chest heaviness despite her cardiac risk factors (including high cholesterol and hypertension) and a prior history of a myocardial infarction for which she was stented by not ordering or obtaining an EKG or cardiac enzymes for Patient B and not examining her heart. [Ex 4A, p 7-8; T 284, 316-318, 403-404] [FOF # 4, 5]

17. Respondent failed to appropriately document and address the results of the CT scan he ordered for Patient B which revealed, most importantly, obstructive right hydroureteronephrosis (dilation of the ureter and kidney resulting from the blockage of the urinary tract along the path of urine flow towards the bladder) due to two obstructing stones. This result was reported to Respondent in the ED by the radiologist over the phone just over an hour after Respondent initially evaluated Patient B. Respondent testified that this condition presented an "emergency" yet he failed to provide appropriate treatment for Patient B. [Ex 4A, p 40; T 326-332, 1544-1545] [FOF # 5, 7]

18. Respondent failed to provide an appropriate amount of IV fluids and IV antibiotics to treat Patient B's sepsis. Respondent's order for Morphine for pain and Zofran for nausea in addition to an inadequate 500cc of IV fluid treated Patient B's symptoms but not their cause and did not address Patient B's infection and her nearly 3° rise in body temperature in the ER. [Ex 4A, p 7, 10; T 314-315, 317-318, 326, 333, 335-336, 396] [FOF # 3, 7, 14]
19. Respondent failed to document the medications that Patient B was currently taking or document that he reviewed her Medication Reconciliation sheet, and he did not document and/or demonstrate that he appropriately ascertained what medical condition(s) Patient B had by documenting the conditions for which Patient B was taking Ticlopidine–an anti-platelet drug, Lopressor–a beta blocker, Enalapril–an ace inhibiter, Zantac–an agent that reduces stomach acidity, Prednisone–a corticosteroid, and SMZ-TMP (Bactrim)–an antibiotic, which information was vital to formulating an appropriate differential diagnosis. [Ex 4A, p 8-11; T 295-302] [FOF # 4, 5, 6]
20. Respondent failed to obtain a history of whether or not Patient B had received or was receiving any treatment for her multiple episodes of renal colic, when in fact she had lithotripsies performed by a urologist. [Ex 4A, p 7-8; T 290-292] [FOF # 4, 19]
21. Respondent failed to assess and address Patient B's complaint of chest heaviness despite her cardiac risk factors (including high cholesterol and hypertension) and a prior history of a myocardial infarction for which she was stented by not ordering or obtaining an EKG or cardiac enzymes for Patient B and not examining her heart. [Ex 4A, p 7-9; T 284, 316-318] [FOF # 4, 5]

22. Respondent failed to maintain a record that accurately reflects his evaluation and treatment of Patient B, particularly as it relates to Patient B's medical history. [Ex 4A, p 8-9; T 295-299, 2036-2038] [FOF #6, 19]

Patient C

23. Patient C was an 83 year old woman when she presented to the NSLIJ Plainview ED from Huntington Hills Nursing Center at approximately 5 pm on April 26, 2009 complaining of abdominal pain and urinary retention. Her past medical history was significant for Clostridium Difficile (C Diff) infection, diabetes, asthma, pleural effusion, hypertension, atrial fibrillation, congestive heart failure (CHF), gastroesophageal reflux disease (GERD), cataracts and depression. The triage nurse indicated that Patient C was allergic to fruit and nuts and documented on her Medication Reconciliation sheet that Patient C was currently taking prescribed doses of several medications including Vancomycin, Flagyl, Bacid, Coumadin, Oxycontin, Insulin, Metoprolol, Spiriva and Lexapro. Patient C's vital signs revealed significant hypotension, tachycardia and hypothermia (low body temperature), suggestive of severe disease. It was also noted that Patient C appeared weak and pale and exhibited a hoarse speaking voice. Respondent was responsible for Patient C's care from the time he initially evaluated her at approximately 6:00 pm until approximately 9:00 pm. [Ex 5A, p 6-7, 9, 11; T 428-430, 432, 438-439, 1425]

24. Respondent failed to obtain an adequate history for Patient C. [Patient C's medical records in total: Ex 5A, 5B, and 5C; T 642] [FOF # 4]

25. Respondent failed to examine Patient C's heart despite her history of congestive heart failure and atrial fibrillation. [Ex 5A, p 9-10; T 498, 599-600, 630-632, 642, 1470-1472, 2199-2200] [FOF # 4]

Patient D

26. Patient D was a 5 month old infant girl when her parents brought her to the NSLIJ Plainview ED just after midnight on Monday, July 27, 2009. Her parents reported that the baby's pediatrician, who saw her the previous Friday for diarrhea and fever, told them to bring her to the ED over the weekend (in advance of the follow-up appointment on Monday morning) if they noticed any change in her behavior or mental status. In the ED, her parents reported that Patient D's diarrhea was increasing to more than 6 times per day, she seemed more lethargic and "her eyes look darker than usual." Patient D's rectal temperature was 101.5 and she weighed approximately 13½ pounds. The triage nurse noted that Patient D was allergic to milk protein and soy, her discomfort level was between 7 and 9 out of 10, and she classified Patient D as a level 1 priority at approximately 12:15 am. [Ex 6, p 4; T 691-694]

27. Respondent improperly diagnosed Patient D with an upper respiratory infection (URI) by documenting "URI" in the "Impression" section of Patient D's chart despite documenting "normal" findings in the "ENT" (ear, nose and throat) and "Respiratory" sections of Patient D's chart for his physical examination, and despite there being no history documented by Respondent or the triage nurse of any symptoms related to an upper respiratory infection in Patient D's chart. [Ex 6, p 5-7; T 711-714] [FOF # 3, 5]

28. Respondent failed to obtain an adequate history of Patient D by failing to obtain or note Patient D's birth history, the pregnancy history of this 5-month old infant's mother, her fluid intake/urine output, or the nature of her diarrhea (color/form or whether or not it contained mucous or blood). [Ex 6, p 5; T 695-700, 705-706] [FOF # 4]

29. Respondent failed to examine Patient D's heart or fontanels which are important in assessing the hydration status of an infant. [Ex 6, p 5-6; T 700-702] [FOF # 4]

30. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient D particularly by failing to note an adequate history and by documenting an impression of URI which is not supported by the history or the normal findings for the ear, nose, throat, and respiratory examinations that Respondent documented in Patient D's chart. [Ex 6; T 695-697-700, 711-713, 1361-1362, 1370-1371] [FOF #6, 27]

Patient E

31. Patient E was a 49 year old man when he presented to the NSLIJ Plainview ED at approximately 10:20 am on July 14, 2009 complaining of "water on lung," shortness of breath and severe back pain. His past medical history was significant for lung cancer, diagnosed 8 months before, and diabetes. Patient E's presenting blood pressure was 114/39, pulse was 66, respiratory rate was 17, his temperature was 98, and his oxygen saturation was saturating 94% on room air. He was triaged as a level 1 priority and Respondent evaluated him at approximately 11:00 am. Patient E was under Respondent's care from that time until at least 1 pm. [Ex 7A, p 9, 10; T 814-817, 1236, 1244]

32. Respondent failed to perform an adequate physical examination on Patient E including a failure to examine his heart. [Ex 7A, p 11; T 819-820, 2370] [FOF # 4]

33. Respondent failed to reevaluate Patient E after he obtained abnormal cardiac blood test results. [Ex 7B, p 20; T 875-876, 1275-1279, 1281-1287] [FOF # 7]

34. Respondent failed to maintain a record that accurately reflects the evaluation and treatment of Patient E. [Ex 7A, 7B] [FOF #6]

Patient F

35. Patient F was a 7 year old girl when her mother brought her to the NSLIJ Plainview ED at approximately 8:12 am on July 14, 2009 with complaints of fever, 10 out of 10 left sided pain, headache, and no bowel movement for 2 days. The triage nurse listed constipation under pertinent past medical history and classified Patient F as a level 1 priority. [Ex 8A, p 4; T 970-972]

36. Respondent failed to obtain an adequate history especially Patient F's 5 year history of urinary tract infections and left urethral reflux diagnosed by voiding cystourethrogram (VCUG) at age 4. [Ex 8A, p 5, 9-10; 8C, p 6-8, 11; T 974-980, 1044-1045] [FOF # 4]

37. Respondent failed to appropriately treat Patient F by ordering a brain scan for her. [Ex 8A, p 4, 7, 13; T 1021-1023, 1056, 1198-1199, 1210-1212] [FOF #3]

38. Respondent failed to maintain a record that accurately reflects his evaluation and treatment of Patient F, particularly as it relates to Patient F's medical history and his treatment of her. [Ex 8A, p 5-7; T 1190-1195, 2430-2432] [FOF #6, 37]

Application for Licensure

39. On or about June 22, 1982, Respondent applied to a third year residency program in general surgery at the then Buffalo General Hospital ("Buffalo General") to begin July 1, 1982 and continue through June 30, 1983 [Ex 10, p 18-21]. Respondent was offered that position [Ex 10, p 6], he accepted the appointment [Ex 10, p 5], commenced the residency program on or about July 1, 1982 [Ex 10, p 9-17], and signed the contract memorializing the appointment on August 12, 1982 [Ex 10, p 22-23]. [Ex 10; T 2462-2463]

40. Respondent was employed at Buffalo General from approximately 7/1/82 to approximately 10/31/82 or shortly thereafter. [Ex 10; T 2470, 2475-2479, 2501]

41. On November 24, 1982, the then Chief of Buffalo General's Department of Surgery wrote to the Executive Committee recommending that Respondent's appointment as a third-year resident be terminated. [Ex 10, p 3]

42. Respondent was not provided with the November 24, 1982 letter recommending his termination. [Ex 10; T 2474]

43. Resident Evaluation Forms ("evaluation forms") pertaining to Respondent were filled out for the periods 7/1-31/82, 8/1-31/82, 9/1-30/82, and 10/1-31/82. [Ex 10, p 9-10, 12-17; T 2515-2516]

44. There is no indication that the evaluation forms for the periods 7/1-31/82, 8/1-31/82, 9/1-30/82, and 10/1-31/82 were ever provided to Respondent. [Ex 10, p 9-10, 12-17; T 2515-2516, 2525-2527]

45. One of the evaluation forms for the period 7/1-31/82, 8/1-31/82 was not provided to Respondent. [Ex 10, p 11; T 2515]

46. Respondent, on his New York State application for a medical license and first registration ("Medical License Application") which he signed and dated June 12, 1991, accurately answered "No" to the question: "Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?" [Ex 2; 10, G dated November 26, 2013; T 1165, 2447, 2482-2483, 2501-2506, 2520-2522] [FOF # 41-45]
47. Respondent provided false information on his Medical License Application by indicating that he had a "Vacation period" from July 1982 through May 1983. [Ex 2, p 22; Ex 10; T 2247-2248, 2512, 2522-2523] [FOF # 39, 40 43]

FACTUAL ALLEGATIONS NOT SUSTAINED[2]

The Committee unanimously determined that the following factual allegations pertaining to Patients A – F were not sustained:

Patient A

The Department charged Respondent with failing to timely diagnose and appropriately treat an acute STEMI (ST-segment elevation myocardial infarction, commonly known as a heart attack (A.1) and with failing to obtain an adequate history, including but not limited to, failing to note any information regarding Patient A's cardiac risk factors and whether or not she had any medical allergies (A.2). The Committee finds that the Department did not prove that Respondent failed to timely diagnose an acute STEMI, and as such dismissed that part of allegation A.1, and the Committee further finds that Respondent did address whether Patient A had any medical allergies

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

by documenting that he reviewed the Medication Reconciliation sheet, and therefore dismissed that part of allegation A.2 which referred to whether or not she had any medical allergies. [Ex 3A, p 5, 7; T 83, 113-114, 116-120, 167, 1707, 1773-1776, 1946-1948]

Patient B

The Department charged Respondent with failing to reevaluate Patient B and failing to assess her response to treatment (B.8), failing to review and/or appropriately address Patient B's hematology results revealing a bandemia of 13% (B.9), and failing to appropriately address Patient B's CT scan revealing obstructive right hydroureteronephrosis, perirenal stranding and reflex ileus (B.10). The Committee finds that the Department did not prove that Respondent was still in charge of Patient B's care at the time the hematology results revealed a bandemia of 13% and when Patient B's CT scan revealed obstructive right hydroureteronephrosis, perirenal stranding and reflex ileus, therefore the Committee did not sustain those charges or the charge that Respondent failed to reevaluate Patient B and failed to assess her response to treatment. [Ex 4A, p 10, 40-41; Ex 4B, p 6; T 1527-1528, 1534, 1536-1537, 1966-1970]

Patient C

The Committee finds that the Department did not prove the majority of its allegations against Respondent regarding Patient C.

The Department charged Respondent with failing to

- appreciate, assess and address the physical signs and diagnostic tests suggestive of sepsis (C.1)
- provide appropriate treatment for sepsis, including but not limited to, emergent antibiotic therapy (C.2)

- review and/or appropriately address information contained on Patient C's Medication Reconciliation Sheet obtained by the triage nurse, which information was vital to an appropriate differential diagnosis (C.3)
- reevaluate Patient C and assess response to treatment (C.6)
- review and/or appropriately address Patient C's hematology results, including but not limited to, an elevated white blood count, elevated blood urea nitrogen (BUN) and creatinine levels, an elevated International Normalized Ratio (INR) and a bandemia of 27% (C.7)
- maintain a record that accurately reflects the evaluation and treatment of Patient C (C.8)

The Committee finds that Respondent assessed and addressed the physical signs and diagnostic tests suggestive of sepsis (C.1) and that he provided appropriate treatment for sepsis, including but not limited to, emergent antibiotic therapy by giving Patient C fluids and antibiotics. The Department's expert testified that the amounts of the fluids and antibiotics were insufficient but Respondent's expert testified that they were sufficient; because the Committee found both experts to be credible in general and specifically about this issue the Committee could not give the Department's expert's opinion greater weight on this point. Since the experts' testimony was given equal weight but the Department has the burden of proof, the Department did not sustain its burden on allegation C.2. The Committee similarly finds that the Department did not meet its burden of proving allegation C.6 that Respondent failed to reevaluate Patient C and assess her response to treatment. [Ex 5A, p 7; T 527-529, 555, 1479-1480, 1492-1493]

The Committee further finds that reviewing the information contained on Patient C's medication reconciliation sheet obtained by the triage nurse was sufficient and that Respondent did review it (C.3) [Ex 5A, p 9, 11; T 435-436], and the Committee also finds that the Department did not prove allegation C.7 that Respondent failed to review and/or appropriately address Patient C's hematology results because he was no longer

on duty and therefore not in charge of Patient C when these results were available at 11:14 pm. [Ex 5B, p 59; T 1425]. Finally, in finding that Respondent's record for his care and treatment of Patient C accurately reflects the findings sustained by the Committee, *i.e.*, that Respondent did not perform a cardiac examination and did not take an appropriate history (FOF # 24 and 25), the Committee dismissed the Department's allegation C.8.

Patient D

The Department charged Respondent with failing to timely diagnose and appropriately treat severe dehydration and improperly diagnosing Patient D with an upper respiratory infection (URI) (D.1). The Committee finds that the Department did not establish a failure by Respondent to timely diagnose and appropriately treat Patient D's dehydration, and therefore dismissed that part of the allegation which charged that he failed to timely diagnose and appropriately treat severe dehydration. [Ex 6, p 7; T 1311, 2247-2249]

Patient E

The Department charged Respondent with failing to timely diagnose and appropriately treat or refer for treatment an acute pericardial effusion which resulted in cardiac tamponade (E.1) and a failure to admit Patient E to a monitored setting, despite his fluctuating, wide range of heart rates (E.4).

The Committee finds that the Department did not meet its burden of proving allegation E.1. The two experts gave opinions which the Committee found were "180° apart" especially with regard to that part of the Department's charge which read "which resulted in cardiac tamponade." Because the Committee found both experts to be

credible in general and specifically about this issue the Committee could not give the Department's expert's opinion greater weight on this point. Since the testimony was given equal weight but the Department has the burden of proof, the Department did not sustain its burden for allegation E.1. [Ex 7A, p 9, 18, 36; T 823-830, 836-840, 2307-2308, 2316-2320, 2329-2332, 2335-2336]. The Committee further finds that Patient E's care was transferred to Dr. Patel, the admitting physician, and it is the admitting physician who determines what level of admission is needed. Because Respondent transferred Patient E to Dr. Patel, the Committee dismissed allegation E.4. [Ex 7A, p 12; T 1237-1238, 2303-2305, 2333]

Patient F

The Department charged Respondent with failing to appropriately treat Patient F including but not limited to prescribing Cefriazone in an inappropriate dose (allegation F.2). The Committee dismissed that part of the Department's allegation F.2 which alleged "including but not limited to, prescribing Cefriazone in an inappropriate dose" because the Committee found that the Department did not meet its burden of proving that the dose was inappropriate under the circumstances. [Ex 8A, p 7, 9; T 1144-1148, 1216-1218, 2392-2394]

CONCLUSIONS OF LAW[3]

Respondent is charged with thirteen Specification of Charges of professional misconduct under Educ. Law §6530. The Committee unanimously concludes that the Second, Fourth, Seventh, Eighth, and Tenth through Twelfth Specifications were

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

sustained, and unanimously concludes that the First, Third, Fifth, Sixth, Ninth, and Thirteenth Specifications were not sustained.

Gross Negligence – Educ. Law §6530(4)

The first to third 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, B, and C. The Committee concludes unanimously that the second specification is sustained and that the first and third specifications of gross negligence are not sustained.

"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 v. Ambach ("Rho"). 74 N.Y.2d 318, 322, 546 N.Y.S.2d 1005 (1989). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. (Rho, supra at 322).

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 Patient A, 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 even all of the sustained allegations taken together did not rise to the level of "multiple acts of negligence that cumulatively amount to egregious conduct".

The Panel especially found that neither of the two sustained allegations regarding Patient C independently rose to the level of 'a single act of negligence of egregious proportions' or that the two sustained allegations taken together rose to the level of 'multiple acts of negligence that cumulatively amount to egregious conduct'.

However, the Panel did find that the sustained allegations regarding Patient B when taken together did rise to the level of 'multiple acts of negligence that cumulatively amount to egregious conduct'.

Accordingly, the second specification is sustained and the first and third specifications are not sustained.

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

The fourth 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 F. The Committee concludes unanimously that the fourth specification of negligence on more than one occasion is sustained.

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.)

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 unanimously that the factual allegations identified in the SOC as A 1 (in part) and 2 (in part), B 8, 9, and 10, C 1, 2, 3, 6, 7, and 8, D 1 (in part), E 1 and 4, and F 2 (in part) were not sustained or did not rise to the level of negligence, the unanimously sustained factual allegations identified in the SOC as A 1 (in part), 2 (in part), 3, and 4, B 1-7 and 11, C 4 and 5, D 1 (in part), 2, 3, and 4, E 2, 3, and 5, and F 1, 2 (in part), and 3 represented failures by Respondent on multiple occasions to exercise the care that a reasonably prudent physician under the circumstances would exercise as credibly testified to by the Department's expert.

Accordingly, the fourth specification is sustained.

Gross Incompetence – Educ. Law §6530(6)

The fifth specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing medicine with gross

incompetence with respect to Patient D. The Committee concludes unanimously that the fifth specification of gross incompetence is not sustained.

Gross Incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences. Post, supra, at 986.

Since the Committee did not sustain allegations of ordinary incompetence with regard to Patient D (see below), there could not be gross incompetence.

Accordingly, the fifth specification is not sustained.

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

The sixth 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 F. The Committee concludes unanimously that the sixth specification of incompetence on more than one occasion is not sustained.

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 F, the Committee found Respondent to have the requisite skill and knowledge

to practice medicine safely, but that such treatment was, in certain instances, rendered negligently (as previously discussed).

Accordingly, the sixth specification is not sustained.

Record Keeping – Educ. Law §6530(32)

The seventh 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 F. The Committee concludes unanimously that the seventh, eighth, tenth, eleventh and twelfth specifications of failure to maintain an accurate record are sustained but that the ninth specification is not sustained.

Based on FOF #6 that documentation in the patient's record –the means by which physicians communicate with other physicians and caregivers– is vital, must be complete, and must include chief complaint, history of present illness, past medical, social and surgical history, allergies including medication allergies, current medications, review of systems, physical examinations, orders for medications and laboratory and radiology tests, and diagnoses and dispositions, the Panel found a substantial amount of this information lacking in Patients A, B, D, E, and F's charts to accurately reflect those patients' course in the ER while under Respondent's care, and sustained this charge for those five patient but the Panel, in finding that Respondent's record for his care and treatment of Patient C accurately reflects the findings sustained by the Committee, did not sustain the recordkeeping charge regarding Patient C.

Accordingly, the seventh, eighth, tenth, eleventh and twelfth specifications are sustained, and the ninth specification is not sustained.

Fraudulent Practice – Educ. Law §6530(2)

The thirteenth specification charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently with respect to answers he gave in his application for licensure to practice medicine in New York State. The Committee concludes unanimously that the thirteenth specification of practicing medicine fraudulently is not sustained.

The Committee found that not only do the documents in Exhibit 10 show that Respondent accepted an appointment [Ex 10, p 5] and signed a contract with Buffalo General [Ex 10, p 22-23] for a third-year residency commencing on July 1, 1982, but in his own admissions in his testimony, Respondent also acknowledged that he commenced that third-year residency program [T 2463, 2501]. Additionally, there is further documentation[4] to support the fact that Respondent was a third year resident at Buffalo General for several months beginning in July 1982.

While the letter dated November 24, 1982 in Exhibit 10 demonstrates that the then Chief of Buffalo General's Department of Surgery wrote to the Executive Committee recommending that Respondent's appointment as a third-year resident be terminated, there is no proof to indicate that Respondent was provided with or made aware of that recommendation nor was there anything further in Exhibit 10 to show any follow-up or action taken on that recommendation. And, indeed, Respondent testified that nothing was provided to him at the time and he was not terminated [T 2474, 2505-2511]. As such, the Department failed to prove that Respondent was terminated from his position at Buffalo General, therefore Respondent's answer "No" to the question

[4] *November 24, 1982 letter recommending termination [Ex 10, p 3] and several evaluation forms [Ex 10, p 9-17]*

"Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges..." on his Medical License Application was accurate.

Likewise, while some "Poor" and even a few "Very Bad" entries were checked on the evaluation forms contained in Exhibit 10, there is no proof to indicate that Respondent was provided with or made aware of those evaluations. One of the check-off boxes on the evaluation forms indicates that the evaluation form was not given to Respondent and neither 'yes' nor 'no' is checked on any of the other evaluation forms. And, again, Respondent testified that he was not provided with these evaluations. As such, the Department failed to prove that Respondent was aware that Buffalo General found his work to be anything less than "Acceptable", therefore Respondent's answer "No" to the question "... or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures[5]?" on his Medical License Application was accurate because there is no evidence that he was provided with the November 24 letter or any of the evaluations; *i.e.*, there is no proof that Respondent was made aware that there was a recommendation to terminate his appointment or that his appointment was in jeopardy based on the evaluation forms so there is no proof that he resigned to avoid a restriction or termination.

However, because Respondent commenced and continued for several months a third-year residency at Buffalo General, Respondent's representation on his Medical License Application that he had a "Vacation period" from July 1982 through May 1983 [Ex 2, p 22] was false[6]. The Committee finds that Respondent provided this false

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[5] *i.e., restricting or terminating his professional training, employment, or privileges*

[6] *Even if Respondent's time at Buffalo General, July to October 1982, was employment in a capacity other than a residency, Respondent's representation on his Medical License Application that he had a "Vacation period" from July 1982 through May 1983 was false.*

information to the Licensing Board and he intended to deceive the Licensing Board with this false information. Respondent's knowledge of the falsity and intent to deceive was inferred based on the following: Respondent knew he commenced but did not complete a third-year residency at Buffalo General and that the incompletion of that residency would require an explanation to the Licensing Board. The incompletion and/or his explanation for the incompletion could have led to the Licensing Board's not granting Respondent the license to practice medicine in NYS that he was seeking. Therefore the Committee inferred that keeping that information from the Licensing Board could have benefitted Respondent; stated differently, keeping that information from the Licensing Board could have prevented the unwanted consequence to Respondent of the Licensing Board potentially denying Respondent a license to practice medicine in NYS at the time he applied.

While Respondent's false statement about a vacation period from July 1982-June 1983 on his application for licensure might have constituted a violation of Educ. Law §6530(1) which reads "[o]btaining the license fraudulently" (emphasis supplied), the Department did not charge Respondent with a violation of Educ. Law §6530(1); instead, the Department charged Respondent with a violation of Educ. Law §6530(2), "[p]racticing the profession fraudulently" (emphasis supplied). Even though there is a definition of misconduct in Educ. Law §6530 to address allegations of lying on an application for licensure (§6530(1)), because the Department did not charge that section, the Committee did not consider whether such conduct constituted obtaining the license fraudulently. The Committee did find that what Respondent did (misrepresenting

on his application for licensure that he had a vacation period from July 1982-June 1983) was not practicing the profession fraudulently as the Department charged.

Additionally, although 10 NYCRR §51.6 allows any party to

> ... [a]mend or supplement a pleading at any time prior to a hearing committee's final determination and order ... by leave of the hearing officer if there is no substantial prejudice to any other party (emphasis supplied)

the Committee is not a party. As such, the Committee cannot seek leave from the hearing officer to find that there is no substantial prejudice to any other party at this late juncture and amend the pleadings to include a fourteenth specification of misconduct under Educ. Law §6530(1) or substitute the Department's thirteenth specification of a violation of Educ. Law §6530(2) with a violation of Educ. Law §6530(1).

Accordingly, the thirteenth specification is not sustained.

DISCUSSION

Credibility and Weight[7]

The Department presented one witness, Joseph Garber, M.D., to testify as an expert witness. Respondent testified in his own behalf and presented one witness, Timothy Haydock, M.D., to testify as an expert witness.

Both Dr. Garber and Dr. Haydock had the requisite experience and credentials to render expert opinions. Both experts were credible but Dr. Haydock lost some credibility in circumstances wherein he was asked a question where he would have to disagree with Respondent's care and treatment and/or recordkeeping and he would find a way to support Respondent, especially when he posited that perhaps Respondent did not document a cardiac examination for each patient because that section appears at the

top of the page so it might not be seen on a clipboard [T 2164-2165, 2213-2214], which was not plausible given that Respondent did fill out similar sections close to the top of the page on other pages.

When something is not written in the chart both experts agreed that it is not known if it wasn't done or just not documented and while both experts acknowledged the axiom in medicine that if it's not written it wasn't done, Dr. Haydock consistently opined that he believed Respondent did it even if he didn't write it [T2199-2203], and this speculation detracted from Dr. Haydock's credibility. Dr. Haydock also testified about a lower standard of care in the ER regarding history taking than Dr. Garber did. Dr. Garber testified that the emergency room physician cannot rely on what others did; he has to do it as well, but Dr. Haydock was more accepting of Respondent's reliance on, for example, others' histories.

Because the Department bears the burden of proof by a preponderance of the evidence, when the two expert's testimony was 180 degrees opposite each other's *i.e.*, the particular care or treatment each expert described/explained/supported was equally weighed, and there was nothing else in the record to guide the Panel either way, the Panel did not sustain that particular allegation. Also, where the Department charged "Respondent failed to appreciate..." the Panel redacted the word "appreciate" as the Panel believed they would need to "go inside Respondent's head" for this; the Panel then determined whether to sustain or dismiss the remainder of that particular charge without the word "appreciate".

Respondent's testimony was not incredible however the Panel found it to be

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

obfuscating, tangential, not forthcoming, and self-contradictory at times, but they found him to have requisite knowledge, training, and experience so that the Panel credited much of Respondent's testimony and gave it weight accordingly with other testimony and support or lack thereof in the records.

The Committee rejects Respondent's repeated explanation that he, in fact, always performs cardiac exams on his ED patients but does not consistently document them and concurs with the Department's expert's opinion that if all or a portion of a physical examination, especially a pertinent part, is not documented, it supports the conclusion that it wasn't performed.

Respondent gave a considerable amount of testimony about his thought process and the factors he was considering for these patients, his reliance on other caregivers' judgment and treatment, and his alleged substantial conversations and discussions with other caregivers and the patients' physicians and/or family. In that light, the Committee found quite disturbing the paucity of information in Respondent's records about what he did, what he considered, and what he discussed with others. The records frequently reflected a dichotomy or disconnect between and among Respondent's recorded histories, physical findings, orders, diagnoses/differential diagnoses, and plans.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

Although Respondent's attorney argued that the Department failed to meet its burden of establishing the factual allegations and specifications in the SOC, there were concessions by Respondent and his expert that Respondent's record keeping was at least somewhat lacking. The Department argued that all the factual allegations and specifications of charges should be sustained and Respondent's license to practice

medicine in New York State should be revoked. After reviewing the entire record, wherein some charges and specifications have been dismissed, the Committee unanimously concluded that the allegations and specifications that were sustained do not warrant a revocation of Respondent's license.

The Hearing Committee has considered the full range of sanctions available pursuant to PHL §230-a, including: censure and reprimand; suspension, wholly or partially, with or without terms or conditions; revocation; limitation on further licensure; monetary penalties; a course of education or training; performance of public service; and probation. Pursuant to the Findings of Fact and Conclusions of Law set forth above, and after due deliberation, the Committee unanimously determined that the appropriate sanction is a suspension of Respondent's license for a period of two (2) years, actual until he satisfactorily demonstrates to the Director of the Office of Professional Medical Conduct ("OPMC") his completion of a course in record keeping previously approved by the Director of OPMC, stayed for the remainder of the 2-year period once the approved course is satisfactorily completed, and probation for a period of two (2) years to include a practice monitor to review Respondent's charts, tolled when Respondent is not registered and not practicing medicine in NYS.

While the Committee's finding that Respondent provided false information on his Medical License Application (FOF #47) almost 25 years ago could be a basis for a finding of misconduct under Educ. Law §6530(1) and its remoteness weighed with its seriousness in determining an appropriate penalty, because no finding of misconduct was made based on FOF #47, the Committee did not factor this factual finding into its determination as to penalty and instead made its penalty determination solely on the

factual allegations and specifications of charges it sustained regarding Patients A – F. Additionally, Dr. Haydock's answers "yes" and "we do it all the time" [T1936] when asked if he thinks "that people who may not document well in a certain situation are capable of remediation" and if that is "readily done," did factor into the Committee's determination as to penalty.

Also, while the duration of the actual suspension is related to Respondent taking and completing a course in recordkeeping, the basis for the Committee's imposition of a period of actual suspension is the negligence and gross negligence findings together with the inadequate recordkeeping findings. And, finally, while the practice monitor will review Respondent's charts but not monitor him while he is treating patients, the practice monitor is to review Respondent's charts to address not only his recordkeeping but also the substance of his care and treatment of the patients whose charts are reviewed.

ORDER

IT IS HEREBY ORDERED THAT:

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

   Educ. Law §6530(4) – practicing with gross negligence
   Educ. Law §6530(3) – practicing with negligence on more than one occasion
   Educ. Law §6530(32) – failure to maintain an accurate record

2. The following charges of misconduct under Educ. Law §6530 are not sustained:

   Educ. Law §6530(6) – practicing with gross incompetence
   Educ. Law §6530(5) – practicing with incompetence on more than one occasion
   Educ. Law §6530(2) – practicing fraudulently

3. Pursuant to PHL §230-a(2)(e) Respondent's license to practice medicine shall be suspended, wholly, until Respondent completes to the satisfaction of the Director

of the Office of Professional Medical Conduct ("OPMC") a course in record keeping, which course shall be proposed by Respondent and subject to written approval of the Director of OPMC.

4. Pursuant to PHL §230-a(9) Respondent shall be placed on Probation for a period of two (2) years, tolled when Respondent is not registered and not practicing medicine in NYS. Terms of Probation are attached to this Determination and Order as Appendix 2. Probation will include a practice monitor for chart review of both Respondent's care and treatment and his recordkeeping of patients for a minimum of one (1) year to commence once the actual suspension is stayed upon completion of the record-keeping course.

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
May 30, 2014

REDACTED

JOAN MARTINEZ-McNICHOLAS, Chair
DAVID HARRIS, M.D., M.P.H.
JILL RABIN, M.D.

To: Christine M. Radman
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street, 4th Floor
New York, New York 10007

Nathan L. Dembin, Esq.
Nathan L. Dembin & Associates, PC
1123 Broadway, Suite 1117
New York, New York 10010

Georges Ramalanjaona, M.D.
REDACTED

APPENDIX 1

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

IN THE MATTER
OF
GEORGES RAMALANJAONA, M.D.

NOTICE
OF
HEARING

TO: GEORGES RAMALANJAONA
REDACTED

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 17, 2013, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 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_____

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, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the

terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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

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

DATE 12/13/12

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

New York, NY

Inquiries should be directed to:
Christine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
(212) 417-4450

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

SECOND
AMENDED
STATEMENT
OF
CHARGES

IN THE MATTER

OF

GEORGES RAMALANJAONA, M.D.

GEORGES RAMALANJAONA, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 11, 1991, by the issuance of license number 187371 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about July 5, 2009, Respondent was Patient A's Emergency Department (ED) attending physician for the North Shore-Long Island Jewish Health System at Plainview Hospital (NSLIJ Plainview). The triage nurse classified Patient A, a 70 year old woman, as a level 1 priority when she presented to the ED complaining of a 7 out of 10 severity epigastric pain going to the chest area and a fainting episode 2 days before. Her past medical history was significant for a pacemaker (for sick sinus syndrome), colon cancer with a colostomy and reversal, appendectomy, hernia, gastro esophageal reflux disease (GERD), tonsillectomy and arthritis of the right hip. Patient A's review of systems was noted to be positive for abdominal pain, nausea and loss of consciousness. Respondent deviated from the standard of care in that he:

1. Failed to timely diagnose and appropriately treat an acute STEMI (ST-segment elevation myocardial infarction, commonly known as a heart attack),

1-2 C 10-8-13

EXHIBIT ID Dept's 1A PW 7-25-13

2. Failed to obtain an adequate history, including but not limited to, failing to note any information regarding Patient A's cardiac risk factors and whether or not she had any medication allergies,
3. Failed to perform an adequate physical examination, including but not limited to, a failure to perform a cardiac examination and
4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.

B. On or about April 8, 2009, Respondent was Patient B's Emergency Department attending physician at NSLIJ Plainview. The triage nurse classified Patient B, a 58 year old woman, as a level 1 priority when she presented to the ED complaining of abdominal pain, vomiting, a 9 out of 10 severity right flank pain and chest heaviness. Her past medical history was significant for myocardial infarction followed by stenting in 2002, hypertension, hypercholesterolemia and renal colic. Patient B's vital signs exhibited hypotension (low blood pressure), tachycardia (fast heart rate), tachypnea (rapid breathing) and elevated temperature. Respondent deviated from the standard of care in that he:
1. Failed to appreciate, assess and address a complaint of chest heaviness in a patient with coronary artery disease, status post cardiac stenting,
2. Failed to appreciate, assess and address the physical signs and diagnostic tests suggestive of sepsis,
3. Failed to provide appropriate treatment for sepsis, including but not limited to, emergent antibiotic therapy,
4. Failed to review and/or appropriately address the information contained on Patient B's medication reconciliation sheet obtained by the triage nurse, which information was vital to an appropriate differential diagnosis,
5. Failed to obtain an adequate history, including but not limited to, Patient B's history of present illness related to a cardiac complaint and prior history of multiple episodes of nephrolithiasis and lithotripsy,
6. Failed to perform an adequate physical examination, including but not limited to, a failure to perform a cardiac examination,

7. Failed to order and obtain the results of an electrocardiogram (EKG) and cardiac enzyme blood work,
8. Failed to reevaluate Patient B and failed to assess response to treatment,
9. Failed to review and/or appropriately address Patient B's hematology results revealing a bandemia of 13%,
10. Failed to appropriately address Patient B's CT scan revealing obstructive right hydroureteronephrosis, perirenal stranding and reflex ileus and
11. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. On or about April 26, 2009, Respondent was Patient C's Emergency Department attending physician at NSLIJ Plainview. This 83 year old woman was transferred from a nursing home to the hospital ED with a medical history significant for current Clostridium Difficile (C Diff) infection, diabetes, asthma, pleural effusion, hypertension, atrial fibrillation, congestive heart failure, GERD, cataracts and depression. Patient C presented with a hoarse voice and appeared pale and weak with a blood pressure of 86/45. Respondent deviated from the standard of care in that he:

1. Failed to appreciate, assess and address the physical signs and diagnostic tests suggestive of sepsis,
2. Failed to provide appropriate treatment for sepsis, including but not limited to, emergent antibiotic therapy,
3. Documented that he did review but, in fact, failed to review and/or appropriately address information contained on Patient C's medication reconciliation sheet obtained by the triage nurse, which information was vital to an appropriate differential diagnosis,
4. Failed to obtain an adequate history,
5. Failed to perform an adequate physical examination, including but not limited to, a failure to perform a cardiac examination,
6. Failed to reevaluate Patient C and failed to assess response to treatment,

7. Failed to review and/or appropriately address Patient C's hematology results, including but not limited to, an elevated white blood count, elevated blood urea nitrogen (BUN) and creatinine levels, an elevated International Normalized Ratio (INR) and a bandemia of 27% and
8. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

D. On or about July 27, 2009, Respondent was Patient D's Emergency Department attending physician at NSLIJ Plainview. The triage nurse classified Patient D, a 5 month old infant girl, as a level 1 priority when her parents brought her to the ED after midnight with fever, lethargy, diarrhea for 3 days increasing to more than 6 times per day, and her eyes "looking darker than usual". They reported that Patient D's pediatrician told them to take their baby to the ED if they noticed any change in her behavior/mental status. Respondent deviated from the standard of care in that he:
   1. Failed to timely diagnose and appropriately treat severe dehydration and improperly diagnosed Patient D with an upper respiratory infection (URI).
   2. Failed to obtain an adequate history, including but not limited to, failing to note Patient D's birth history and the pregnancy history of her mother,
   3. Failed to perform an adequate physical examination to appropriately assess hydration status, including but not limited to, a failure to perform a cardiac examination and an examination of Patient D's fontanelles and
   4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

E. On or about July 14, 2009, Respondent was Patient E's Emergency Department attending physician at NSLIJ Plainview. The triage nurse classified Patient E, a 49 year old man, as a level 1 priority when he presented to the ED complaining of "water on the lung" with an 8 out of 10 severity back pain and shortness of breath. Patient E had a medical history of diabetes mellitus and

was diagnosed in November of 2008 with small cell right lung carcinoma. Respondent deviated from the standard of care in that he:

1. Failed to timely diagnose and appropriately treat or refer for treatment an acute pericardial effusion which resulted in cardiac tamponade,
2. Failed to perform an adequate physical examination, including but not limited to, a failure to perform a cardiac examination,
3. Failed to reevaluate Patient E and failed to assess response to treatment,
4. Failed to admit Patient E to a monitored setting, despite his fluctuating, wide range of heart rates and
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient E.

F. On or about July 14, 2009, Respondent was Patient F's Emergency Department attending physician at NSLIJ Plainview. The triage nurse classified Patient F, a 7 year old girl, as a level 1 priority when she presented to the ED complaining of a 10 out of 10 left sided abdominal pain, headache, fever and no bowel movement for two days. The nurse documented a history of constipation. Respondent deviated from the standard of care in that he:

1. Failed to obtain an adequate history, including but not limited to, a failure to document and/or appropriately address Patient F's 5 year history of urinary tract infections and left urethral reflux diagnosed by voiding cysto-urethrogarm (VCUG) at age 4,
2. Failing to appropriately treat Patient F, including but not limited to, prescribing Ceftriaxone in an inappropriate dose and
3. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient F.

G. On or about June 22, 1982, Respondent applied to a third year residency program in general surgery at the then Buffalo General Hospital to begin July 1, 1982 and continue through June 30, 1983. He was offered that position, accepted the appointment, signed the contract memorializing the same on

August 12, 1982 and practiced medicine within that residency program beginning July 1, 1982 until his termination therefrom on or about December 1, 1982. Respondent provided false information on his New York State application for a medical license and first registration, which he signed and dated on June 12, 1991 in that he:

1. Answered "No" to the question: "Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition ~~of~~ of such measures"? amended August 26, 2013 AG

   a. Respondent did so with intent to deceive.

2. Indicated that he had a "Vacation period" from July 1982 through May 1983.

   9. ~~b~~. Respondent did so with intent to deceive.

amended 11-26-13 AG

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

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

1. Paragraph A and each of its subparagraphs.
2. Paragraph B and each of its subparagraphs.
3. Paragraph C and each of its subparagraphs.

FOURTH 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:

4. Paragraph A and each of its subparagraphs, Paragraph B and each of its subparagraphs, Paragraph C and each of its subparagraphs, Paragraph D and each of its subparagraphs, Paragraph E and each of its subparagraphs, and/or Paragraph F and each of its subparagraphs.

FIFTH SPECIFICATION

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:

5. Paragraph D and each of its subparagraphs.

SIXTH 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:

6. Paragraph A and each of its subparagraphs, Paragraph B and each of its subparagraphs, Paragraph C and each of its subparagraphs, Paragraph D and each of its subparagraphs, Paragraph E and each of its subparagraphs, and/or Paragraph F and each of its subparagraphs.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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 evaluation and treatment of the patient, as alleged in the facts of:

7. Paragraphs A and A(4),
8. Paragraphs B and B(11),
9. Paragraphs C and C(8),
10. Paragraphs D and D(4),
11. Paragraphs E and E(5) and
12. Paragraphs F and F(3).

THIRTEENTH SPECIFICATION

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:

1. Paragraph G and each of its subparagraphs.

DATE: July 21, 2013
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

Terms of Probation

1. 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.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Menands, New York 12204-2719. Said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent shall provide the Director of OPMC with 90 days' notice prior to his return to practice medicine in New York State, except that Respondent shall immediately notify the Director of OPMC of his completion of the medical records course ordered pursuant to Paragraph 3 of the Order to which these Terms of Probation are appended.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. 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. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's return to practice medicine in New York State.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to law.