NEW YORK
state department of
HEALTH

PUBLIC

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

Sue Kelly
Executive Deputy Commissioner

July 28, 2014

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert R. DeMeo, M.D.
ADDRESS REDACTED

Steven I. Rubin, Esq.
Shaub, Ahmuty, Citrin, Spratt, LLP
77 Water Street
New York, New York 10005

Daniel Guenzburger, Associate Counsel
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Robert R. DeMeo, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 14-188) 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.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

SIGNATURE REDACTED

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

IN THE MATTER
OF
ROBERT R. DEMEO, M.D.

DETERMINATION
AND
ORDER

BPMC #14-188

A Notice of Hearing and a Statement of Charges, both dated December 23, 2013 were served on the Respondent's attorney who accepted service on the Respondent's behalf. (Prehearing transcript, p. 6) Steven I. Sherman, D.O., Chair, Cassandra Henderson, M.D., and Thea Graves Pellman, members of the State Board for Professional Medical Conduct ("BPMC"), served as the hearing committee in this matter pursuant to Section 230(10) of the Public Health Law ("PHL"). Denise Lepicier, Esq., Administrative Law Judge ("ALJ"), served as the hearing officer.

The Department of Health appeared by Daniel Guenzburger, Esq., Associate Counsel, Bureau of Professional Medical Conduct. Respondent Robert R. DeMeo, M.D., was represented by Steven I. Rubin of Shaub, Ahmutt, Citrin & Spratt, L.L.P., attorneys for the Respondent. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made. After consideration of the entire record, the hearing committee issues this Determination and Order.

PROCEDURAL HISTORY

Answer Filed by Respondent:	January 28, 2014
Pre-Hearing Conference:	January 13, 2014

Hearing Dates	January 28, 2014
	February 11, 2014
	April 25, 2014
Witness for Petitioner:	NAME REDACTED
Witnesses for Respondent:	Robert R. DeMeo, M.D.
	NAME REDACTED
Deliberations Held:	July 11, 2014

BACKGROUND

The State Board for Professional Medical Conduct ("BPMC") is a professional disciplinary board of the State of New York, authorized pursuant to PHL § 230, *et seq.*, to consider certain disciplinary matters brought by the New York State Department of Health. The Department of Health has jurisdiction to conduct disciplinary hearings for physicians, physician assistants, specialist's assistants, physicians working on a limited permit, and medical residents when there is a violation of the misconduct provisions of the N.Y. Education Law ("Educ. Law").

The Respondent is charged with eighteen specifications of misconduct in the Statement of Charges. Specifications one, two and four charge the Respondent with negligence, incompetence and gross incompetence, respectively, in violation of Educ. Law § 6530(3), (5) and (6) with respect to his care and treatment of four patients. The third specification charges the Respondent with gross negligence in the treatment of one patient in violation of Educ. Law § 6530(4). The fifth through eighth specifications charge violations of Educ. Law § 6530(32) in that Respondent failed to maintain a record which accurately reflected the evaluation and

treatment of the four patients. The ninth through eleventh specifications charge violations of Educ. Law § 6530(2) in that Respondent failed to reveal the truth about two criminal convictions he had for driving under the influence of alcohol on three applications for reappointment to the medical staff at the Richmond University Medical Center. The twelfth specification charges a violation of Educ. Law § 6530(2) in that Respondent failed to reveal the truth about a prior BPMC disciplinary order while under oath. The thirteenth through fifteenth specifications charge violations of Educ. Law § 6530(21) in that Respondent made and filed false applications for reappointment to the medical staff at the Richmond University Medical Center. The sixteenth through eighteenth specifications charge violations of Educ. Law § 6530(14) in that Respondent violated Public Health Law § 2805-k (required information on hospital privilege applications) with respect to three reappointment applications.

Respondent filed an answer to the Statement of Charges denying all the factual allegations and specifications, except those alleging the licensure of the Respondent. (Ex. A) A copy of the Statement of Charges is attached to this Determination and Order as Appendix 1. A copy of the Respondent's Answer is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers and letters in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the hearing committee in arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited evidence.

General Findings

1. The Respondent was licensed to practice medicine as a physician in the State of New

York on September 11, 1974 upon issuance of license number 121217 by the New York State Education Department. (Ex. 2; Ex. A, p. 1)

2. The purpose of documentation of an eye examination in the medical record is so that the physician can review the past medical exams when he needs to do so in the future and so that another physician can see what the patient's history and the structure of the eye has been. (T. 48, 76, 97, 234)

3. A minimally acceptable ophthalmology medical record should document a chief complaint and how the complaint affects the patient, the results of a slit lamp examination, and the results of an A-scan examination if one is performed. (T. 107-108, 245-246) There is an unwritten rule in medicine that if it was not written down, it was not done. (T. 246-247)

4. A slit lamp examination is a fundamental examination in ophthalmology by which an ophthalmologist examines a patient's eye. With rare exceptions, a slit lamp examination should be performed at every visit. Not to conduct a slit lamp examination when it is not contraindicated is a deviation from accepted medical standards. (T. 43-47, 102-105, 111, 234)

5. There must be appropriate documentation of a slit lamp examination in the record including comment about the lids, lashes, lacrimal gland, cornea, sclera, anterior chamber, iris, and lens. (T. 43-47, 74-76, 192, 236-238)

6. Part of the slit lamp examination is applanation tonometry which is a measure of intraocular pressure. This is a standard and central part of an eye examination. The tonometer gives a number reading of the pressure in the eye. (T. 44-46) An intraocular pressure may also be taken with the use of a Tono-Pen, a device used only for taking eye pressure. (T. 72, 177-178, 226-227)

7. A dilated fundus exam should be performed on the first visit with rare exceptions, and

every two years thereafter if there is no other reason to do so in the interim. (T. 46-47) The pupil needs to be dilated before cataract surgery to assess a number of eye structures. (T. 110-111)

8. Before performing cataract surgery, an A-scan must be done on the patient to determine which intraocular lens will be implanted. An A-scan measures the axial length of the eye so that an appropriate lens may be chosen for the patient. (T. 52-53, 133-134) Respondent threw out the results of the A-scan testing he performed on his patients and never made the results part of the patient record. (T. 308-313, 338-338)

9. On September 22, 2004, Respondent was convicted of a violation of Vehicle and Traffic Law § 1192(2) which prohibits driving while intoxicated as evidenced by chemical analysis. (Ex. 20) This offense is a misdemeanor. Vehicle and Traffic Law § 1193(b). Respondent pled guilty and was sentenced to a license revocation, a $500 fine, thirty days in jail, a conditional discharge for one year, and a drinking driver referral. (A conditional discharge is imposed at the time of sentencing. If the offender subject to the discharge does not comply with certain conditions set by the sentencing court, the sentence may be revoked and the offender may be resentenced. It is not a dismissal of charges. Penal Law § 65.05 et seq.) There is no evidence this charge was dismissed. (Ex. 20)

10. On January 31, 2008, Respondent was convicted of a violation of Vehicle and Traffic Law § 1192(3) which also prohibits driving while intoxicated. (Ex. 19) This offense is also a misdemeanor. Vehicle and Traffic Law § 1193(b). Respondent pled guilty and was sentenced to a license revocation, $500 fine, a conditional discharge for one year, and a drinking driver referral. There is no evidence this charge was dismissed. (Ex. 19)

Patient A

11. Patient A's first visit with Respondent was July 28, 2008. The Respondent noted a left

eye cataract greater than the right eye and notes a plan for "surgery left eye." (T. 42-43; Ex. 3, p. 4; Ex. 4, p.1) There is no description of the cataract, or where the opacity is located, or whether other issues might be causing the decreased vision. (T. 111-112)

12. Respondent notes that the pressure in the patient's eye is "soft" at the July 28, 2008 office visit. This is not a pressure taken with the use of an applanation tonometer either by slit lamp or with use of a "Tono-Pen." The designation of "soft" is used when a pressure is performed by pressing the eyelid covering the eye with a finger. This is not an accurate measure of eye pressure and is not standard of care for such measurement. (T. 44-46)

13. Patient A was significantly nearsighted in his left eye. (T. 114) Patients who are nearsighted have a higher incidence of retinal holes or tears and can experience retinal detachments at a higher rate after cataract surgery. (T. 116) There is no evidence that Respondent examined the retina of the left eye through a dilated fundus exam for the presence or absence of holes or tears at the periphery of the retina either before or after surgery. (T. 46-48, 116-117; Ex. 3, p. 4-5; Ex. 4, p. 1-2)

14. There is no evidence Respondent performed a slit lamp examination of Patient A on any of his office visits. (T. 57, 61, 121-123; Ex. 3, p. 4-5; Ex. 4) Indeed, at the August 25, 2008 visit, the Respondent notes that he examined this patient with loupes, which are a jeweler's tool which provide magnification, but are not the standard of care for an ophthalmologist to examine the inside of the eye. (T. 137-138; Ex. 3, p.4; Ex. 4, p. 1; Ex. 23, p. 152)

15. There is no evidence Respondent performed a dilated fundus examination on Patient A at any visit. (T. 48; Ex. 3, p. 4; Ex. 4, p. 142)

16. There is no evidence prior to cataract surgery that the Respondent performed an A-scan on Patient A. (T. 53-54; Ex. 3, p. 4-5; Ex. 4, p. 1)

17. Respondent performed cataract surgery on Patient A's left eye on August 22, 2008. (Ex. 3, p. 8-9; Ex. 5, p. 20-21)

18. On August 25, 2008, Respondent saw Patient A at his office and in his typed translation of his record he noted "painful and purulent" and his impression was periorbital cellulitis. (T. 56-57; Ex. 4, p. 1) There is no indication in the record of an eye examination at this visit. (T. 80-83)

19. In his handwritten original record for this patient, Respondent noted "Proptotic and Purulent." Proptotic means the eyeball or orbit was bulging. (Ex. 3. P. 4)

20. Purulence is the presence of pus. (T. 57)

21. Pain and decreased vision are signs of endophthalmitis, a postoperative infection that requires that the patient be evaluated for endophthalmitis immediately because untreated the patient can go blind very quickly. (T. 58, 126-127)

22. Respondent did not know that pain was a key symptom for the presence of endophthalmitis. (T. 58-61; Ex. 23, p. 170-173)

23. On August 25, 2008, Respondent diagnosed Patient A as having periorbital cellulitis and gave the patient oral Cipro tablets and ice packs. Periorbital means around the eye, not in the orbit. (T. 61-62; Ex. 3, p. 4; Ex. 4, p. 1)

24. There is nothing documented in the record to support Respondent's conclusory diagnosis of periorbital cellulitis. (Ex. 3, p. 4; Ex. 4, p. 1)

25. The treatment of endophthalmitis with orally administered antibiotics (Cipro) is ineffectual. The treatment is with topical drop medication and/or injection of antibiotics into the vitreous. (T. 62)

26. Patient A returned to the Respondent's office on September 2, 2008. There is no record

of a slit lamp exam recorded. Respondent notes "decreased swelling in the left eye, rule out endophthalmitis", and "Woo ASAP, 1:25 Thursday." (T. 63; Ex. 3, p. 5; Ex. 4, p. 2)

27. Dr. Woo is a retinal specialist. (Ex. 3, p. 12-13)

28. September 2, 2008 was a Tuesday. (T. 8)

29. To defer treatment for two days when endophthalmitis is suspected is not the standard of care. Endophthalmitis must be treated within a matter of hours if an eye is to be saved. (T. 63-64, 87)

30. Dr. Woo did see Patient A for evaluation and diagnosed orbital cellulitis and endophthalmitis. (T. 64; Ex. 3, p. 12-13) By December 18, 2008, Dr. Woo indicated that Patient A had no light perception in the left eye and that the eye itself was shrinking. (Ex. 3, p. 13) The shrinking of the eye itself is often caused by chronic infection. (T. 64) Dr. Woo also wrote in his report that he had advised both the patient and his daughter that the left eye "will not improve due to the severe damage from the infection." (Ex. 3, p. 13)

31. Respondent had never conducted an appropriate evaluation of Patient A's eye after surgery to rule out endophthalmitis as the cause of Patient A's "painful and purulent" eye.

32. Respondent testified that he only records positives and pertinent negatives in his medical records, but there is ample evidence that he does not do so. (T. 280-282, 284-293, 297, 330, 337-340, 359-360, 377-382, 389-390, 405-409, 420-421, 426-430) Indeed, Respondent rarely records a complaint or reason for a visit. (T. 246; Ex. 3; Ex. 4) Respondent also admitted that his notes do not contain sufficient information. (T. 436-438)

Patient B

33. On January 4, 2007 at the first visit, Patient B complained that her right eye "gets blurry" starting two months ago. (T. 141; Ex. 6, p. 3; Ex. 7, p. 1)

34. A dilated fundus exam was not performed at the first (January 4, 2007) or second (June 27, 2008) visit. (T. 141-142; Ex. 6, p.3; Ex.7, p. 1)

35. There is no evidence that a slit lamp examination was performed at the first visit because the only thing that was recorded was an eye pressure which could have been performed by use of a "Tono-Pen." (T. 141-142; 177-178; Ex. 6, p. 3; Ex. 7, p. 1)

36. There is no evidence that a slit lamp examination was performed at the June 27, 2008 second visit because the only thing again that was recorded was an eye pressure which could have been performed by use of a "Tono-Pen." (T. 142-143, 177-178; Ex. 6, p. 3; Ex. 7, p. 1)

37. There is no evidence that an A-scan was performed on this patient in either the office record or the hospital record as is required before cataract surgery. (T. 146; Ex. 6; Ex. 7; Ex. 8; Ex. 9)

38. At the June 27, 2008 office visit, Respondent recorded "Cataract right greater than left." The plan was "surgery right eye." (T. 143; Ex. 6, p.3; Ex. 7, p. 1)

39. Respondent performed surgery on Patient B on July 22, 2008. (T. 143; Ex. 8, p. 20-21)

40. During surgery, a piece of the nucleus fell into the vitreous of the eye during or after phacoemulsification, which is the breaking up of the nucleus in the center of the eye. (T. 143-144; Ex. 8, p. 20-21) The eye does not tolerate a piece of the nucleus in the vitreous well and an inflammatory response will start in the eye often producing pain, redness, a rise in pressure and decreased vision. The patient must be followed and the piece of nucleus, if anything more than a sliver, needs to be removed. (T. 144-145; Ex. 8, p. 20-21) The patient must be seen by a retinal specialist the first day postoperatively. (T. 183-184)

41. The postoperative follow up of the patient with a piece of nucleus in the vitreous would include dilation of the eye and either a slit lamp examination or an indirect ophthalmoscopy

exam to determine where the piece is, how big it is and how much inflammation it is causing. (T. 145) There is no evidence in the record that this was done for Patient B. (Ex. 6, p. 3-4; Ex. 7, p. 2)

42. The Department's expert was asked by Respondent's counsel to assume that the Respondent testified in a deposition that the fragment of the nucleus that fell into the vitreous was about 25% of the nucleus. (T. 162) A piece that is about 20% of the nucleus is a big piece of the nucleus to fall into the vitreous. (T. 163)

43. At the July 23, 2008 office visit, the Respondent notes the power of the intraocular lens, the pressure of the eye, red conjunctiva, and slight edema of the cornea. He also notes that the intraocular device is in place. (T. 147; Ex. 6, p. 3; Ex. 7, p. 2) The Respondent did not perform a dilated fundus exam. The Respondent did not record any information about the piece of the nucleus.

44. Postoperatively, at this visit on July 23, 2008, the Respondent prescribed Zylet which was not a sufficiently strong steroid to treat the inflamed eye caused by the piece of nucleus in the vitreous. (T. 147-148, 168, 169; Ex. 6, p. 3; Ex. 7, p. 2)

45. At the July 26, 2008 office visit the Respondent noted 20/400 vision and that the eye pressure had come down, the conjunctiva are clear, the cornea has slight edema, and the intraocular lens is in place. The Respondent did not do a dilated fundus examination at this visit, although one was indicated. (T. 148-149; Ex. 6, p. 4; Ex. 7, p. 2)

46. On July 28, 2008, the patient apparently called complaining of pain and the Respondent prescribed Tylenol. (T.149; Ex. 6, p. 4; Ex. 7, p. 2) The Respondent should have seen the patient that day because six days post operatively there is a danger of endophthalmitis, particularly in a patient who had the capsule broken and the vitreous disturbed. (T. 149-150,

171-173) There is no evidence the Respondent saw this patient with respect to this complaint of pain. (T. 150; Ex. 6, p. 4; Ex. 7, p. 2)

47. Pain medication should not be prescribed over the phone in the immediate postoperative period because it may mask endophthalmitis. (T. 174-175)

48. When a piece of the nucleus falls into the vitreous and is not removed during surgery, as in the case of Patient B, a retinal specialist should be involved in the case the next day to follow the patient and remove the piece of nucleus. There is no evidence that a retinal specialist was involved in Patient B's care postoperatively. (T. 163-164; Ex. 6; Ex. 7)

49. There is no evidence that the Respondent properly evaluated or promptly referred this patient with a piece of nucleus in the patient's vitreous. (T. 171; Ex. 6; Ex. 7)

50. Respondent testified that he only records positives and pertinent negatives in his medical records, but there is ample evidence that he does not do so. (T. 280-282, 284-293, 297, 330, 337-340, 467) Indeed, Respondent rarely records a complaint or reason for a visit. (T. 246; Ex. 6; Ex.7)

Patient C

51. Respondent first saw Patient C on November 3, 2004 and the chief complaint was that there was something growing on the lid for six or seven months. (T. 191; Ex. 9, p. 1; Ex. 10, p.1)

52. There is no evidence a slit lamp examination was done at any of the office visits prior to this patient's first or second cataract surgery. (T. 191-194, 199; Ex. 9, p. 1-3; Ex. 10, p. 1-4)

53. There is no evidence that a dilated fundus examination was ever performed, or that the retina was examined in any manner prior to the first or second cataract surgeries. (T. 191-194, 199; Ex. 9, p. 1-3; Ex. 10, p. 1-4)

54. On March 11, 2010, Respondent did not conduct an appropriate preoperative evaluation of the patient. There is no evidence in the patient's record that the patient's vision had decreased. In fact, the patient's vision in the right eye was 20/30 which is very good vision. There is also no evidence that the risks and benefits of the surgery were discussed. (T. 199, 223-224; Ex. 9, p. 3; Ex. 10, p. 4)

55. There is no evidence that an A-scan was performed in Respondent's office or at the hospital prior to the first or second cataract surgery. (T. 201; Ex. 9, p. 1-3; Ex. 10, p. 1-4)

56. Respondent performed cataract surgery on Patient C's right eye on March 26, 2010, and there was a complication during surgery when a "light piece of the material rupture[d] the posterior capsule." The operative report does not specify whether the piece of material was a piece of the nucleus or the cortex. (T. 197; Ex. 11, p. 20)

57. Any material falling into the vitreous raises concerns for an ophthalmologist about the patient postoperatively. (T. 198)

58. On March 27, 2010, Patient C went to Respondent's office for a postoperative visit. (T. 199-200; Ex. 9, p. 3; Ex. 10, p. 4)

59. There is no evidence a dilated fundus examination or slit lamp examination was performed at the March 27, 2010 visit, although it was even more important to do so because of the complication during surgery. (T. 200-201; Ex. 9, p. 3; Ex. 10, p. 4)

60. There is no evidence a dilated fundus examination or slit lamp examination was performed at the March 31, 2010 visit. (T. 201-203; Ex. 9, p. 3; Ex. 10, p. 4)

61. There is no evidence a dilated fundus examination or slit lamp examination was performed at the April 6, 2010 visit. (T. 203; Ex. 9, p. 3; Ex. 10, p. 4)

62. Respondent testified that he only records positives and pertinent negatives in his medical

records, but there is ample evidence that he does not do so. (T. 280-282, 284-293, 297, 330, 337-340, 487-488, 498-499, 501,506-510, 511-515, 516, 518-519) Indeed, Respondent rarely records a complaint or reason for a visit. (T. 246; Ex. 9; Ex. 10)

Patient D

63. There is no evidence in the office record that a slit lamp examination was performed on this patient prior to surgery on July 27, 2007. (T. 226-227; Ex. 12, p. 3-4; Ex. 13, p. 1-2)

64. There is no evidence in the office record that a dilated fundus examination was performed on this patient prior to surgery on July 27, 2007. (T. 227; Ex. 12, p. 3-4; Ex. 13, p. 1-2)

65. There is no evidence in the office or hospital record that an A-scan was performed on this patient prior to cataract surgery on July 27, 2007. (T. 225-226; Ex. 12; Ex. 13; Ex. 14, p. 18)

66. There is no evidence in the office record that a slit lamp examination or a dilated fundus examination was performed on this patient after surgery on July 27, 2007. (T. 229-230; Ex. 12, p. 4; Ex. 13, p. 2-3)

67. Patient D's vision was tested on September 22, 2007 and found to be 20/40 in the eye on which Respondent operated, but the patient is nearsighted which means that the choice of the intraoperative lens was not optimal. An A-scan should have been performed to determine the appropriate lens for this patient. (T. 231; Ex. 12, p. 4; Ex. 13, p. 2-3)

68. Respondent had an obligation to determine why Patient D's vision was not corrected to 20/20 after surgery, but there is no evidence that the Respondent tried to determine why the vision was not better through either a slit lamp examination or a dilated fundus examination. (T. 231-234; Ex. 12, p. 4; Ex. 13, p. 3)

69. Respondent testified that he only records positives and pertinent negatives in his medical

records, but there is ample evidence that he does not do so. (T. 280-282, 284-293, 297, 330, 337-340, 542-544) Indeed, Respondent rarely records a complaint or reason for a visit. (T. 246; Ex. 12; Ex. 13)

February 2, 2007 Reappointment Application

70. When asked on a reappointment application to the Richmond University Medical Center medical staff, signed by Respondent on February 2, 2007, whether Respondent had ever been convicted of any crime, Respondent answered "NO" falsely and with the intent to mislead. (Ex. 15, p. 2)

November 21, 2008 Reappointment Application

71. When asked on a reappointment application to the Richmond University Medical Center medical staff, signed by the Respondent on November 21, 2008, whether Respondent had ever been convicted of any crime, Respondent answered "NO" falsely and with the intent to mislead. (Ex. 16, p. 4)

February 7, 2011 Reappointment Application

72. When asked on a reappointment application to the Richmond University Medical Center medical staff, signed by the Respondent on February 7, 2011, whether Respondent had ever been convicted of any crime, Respondent answered "Yes" but wrote in under the question "was charged with driving under the influence of alcohol in, on or about ~~May~~ 2004, November 2007 under the Vehicle Traffic Law (not NYS Penal Law) was ordered by court to satisfactorily complete Alcohol Therapy classes which were completed with all charges dismissed by Court." (Ex. 17, p. 1) Respondent's criminal convictions have never been dismissed. (Ex. 19; Ex. 20)

Testimony Under Oath

73. On November 30, 2011, a hearing committee of the State Board for Professional Medical

Conduct found Respondent guilty of four allegations of professional misconduct. (Ex. 18, Determination and Order, p. 17-26) Two of the allegations involved Respondent's pleas of guilty to misdemeanor charges of driving while intoxicated. (Ex. 18, p. 8-9) Two of the allegations involved Respondent providing false answers on his reregistration forms to questions asking whether he had any criminal convictions. (Ex. 18, p. 8-9)

74. Despite the hearing committee decision, on January 23, 2012, Respondent was permitted to enter into a settlement of this prior disciplinary matter and Respondent admitted the four specifications of misconduct (being convicted of two crimes and practicing the profession fraudulently) based on the four factual allegations in the Statement of Charges as part of a consent agreement with the Board. (Ex. 18, p. 3, 31-32)

75. On March 20, 2013, Respondent testified under oath in an examination before trial and denied having his medical license in New York restricted or limited in any way. (Ex. 21, p. 16)

76. Respondent knew he had been disciplined by the Board for Professional Medical Conduct and that among the sanctions imposed by the BPMC was a probation term of five years which included, among seventeen terms, a term requiring Respondent to remain drug and alcohol free; a term requiring him to remain active in a group such as Narcotics Anonymous, Alcoholics Anonymous and /or Caduceus; a term requiring that Respondent notify all treating physicians of his history of substance abuse; a term requiring that Respondent have a Sobriety Monitor, a Practice supervisor, and a Therapist, without which the Respondent could not practice, all approved by the Director of the OPMC; a term requiring that Respondent submit to blood, breath and urine screens for the presence of drugs and alcohol; and a term requiring that Respondent submit to psychiatric evaluations at the direction of the Director of the Office of Professional Medical Conduct. (Ex. 18, p. 10-13) These terms all imposed restrictions and/or limitations on

Respondent's ability to practice.

77. On March 20, 2013, Respondent testified under oath in an examination before trial that he had been disciplined by the BPMC for having a driving while intoxicated conviction from five years before the discipline. (Ex. 21, p. 116-117)

78. In 2013 Respondent was aware that he had two convictions for driving while intoxicated in both 2004 and 2008. (Ex. 17; T. 675-678)

DISCUSSION

The hearing committee has unanimously determined to sustain all but one of the factual allegations. In doing so it considered all the evidence presented by each of the parties and credited the evidence it found persuasive. The committee did not sustain factual allegation A1(c) because the factual allegation alleges that the Respondent failed to "refer Patient A to a specialist for evaluation and treatment," but Respondent did refer Patient A to a retinal specialist, he just did not do so in a timely fashion. All the Department's other factual allegations were sustained.

Part of the reason the committee credited the Department's evidence was that the Respondent's testimony was so often inconsistent with what was written in the Respondent's own records. For instance, Respondent claimed to employ a style of documentation by which he only recorded positives and pertinent negatives, but this was repeatedly shown not to be the case.

Respondent's testimony was also undercut by his own witness, Dr. D'Amico. Respondent insisted that he performed A-scans in his office, wrote the results on a piece of paper, and had the Resident at the hospital do an A-scan at the hospital on the day of surgery to confirm his findings, despite the fact that the findings are not recorded in his office record. (T. 308-313)

Indeed, Dr. DeMeo testified that he would throw the results of the A-scan out after the surgery. (T. 338-339) The test results never became a part of the patient's record! Dr. D'Amico testified that it would not be routine for a private patient to have an A-scan at the hospital, particularly on the day of surgery because of the risk of contamination of the surgical site and because the hospital might not have the appropriate lenses in stock. (T. 569, 572-57 9, 585-585, 604) Dr. D'Amico also confirmed that A-scan results should be maintained in the patient's office record. (T. 598-601)

Finally, the committee was able to conclude that Respondent knew he had been convicted of two crimes and intended to mislead about them and his prior BPMC discipline. They felt that at hearing, Respondent was always trying to figure out what the "right" answer would be and parried words with the Committee in an attempt to avoid answering questions directly. Also, when on March 20, 2013, after having pled guilty in court to the two separate DWI convictions, after having gone through a BPMC hearing where another Board committee found he had misled about these convictions, and after having to admit that he lied about the convictions in a BPMC post-hearing settlement (consent order) of the hearing charges, Respondent still dissembled at an examination before trial, it became absolutely clear to this committee that Respondent intended and continues to intend to minimize his culpability even under oath.

On March 20, 2013, Respondent only admitted to one conviction five years previously. (Ex. 21, p. 117) He also stated that BPMC found he lied about this on an application for staff privileges and fined him $2,000. (Ex. 21, p. 117) The BPMC had found that he lied about his two convictions on two applications. The twenty-nine page settlement agreement imposed a great many restrictions on his ability to practice including the imposition of a practice monitor, a sobriety monitor, and a therapist, and various terms relating to alcohol abuse. Respondent's

continued dissembling as recently as 2013 about his convictions and his BPMC order confirms to this committee that Respondent has always intended to mislead about his criminal and BPMC difficulties. This is his pattern of behavior and it is in his interest to lie about these issues as hospitals and other facilities take such issues most seriously. For these reasons, the committee found that Respondent knew about his convictions and intended to mislead about them when answering on his reappointment applications and when under oath, and similarly intended to mislead about his BPMC discipline.

SPECIFICATIONS OF MISCONDUCT

All the following determinations with respect to the specifications were unanimous. The committee relied on a memorandum of law by former counsel for the Department of Health relating to various definitions of misconduct where appropriate to make its determinations. The parties were invited to challenge the definitions at the beginning of the hearing but neither of the parties did so.

The first specification charges negligence on more than one occasion in violation of Education Law § 6530(3) and relies on all the factual allegations with respect to the four patients who were the subject of this case. The Department has demonstrated with respect to each of the sustained factual allegations that the Respondent did not meet the standard of care that is required of a reasonably prudent physician under the circumstances. **The FIRST SPECIFICATION of misconduct is SUSTAINED.**

The second specification charges incompetence on more than one occasion in violation of Education Law § 6530(5) and relies on all the factual allegations with respect to the four patients who were the subject of this case. The Department has demonstrated with respect to each of the sustained factual allegations that the Respondent lacks the requisite skill or knowledge to

practice medicine safely. Indeed, the committee was concerned by Respondent's lack of understanding of some fundamental and basic medical issues in his own field of ophthalmology. (T. 372-374, 385, 395-402, 409-410, 476-478, 520-521) **The SECOND SPECIFICATION of misconduct is SUSTAINED.**

The third specification charges gross negligence on one occasion in violation of Education Law § 6530(4) and relies on all the factual allegations alleged with respect to Patient A. Patient A lost his vision in his left eye as a result of endophthalmitis. Respondent clearly did not conduct the appropriate examinations on the patient, nor did he refer the patient to a retinal specialist in a timely fashion. (Factual Allegation A2) The committee notes that while Respondent insisted at hearing that this patient did not have endophthalmitis when he saw the patient in the first post-operative visits and that he was simply concerned about what might happen in the future when he referred the patient to a retinologist, at an examination before trial Respondent admitted that there was something going on in the patient's eye that he could not diagnose with his equipment. (Ex. 24, 183) Gross negligence is a single act of egregious proportions or multiple acts of negligence which cumulatively amount to egregious conduct. The failure to refer this patient in a timely fashion when endophthalmitis should have been suspected is certainly egregious. Also however, in this case the Department has charged a series of acts with respect to the care of this patient which as a whole amount to egregious conduct. Gross negligence can be sustained on either legal theory. **The THIRD SPECIFICATION of misconduct is SUSTAINED.**

The fourth specification charges gross incompetence with respect to the care and treatment of all four patients and relies on all the factual allegations alleged with respect to Patient A, Patient B, Patient C, and Patient D. The Department has demonstrated with respect to each of the

sustained factual allegations that the Respondent lacks the requisite skill or knowledge to practice medicine safely. The failure of Respondent to conduct and record appropriate examinations, to diagnose correctly, to refer when appropriate, and to prescribe appropriately, combine to evidence gross incompetence. This view is only bolstered by Respondent's demonstrated deficits in basic knowledge in his field as discussed above. Gross incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences. **The FOURTH SPECIFICATION of misconduct is SUSTAINED.**

The fifth through eighth specifications of misconduct charge a failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in violation of Education Law § 6530(32) as alleged in paragraphs A and A5, B and B5, C and C3, and D and D3 in the factual allegations. The committee sustains this charge because Respondent did not record a great deal of pertinent information for each of these patients, including at a minimum a description of their cataracts and details of their retinas and eye examinations. Although Respondent claimed to record all positives and pertinent negatives, it was apparent at hearing that he does not do so. **The FIFTH through EIGHTH SPECIFICATIONS of misconduct are SUSTAINED.**

The ninth through twelfth specifications of misconduct charge the fraudulent practice of medicine in violation of Education Law § 6530(2) as alleged in paragraphs E, F, G, and H, H1, H2, and H3. The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Matter of Choudhry v. Sobol, 170 A.D.2d 893, 894, 566 N.Y.S.2d 723, 725 (3d Dept. 1991), citing Matter of Brestin v. Commissioner of Education, 116 A.D.2d 357, 359, 501 N.Y.S.2d 923, 925 (3d Dept. 1986). In order to sustain a charge that a licensee was engaged in the fraudulent

practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (3d Dept. 1966), aff'd 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must specifically state the inferences it is drawing regarding knowledge and intent. Choudhry, at 894, citing Brestin. See also, Adler v. Bureau of Professional Medical Conduct, 211 A.D.2d 990, 622 N.Y.S.2d 609 (3d Dept. 1995; Berger v. Board of Regents, 178 A.D.2d 748; 577 N.Y.S.2d 500 (3d Dept. 1991).

The Department proved with respect to each of the factual allegations charged that Respondent made a false representation, either overtly or by omission, and that the Respondent knew the representations were false and intended the misrepresentations to mislead. **The NINTH through TWLFTH SPECIFICATIONS of misconduct are SUSTAINED.**

The thirteenth through fifteenth specifications of misconduct charge that the Respondent made a false report in three instances in violation of Education Law § 6530(21) as alleged in paragraphs E, F and G. Each of these paragraphs alleges a misrepresentation with respect to Respondent's reappointment applications to the Richmond University Medical Center. In each case, the hearing committee has found that Respondent made misrepresentations in his reappointment applications knowing the representations were false and willfully doing so. **The THIRTEENTH through FIFTEENTH SPECIFICATIONS of misconduct are SUSTAINED.**

The Sixteenth through Eighteenth specifications charge violations of Education Law §

6530(14) which makes it misconduct to violate Public Health Law § 2805-k. Section 2805-k of the Public Health Law relates to hospital investigations prior to granting or renewing privileges and it states in relevant part:

> 1. Prior to granting or renewing professional privileges or association of any physician . . . , a hospital or facility approved pursuant to this article shall request from the physician . . . , and the physician . . . shall be required to provide the following information:
> (a) The name of any hospital or facility with or at which the physician . . . had or has any association, employment, privileges or practice;
> (b) Where such association, employment, privilege or practice was discontinued, the reasons for its discontinuation;
> (c) Any pending professional medical . . . misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in such proceedings or actions, and any additional information concerning such proceedings or actions as the physician . . . may deem appropriate;
> (d) The substance of the findings in such actions or proceedings and any additional information concerning such actions or proceedings as the physician . . . may deem appropriate;
> (e) A waiver by the physician . . . of any confidentiality provisions concerning the information required to be provided to hospitals pursuant to this subdivision; and
> (f) Documentation that the physician . . . has completed the course work or training as mandated by section two hundred thirty-nine of this chapter or section six thousand five hundred five-b of the education law. A hospital or facility shall not grant or renew professional privileges or association to a physician . . . who has not completed such course work or training.
> (g) A verification by the physician . . . that the information provided by the physician . . . is true and accurate.

The remainder of 2805-k imposes additional responsibilities on the hospital or facility only.

The structure of this statute is that it requires the physician to comply with requests for information from the hospital or facility with regard to certain information and to provide a verification that the information is true. The factual allegations underlying the charges in these three specifications relate to Respondent's failure to report accurately concerning his criminal convictions. While it is undoubtedly wise for a hospital or facility to request information about

criminal convictions, and not providing truthful information when requested may be grounds for a specification of misconduct for fraud and/or wilfully making a false report, criminal convictions are not one of the types of information required to be provided by this statute. As such, **the SIXTEENTH through EIGHTEENTH SPECIFICATIONS are NOT SUSTAINED.**

DETERMINATION AS TO SANCTION

The Hearing Committee has considered the full range of sanctions available pursuant to PHL § 230-a, including: (1) censure and reprimand; (2) suspension of the license, wholly or partially; (3) limitation on practice; (4) revocation of the license; (5) annulment of the license or registration; (6) limitation on registration or further licensure; (7) monetary penalties; (8) a course of education or training; (9) performance of public service; and, (10) probation. The Committee has concluded that the only appropriate sanction is revocation of the Respondent's license.

The Committee considers this an appropriate sanction in light of the fact that Respondent has demonstrated significant deficits in his fund of medical knowledge, has been found to have been both negligent and incompetent on multiple occasions, and has continued to lie about his DWI convictions even after having been sanctioned by the Board for doing so.

ORDER

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

1. The **FIRST** through **FIFTEENTH SPECIFICATIONS** contained in the Statement of Charges are **SUSTAINED**; and

2. The **SIXTEENTH** through **EIGHTEENTH SPECIFICATIONS** contained in the Statement of Charges are **DISMISSED**; and

3. Respondent's license to practice medicine in the State of New York is **REVOKED**, and

4. This Order shall be effective on personal service on the Respondent, or seven (7) days after the date of mailing of a copy to Respondent's last known address by certified mail.

DATED: New York
July 26, 2014

SIGNATURE REDACTED

STEVEN I. SHERMAN, D.O., Chair

CASSANDRA HENDERSON, M.D.
THEA PELLMAN

APPENDIX 1

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

IN THE MATTER OF ROBERT R. DEMEO, M.D.	STATEMENT OF CHARGES

ROBERT R. DEMEO, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 11, 1974, by the issuance of license number 121217 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent evaluated Patient A, a 76 year old male with a history of diabetes mellitus, for possible left eye cataract surgery on July 28, 2008. Respondent performed the cataract surgery on August 22, 2008 at the Richmond University Medical Center, Staten Island, New York. On August 25, 2008, post-operative day three, the Respondent noted that Patient A had a "painful and purulent" left eye. He diagnosed periorbital cellulitis and prescribed Cipro by mouth. Patient A returned to Respondent's office on September 2, 2008 at which time Respondent suspected endophthalmitis and arranged to have the Patient examined by a retinal specialist two days later, on or about September 4, 2008. (Patient A and the other Patients in the Statement of Charges are identified in the annexed appendix.) Respondent deviated from medically accepted standards in that:

1. At the August 25, 2008 office visit, Respondent:

a. Failed to conduct an appropriate evaluation to rule out endophthalmitis as the cause of the Patient's "painful and purulent" left eye.

b. Inappropriately diagnosed periorbital cellulitis.

c. Failed to refer Patient A to a specialist for evaluation and treatment.

d. Inappropriately prescribed oral Cipro.

2. At the September 2, 2008 office visit Respondent failed to arrange for the immediate evaluation of Patient A by a specialist. Respondent scheduled a visit with a retinal specialist for September 4, 2008.

3. Respondent failed to perform A scan biometry prior to performing cataract surgery.

4. Respondent failed to adequately examine the Patient by failing to perform slit lamp examinations and dilated fundus examinations at multiple office visits.

5. Respondent failed to maintain a record that accurately reflects his evaluation and treatment.

B. On or about and between January 4, 2007 and July 28, 2008 the Respondent treated Patient B at his office and at the Richmond University Medical Center. On July 22, 2008, the Respondent performed cataract surgery on Patient B's right eye. The surgery was complicated by a rupture of the posterior capsule with a fragment of the lens nucleus falling into the posterior chamber. On post-operative visits dated July 23, 2008 and July 26, 2008, the Respondent noted that Patient A had corneal edema. On July 28, 2008 Patient B informed Respondent in a telephone conversation that she had "pain" in her recently operated on right eye. Respondent deviated from medically accepted standards in that he:

1. Failed to adequately examine Patient B by failing to perform slit lamp examinations and dilated fundus examinations at multiple office visits.

2. Failed to perform A scan biometry prior to performing cataract surgery.
3. Failed to appropriately follow-up on Patient B's July 28, 2008 telephone report of "pain". Respondent should have ordered an immediate evaluation.
4. Inappropriately prescribed Zylet as the only post-operative topical medication.
5. Failed to maintain a record that accurately reflects his evaluation and treatment.

C. On or about and between November 3, 2004 and April 6, 2010 the Respondent treated Patient C at his office and the Richmond University Medical Center, Staten Island, New York. On or about March 26, 2010 the Respondent performed cataract surgery on Patient C's right eye. Respondent deviated from medically accepted standards in that he:

1. Failed to perform A scan biometry prior to performing cataract surgery.
2. Failed to adequately examine Patient C by failing to perform slit lamp examinations and dilated fundus examinations at multiple office visits.
3. Failed to maintain a record that accurately reflected his evaluation and treatment.

D. On or about and between July 17, 2002 and September 22, 2007 the Respondent treated Patient D at his office and at the Richmond University Medical Center. On July 27, 2007 Respondent performed cataract surgery on Patient D's left eye. Respondent deviated from medically accepted standards in that he:

1. Failed to adequately examine Patient D by failing to perform slit lamp examinations and dilated fundus examinations at multiple office visits.
2. Failed to perform A scan biometry prior to cataract surgery.
3. Failed to maintain a record that accurately reflects his evaluation and treatment.

E. In Respondent's application for reappointment to the medical staff of the Richmond University Medical Center dated February 2, 2007, Respondent knowingly and falsely represented that he had never been convicted of any crime, when, in fact, Respondent knew that on September 22, 2004 he pled guilty to the crime of operating a motor

vehicle while under the influence of alcohol. (Vehicle and Traffic Law Section 1192.2) Respondent intended to deceive.

F. In Respondent's application for reappointment to the medical staff of Richmond University Medical Center dated November 21, 2008 Respondent knowingly and falsely represented that he had never been convicted of any crime, when, in fact, Respondent knew that he had been convicted of the crime alleged in Paragraph E and, in addition, on January 31, 2008 he pled guilty to the crime of operating a motor vehicle while under the influence of alcohol (Vehicle and Traffic Law Section 1192.3) Respondent intended to deceive.

G. In Respondent's application for reappointment to the medical staff of Richmond University Medical Center dated February 7, 2011, Respondent conceded that he had been criminally convicted, but knowingly and falsely represented that the criminal convictions in both cases were dismissed by the court after he satisfactorily completed alcohol therapy cases. Respondent intended to deceive.

H. In testimony that Respondent gave under oath on March 20, 2013 at an examination before trial ("EBT"), Respondent concealed with the intent to deceive significant information about the issues charged and sanction imposed in the Board of Professional Misconduct proceeding In the Matter of Robert R. De Meo, M.D. BPMC # 11-283 and BPMC #12-19. Although Respondent disclosed that he had been previously disciplined by the Board of Professional Medical Conduct, Respondent:

1. Concealed that he been charged and found to have committed professional misconduct for having been criminally convicted twice for driving while intoxicated. In testimony at the EBT Respondent acknowledged only one conviction.
2. Concealed the sanction imposed restrictions on his license. Respondent failed to disclose that for a five year period he could only practice medicine if his

practice was monitored by qualified health care professional monitors approved by the Office of Professional Medical Conduct.

3. Concealed that BPMC Order No. 12-19 imposed multiple requirements related to alcohol rehabilitation, including that he engage in a course of therapy and that he submit to random, unannounced alcohol screening.

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:

1. A, A1, A1(a), A1(b), A1(c), A1(d), A2, A3, A4, A5. B, B1, B2, B3, B4, B5, C, C1, C2, C3, D, D1, D2 and/or D3.

SECOND 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:

2. A, A1, A1(a), A1(b), A1(c), A1(d), A2, A3, A4, A5, B, B1, B2, B3, B4, B5, C, C1, C2, C3, D, D1, D2 and/or D3.

THIRD 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 on a particular occasion as alleged in the facts of the following:

3. Paragraph A and its subparagraphs.

FOURTH 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:

4. Paragraph A, B, C, D and the respective subparagraphs.

FIFTH THROUGH EIGHTH 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:

5. A and A5.

6. B and B5.

7. C and C3.

8. D and D3.

NINTH THROUGH TWELVETH SPECIFICATIONS

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:

9. Paragraph E.

10. Paragraph F.

11. Paragraph G

12. Paragraphs H, H1, H2, and/or H3.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report

required by law or by the department of health or the education department, as alleged in the facts of:

13. Paragraph E.

14. Paragraph F.

15. Paragraph G.

SIXTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

VIOLATION OF § TWENTY-EIGHT HUNDRED FIVE-K

OF THE PUBLIC HEALTH LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(14) by violating section twenty-eight hundred five-k of the Public Health Law, as alleged in the facts of:

16. Paragraph E.

17. Paragraph F.

18. Paragraph G.

DATE: December 23, 2013
New York, New York

SIGNATURE REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

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

IN THE MATTER
OF
ROBERT R. DEMEO, M.D.

ANSWER TO STATEMENT OF CHARGES

Respondent Robert R. DeMeo, M.D., by his attorneys, Shaub, Ahmuty, Citrin and Spratt, LLP, answers the Statement of Charges of the Bureau of Professional Medical Conduct as follows:

1. Admits that Respondent was authorized to practice medicine in New York State in 1974, by the issuance of License No. 121217 by the New York State Education Department.

2. Denies each and every allegation contained in the Factual Allegations paragraphs of the Statement of Charges designated A, A1-A5, B, B1-5, C, C1-3, D, D1-3, E, F, G, H, H1-3, and denies all Specifications of Professional Misconduct designated as 1-18.

AS A FIRST AFFIRMATIVE DEFENSE

4. Petitioner is estopped from pursuing Respondent for alleged acts of misconduct as alleged in paragraphs A-H of the Factual Allegations and 1-18 in the Specifications of Misconduct in the Statement of Charges on the basis that the allegations therein lack the specificity and particularity necessary to permit Respondent to properly defend against the alleged acts of misconduct.

AS A SECOND AFFIRMATIVE DEFENSE

5. As provided for in the preface to Section 6530 of the New York State Education Law, the Charges and Specifications alleged in the Statement of Charges should be dismissed in the interest of justice.

AS A THIRD AFFIRMATIVE DEFENSE

6. Petitioner is barred by the doctrines of laches from presenting evidence or pursuing charges pertaining to all allegations and specifications.

AS A FOURTH AFFIRMATIVE DEFENSE

7. Petitioner is barred from presenting evidence or pursuing all charges based upon the doctrine of equitable estoppel.

AS A FIFTH AFFIRMATIVE DEFENSE

8. Pursuant to Section 230(10)(C) of the New York Public Health Law, petitioner is barred from presenting evidence or pursuing charges pertaining to the allegations and specifications as an investigation committee was not convened within 90 days of the interview of the licensee Dr. DeMeo on July 18, 2013.

AS A SIXTH AFFIRMATIVE DEFENSE

9. Respondent's rights to due process conferred upon him by the Federal and State Constitutions, bar Petitioner from adjudicating this matter.

WHEREFORE, Respondent prays for decision dismissing the Statement of Charges and Specification of Charges in their entirety.

DATED: New York, New York
January 9, 2014

SHAUB, AHMUTY, CITRIN & SPRATT
Attorneys for Respondent

SIGNATURE REDACTED

By:_____
Steven I. Rubin, Esq.
77 Water Street
New York, NY 10005