



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
Commissioner

*Public*

Dennis P. Whalen  
Executive Deputy Commissioner

September 28, 2005

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Donald Forester, M.D.  
1691 August Road  
North Babylon, New York 11703

William L. Wood, Jr., Esq.  
Wood & Scher  
222 Bloomingdale Road, Suite 311  
White Plains, New York 10605

Terrence J. Sheehan, Esq.  
NYS Department of Health  
Bureau of Professional Medical Conduct  
Division of Legal Affairs  
90 Church Street, 4<sup>th</sup> Floor  
New York, New York 10007

**RE: In the Matter of Donald Forester, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 05-155) 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  
Hedley Park Place  
433 River Street - Fourth Floor  
Troy, New York 12180

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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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.

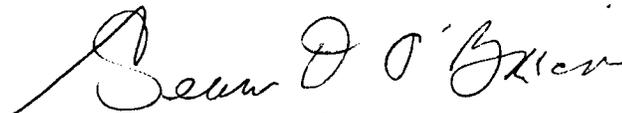
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge  
New York State Department of Health  
Bureau of Adjudication  
Hedley Park Place  
433 River Street, Fifth Floor  
Troy, New York 12180

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,



Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:djh

Enclosure

**COPY**

**DETERMINATION**

**AND**

**ORDER**

**IN THE MATTER  
OF  
DONALD FORESTER, M.D.**

OPMC NO. 05-155

ALAN KOPMAN, Chairperson, THEODORE A. SPEVACK, D.O., and PASCAL JAMES IMPERATO, M.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10)(e) and (12) of the Public Health Law ["PHL"]. DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

**STATEMENT OF CHARGES**

The Statement of Charges charges the Respondent with professional misconduct by practicing the profession of medicine with gross negligence on a particular occasion (four specifications) and with gross incompetence (one specification), by practicing the profession of medicine with negligence on more than one occasion (one specification) and with incompetence on more than one occasion (one specification), and by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (four specifications).

The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

### SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing and Statement of Charges Dated:	April 28, 2005 and April 27, 2005 respectively
Date of Service of Commissioner's Order and Notice of Hearing and Statement of Charges:	April 30, 2005 <sup>1</sup>
Amended Statement of Charges Dated:	June 14, 2005 <sup>2</sup>
Prehearing Conference Dates:	May 5, 2005 May 9, 2005
Hearing Dates:	May 9, 2005 June 1, 2005 June 15, 2005 June 20, 2005
Hearing Committee's Recommendation and Commissioner's Interim Order Dated:	June 20, 2005 and July 6, 2005 respectively
Deliberation Date:	July 11, 2005
Preliminary Determination and Order Dated:	July 22, 2005
Place of Hearing:	NYS Department of Health 90 Church Street, 4 <sup>th</sup> Floor New York, New York

<sup>1</sup> See stipulation appearing on pages 38 and 39 of the transcript of the Continued Prehearing Conference conducted on May 9, 2005.

<sup>2</sup> On June 15, 2005 the original Statement of Charges dated April 27, 2005 (included in Ex. 1) was replaced by the Amended Statement of Charges dated June 14, 2005 (Ex. 1A) upon the request of the Petitioner and over the objection of the Respondent (Intrahearing Conference Tr. 14-19 and Hearing Tr. 149-150 and 313-319).

Petitioner Appeared By:

Terrence J. Sheehan, Esq.  
Associate Counsel  
NYS Department of Health, Bureau  
of Professional Medical Conduct,  
Division of Legal Affairs

Respondent Appeared By:

Wood & Scher  
222 Bloomingdale Road, Suite 311  
White Plains, New York 10605  
By: William L. Wood, Jr., Esq.

**WITNESSES**

For the Petitioner:

Mark S. Silberman, M.D.

For the Respondent:

Donald Forester, M.D.

**FINDINGS OF FACT**

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

## GENERAL FINDINGS AS TO THE RESPONDENT

1. Donald Forester, M.D. ["the Respondent"] was authorized to practice medicine in New York State since 1965 by the issuance of license number 096132 by the New York State Education Department (Tr. 151-152).
2. The Respondent attended medical school at the University of Munich in Munich, Germany (1957-1963), where he received his M.D. Degree (Tr. 342; Ex. A).
3. After graduating medical school the Respondent received postgraduate medical training at Albert Einstein Medical Center in Philadelphia, Pennsylvania (1963-1964), where he did a rotating internship, and, at New York Medical College-Metropolitan Hospital in New York, New York (1964-1967), where he did a residency in internal medicine and served as Chief Resident during his final year (Tr. 342-343; Ex. A).
4. Following his residency the Respondent entered the military and served as a Captain in the United States Air Force (1967-1969). He worked in the Chief Officers Ward as an internal medicine consultant. (Tr. 343; Ex. A).
5. After leaving the military the Respondent began his career in emergency medicine. Since 1969 the Respondent held Emergency Room positions at various medical institutions, which included the following: Director of the Emergency Unit at Medical College of Pennsylvania in Philadelphia, Pennsylvania (1969-1972); Director of Emergency Medicine at Albert Einstein Medical Center-Daroff Division in Philadelphia, Pennsylvania (1972-1977); Physician-In-Charge of the Emergency Room at Queens Hospital Center in Jamaica, New York (1978-1980); Chief of Emergency Medicine at Mount Vernon Hospital in Mount Vernon, New York (1980-1994); and, Emergency

Room Attending Physician at Good Samaritan Hospital Medical Center in West Islip, New York (1995-present). (Tr. 343-345; Ex. A).

6. The Respondent held several academic appointments and presented a long list of publications (Tr. 347-348; Ex. A).
7. The Respondent had been board certified in emergency medicine in 1992. However, the Respondent's board certification lapsed in 2002 and was never renewed (Tr. 370-373; Ex. A).
8. Nevertheless, the Respondent has certifications for ACLS, BLS, PALS and ATLS, and all such certifications are current (Tr. 374-375, 382 and 391-393; Ex. E).

### **SPECIFIC FINDINGS AS TO EACH PATIENT**

#### **Patient A**

9. On March 17, 2002 at about 11:35 A.M., Patient A, a 27 year-old male, presented to the Emergency Department of Good Samaritan Hospital Medical Center in West Islip, New York ["Good Samaritan"], with a chief complaint of abdominal pain starting the previous day. The patient was seen by Dr. Khokar, who ordered a CBC, SMA14, Amylase, Lipase, Prothrombin Time, and International Normalized Ratio (INR). Dr. Khokar noted tenderness to deep palpation in the epigastric region and the left upper quadrant, and a previous history of gastritis. (Tr. 24-28; Ex. 3, pp. 5 and 7).
10. The laboratory results showed an elevated white count of 11.8 with a shift to the left. All other tests were within normal limits. The patient was given intravenous Pepcid and intramuscular Visteril. The patient was discharged the same day at 2:30 P.M. with a

diagnosis of gastritis and rule out peptic ulcer disease, and instructed to take Prilosec, Vicodin, and oral fluids. (Tr. 28-29 and 56; Ex. 3, pp. 5, 7, 9 and 11).

11. At 5:37 P.M. that same day, Patient A re-presented to the Emergency Department of Good Samaritan complaining of the same pain that he had reported earlier, and which he now rated 10 on a scale of 1 to 10. The triage nurse noted that the patient was "moaning and rocking". The patient was seen by the Respondent, who noted that on physical examination of the abdomen the patient had epigastric tenderness with positive guarding and variable tenderness throughout the rest of the abdomen. (Tr. 29-32; Ex. 3, pp. 14 and 15).
12. Both the history documented by the Respondent and the physical examination performed by the Respondent were inadequate and incomplete. Despite a history of vomiting elicited by the Respondent and of possible peptic ulcer disease, the Respondent did not record the character of the vomitus. Similarly, given the possibility of bleeding from a peptic ulcer, the Respondent should have performed a rectal examination and examined the stool for occult blood, which he did not do. (Tr. 32-33, 42-43 and 627-629; Ex. 3, pp. 14 and 15). Furthermore, the medical history and physical examination, as documented by the Respondent on the patient's chart, do not indicate that the Respondent considered a possible diagnosis of acute appendicitis (Tr. 34-36; Ex.3, p. 15).
13. The Respondent ordered a repeat CBC, SMA14, Amylase/Lipase and urine toxicology as well as an abdominal ultrasound. The patient was treated with IV Pepcid, 30 mg of IV Toradol, IM Tigan, oral Mylanta, and oral Donnitol elixir. The laboratory results were notable for an increase in the white blood cell count to 15,300 with a shift to the left. The administration of Toradol to a patient with a possible peptic ulcer and possible other

- abdominal pathology is contraindicated because it can worsen symptoms of peptic ulcer disease and mask signs of other conditions. (Tr. 33 and 35-38; Ex. 3, pp. 14, 15 and 20).
14. As a result of the administration of Toradol by the Respondent, future serial examinations of the patient's abdomen were compromised. Furthermore, although warranted, the Respondent did not perform any serial examinations of the patient's abdomen. Such examinations are necessary for the accurate diagnosis of various intra-abdominal pathologies, including acute appendicitis. (Tr. 38-40; Ex. 3).
  15. The Respondent did not order a CT scan to consider the possibility of acute appendicitis. Such failure constitutes a departure from acceptable medical practice. (Tr. 36 and 41-42; Ex. 3).
  16. At 12:20 A.M. on March 18, 2002, approximately seven hours after returning to the Emergency Department at Good Samaritan, Patient A was inappropriately discharged by the Respondent with a diagnosis of rule out peptic ulcer disease with *Helicobacter* and Gilbert's Disease (the latter based on an elevated bilirubin of 1.8), despite evidence of serious intra-abdominal pathology. (Tr. 34 and 39-41; Ex. 3, pp. 14, 15, 17 and 18).
  17. The Respondent discharged the patient on Prilosec, Donnatoil elixir, and Mylanta. He recommended that the patient avoid aspirin, alcohol, and non-steroidal anti-inflammatory medications. Yet, less than four hours before the patient was discharged, the Respondent gave the patient 30 mg intravenously of Toradol, a powerful non-steroidal anti-inflammatory agent. (Tr. 36-37 and 72-73; Ex. 3, pp. 14, 15 and 17).
  18. On March 18, 2002 at 10:04 A.M., almost ten hours after Patient A was discharged by the Respondent, Patient A returned to the Emergency Department of Good Samaritan complaining of persistent pain of increasing severity. The Emergency Room physician

recorded that the pain was now in the right lower quadrant where there was tenderness and guarding on physical examination. A CT scan demonstrated an acute appendicitis and an emergency appendectomy was performed. At surgery, a retrocecal appendix was found. (Ex. 3, pp. 23, 25 and 30-35).

19. While the Respondent's evaluation was incomplete, his treatments inappropriate, and his diagnosis inaccurate, he did maintain a medical record that documents his evaluation and treatment (Ex. 3).

#### **Patient B**

20. On November 28, 2002 at 9:55 A.M., Patient B, a 49 year-old male, was brought by ambulance to the Emergency Department of Good Samaritan. The triage nurse noted that the patient had been discharged the previous day from North Shore University Hospital following hospitalization for an acute myocardial infarction, diabetes mellitus, and deep venous thrombosis in the left leg. The nurse also noted that the patient looked gray, had grayish-colored fingernail beds, cyanosis, a hemodialysis AV fistula, bilateral leg edema, left leg cyanotic discoloration, and no pedal pulses bilaterally. In addition, the nurse noted that the patient was on oxycodone, minocycline, renagel, and epogen. The patient was assigned to a triage category 2 (urgent). The triage nurse was unable to obtain a blood pressure on auscultation and obtained a systolic blood pressure of 108 via Doppler. She also found the patient to be hypothermic with a temperature of 94.3. (Tr. 96-100; Ex. 4, pp. 6 and 8).

21. The patient was seen by the Respondent, who prepared a brief, untimed note stating that the patient had been brought to Good Samaritan for transfer to North Shore University Hospital, and that the patient had been discharged the day before with leg clots, was on dialysis, and was post-myocardial infarction with a pacemaker and central port. (Tr. 100-101; Ex. 4, p. 8).
22. The Respondent's physical examination of the patient revealed violaceous discoloration of the legs, cold fingers with violaceous tips, and pallor suggestive of Raynaud's or hypercoagulable syndrome. This physical examination and history were superficial. In addition, the history and physical findings did not support these diagnoses. (Tr. 101-104 and 110-112; Ex. 4, p. 8).
23. The Respondent failed to realize that Patient B may have been in shock, was critically unstable, and may have had life-threatening hyperkalemia. He did not order a 12-lead EKG to detect hyperkalemia, which was indicated. (Tr. 98-99 and 102-108; Ex. 4, pp. 6-8).
24. In addition, the Respondent failed to recognize that Patient B was extremely unstable, as evidenced by the patient's pallor, cyanosis, absence of pedal pulses, hypothermia, and systolic blood pressure obtainable only by Doppler (Tr. 102-104 and 107-108; Ex. 4, pp. 6 and 8).
25. The Respondent failed to order any laboratory studies, including a 12-lead EKG, ABG, CBC, and cardiac enzymes, which were vital for the management of the patient (Tr. 103-107; Ex. 4, pp. 6 and 8).

26. The Respondent failed to note in Patient B's chart whether or not the patient was stable (Tr. 109-110; Ex. 4, pp. 6, 8 and 12). However, despite the inadequate clinical evaluation and the patient's unstable clinical status, the Respondent ordered the patient transferred to North Shore University Hospital (Tr. 107-109; Ex. 4, pp. 6 and 12).
27. A Basic Life Support ambulance team initially responded to transport Patient B to North Shore University Hospital. After this team indicated their discomfort with assuming care of the patient, an Advanced Life Support ambulance team was requested. (Tr. 112-113; Ex. 4, p. 7).
28. Before the arrival of the Advanced Life Support ambulance team, Patient B went into ventricular fibrillation. A code was called at 11:19 A.M., one hour and 24 minutes after the patient was initially seen by the triage nurse. During this period the Respondent failed to take adequate measures to monitor and stabilize the patient. (Tr. 108-109 and 113-117; Ex. 4, p. 20; See finding 20, *supra*).
29. The resuscitation efforts were unsuccessful and Patient B died at 12:43 P.M. (Tr. 113-114; Ex. 4, pp. 19-21 and 23).
30. Despite the patient's medical history, signs and symptoms elicited by the triage nurse, and the reluctance of the Basic Life Support ambulance team to transfer the patient, the Respondent failed to recognize the patient's extremely unstable condition and instead made a diagnosis of Raynaud's Disease or hypercoagulable syndrome, which was not supported by the evidence. (Tr. 110-112; Ex. 4, p. 8; See finding 22, *supra*).
31. The fact that the patient developed ventricular fibrillation one hour and 24 minutes after his arrival at the Emergency Department and the fact that he was pronounced dead 24 minutes later (after he developed ventricular fibrillation) are clear evidence of his

unstable condition. The Respondent's decision to transfer the patient to another institution reflects his failure to accurately assess and diagnose a patient who was so seriously ill. (Tr. 113-117; Ex. 4, pp. 6-8, 12, 19-21 and 23; See findings 28 and 29, *supra*).

32. Finally, the Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment provided, including patient history, physical examination and basis for transfer orders (Tr. 107-110 and 120-121; Ex. 4).

#### **Patient C**

33. On September 27, 2003 at 11:12 A.M., Patient C, a 46 year-old female, presented to the Emergency Department of Good Samaritan with complaints of nausea, vomiting, arm tightness, and chest pain radiating to the right leg and gluteal region. She also indicated that she had been diaphoretic. She described her pain as a 10 on a scale of 1 to 10, and was categorized by the triage nurse as Class 1 – “Emergent” – the most serious emergency type of patient. (Tr. 155-156; Ex. 5, pp. 2 and 3).
34. The patient was seen by the Respondent, who prepared a note that was not timed. While the Respondent obtained a medical history, the medical history failed to address the chief complaint documented by the triage nurse, which indicated with reasonable probability that the patient was suffering from an acute coronary syndrome, and, even possibly, an acute myocardial infarction. While taking the medical history, the Respondent also failed to address the patient's possible risk factors for coronary artery disease. These failures constitute a departure from acceptable medical practice. (Tr. 157-161 and 173; Ex. 5, pp.3 and 4).

35. Although the Respondent ordered an electrocardiogram, there is no evidence that it was ever performed, reviewed, or interpreted. Furthermore, the Respondent failed to document an interpretation of the electrocardiogram in the physician section of the Emergency Department medical record designated "EKG Interpretations". These failures are unacceptable and do not meet minimum medical standards. (Tr. 161-169 and 535-537; Ex. 5, pp. 3-5).
36. The Respondent discharged Patient C without performing a complete cardiac assessment, which should have included an EKG. Such discharge was premature and did not comply with acceptable medical practice. (Tr. 168-169; Ex. 5, pp. 3, 4 and 6).
37. The Respondent's evaluation and differential diagnoses (erlichiosis, Lyme disease, carpal tunnel syndrome, and obturator hernia) failed to include the most likely life-threatening cause of Patient C's symptoms, acute coronary syndrome, and demonstrates an inability of the Respondent to synthesize the variety of information available to him. (Tr. 158-161, 169 and 535; Ex. 5, pp. 3 and 4).
38. On September 28, 2003 at 10:46 A.M., Patient C's husband called 911 from their home and reported that he found his wife not breathing. An EMS team from the Deer Park Fire Department responded to the call and found Patient C on the floor and she was apneic and pulseless. Resuscitation efforts were initiated by the EMS team and Patient C was transported to Good Samaritan. Patient C arrived at the Emergency Department at 11:08 A.M. The resuscitation efforts continued at the hospital. However the resuscitation efforts were unsuccessful and Patient C was pronounced dead at 11:32 A.M. (Tr. 169-172; Ex. 5, pp. 28, 29, 32 and 33).

39. An autopsy performed on September 29, 2003 by James C. Wilson, M.D., Deputy Medical Examiner of Suffolk County, found that the cause of death was "atherosclerotic coronary heart disease with thrombotic occlusion and acute myocardial infarction" (Tr. 171-172; Ex. 6, p. 2).

#### **Patient D**

40. On September 14, 2003 at 10:50 A.M., Patient D, a 69 year-old female, presented to the Emergency Department of Good Samaritan. The triage nurse noted a chief complaint of abdominal pain for two days and that the patient's respirations were labored with audible wheezing, lower extremity edema, and an abdomen distended and firm. The patient was initially evaluated by the emergency physician then on duty, who started a workup on the patient, which included an abdominal CT scan. The care of the patient was subsequently turned over to the Respondent, who came on duty at approximately 1:00 P.M. that afternoon. (Tr. 239-240, 242, 444-445 and 474; Ex. 7, pp. 3 and 4; Ex. C).
41. While the Respondent took over the care of the patient and reviewed the laboratory and radiology studies that had been ordered by the original emergency physician, there is no evidence that the Respondent ever personally examined the patient. (Tr. 242-243, 251-252, 454-455, 475, 484 and 509-510; Ex. 7, pp. 4 and 14).
42. The Respondent's failure to perform repeat abdominal examinations on this patient with abdominal pain of unclear etiology, fell below acceptable medical standards (Tr. 253-254).
43. Furthermore, there is no evidence that the Respondent reviewed the triage nurse's assessment relating to the patient's respiratory problems that appear in the notation that the patient's respirations were labored with audible wheezing. Despite a low pulse

oximetry saturation of only 90% and an elevated serum bicarbonate level of 36, the Respondent failed to address, follow-up on, or order additional studies to assess, the patient's respiratory status and acid-base balance, including arterial blood gas analysis. Such failure constitutes a departure from acceptable medical practice. (Tr. 240-246; Ex. 7, pp. 3, 4 and 17; See finding 40, *supra*).

44. The Respondent failed to appreciate the significance of the abnormality reported by the radiologist on the abdominal CT scan when the radiologist stated that "There is a large amount of edema throughout the subcutaneous tissues of the lower abdomen." In addition, the Respondent incorrectly documented the CT scan reading as negative. Furthermore, the Respondent failed to integrate the information learned from the CT scan with the information relating to the patient's respiratory problems, the totality of which indicates significant lung disease with secondary heart disease, and that the patient was suffering from cor pulmonale. These failures constitute a departure from acceptable medical practice. (Tr. 248-252, 261 and 267-268; Ex. 7, pp. 4, 13 and 14).
45. The patient was discharged by the Respondent at 7:20 P.M. (Tr. 253; Ex. 7, p. 6). The Respondent discharged the patient without: repeat vital signs; reassessment of the pulse oximetry; ever personally examining the patient; formulating any reasonable differential diagnoses; taking appropriate steps to rule out any life-threatening diagnoses; and, adequately assessing the etiology of the patient's abdominal pain and respiratory distress. (Tr. 261 and 485-486; Ex. 7, pp. 4-6; See findings 41 and 43, *supra*).
46. The Respondent demonstrated an inability to gather and synthesize the information that was available to him, and thus failed to make an accurate diagnosis (Tr. 256 and 260-261; Ex. 7, p. 3; See finding 44, *supra*).

47. The Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided, including diagnoses, interpretation of diagnostic tests and rationale for discharge (Tr. 255-258, 464 and 487; Ex. 7).

### CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did practice medicine with gross negligence on a particular occasion. The Petitioner has proved by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C and D, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did practice medicine with gross incompetence. The Petitioner has proved by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients B and D.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C and D, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did practice medicine with incompetence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients B, C and D.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patients B and D, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of each of these patients.

### DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

### **Discussion of the Witnesses**

The Petitioner relies primarily on the medical testimony of Mark S. Silberman, M.D., in its efforts to establish its case against the Respondent. Dr. Silberman, the Petitioner's only witness, was presented as an expert in the field of emergency medicine. He testified with regard to the Respondent's medical care and treatment of the four patients listed in the Amended Statement of Charges.

Dr. Silberman received his medical training at Northwestern University Medical School in Chicago, Illinois (1980-1984). After graduating medical school he did an internship and residency in internal medicine (1984-1987) and a fellowship in Pulmonary and Critical Care Medicine (1987-1990) at The Presbyterian Hospital, Columbia University College of Physicians & Surgeons in New York, New York ["Columbia-Presbyterian"]. He also served as an Instructor in Clinical Medicine (1987-1990) and currently serves as an Assistant Professor of Clinical Medicine (1990-present) at Columbia-Presbyterian.

Dr. Silberman is affiliated with New York Presbyterian Hospital in New York, New York, where he served as Associate Director of Emergency Medicine (1997-2000) and currently serves as an Attending Emergency Physician (1990-present). He is also affiliated with Community Hospital at Dobbs Ferry in Dobbs Ferry, New York, where he serves as an Emergency Physician (1989-present), Director of Emergency Medicine (1990-present), and Hospital Medical Director (1997-present).

In addition, Dr. Silberman is board-certified in four separate disciplines of medicine – Emergency Medicine (1996), Critical Care Medicine (1991, recertified 2002), Pulmonary Medicine (1990, recertified 2002), and Internal Medicine (1987). Furthermore, he is a Certified Provider, Instructor and Course Director of Advanced Cardiac Life Support; a

Certified Provider and Instructor of Advanced Trauma Life Support; and, a Certified Provider of Pediatric Advanced Life Support. (Tr. 17-20; Ex. 8).

The Hearing Committee found Dr. Silberman to be a very convincing and highly credible witness. He was straightforward, non-evasive, extremely knowledgeable and his testimony was balanced and unbiased. His credentials are quite impressive and he demonstrated a far-reaching command of the field of emergency medicine as well as a thoughtful and well-reasoned analysis of the issues involved in this matter. Furthermore, he was well prepared, thoroughly familiar with the cases that were the subject of his testimony, and highly articulate.

The Respondent's case relies primarily on the medical testimony of the Respondent, who was the only witness to testify in support of the Respondent's case. The Respondent has extensive experience in emergency medicine and has worked as an Emergency Room Attending Physician at Good Samaritan since 1995. The Respondent had been board certified in emergency medicine in 1992, but his board certification lapsed in 2002 and was never renewed. However, he is currently certified for ACLS, BLS, PALS and ATLS. (See findings 1 through 8, *supra*).

The Respondent testified at length in his own behalf. The Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. His credibility was weakened by his evasiveness under questioning, lack of candor, and his selective and faulty memory. In addition, his testimony was frequently self-serving, inconsistent and contradicted by other independent evidence.

The Hearing Committee detected a pattern of deception throughout the Respondent's testimony. For example, the Hearing Committee found that the Respondent's *curriculum vitae* was embellished and misleading. Publications are listed in his *curriculum vitae* as if they were all published peer review journals, when many, if not most, were not. Such a presentation goes beyond academic rigor, and demonstrates a tendency to embellish and mislead. (Tr. 347-348 and 359-370; Ex. A). Similarly, the Respondent listed in his *curriculum vitae* that he is board certified in emergency medicine. However, this listing is incorrect since the Respondent's board certification in emergency medicine lapsed in 2002 and was never renewed. (Tr. 370-374; Ex. A).

The Hearing Committee also found that the Respondent was evasive. For example, when asked if Patient B was critically unstable from the moment he entered the Emergency Room until the moment he died, the Respondent stated that he couldn't answer this question because he didn't see the ambulance report in the patient's chart (Tr. 655-656). Why is the ambulance report needed to answer this particular question about Patient B's stability while he was in the Emergency Room? It is not! The triage nurse's notations appearing in the patient's chart clearly indicate the instability of the patient at the time of arrival. These notations include the following observations which demonstrate the patient's instability: unstable vital signs; gray-ash color; discolored and cyanotic leg; and, lack of pedal pulses in extremities. (Ex. 4, p. 6; See finding 20, *supra*).

In addition, the Hearing Committee believes that the Respondent was disingenuous when he frequently and repeatedly claimed to have no memory or recollection of certain dates, documents and/or events that were specifically brought to his attention. For example, the Respondent unequivocally stated that he had no recollection of ever having had any

annual performance reviews or appraisals while at Good Samaritan (Tr. 390 and 394-395). However, when he was shown two separate Good Samaritan Physician Performance Appraisals that contradicted this statement (Exhibits 10 and 11), he stated that he still had no recollection of having any performance appraisal at Good Samaritan. Furthermore, he even stated that he had no recollection of the documents that were shown to him, despite admitting that the signature on each of these documents was his. (Tr. 398-400 and 403; Exs. 10 and 11).

In addition, the Respondent testified that he didn't remember ever receiving a letter or memo from the Good Samaritan Emergency Department Peer Review Committee about one or more of his cases (Tr. 406) or having any Peer Review Committee meetings at Good Samaritan relating to his care of three of the patients involved in this hearing (Tr. 410). Nevertheless, a stipulation was entered into by the Respondent and the Petitioner that there were peer reviews conducted at Good Samaritan in connection with three of the four cases that are the subject of this hearing (Tr. 423-424).

The Hearing Committee is also skeptical of the Respondent's assertion that he had no recollection of Patient B whatsoever (Tr. 118). This claim is highly unlikely since the Respondent was actively attempting to transfer this patient who experienced cardio-pulmonary arrest, could not be resuscitated, and expired. This was a dramatic and unusual event that would have made a lasting impression on the Respondent.

It is interesting to note that despite the Respondent's frequent and repeated claims of having no memory or recollection that appear throughout his testimony, the Respondent unequivocally stated that he has no problem with his memory (Tr. 400).

Finally, the Hearing Committee noted that the Respondent demonstrated a reluctance to accept responsibility for his actions. He didn't seem to fully appreciate or accept responsibility for his failure to adhere to acceptable medical standards. He also had difficulty recognizing his own shortcomings. In addition, the Hearing Committee observed a pattern demonstrating the Respondent's inability to synthesize the information from the various sources available to him and to adequately utilize this information in connection with the patient care that he provided.

### **Discussion of the Charges**

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

The Respondent deviated from acceptable medical standards in connection with the care and treatment that he provided to Patients A, B, C and D. Consequently, the Hearing Committee found the Respondent negligent in connection with the medical care and treatment that he provided to each of the four patients. In addition, the Hearing Committee found that the Respondent's negligence regarding Patients A, B, C and D, was, in certain instances, egregious and conspicuously bad, and thereby constituted gross negligence.

In addition, the Respondent lacked the requisite skill or knowledge to practice medicine in connection with the care and treatment that he provided to Patients B, C and D. Consequently, the Hearing Committee found the Respondent incompetent in connection with the medical care and treatment that he provided to each of these three patients. Furthermore, the Hearing Committee found that the Respondent's incompetence regarding Patients B and D, involved, in certain instances, a total and flagrant lack of necessary knowledge or ability to

practice medicine, and thereby constituted gross incompetence. Although the Hearing Committee found the Respondent incompetent in connection with the medical care that he provided to Patient C, the Hearing Committee does not believe that any of the proven allegations relating to Patient C rises to the level of gross incompetence.

Finally, the resolution of the recordkeeping issues required an examination of the entries made by the Respondent in the medical records for each patient as well as an evaluation of the medical testimony relating to the adequacy of each of these medical records.

The Respondent failed to maintain records for Patients B and D that accurately reflect his evaluation and treatment of each of these patients. Consequently, the Hearing Committee found that the Respondent failed to maintain adequate records for each of these two patients.

### **VOTE OF THE HEARING COMMITTEE**

**(All votes were unanimous unless otherwise specified)**

#### **Factual Allegations**

##### **Factual Allegations relating to the treatment of Patient A**

Sustained: A, A1, A3, A4, A5 and A6

Not Sustained: A2 and A7

##### **Factual Allegations relating to the treatment of Patient B**

Sustained: B, B1, B2, B3, B4, B6, B7 and B8

Not Sustained: B5

##### **Factual Allegations relating to the treatment of Patient C**

Sustained: C, C1, C2, C3, C4 and CC

Factual Allegations relating to the treatment of Patient D

Sustained: D, D1, D2, D3, D4, D5, D6, D7 and D8

**Specifications**

Gross Negligence

1<sup>st</sup> Specification (Treatment of Patient A) Sustained

Sustained Factual Allegations in Support of the 1<sup>st</sup> Specification: A, A5 and A6

2<sup>nd</sup> Specification (Treatment of Patient B) Sustained

Sustained Factual Allegations in Support of the 2<sup>nd</sup> Specification: B, B1, B2, B3, B4  
and B7

3<sup>rd</sup> Specification (Treatment of Patient C) Sustained

Sustained Factual Allegations in Support of the 3<sup>rd</sup> Specification: C, C2, C3 and C4

4<sup>th</sup> Specification (Treatment of Patient D) Sustained

Sustained Factual Allegations in Support of the 4<sup>th</sup> Specification: D, D1, D2, D3, D4,  
D5, D6 and D7

Gross Incompetence

5<sup>th</sup> Specification Sustained

Sustained Factual Allegations in Support of the 5<sup>th</sup> Specification:

Treatment of Patient B: B, B2, B3, B4, B6 and B7

Treatment of Patient D: D, D6 and D7

Negligence on More than One Occasion

6<sup>th</sup> Specification

Sustained

Sustained Factual Allegations in Support of the 6<sup>th</sup> Specification:

Treatment of Patient A: A, A1, A3, A4, A5 and A6  
Treatment of Patient B: B, B1, B2, B3, B4 and B7  
Treatment of Patient C: C, C1, C2, C3 and C4  
Treatment of Patient D: D, D1, D2, D3, D4, D5, D6 and D7

Incompetence on More than One Occasion

7<sup>th</sup> Specification

Sustained

Sustained Factual Allegations in Support of the 7<sup>th</sup> Specification:

Treatment of Patient B: B, B2, B3, B4, B6 and B7  
Treatment of Patient C: C and C4  
Treatment of Patient D: D, D4, D5, D6 and D7

Failure to Maintain a Patient Record

8<sup>th</sup> Specification

(Medical Record of Patient A)

Not Sustained

9<sup>th</sup> Specification

(Medical Record of Patient B)

Sustained

Sustained Factual Allegations in Support of the 9<sup>th</sup> Specification: B, B1 and B8

10<sup>th</sup> Specification

(Medical Record of Patient C)

Not Sustained

11<sup>th</sup> Specification

(Medical Record of Patient D)

Sustained

Sustained Factual Allegations in Support of the 11<sup>th</sup> Specification: D and D8

## **DETERMINATION AS TO PENALTY**

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be revoked.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee believes that the Respondent does not fully appreciate the seriousness of his failure to respond appropriately to the particular patient problems that were presented during the course of this hearing. The Hearing Committee noted that despite postgraduate training in internal medicine and extensive experience in emergency medicine, the Respondent repeatedly demonstrated an inability to synthesize the variety of available information relating to each particular patient. This shortcoming impairs the Respondent's ability to adequately evaluate, diagnose and treat each of his patients. The Respondent further demonstrated: 1) a lack of insight into his deficiencies; 2) an inability to learn from his mistakes; and 3) a reluctance to take responsibility for his actions.

During the course of the hearing a consistent, long-term, pattern of negligence and incompetence, emerged from the evidence presented. The Hearing Committee believes that the Respondent presents a danger to the public because of his adherence to this pattern and he

practices medicine in a substandard fashion. The Hearing Committee also believes that the Respondent is not a good candidate for retraining or practicing under supervision. Since the Respondent does not appear to believe that he is practicing outside the scope of acceptable medical standards, there is no reason to assume that his behavior will change.

The Hearing Committee unanimously concluded that the Respondent's conduct was unacceptable and that public safety requires that it not be permitted to continue. In view of the Respondent's long-term, repeated and egregious failure to care for his patients within acceptable medical standards, together with his failure to fully appreciate the seriousness of his misconduct and to genuinely accept the responsibility for his actions, the Hearing Committee finds that the only appropriate and acceptable penalty is revocation.

### ORDER

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

1. The 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 9<sup>th</sup> and 11<sup>th</sup> Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I), are **SUSTAINED**; and
2. The 8<sup>th</sup> and 10<sup>th</sup> Specifications of professional misconduct contained within the Amended Statement of Charges (Appendix I) are **DISMISSED**; and
3. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York  
September 27, 2005



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ALAN KOPMAN  
Chairperson

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**APPENDIX I**

**IN THE MATTER**  
**OF**  
**DONALD FORESTER, M.D.**

**AMENDED**  
**STATEMENT**  
**OF**  
**CHARGES**

DONALD FORESTER, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 31, 1965, by the issuance of license number 096132 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. On or about March 17, 2002, Respondent treated Patient A (whose name together with other patient names are contained in the attached Appendix) in the emergency room at Good Samaritan Hospital, West Islip, New York. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:
1. Respondent failed to perform and document an adequate history and physical examination.
  2. Although Respondent's physical examination revealed signs consistent with acute appendicitis, Respondent failed to consider and follow-up this differential diagnosis.
  3. Respondent failed to order a CT scan of the abdomen and pelvis.

4. Respondent ordered Toradol which was contraindicated.
  5. Patient A spent seven hours in the ER. During that period Respondent failed to perform serial abdominal examinations, despite evidence of an acute abdomen.
  6. Respondent discharged Patient A without properly following up numerous findings suggestive of serious intra-abdominal pathology.
  7. Respondent failed to maintain a medical record for Patient A which accurately reflects the evaluation and treatment he provided, including patient history and physical, diagnoses, follow-up of test results and rationales for discharge.
- B. On or about November 28, 2002, Respondent treated Patient B in the emergency room of Good Samaritan Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:
1. Respondent failed to document and perform an adequate history and physical examination.
  2. Respondent failed to recognize that Patient B was critically unstable during his entire stay in the emergency room.

3. Respondent failed to order basic laboratory studies, including ABG, CBC, electrolytes, cardiac enzymes and EKG.
  4. Respondent inappropriately ordered Patient B to be transferred to another hospital despite the patient's critically unstable condition,.
  5. Respondent falsely noted in Patient B's chart that the patient was "stable".
  6. Respondent made diagnoses of Raynaud's and hypercoagulable syndrome which were not indicated.
  7. Patient B went into cardiac arrest one hour and 25 minutes after he arrived in triage. Respondent failed to adequately monitor Patient B's vital signs during this time period.
  8. Respondent failed to maintain a medical record for Patient B which accurately reflects the evaluation and treatment provided, including patient history, physical examination, diagnoses, descriptions of patient status and relative stability and bases for transfer orders.
- C. On or about September 27, 2003, Respondent treated Patient C in the emergency room at Good Samaritan Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. After interviewing and examining Patient C, Respondent failed to include acute cardiac disease among his differential diagnoses.
2. Although Respondent properly ordered an EKG, he failed to insure that it was, in fact, performed.
3. Respondent failed to document a review or interpretation of an EKG.
4. Respondent discharged Patient C without performing a complete cardiac assessment, including a review of an EKG.

CC. On or about September 28, 2003, Patient C was found at home in full cardiac arrest. Resuscitation efforts were unsuccessful. On autopsy she was found to have died from an acute myocardial ~~infraction~~ infarction.  
BYB  
ALJ

D. On or about September 14, 2003, Respondent treated Patient D in the emergency room at Good Samaritan Hospital. Respondent's management and treatment departed from accepted standards of medical practice in the following respects:

1. Respondent failed to perform repeat abdominal examinations on a patient with abdominal pain of unclear etiology.
2. Respondent failed to recognize and treat Patient D's respiratory

distress as evidenced by an oxygen saturation reading of 90%.

3. Respondent failed to order arterial blood gas analysis.
4. A CT scan revealed several positive findings including the existence of a large amount of subcutaneous edema. Respondent failed to appreciate or follow-up these findings.
5. Respondent incorrectly noted in Patient D's chart that the CT scan was "negative".
6. Respondent failed to formulate any reasonable differential diagnoses or take appropriate steps to rule out any life threatening diagnoses.
7. Respondent discharged Patient D without adequately assessing the etiology of the patient's abdominal pain and respiratory distress.
8. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided including diagnoses, interpretation of diagnostic tests and rationale for discharge.

## **SPECIFICATION OF CHARGES**

### **FIRST THROUGH FOURTH 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:

1. Paragraphs A and A(1) - A(6).
2. Paragraphs B and B(1)-B(7).
3. Paragraphs C and C(1)-C(4).
4. Paragraphs D and D(1)-D(7).

### **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. Paragraphs A and A(1)-A(6); B and B(1)-B(7); C and C(1)-C(4); and/or D and D(1)-D(7).

**SIXTH SPECIFICATION**  
**NEGLIGENCE ON MORE THAN ONE OCCASION**

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

6. Paragraphs A and A(1)-A(7); B and B(1)-B(8); C and C(1)-C(4); CC; and/or D and D(1)-D(8).

**SEVENTH SPECIFICATION**  
**INCOMPETENCE ON MORE THAN ONE OCCASION**

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

7. Paragraphs A and A(1)-A(7); B and B(1)-B(8); C and C(1)-C(4); CC; and/or D and D(1)-D(8).

**EIGHTH THROUGH ELEVENTH SPECIFICATION**  
**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 care and treatment of the patient, as alleged in the facts of:

8. Paragraphs A and A(1), A(7).
9. Paragraphs B and B(1), B(5), B(8).
10. Paragraphs C and .
11. Paragraphs D and D(5), D(8).

DATED: June 14, 2005  
New York, New York