

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

PUBLIC

IN THE MATTER
OF
DONALD FORESTER

COMMISSIONER'S
ORDER AND
NOTICE OF
HEARING

TO: DONALD FORESTER
Wingate Inn - Room 225
801 Crooked Hill Rd.
Brentwood, N.Y. 11717

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by DONALD FORESTER, the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately DONALD FORESTER, Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 9, 2005, at 10:00 a.m., at the offices of the New York State Health Department, 90 Church Street, 4th Floor, New York, NY 10007, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of

Charges with the below-named attorney for the Department of Health.

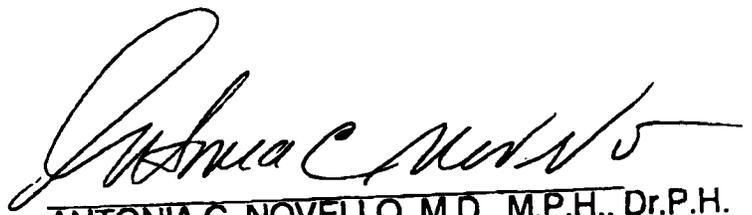
At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

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

DATED: Albany, New York
April 28, 2005



ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Terrence Sheehan
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
90 Church Street - 4th Floor
New York, NY 10007

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name _____ Date of Proceeding _____

Name of person to be admitted _____

Status of person to be admitted _____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

Signature (of licensee or licensee's attorney) _____

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

IN THE MATTER
OF
DONALD FORESTER, M.D.

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.
 5. The following morning after she was discharged 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.
- 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(5); 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:

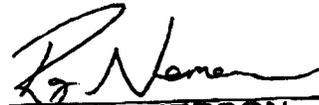
7. Paragraphs A and A(1)-A(7); B and B(1)-B(8); C and C(1)-C(5); and/or D and D(1)-D(8).

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 C(5).
11. Paragraphs D and D(5), D(8).

DATED: April 27, 2005
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct