STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Public

November 6, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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Bureau of Professional Medical Conduct
ESP - Corning Tower - Room 2512
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RE: In the Matter of L. Mario DiBlasio, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-128) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

James F. Horan

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of L. Mario DiBlasio, M.D. (Respondent) A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	Administrative Review Board (ARB) Determination and Order No. 07-128

Before ARB Members Grossman, Lynch, Pellman, Wagle and Wilson

Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Richard J. Zahnleuter, Esq.
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For the Respondent: Kevin A. Harrington, Esq.
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After a hearing below, a BPMC Committee sustained charges that the Respondent practiced with gross negligence and gross incompetence, that the Respondent practiced with negligence and incompetence more than one occasion and that the Respondent willfully filed false reports. The Committee voted to suspend the Respondent's license to practice medicine in New York State, to stay the suspension, to limit the Respondent's License and to place the Respondent on probation for three years. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2007), both parties ask the ARB to modify and/or overturn portions of the Committee's Determination. After reviewing the record below and the review submissions by the parties, the ARB sustains in full the Committee's Determination on the charges, but we vote 5-0 to overturn the Committee's Determination as to penalty. The ARB revokes the Respondent's License.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent violated New York Education Law (EL) §§ 6530(2-6), 6530(20-21) & 6530(24)(McKinney 2007) by committing professional misconduct under the following specifications:

- practicing fraudulently,
- practicing with negligence on more than one occasion,
- practicing with gross negligence,
- practicing with incompetence on more than one occasion,
- practicing with gross incompetence,
- engaging in conduct that evidences moral unfitness,
- willfully filing or making a false report, and,
- accepting and performing professional services beyond competence level.

The charges relating to practice involved the Respondent's interpretation of diagnostic x-rays, mammograms and/or sonograms on seven persons (Patients A-G). The fraud, moral unfitness and false report charges arose from applications that the Respondent made to various medical facilities for medical staff appointment or re-appointment. The Respondent denied the charges and raised several affirmative defenses and a hearing followed pursuant to PHL § 230(10) (McKinney Supp. 2007). Following the hearing the Committee rendered the written determination and order now on review.

The Committee dismissed all charges relating to Patients C, D and E. The Committee sustained charges that the Respondent practiced with negligence on more than one occasion in making the interpretations for Patients A, B, G and F. The Committee found that the Respondent practiced with incompetence on more than one occasion in making the interpretations for Patients A, B and G. The Committee found further that the Respondent practiced with gross negligence in making the interpretations concerning Patients A and G and with gross incompetence in making the interpretations for Patient A. The Committee dismissed the charges that the Respondent practiced fraudulently and that the Respondent engaged in conduct that evidenced moral unfitness in medical practice. The Committee sustained the charges that the Respondent willfully filed false reports on thirty-three occasions.

The Committee's findings concerning Patient A involved the Respondent's interpretations on mammogram screenings on March 12 and April 10, 2000. The Committee found that the Respondent failed on those dates to identify and to understand the significance of calcifications, which were increasing in number and highly suggestive of malignancy. The Committee also found that the Respondent issued an erroneous report that indicated no malignancy, failed to recommend a prompt surgical biopsy and delayed detection, diagnosis and treatment of a cancerous legion, thereby subjecting Patient A to an increased risk of morbidity and mortality. The findings concerning Patient B involved a mammogram interpretation for March 30, 1999. The Committee found that the Respondent issued a report showing that the Respondent failed to understand that a palpable, spiculated mass or lesion apparent on the mammogram was an abnormal feature and failed to identify that lesion as highly suggestive of

malignancy. The Committee found that the Respondent's errors delayed the detection, diagnosis and treatment of Patient B's malignancy and subjected the Patient to an increased risk of morbidity and mortality. The care for Patient F involved the Respondent's interpretation of diagnostic x-rays on March 27, 2002. The Committee found that the Respondent failed to perceive the significance of abnormalities apparent on the x-ray of the Patient's right hip, failed to identify the abnormalities as consistent with a fracture, caused a report to issue with a finding of no fracture and delayed the detection, diagnosis and treatment of the right hip fracture and thereby subjected the Patient to an increased risk of morbidity and mortality. The findings involving Patient G concerned the interpretation of a diagnostic x-ray on December 24, 2001. The Committee found that the Respondent failed to determine correctly the presence of a large effusion on the Patient's left side. The Respondent reported the effusion as present on the right side, which contributed to the insertion of a chest tube incorrectly into the right side and subjected the Patient to an increased risk of morbidity and mortality.

The Committee sustained allegations that the Respondent willfully made or filed a false report on thirty-three occasions between 1995 and 2001. The allegations concerned seven credentialing or employment applications (Applications) that the Respondent submitted to three healthcare entities during those years. The answers on those Applications concerned prior criminal convictions or disciplinary actions and the Respondent's professional employment.

The Committee found that the Respondent was convicted in New Jersey in 1989 for possession of a controlled, dangerous substance with the intent to distribute. The Committee found further that the Respondent was convicted in New York in 1992 for criminal possession of a controlled substance in the fourth degree. In March 1986, the Respondent's License was revoked, but the revocation was stayed indefinitely, with five years on probation. In October 1987, the Respondent's License was revoked. In 1995, as a result of the Respondent's petition for restoration, the 1987 revocation was stayed and the Respondent received two years on probation. In 1989, the Respondent's New Jersey medical license was revoked and that license was reinstated with monitoring in 1996. The Committee also found that the Respondent was incarcerated in the New York State prison system between 1986 and 1991. Finally, the

Committee found that when the Respondent faced disciplinary actions by Brooklyn Hospital in 1984, the Respondent opted "to quit" as requested by the Hospital.

The Committee found that the Respondent's answers on the Applications at issue denied prior criminal convictions in New York and other jurisdictions, denied being found guilty of misconduct or being placed on probation, made false answers concerning employment in the years 1986 to 1991 and denied any prior relinquishment or discontinuation in a staff appointment or employment status. The Committee concluded that the Respondent provided false answers on the Applications and concluded that the false answers amounted to making and/or filing false reports. The Committee concluded further that, in making the false answers, the Respondent lacked the intent to mislead, so the Committee dismissed the fraud and moral unfitness charges.

In making the findings and conclusions, the Committee found the Petitioner's expert witnesses, John C. Wandtke, M.D. and Edward Alan Sickles, M.D., and the Respondent's expert, Robert Albert Schmidt, M.D., to be highly qualified and experienced radiologists. The Committee found that Dr. Sickles and Dr. Schmidt were in agreement about most of the aspects of the mammograms and sonograms for Patients A-E. The Committee stated that in areas in which the experts disagreed, the Committee gave benefit of the doubt to the Respondent, because the Petitioner bore the burden of proof. The Committee found the Respondent's testimony credible, forthright, sincere and remorseful. The Committee found that Dr. Sickles and Dr. Schmidt agreed that the Respondent's care for Patients A and B failed to meet the standards of care. The Committee found that the Respondent missed an obvious hip fracture for Patient F, that Dr. Wandtke described the failure to diagnose the fracture as a serious deviation and that the Respondent admitted to his supervisor that the Respondent missed an obvious fracture. As to the care for Patient G, the Respondent asserted that the improper care and treatment for that Patient resulted from a series of errors by several staff and physicians. On that point, however, the Committee credited testimony by Dr. Wandtke that the radiologist bears ultimate responsibility for radiological interpretation and determining right/left sidedness in a chest x-ray.

The Committee voted to suspend the Respondent's License for three years, to stay the suspension in full and to place the Respondent on probation for three years under the terms that

appear at Appendix 3 to the Committee's Determination. The Committee also limited the Respondent's practice to general radiology, but the Committee provided that if the Respondent desired to interpret mammograms or sonograms, the Respondent should practice under supervision.

Review History and Issues

The Committee rendered their Determination on June 25, 2007. This proceeding commenced on July 9, 2007, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and reply brief and the Respondent's brief and reply brief. The record closed when the ARB received the reply briefs on August 17, 2007.

The Petitioner made no challenge to the Committee's Determination on the charges. The Petitioner asked that the ARB overturn the Committee and revoke the Respondent's License. The Petitioner argued that under the 1995 order restoring the Respondent's License, the Respondent's License is under a stayed revocation and that the Committee has found that the Respondent engaged in forty-six additional instances of misconduct since the restoration order. The Petitioner argued that the ARB should return the Respondent's License to revocation status, but with no stay.

The Respondent contends that no basis exists to increase the penalty and asks that the ARB to reduce the penalty to a dismissal or a censure. The Respondent argues that the Committee failed to address properly uncontested evidence that the Respondent's error rate was actually below the error rates for similarly situated physicians and that such evidence precluded the Committee's findings relating to Patients A, B, F and G. The Respondent argues further that no basis exists for the findings as to Patients F and G, because the Committee applied improperly

a "root cause" analysis in making the findings as to Patients F and G. The Respondent also argues that no basis existed to find the Respondent willfully filed false reports, because, the Committee found that the Respondent lacked the intent to mislead.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence

from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination on the charges. We overturn the Committee's Determination on penalty. The ARB revokes the Respondent's License.

Neither party challenged the Committee's Determination to dismiss the fraud and moral unfitness charges and neither party challenged the Determination to dismiss all charges relating to the care for Patients B, D and E.

The Respondent challenged the Committee's findings as to Patients A, B, F and G on grounds that the Respondent offered proof that the Respondent's error rate was below the error rates for similarly situated physicians. The Committee rejected that proof on the grounds that error rates were irrelevant to whether a physician failed to meet the standard of care in treating a particular case [Committee Determination page 36]. The ARB agrees with the Committee that evidence on error rates has no bearing on whether a physician met the standard of care in a particular case or whether a physician failed to demonstrate a level of skill or knowledge necessary to practice medicine safely. The Committee also rejected the Respondent's arguments

that no basis existed for the findings on Patients F and G due to the use of a "root cause" analysis the Petitioner used [Committee Determination page 36]. The Committee found that the Petitioner never used a "root cause" analysis in presenting its case. The ARB again agrees with the Committee.

The evidence that the Committee found credible, including testimony by the Respondent's expert, demonstrated that the Respondent practiced with incompetence on more than one occasion, negligence on more than one occasion, gross incompetence and gross negligence. We defer to the Committee's findings of fact and we affirm the Committee's Determination on the negligence and incompetence charges.

The Respondent challenged the Determination on willfully filing false reports on the grounds that the Committee could not sustain those charges after finding that the Respondent lacked intent to mislead. The ARB finds no merit to that argument. The Committee found that the intent to mislead was not an essential element in proving willfully filing a false report. The ARB agrees. To find willful conduct requires only a finding that the conduct was knowing and deliberate, as opposed to a mistake. The Committee found that the information on the Applications was false, that the Respondent knew the information was false and that the Respondent gave the answers for privacy reasons, because the Respondent did not want the information available to anyone who might run across the Applications on someone's desk. The ARB holds that the evidence before the Committee demonstrated that the Respondent willfully made and filed false reports.

The ARB finds the penalty the Committee imposed inconsistent with the Committee's findings on the charges and inappropriate to protect the public. The Committee found serious and repeated deviations from accepted care standards and found that the Respondent missed making

findings in his practice as a radiologist that the Committee described as obvious and basic. The Committee, however, restricted the Respondent to the general practice of radiology. The Committee also placed the Respondent on probation, even though the Respondent practiced and completed probation on two other occasions prior to the misconduct at issue here. The ARB questions how probation will protect the public now, when the prior probationary sanctions have failed to deter the Respondent from further misconduct. The Respondent has practiced under a stayed revocation since 1995, but that status failed to impress upon the Respondent the need to practice according to accepted care standards in the cases at issue in this proceeding. The Respondent spent time away from practice previously, but the experience of being without his License failed to deter the Respondent from providing false information repeatedly on the Applications.

The ARB engaged in extensive discussion about possible penalties in this case, but we saw no means to deter the Respondent from future misconduct, other than revoking the Respondent's License. There are mitigating factors in this record, but there are numerous aggravating factors as well. The Respondent's case dealt extensively with the previous action against him and his lawsuit against the Health Department and the former Commissioner. The Committee concluded that the prior case held no bearing in considering the action to take against the Respondent for the misconduct here that placed patients at risk. The ARB agrees. The Respondent can address his grievances about the prior case in the lawsuit. At the point that the Respondent regained his License in 1995, the Respondent had overcome much and he stood at a crossroad at which he had the chance to leave his past mistakes behind him and rise to a higher level. Instead, the Respondent has engaged in continued misconduct that involved both serious

deficiencies in the care that he provided and repeated falsifications and the ARB believes that the Respondent remains at risk to repeat such misconduct in the future.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB overturns the Committee's Determination to limit the Respondent's License, suspend the Respondent's License, stay the suspension and place the Respondent on probation.
3. The ARB votes 5-0 to revoke the Respondent's License.

Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Linda Prescott Wilson
Therese G. Lynch, M.D.

In the Matter of L. Mario DiBlasio, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. DiBlasio.

Dated: 2 November, 2007

Linda Prescott Wilson

In the Matter of L. Mario DiBlasio, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. DiBlasio.

Dated: Nov. 5, 2007

Thea Graves Pellman

In the Matter of L. Mario DiBlasio, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. DiBlasio.

Dated: 10/2/, 2007

Datta G. Wagle, M.D.

In the Matter of L. Mario DiBlasio, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. DiBlasio.

Dated: November 2, 2007

Stanley L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of L. Mario DiBlasio, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. DiBlasio.

Dated: November 1, 2007

Therese G Lynch M.D

Therese G. Lynch, M.D.