

January 4, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee A. Davis, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Corey J. Meyers, M.D.
REDACTED ADDRESS

Peter G. Barber, Esq.
Murphy, Burns, Barber & Murphy, LLP
226 Great Oaks Boulevard
Albany, New York 12203

RE: In the Matter of Corey J. Meyers, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-02) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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
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,

REDACTED SIGNATURE

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

COPY

-----X
IN THE MATTER : DETERMINATION
OF :
COREY J. MEYERS, M.D. : ORDER
-----X
BPMC #12-02

A Notice of Hearing and Statement of Charges, both dated March 3, 2011, were served upon the Respondent, Corey J. Meyers, M.D. GERALD M. BRODY, M.D. (CHAIR), JOSE M. DAVID, M.D., AND DENNIS ZIMMERMAN, M.S., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10) (Executive) of the Public Health Law. LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Esq., Associate Counsel. The Respondent appeared by Murphy, Burns, Barber & Murphy, LLP, Peter G. Barber, Esq., of Counsel. 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

Date of Service:	March 11, 2011
Answer Filed:	March 8, 2011
Pre-Hearing Conference:	May 5, 2011
Hearing Dates:	May 20, 2011 July 20, 2011 August 1, 2011
Witnesses for Petitioner:	Sachin J. Shah, M.D. Joanne Wenke, R.N. Wayne Maben, M.D. Patient C's Mother
Witnesses for Respondent:	Corey J. Meyers, M.D.
Deliberations Held:	September 7, 2011

STATEMENT OF CASE

Petitioner has charged Respondent, an internal medicine practitioner, with fourteen specifications of professional misconduct. Eleven of the specifications relate to Respondent's medical care and treatment of four patients in the Emergency Department of Columbia Memorial Hospital, in Hudson, New York. The charges include allegations of gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, and failing to maintain accurate medical records. The remaining three specifications relate to statements made by Respondent on his application for

appointment to the medical staff of Catskill Regional Medical Center, in Harris, New York. Respondent denied the allegations.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers 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, if any, was considered and rejected in favor of the cited evidence.

1. Corey J. Meyers, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 242365 on or about November 13, 2006. (Ex. #3).

Patient A

2. Respondent treated Patient A, a 60 year-old female who presented to the Emergency Department at Columbia Memorial Hospital ("CMH") on May 4, 2007 at 19:43. Patient A's chief complaint was pain and painful back, 10/10, mid-back between the shoulders, radiating left around to under her left breast.

The pain was sudden onset and started at approximately 19:00. The pain was associated with dyspnea and diaphoresis and started when the patient was taking food out of her refrigerator. (T. 22-23; Exhibit #4, p. 4).

3. The nursing triage notes record that Patient A presented with an initial blood pressure of 229/125, with respirations of 22 breaths per minute, and had a pain score of 10/10. (T. 23, Exhibit #4, p. 30).

4. A physician is required to obtain a history from his patient. 80 to 85 percent of the time a diagnosis can be determined by obtaining a history and performing a physical examination. (T. 29).

5. The patient's history will inform the physician as to why the patient is in the emergency department and whether or not she is in pain. If there is pain, a good history will identify the type of pain, what is associated with the pain, the quality, duration and radiation of the pain, as well as whether the patient has ever experienced anything like this previously. (T. 29-30).

6. A proper history will include family history to see if there is a potential of an hereditary disease, identify medications taken by the patient, and learn about any prior

surgeries. The history will also help identify further medical tests for the patient. (T. 30).

7. Respondent recorded the following under his "History of Presenting Illness": "chest pain, maybe epigastric pain, stopped Zantac, no SOB. No V or D. No dysuria or changes in bowel. The patient noted while lying flat, not while physically active." (T. 31, Exhibit #4, p. 10).

8. Under "Constitutional", Respondent record for Cardiac, "No SOB" and under M/S (Musculoskeletal) "No... back pain." (T. 31; Exhibit #4, p.10).

9. Respondent failed to record the patient's complaint of back pain or shortness of breath, as indicated in the nurse's notes. Respondent failed to mention the patient's pain, or to describe it quality, severity, radiation or duration. He also failed to address any associated symptoms or record a past medical history. (T. 31-32, Exhibit #4, p. 10).

10. The emergency department physician must reconcile any differences found in the histories obtained by the nurses and the physician. Respondent failed to do this. (T. 33-34, 128-131).

11. Respondent's history for Patient A deviated from the accepted standard of care. (T. 51).

12. An aortic dissection is the tearing away of the innermost layer of the aorta from the walls of the vessel.

(T. 24).

13. A common classification of aortic dissection is the Stamford classification, which differentiates between type A and type B dissections. Type A is ascending, with or without descending involvement, and Type B is descending only.

(T. 24-25).

14. There is grave risk of harm associated with aortic dissection. The condition can cause a progressive loss of blood flow to the organs that are supplied by the aorta. These include the kidneys, the gut, the spinal cord and the legs. It is a very serious condition. (T. 25).

15. Death can occur very quickly (within seconds to hours) and in several different ways. The blood supply from the heart can be cut off with an ascending dissection, or it can cause tamponade if the pericardium is involved. If the dissection is severe, the patient can experience hemorrhagic shock. (T. 25).

16. The treatment for either type of aortic dissection requires admission of the patient to the hospital.

(T. 26).

17. Many of Patient A's differential diagnoses were potentially lethal and therefore required immediate treatment to aggressively lower her blood pressure. (T. 26-27, 48-49).

18. Patient A had a history of chronic hypertension with poor control. (T. 155; Exhibit #4, p.3).

19. Elevated blood pressure can make an aortic dissection worse by propagating the tear. The increased blood pressure forces blood flow into the area of tearing and widens it. Therefore, aggressive treatment of Patient A's blood pressure was indicated. (T. 27, 47-49)>

20. Patient A's blood pressure was significantly elevated from the time of her presentation to the emergency department at 19:45 until 21:35. Her blood pressure became significantly elevated again at 02:45 and remained elevated until 9:27. Respondent's initial treatment of her blood pressure was not effective or sufficiently aggressive. (T. 47, 135, 137-138, 154; Exhibit #4, p. 3).

21. Patient A's blood pressure decreased from 215/143 at initial presentation, to 157/104 at 20:45. Although an improvement, this does not represent adequate blood pressure control, given Patient A's circumstances. (T. 139; Exhibit #4, p. 3).

22. Respondent ordered three administrations of nitroglycerin for Patient A, each of which was provided. (Exhibit #4, pp. 8, 11).

23. Nitroglycerin is not a good medication for treating blood pressure. Studies have demonstrated there is no improvement in morbidity or mortality when blood pressure is treated with nitroglycerin, and the effects are inconsistent. A rebound or reflex tachycardia is sometimes exhibited following the administration of nitroglycerin, which could be dangerous for the patient. (T. 47-48).

24. Respondent also twice ordered one liter administrations of normal saline, wide open. Both were administered to the patient. (Exhibit #4, pp. 8, 11).

25. Providing a bolus of normal saline was contraindicated for Patient A, as she was neither experiencing tachycardia nor was she hypotensive. Two boluses of normal saline could have raised her blood pressure due to increased intravascular volume, increasing the risk to the patient. (T. 49-50).

26. Patient A's blood pressure did increase following the two administrations of normal saline at 23:50 and 02:00, respectively. (Exhibit #4, pp. 3-8).

27. Respondent's failure to aggressively treat Patient A's hypertension posed a risk of propagating the dissection, and represented a deviation from the accepted standard of care. (T. 50-52).

28. A CT scan early in the patient's treatment at the emergency department was warranted, as most of the serious differential diagnoses for Patient A can be ruled in or out with a scan. (T. 27-28).

29. On May 5, 2007 at 00:14, Respondent noted that the "medistium [sic] slightly widened [sic]?" (Exhibit #4, p. 14).

30. The mediastinum is a projection on x-ray or CT scan of the central structures in the chest, primarily the aorta and pulmonary vessels, and the hilum of the lungs. A widened mediastinum raises the suspicion of a developing aortic dissection. (T. 38-39).

31. Given the finding of a widened mediastinum, together with Patient A's presentation and continuing high blood pressure at this time, Respondent should have ordered a CT scan. (T. 39-40).

32. Respondent failed to order any CT scans until 05:30, more than nine hours after Patient A had presented to the emergency department. (T. 41-42; Exhibit #4, p. 12).

33. The delay in ordering a CT scan for Patient A placed her at increased risk, because the delay allowed more time for a potential dissection to propagate. (T. 43, 46).

34. Respondent deviated from the accepted standard of care by delaying the ordering of CT scans for nine hours. (T. 53).

35. Although not documented in the chart, Respondent testified that he was aware of the patient's chief complaint, her initial blood pressure readings and her extreme pain. (T. 379-380).

36. Respondent's initial note stated that Patient A's pain may be "epigastric pain". (Exhibit #4, p. 10).

37. Respondent's initial orders for Patient A included a "GI cocktail" which consists of Maalox, Donnato1, and viscous Lidocaine. The "cocktail" is intended to treat GI pathology, primarily esophagitis or gastritis. Respondent also ordered Protonix. (T. 34-35; Exhibit #4, p. 11).

38. A GI cocktail provides quick relief to a patient who has esophagitis or gastritis because it coats the tissues of the esophagus and stomach. (T. 35).

39. The GI cocktail was administered to Patient A at 20:05, 22 minutes after arrival at the emergency department. (T. 35-36; Exhibit #4, p. 7).

40. One and a half hours after receiving the GI cocktail, Patient A was still reporting pain of 10/10. (T. 36; Exhibit #4, p. 3).

41. The nurse who administered the cocktail also noted that it had "no effect and pain remains 10/10". (T. 35-36; Exhibit #4, p. 5).

42. In the same progress note in which Respondent noted a widened mediastinum, he recorded an impression of likely "gastr/esoh itus". (Exhibit #4, p. 14).

43. At the time Respondent wrote this note (00:14), there was nothing in the patient's record that would indicate that she was suffering gastroesophagitis or gastritis. Patient A had not complained of abdominal pain. The nursing note indicated that her abdomen was soft and non-tender. The GI cocktail provided no relief, and the abdominal blood work came back as reasonably normal. (T. 40-41, 157-158).

44. In a progress note times at 02:11, Respondent wrote, "patient is feeling much better...more IVF then ambulate and likely D/C". (exhibit #4, p. 14).

45. Discharge plans were noted in the chart, but the patient expressed dissatisfaction with those plans, causing Respondent to consider further CT studies of her thorax,

abdomen and pelvis to "look for vasc catastrophe." (Exhibit #4, pp. 14-15).

46. Despite Respondent's order of CT scans, he still recorded an impression as "unclear but it is most likely gastro/esoph and possible partial SBO." (Exhibit #4, pp. 14-15).

47. The first mention of the diagnosis of an aortic dissection was not made until 09:44 on May 5, 2007 (14 hours after Patient A arrived at the emergency department) by the physician who received the patient from Respondent at 8:30 a.m. (T. 45; Exhibit #4, p. 14).

48. At that time, the CT scans revealed a type B thoraco-abdominal aneurysm dissecting to the level of the iliac arteries. (T. 45; Exhibit #4, p. 14).

49. An aortic dissection to this level disrupts the blood supply to the spinal cord, gut, kidneys and legs, presenting an extreme risk of harm. (T. 45-46).

50. The diagnosis of aortic dissection was not made in a timely manner, as it took almost 14 hours after the patient had presented to the emergency department. (T. 46).

51. Respondent deviated from the accepted standard of care by failing to timely diagnose Patient A's aortic dissection. (T. 54).

52. Respondent's history for Patient A was inadequate, and he failed to reconcile the conflicts between the history he recorded and that recorded by the nurse. (T. 56).

53. Respondent failed to record his reading of the x-ray until three hours forty-five minutes after the x-ray was available. (T. 60).

54. Respondent failed to address the significantly elevated blood pressures recorded for Patient A. (T. 60-61).

55. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A. (T. 54).

Patient B

56. Patient B was a 58 year-old developmentally disabled woman who presented to the Columbia Memorial Hospital emergency department on January 14, 2007 with a chief complaint of vomiting. The patient was reported to have started vomiting approximately one week previously. For the two nights prior to arriving at the hospital, she was reported to start vomiting while eating dinner. (T. 69; Exhibit #5, p. 3).

57. Respondent ordered blood work, including a complete blood count (CBC), comprehensive metabolic panel,

lipase, serum amylase, and a urinalysis. (T. 70; Exhibit #5, p. 7).

58. Patient B's liver enzymes were abnormally high. Her AST was 170, the ALT was 220, and the alkaline phosphatase was elevated to 881. She also had an elevated white blood cell count of 12.9, and a total bilirubin of 5.0, the upper limit of normal for this hospital laboratory. (T. 71; Exhibit #5, pp. 17-18).

59. The elevated bilirubin indicates that the patient's liver was not properly processing the bilirubin or the body is not excreting it. (T. 71).

60. The highly elevated alkaline phosphatase, when viewed in conjunction with the increased bilirubin, is a strong indication of obstructive jaundice. (T. 72; Exhibit #5, p. 17).

61. Obstructive jaundice occurs when there is a gallstone or other object blocking the common bile duct. (T. 72).

62. The elevated liver enzymes, combined with the elevated white blood cell count, are indicative of possible inflammation and infection in the biliary tree or gall bladder. (T. 73).

63. At 23:40, Respondent ordered an ultrasound of the abdomen with the presumptive diagnosis of cholelithiasis. (T. 73; Exhibit #5, p.7).

64. The ultrasound revealed a thickened gall bladder wall up to 6 millimeters demonstrating cholecystitis, as well as a dilated common bile duct. (T. 77; Exhibit #5, p. 7).

65. The ultrasound confirmed the presence of an obstruction in the bile duct. (T. 77-78).

66. Obstructive jaundice presents a risk of harm because it can rapidly progress to an infection of the common bile duct. Such an infection can progress into the gallbladder, biliary tree, and liver, ending in sepsis. (T. 74).

67. Sepsis represents a constellation of phenomena that occur in the presence of a significant infection. Left untreated, sepsis will most likely result in death within a matter of hours. (T. 74-75).

68. At 00:59, the preliminary read of the ultrasound was entered into Patient B's medical record. (Exhibit #5, p. 7).

69. Nine minutes later, at 01:08, Respondent acknowledged the ultrasound in his progress note. (Exhibit #5, p. 8).

70. Given the ultrasound and laboratory findings, the minimum standard of care required that Respondent admit Patient B for an ERCP to confirm the presence of an obstruction, the cause of the obstruction, as well as resolve the obstruction. (T. 79, 163).

71. Given the elevated white blood cell count, Respondent should have administered antibiotics to prevent the potential spread of infection. He failed to do so. (T. 79-80).

72. In the same progress note where Respondent acknowledged the ultrasound report, he wrote "case reviewed with Dr. Maben. Pt to f/u with Dr. Mabens [sic] office tomorrow". (Exhibit #5, p. 8).

73. Wayne Maben, M.D. is a physician licensed in the State of New York who has been practicing general surgery since 1986. (T. 228).

74. At 01:10, Respondent discharged Patient B to her adult home residence with the instruction to follow-up with her regular physician. (Exhibit #5, p. 8).

75. The patient was released from the hospital on January 15, 2007 at 02:24. (Exhibit #5, p. 9).

76. Ten hours and 24 minutes later, at 12:48 on January 15, 2007, Patient B returned to the Columbia Memorial

Hospital emergency department. The chief complaint was recorded as follows: "Dr. Maben called this a.m. [Patient B] was seen here yesterday for an acute gallbladder. She was discharged with instructions to see him today. He has no office hours today but COARC workers thought she looked worse today and brought her in. She is nonverbal, no facial grimaces to indicate pain. However, her skin has a yellow tinge to it. Dr. Maben suggested a [sic] ERCP with Dr. Packard and admission by the hospitalist if deemed necessary." (Exhibit #5, p. 34).

77. Dr. Maben is currently an attending general surgeon at Columbia Memorial Hospital, and has been an attending for the past 25 years. (T. 228).

78. Dr. Maben performs approximately 500 surgeries a year, 50 to 60 of which are cholecystectomies. (T. 229).

79. The general surgeons at Columbia Memorial Hospital are on a rotating call schedule. When not at the hospital, particularly at night, the on-call surgeon is available by telephone. (T. 230).

80. If cases are transferred to a surgeon at Columbia Memorial Hospital, that process can take place by telephone with verbal orders by the surgeon. It is not necessary for

the surgeon to come into the facility to admit a patient. (T. 230).

81. Dr. Maben testified that in early 2007, he did not have the ability to access medical records from his home computer. (T. 231).

82. Dr. Maben also testified that radiology services such as CT scans were available during the overnight hours during 2007. (T. 231).

83. Dr. Maben testified that he did not recall discussing Patient B with Respondent during the night of January 15, 2007, although after reviewing the records, he confirmed that he did treat Patient B in early 2007. (T. 231, 233).

84. Dr. Maben further testified that if he had been consulted in the middle of the night with the presentation, lab values and ultrasound findings as set forth in Patient B's medical record, he would have recommended admission with I.V. fluids, antibiotics and an ERCP. (T. 237-238).

85. Upon Patient B's return to the hospital on January 15, 2007, Dr. Maben provided a surgical consult. He then recommended a GI consult for the ERCP and a "Lap Chole" (laparoscopic cholecystectomy). (Exhibit #5, p. 78).

86. Following the ERCP, Dr. Maben performed the cholecystectomy and removed a chronically inflamed gallbladder. (T. 235).

87. Even if an ERCP was not available during the overnight hours when Patient B was treated by Respondent, she should still have been admitted. (T. 85-86).

88. Respondent admitted that he had the ability to admit Patient B to the hospital under the service of the hospitalist if Dr. Maben had, in fact, refused to have the patient admitted. (T. 392).

Patient C

89. Patient C was an eleven year old female who presented to the Columbia Memorial Hospital emergency department on December 31, 2006, with a chief complaint of congestion, cough and a temperature of 100.9. (Exhibit #6, p. 4).

90. Patient C was reported to be allergic to Sulfa and Augmentin. A list of current medications included Amoxicillin. (Exhibit #6, p. 4).

91. In addition to her fever, Patient C was slightly tachycardic, at 113 beats per minute. (T. 89).

92. Patient C's symptoms began approximately two weeks prior to her visit to the emergency department. Her mother took the child to see her pediatrician. (T. 241-242).

93. The pediatrician suspected that the patient's symptoms were related to a viral infection. Patient C's parents were given a prescription for Amoxicillin to be used if the symptoms worsened. At some point, the prescription was filled and started for Patient C. (T. 242-243).

94. After a few days on the Amoxicillin, the patient was coughing more and became listless. Her mother then brought her to the emergency room on December 31, 2006. (T. 243).

95. Respondent's documented history of present illness contained no reference to fever or cough, in contrast to the findings in the triage notes. (Exhibit #6, pp. 4-5).

96. Respondent ordered chest x-rays of the patient, both PA and lateral. (T. 90; Exhibit #6, p. 6).

97. Respondent interpreted the x-rays as "no acute pathology" and "likely neg" [negative]. (T. 90-91; Exhibit #6, p. 6).

98. The lateral view of Patient C's lungs demonstrated a significant haziness in the posterior aspect of the projection. This represents a consolidation or collection

of white blood cells in fluid, and is indicative of pneumonia. (T. 94-95).

99. Patient C's clinical presentation was consistent with pneumonia. (T. 173, 175).

100. An emergency room physician should be able to read and interpret plain films. Respondent's failure to accurately interpret Patient C's x-ray films was a deviation from the accepted standard of care. (T. 95-96).

101. Respondent discharged Patient C with a diagnosis of upper respiratory infection, and continued her on the Amoxicillin prescribed by her pediatrician. (Exhibit #6, p. 6).

102. Pneumonia is a lower respiratory tract infection, while an upper respiratory infection involves the sinus passages, nose and throat. (T. 96).

103. Respondent's failure to accurately diagnose Patient C as having pneumonia was a deviation from the accepted standard of care. (T. 95-96).

104. Respondent's failure to accurately diagnose pneumonia placed Patient C at increased risk of respiratory compromise, sepsis and ultimately death. (T. 96-97).

105. Given that Patient C had been on Amoxicillin for two to three days prior to December 31, and was still febrile, Respondent should have changed her antibiotic. (T. 97-98).

106. Three days after her emergency room visit, Patient C was seen by her primary care physician. Her pediatrician diagnosed her pneumonia based upon the same x-ray films reviewed by Respondent. (T. 98, 244-245).

107. The pediatrician changed Patient C's antibiotic to Azithromycin, a different class of antibiotic. (T. 98-99, 184-185).

108. The record does not accurately reflect Respondent's evaluation and treatment of Patient C. His history notes no fever, even though the patient presented to the emergency department with a temperature of 100.9. In addition, Respondent's respiratory findings included an absence of cough, when the patient's chief complaint was cough. (T. 103-104, 174-175; Exhibit #6, pp. 4-5).

Patient D

109. Patient D was a 70 year old female who presented to the Columbia Memorial Hospital emergency department on March 17, 2007 at 20:06 with a chief complaint of "vomiting and abdominal pain." (T. 104; Exhibit #9, p. 14).

110. Respondent noted that Patient D's abdomen revealed "normal bowel sounds, mildly distended; diffusely tender; no palpable organomegaly." (Exhibit #9, p. 18).

111. Under "History of Present Illness", Respondent noted "one day of vomiting and diarrhea. + ABD pain, no CP [chest pain] or SOB [shortness of breath]. (Exhibit #9, p. 18).

112. Respondent's recorded history for Patient D failed to adequately explore the nature of her abdominal pain. There is no description of the severity or quality of the pain, its radiation, associated symptoms, or the time course of the pain. (T. 106-107).

113. In fact, Patient D did present with significant medical history, which she was able to provide to the consulting physician, Clarence Henry, M.D. (Exhibit #9, pp. 33-34).

114. Dr. Henry noted that "the patient gives a history of hypertension, non-insulin dependent diabetes mellitus, total abdominal hysterectomy and bilateral salpingo-oophorectomy. She then had pelvic cancer surgery. She however, does [not] know the type of cancer she had. The patient does not know any of her medications. She gives a one-day complaint of sudden abdominal pain followed by nausea,

vomiting, diaphoresis and a gait disorder whereby she had difficulty walking. She was found to have diarrhea when she presented to the Emergency Department. She denied any other gastrointestinal symptoms." (Exhibit #9, p. 33).

115. Dr. Henry also solicited the following social history from Patient D. "She admits to smoking a pack a day for at least 45 years and stopped a few years ago. She admits to drinking two pints per day of scotch and stopped some time in the 1980's. She is nonspecific about how many years she did it. She formerly worked in a hat factory. (Exhibit #9, p. 33).

116. Patient D's history of diabetes, cancer, and at least one abdominal surgery are all significant. Past abdominal surgeries can result in adhesions or obstructions which must be considered by the emergency room physician. (T. 109).

117. Patient D's history of abdominal pain followed by nausea and vomiting is more consistent with differential diagnoses such as cholecystitis, diverticulitis, appendicitis, and bowel ischemia. This history does not suggest a differential diagnosis of stomach flu or viral gastroenteritis. (T. 108-109).

125. The lab work also revealed a value of 15% lymphocytes. This is abnormally low and makes a viral process less likely. (T. 113; Exhibit #9, pp. 99).

126. Given the patient's age, prior surgical history and laboratory values, the failure to order a CT scan was a deviation from the accepted standard of care. (T. 113-114).

127. If a CT scan was not available in the overnight hours, then Respondent should have admitted Patient D for further work-up and observation. Respondent did not admit the patient until 06:59. (T. 115, 118; Exhibit #9, p. 21).

128. This was not a timely admission, as Respondent had the necessary information hours earlier. (T. 118).

129. Patient D ultimately did undergo CT examination. The scans revealed free fluid in her pelvis and some dilated proximal colon with gradual change in caliber size in the rectal sigmoid region. The descending and sigmoid colon appeared surrounded by inflammatory changes and a thickened wall. No free air or abscess was found. She was diagnosed with suspected ischemic colitis. (T. 117-118; Exhibit #9, pp. 35-37).

130. Patient D ultimately had an episode of aspiration which led to respiratory arrest, and she expired on March 18, 2007. (Exhibit #9, pp. 35-37).

Application to Catskill Regional Medical Center

131. On August 5, 2009, Respondent submitted a Medical Staff Application to the Catskill Regional Medical Center ("Catskill"). (T. 272; Exhibit #10, p. 13).

132. In Section G "ADDITIONAL INFORMATION" of the application, Respondent was directed to provide "A MINIMUM OF 10 (TEN) YEARS OF BACKGROUND INFORMATION". (Exhibit #10, p. 7).

133. Respondent failed to list his affiliation with Columbia Memorial Hospital from December 2006 through May 2007. (Exhibit #10, pp. 7-9).

134. When signing the Catskill application, Respondent signed under the following language, "I hereby confirm that all the statements made and information submitted in connection with this application are complete, true and accurate. I understand that I have a continuing obligation to update and/or correct such information during the pendency of my application". (Exhibit #10, p. 13).

CONCLUSIONS OF LAW

Respondent is charged with fourteen specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the

purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). Gross negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Gross Incompetence is a lack of the skill or knowledge necessary to practice medicine safely which is significantly or seriously substandard and creates the risk of potentially grave

consequences to the patient. Post, supra, at 986; Minielly, supra, at 751.

Fraudulent Practice.

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (3rd Dept. 1991), citing Brestin v. Commissioner of Education, 116 A.D.2d 357, 501 N.Y.S.2d 923 (3rd 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 (3rd 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.

The other charged specifications of misconduct allege the failure to maintain records which accurately reflect the

care and treatment of the patient, in violation of N.Y. Education Law §6530(32), filing a false report, in violation of N.Y. Education Law §6530(21), and a violation of N.Y. Education Law §6530(14) by failing to disclose information required by Public Health Law §2805-k(1)(a). The Hearing Committee interpreted these statutes in light of the usual and commonly understood meaning of the underlying language. (See, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented testimony from four witnesses. Three fact witnesses testified: Patient C's mother, Wayne Maben, M.D., and Joanne Wenke, R.N. Patient C's mother testified regarding the facts and circumstances surrounding her daughter's visit to the emergency department, and Respondent's involvement in her care. Dr. Maben testified regarding certain specifics of practice at Columbia Memorial Hospital, including the availability of overnight radiology services, and remote

computer access to laboratory data. He also testified as to his lack of a specific recollection of any conversation with Respondent regarding Patient B. Ms. Wenke described the OPMC investigatory process and her involvement in Respondent's investigation.

All three of these witnesses testified in a forthright and credible manner. The Committee determined that they were credible witnesses.

The Department also presented expert testimony by Sachin Shah, M.D. Dr. Shah is board-certified in emergency medicine and is the Director of Emergency Services at Nyack Hospital, in Nyack, New York. Dr. Shah was knowledgeable in regard to all of the subject matters discussed, and gave clear and balanced testimony. The Committee found Dr. Shah to be a credible witness.

Respondent failed to present an expert witness, but did testify on his own behalf. Respondent clearly has a vested interest in the outcome of this proceeding, and his testimony was evaluated accordingly.

Respondent's testimony, particularly on cross-examination or in response to Hearing Committee questions was often evasive and non-responsive, and often at odds with the medical records. For example, Respondent initially testified

that a CT scan was not available during the overnight hours (T. 310-311), but then contradicted himself by stating that if a patient was critically ill, he could make arrangements to have a scan performed. (T. 311). On cross-examination, Respondent admitted that Patient D was "critically ill" (T. 316) yet he never ordered a CT scan, and his records indicated that he was considering a diagnosis of gastroenteritis.

Respondent's attempt to explain this apparent contradiction was evasive and disjointed: "In everything I do in life, I could have done better. And when you ask me that question, I say, "wow," you know. I know I was talking about getting a CT scan. I know I asked the staff for it. I know that CT scan wasn't available. I know, yes, maybe I could have sent the patient out." (T. 334).

Respondent made much of the electronic record-keeping system at the hospital, implying that shortcomings in the system were to blame for his poor care or poor record-keeping. However, the only times Respondent blamed the system was when it failed to record his own failures: failing to record an accurate history; failing to order CT scans; failing to read lab reports in a timely manner, or failing to follow-up on significant lab data.

The essence of Respondent's lack of fundamental honesty and integrity was demonstrated by his answer to an inquiry as to whether he understands the importance of being open and honest about his past employment history and investigations. Respondent stated that "I understand that there are two issues. One is being open and honest, and one is being able to support my wife and son. And when [in my opinion] false, malignant allegations have been made against me and it has made me unemployable, I have to weigh those issues." (T. 284).

Clearly, Respondent will say anything if he believes it necessary to preserve his ability to practice medicine. The Committee unanimously concluded that Respondent was a fundamentally untrustworthy witness, and gave no credence to his testimony.

Patient A

Patient A presented with classic symptoms of an aortic dissection. Nevertheless, Respondent failed to order a CT scan until nearly 10 hours after Patient A presented to the emergency department. Respondent claimed that he was aware of the possibility of this potentially catastrophic illness during his testimony. However, the medical records clearly demonstrate that he missed this diagnosis completely. It was only after the

patient refused discharge in the early hours of the morning on May 5, 2007 that Respondent finally ordered the CT scan to rule out a dissection.

The record demonstrates that from the initial presentation Respondent was considering a gastrointestinal problem as the likely diagnosis. His physical examination noted no findings other than epigastric tenderness. Even when he finally ordered the CT scan, Respondent noted that he would order the scan to look for a "vasc catastrophe", but his impression was still "Unclear, but it is most likely that gastro/esoph".... (Exhibit #4, p. 11).

Respondent's initial order of a GI cocktail was consistent with his working diagnosis of a gastrointestinal problem. However, this failed to effectively reduce the patient's pain or blood pressure. Nevertheless, he persisted with the GI theory, ignoring the evidence of a widened mediastinum on x-ray. Although Respondent attempted to claim that he was considering an aortic process all along, his recorded impressions all pointed to discharge. (Exhibit #4, p. 14).

Respondent gave conflicting explanations for the delay in ordering a CT scan. First, he claimed that he ordered the test "shortly after presentation", but it was not called in

until many hours later. (T. 342). Next he claimed that he didn't order the CT because the patient wasn't clinically stable. (T. 343). Moments later he testified that he was considering discharging the patient because she was "sleeping comfortably". (T. 383-384).

Logic dictates that Respondent's delay in ordering the CT scan was due to the fact that he failed to appreciate the gravity of Patient A's condition. Although his initial treatment of her blood pressure was reasonable, he failed to attack it aggressively, allowing the dissection to continue to extend. The patient's aortic dissection was not discovered until after Respondent turned the care of Patient A over to the physician on the day shift.

The Hearing Committee unanimously concluded that Respondent's deviations from the standard of care with regard to Patient A were especially egregious, demonstrating both gross negligence and gross incompetence, as defined above. Accordingly, the Committee voted to sustain the Third and Seventh Specifications of professional misconduct, as set forth in the Statement of Charges. The Committee also concluded that Respondent failed to maintain a record for Patient A that accurately reflected the evaluation and treatment of the patient (Eleventh Specification).

Patient B

Patient B's clinical presentation, including her complaints, symptoms, lab values and ultrasound imaging, demonstrated a clear picture of a patient with obstructive jaundice. Respondent should have had Patient B admitted with IV fluids and antibiotics, in order to stabilize the patient until an ERCP could be performed. Instead, Respondent sent the patient home.

There was a dispute over the nature of any communication between Respondent and the surgeon, Dr. Maben, regarding the patient's condition. Dr. Maben did not deny the possibility of a consult, although he had no direct recollection of such a conversation. He did state that had he been presented with a complete picture of the patient's test results, he would have admitted the patient.

Respondent, of course, claimed that he gave a detailed history to Dr. Maben, who then instructed him to send the patient home. Respondent claimed that he wanted to admit the patient (T. 398) but Dr. Maben said no. However, when asked whether he could have admitted the patient to the hospitalist's service, he stated "To admit this patient who was comfortable, in no distress whatsoever, to a hospital service would be an improper use of the hospital service". (T. 398-

399). The Committee finds it far more likely that Respondent failed to adequately synthesize the information available to him in order to correctly diagnose Patient B.

This would help explain what may have actually been told to Dr. Maben by Respondent. Even though Dr. Maben testified that it is his custom and practice to admit a patient who exhibited the symptoms and diagnostic test results seen for Patient B, we find it more likely than not that Respondent did not convey all of this information to him. More likely, Respondent told Dr. Maben that the patient was looking good and comfortably walking around. This is far more likely an explanation than Respondent's convoluted and contradictory version of events.

The Hearing Committee unanimously concluded that Respondent's care and treatment of Patient B demonstrated both negligence (First Specification) and incompetence (Second Specification), as defined above. However, we further concluded that his actions did not rise to the level of gross negligence or incompetence. Accordingly, the Committee voted to dismiss the Fourth and Eighth Specifications. The Committee further concluded that Respondent's medical record for Patient B met minimal standards, and dismissed that portion of the Eleventh Specification that referenced Patient B.

Patient C

Patient C was an 11 year-old girl who was brought to the Columbia Memorial Hospital emergency department by her mother on New Year's Eve 2006. She presented with a fever of 100.9°, congestion and a worsening cough, despite being on amoxicillin for three days. Respondent failed to identify or acknowledge the cough and congestion. He appropriately ordered a PA and lateral chest x-ray, but then misread the films which clearly showed that the patient had pneumonia. An emergency room physician must be able to correctly read plain films. Respondent's failure to identify Patient C's pneumonia was a clear deviation from the minimally accepted standards of care. He further deviated from accepted standards by not changing Patient C's antibiotic, since the amoxicillin had not been effective.

As with his other testimony in this hearing, Respondent's version of events is at odds with the medical record, as well as in conflict with the testimony given by Patient C's mother. Respondent testified that Patient C was "young, pretty. Healthy, spoke in full sentences, had no difficulty speaking, no obvious coughing, no obvious stress of any kind. Very talkative." (T. 410). However, Patient C's mother noted that she brought her daughter to the emergency

department on New Year's Eve because of her worsening cough, congestion, and listlessness. (T. 243).

Dr. Shah, the hospital radiologist, and Patient C's primary care physician were all able to identify the pneumonia present in the x-ray films. However, Respondent listed his interpretation as "No acute Pathology" and "likely neg." (Exhibit #6, p. 6). Significantly, Respondent chose not to project the actual x-ray films during his testimony to identify the markings of poor inspiration which he claimed prevented him from accurately reading the images. (T. 411-412).

We therefore concluded that Respondent failed to appropriately diagnose Patient C's pneumonia, and discharged her with an incorrect diagnosis and on an ineffective antibiotic. We further concluded that Respondent's treatment of Patient C demonstrated both negligence and incompetence, but did not rise to the level of gross negligence or gross incompetence. Therefore, the Committee voted to dismiss the Fifth and Ninth Specifications. In addition, the Committee found that Respondent's medical record met accepted standards, and did not sustain the Eleventh Specification as applied to Patient C.

Patient D

Patient D was a 70 year old woman who presented with complaints of vomiting and abdominal pain. Respondent noted the

patient to have abdominal pain and a mildly distended, diffusely tender abdomen, yet he failed to timely order a CT scan.

Despite the fact that he considered the patient to be "critically ill", Respondent failed to adequately address Patient D's pain, failing to determine the quality of the pain, whether it was radiating, the associated symptoms, severity or duration.

Without any supporting evidence in the record, Respondent claimed that he was unable to obtain any history from Patient D, as she "could not really provide much data". (T. 300-301). However, Dr. Henry, a consulting physician who evaluated Patient D after her admission, had no difficulty in obtaining a very detailed medical history from the patient. Her medical history included diabetes, pelvic cancer surgery, and a total abdominal hysterectomy, among other events. (Exhibit #9, p. 33).

All of this significant information was missed by Respondent. Previous abdominal surgeries raise the risk of adhesions or obstructions. A timely CT scan would have been very helpful in diagnosing this patient.

As was seen with the other patients, Respondent gave confusing, and contradictory explanations for the management of Patient D's care. He testified that the patient was critically

ill, and admitted that if felt it warranted, could obtain a CT scan during the overnight hours. However, the record reflects that despite laboratory data suggestive of a bacterial infection, Respondent was planning to discharge the patient with a diagnosis of viral gastroenteritis. He claimed that this was because the patient was a "little old lady" who wanted to go home. (T. 330-331). Naturally, there is no evidence in the record to support this claim.

The Hearing Committee concluded that the most likely explanation for Patient D's course of treatment in the emergency department was that Respondent failed to obtain relevant history from the patient, thereby leading to his failure to order the CT scan. His errors were then compounded by his failure to appreciate the significance of the laboratory data, leading to his plan of discharge with an incorrect diagnosis of viral gastroenteritis.

The Hearing Committee further concluded that Respondent's departure from the standard of care represented a particularly egregious deviation. His actions rose to the level of both gross negligence and gross incompetence, as defined previously. As a result, the Committee voted to sustain the Sixth and Tenth Specifications of professional misconduct set forth in the Statement of Charges. The Committee further

concluded that Respondent's medical record for Patient D failed to meet acceptable minimum standards and voted to sustain that portion of the Eleventh Specification that pertained to Patient D.

Application to Catskill Regional Medical Center

The plain language of the application submitted by Respondent to Catskill Regional Medical Center reveals that he failed to list his work experience at Columbia Memorial Hospital. (Exhibit #10, pp. 7-9). Although Respondent claimed that he did fully disclose his tenure during an interview at Catskill, he produced no witness or other credible evidence to corroborate his testimony.

Given Respondent's belief that there are two issues when it comes to being open and honest, "one is being open and honest, and one is being able to support my wife and son", the Committee concluded that it was far more likely that Respondent deliberately withheld information about Columbia Memorial Hospital in order to obtain employment at Catskill. We therefore find that Respondent intentionally sought to mislead Catskill Regional Medical Center in order to obtain a benefit to himself (employment). Accordingly, the Committee concluded that this conduct demonstrated a clear intent to commit fraud in the practice of medicine, and we sustain the Twelfth Specification.

The Committee further concluded that Respondent's submission of the three applications constituted the filing of false reports, as set forth in New York Education Law §6530(21), and voted to sustain the Thirteenth Specification of professional misconduct.

Public Health Law §2805(k) sets forth the requirements for investigations prior to the granting or renewing of clinical privileges by hospitals. The statute provides, in pertinent part "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... (b) where such association, employment, privilege or practice was discontinued, the reasons for its discontinuation". [Emphasis supplied].

The evidence has established that Respondent failed to disclose the fact that he had been employed at Columbia Memorial Hospital and the reasons for his departure. Therefore, he violated the provisions of Public Health Law §2805-k(b). As a result, the Committee voted to sustain the Fourteenth Specification of professional misconduct.

Negligence/Incompetence on More Than One Occasion

Having found Respondent guilty of both negligence and incompetence with regard to each of the four patients, it we therefore conclude that both the First Specification (negligence on more than one occasion) and Second Specification (incompetence on more than one occasion) are sustained, as well as the specifications of gross negligence and gross incompetence outlined above.

Failure to Maintain Accurate Records

The Hearing Committee concluded that the medical records for Patient A and Patient D failed to accurately reflect the care and treatment rendered by Respondent. Therefore, the Hearing Committee voted to sustain the Eleventh Specification with respect to those two patients.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including

revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The evidence established that Respondent mismanaged the medical care of all four patients at issue in this case. He demonstrated a significant lack of medical knowledge, as well as a failure to recognize when a patient's condition is serious and in need of aggressive treatment. He repeatedly offered explanations for his treatment that were in conflict with, or not supported by the records he created.

The public relies upon knowledgeable and experienced physicians to obtain safe, appropriate health care. Unfortunately, Respondent has demonstrated that he is not capable of providing such care.

Under the circumstances, we unanimously concluded that Respondent is not a viable candidate for re-training. Similarly, no amount of supervision would correct the deficiencies in Respondent's clinical abilities. Therefore, revocation of his medical license is the only sanction which will adequately protect the public.

Respondent's willingness to commit fraud in order to obtain employment at Catskill Regional Medical Center also demonstrated a fundamental lack of integrity. No amount of retraining or supervision can correct a basic lack of honesty.

This led the Hearing Committee to the conclusion that Respondent's fraud provides a separate and independent basis for the revocation of Respondent's license to practice medicine in New York State.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First through Third, Sixth, Seventh, Tenth through Fourteenth Specifications of professional misconduct, as set forth in the Statement of Charges, (Exhibit #1) are SUSTAINED;

2. The Fourth, Fifth, Eighth, and Ninth Specifications of professional misconduct, as set forth in the Statement of Charges are DISMISSED;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is REVOKED;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Tuckahoe, New York
January 4, 2012

REDACTED SIGNATURE

~~GERALD M. BRODY, M.D. (CHAIR)~~

JOSE M. DAVID, M.D.
DENNIS ZIMMERMAN, M.S.

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APPENDIX I

IN THE MATTER
OF
COREY J. MEYERS, M.D.

STATEMENT
OF
CHARGES

COREY J. MEYERS, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 13, 2006, by the issuance of license number 242365 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care to Patient (Patients are identified by name in Appendix A), a 60 year old woman who presented to the Emergency Department of Columbia Memorial Hospital, in Hudson, New York on May 4, 2007 for complaints of sudden onset of severe mid-back pain between her shoulders radiating left around to under her left breast, shortness of breath and diaphoresis with elevated blood pressure values. Respondent's care of Patient A deviated from accepted standards of medical care as follows:
1. Respondent failed to obtain an adequate history of Patient A.
 2. Respondent failed to adequately treat and/or appropriately address Patient A's elevated blood pressure, placing the patient at risk of harm of increased morbidity and mortality.
 3. Respondent failed to timely order a CT scan of Patient A's aorta, placing the patient at risk of harm of increased morbidity and mortality.
 4. Respondent failed to diagnose Patient A's aortic dissection in a timely fashion, placing the patient at risk of harm of increased morbidity and mortality.

5. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.
- B. Respondent provided medical care to Patient B, a 58 year old woman who presented to the Emergency Department of Columbia Memorial Hospital, in Hudson, New York on January 14, 2007 for complaints of nausea and vomiting for one week, with a history of gallbladder problems, and who returned the following lab values and test results while in the Emergency Department: a WBC of 12.9 thou/mm³, total bilirubin of 5 mg/dL, an AST of 170 U/L, an ALT of 220 U/L, an Alkaline Phosphate of 881 U/L and a preliminary ultrasound study indicating multiple gallstones, a gallbladder wall with thickening up to 6mm and a dilated Common Bile Duct measuring up to 7.4mm. Respondent's care of Patient B deviated from accepted standards of medical care as follows:
1. Respondent failed to appropriately and/or adequately diagnose Patient B's condition.
 2. Respondent failed to appropriately and/or adequately manage Patient B's care.
 3. Respondent failed to seek the admission of Patient B, placing the patient at risk of harm of increased morbidity and mortality.
 4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient B.
- C. Respondent provided medical care to Patient C, an 11 year old girl who presented to Emergency Department of Columbia Memorial Hospital, in Hudson, New York on December 31, 2006 for complaints of cough, congestion, fever, and on Amoxicillin for 2 days. Respondent's care of Patient C deviated from accepted standards of medical care as follows:
1. Respondent failed to identify the left lower lobe pneumonia on

the chest x-ray he ordered.

2. Respondent failed to diagnose Patient C's pneumonia prior to her discharge from the Emergency Department, placing the patient at risk of harm of increased morbidity and mortality.
3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C.

D. Respondent provided medical care to Patient D, a 70 year old woman who presented to the Emergency Department of Columbia Memorial Hospital, in Hudson, New York on March 17, 2007 with a history of diabetes, hypertension, multiple abdominal surgeries and complaining of vomiting, diarrhea and abdominal pain and blood values demonstrating 18% bands. Respondent's care of Patient D deviated from accepted standards of medical care as follows:

1. Respondent failed to obtain an adequate medical history of Patient D.
2. Respondent failed to timely review the results of the lab work he ordered.
3. Respondent failed to read and/or record his reading of the x-rays he ordered.
4. Respondent failed to order appropriate and/or adequate tests and/or imaging for Patient D, placing the patient at risk of harm of increased morbidity and mortality.
5. Respondent improperly diagnosed Patient D with viral gastroenteritis, placing the patient at risk of harm of increased morbidity and mortality.
6. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

E. Respondent, on or about August 5, 2009, completed an application for his appointment to the medical staff of Catskill Regional Medical Center (CRMC), Harris, New York. Section G. of that application instructed Respondent to provide information for the ten (10) years preceding the date of the application. Respondent failed to list Columbia Memorial Hospital in the information he provided as an attachment in response to the following instruction of G.1:

"Please list the names, addresses, dates and nature of the affiliation with each hospital or facility with which you have had any association, employment, privileges or practice."

The CRMC application included the following oath by Respondent:

"I hereby confirm that all the statements made and information submitted in connection with this application are complete, true and accurate. I understand that I have a continuing obligation to update and/or correct such information during the dependency [sic] of my application."

Respondent's conduct in completing the CRMC application deviated from accepted standards of care as follows:

1. Respondent knowingly failed to list his affiliation with Columbia Memorial Hospital in response to question G.1 on pages 4 of 6 of the CRMC application.
 - a. Respondent intended to mislead by omitting his affiliation with Columbia Memorial Hospital.
2. Respondent represented on his CRMC application that the information submitted in connection with the application were complete, true and accurate when Respondent knew that the information was not complete, true or accurate, and that he

omitted requested information from the application.

- a. Respondent intended to mislead by omitting his affiliation with Columbia Memorial Hospital.

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 two or more of the following:

1. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5 and/or D and D.6.

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 two or more of the following:

2. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5 and/or D and D.6.

THIRD THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

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

3. The facts set forth in paragraphs A and A.1, and/or A and A.2, and/or A and 3, and/or A and A.4.
4. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or B and B.3.
5. The facts set forth in paragraphs C and C.1, and/or C and C.2.
6. The facts set forth in paragraphs D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5.

SEVENTH THROUGH TENTH SPECIFICATIONS

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:

7. The facts set forth in paragraphs A and A.1, and/or A and A.2, and/or A and 3, and/or A and A.4.
8. The facts set forth in paragraphs B and B.1, and/or B and B.2, and/or B and B.3.
9. The facts set forth in paragraphs C and C.1, and/or C and C.2.
10. The facts set forth in paragraphs D and D.1, and/or D and D.2, and/or D and D.3, and/or D and D.4, and/or D and D.5.

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:

11. Paragraphs A and A.5, and/or B and B.4, and/or C and C.3, and/or D and D.6.

TWELFTH SPECIFICATION
FRAUD IN THE PRACTICE OF MEDICINE

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:

12. Paragraphs E, E.1 and E.1a, and/or E, E.2 and E.2a.

THIRTEENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the State Education Department, as alleged in the facts of:

13. Paragraphs E and E.1, and/or E and E.2.

FOURTEENTH SPECIFICATION
VIOLATION OF § 2805-k (1) (a)
OF THE PUBLIC HEALTH LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(14) by not reporting his prior association with Columbia Memorial Hospital in his application with CRMC, thereby violating § 2805-k (1) (a) of the Public Health Law, as alleged in the facts of:

14. Paragraphs E and E.1.

DATE: March 3, 2011
New York, New York

REDACTED SIGNATURE

Roy P. Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct