Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 6, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leslie Eisenberg, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Robert F. Hosty, M.D.
REDACTED ADDRESS

David Gevanter, Esq.
16 West Hoffman Avenue
Lindenhurst, New York 11757

RE: In the Matter of Robert F. Hosty, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-18) 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

IN THE MATTER	:	DETERMINATION
OF	:	AND
ROBERT F. HOSTY, M.D.	:	ORDER

BPMC #12-18

A Notice of Hearing and Statement of Charges, both dated July 7, 2011, were served upon ROBERT F. HOSTY, M.D., Respondent. GREGORY FRIED,M.D Chairperson, CASSANDRA E. HENDERSON, M.D., and RUTH HOROWITZ, Ph.D, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. CHRISTINE C. TRASKOS, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer.

The Department of Health ("the Department") appeared by JAMES DERING, General Counsel, by LESLIE EISENBERG, ESQ., of Counsel. The Respondent appeared by DAVID GEVANTER, ESQ. 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

Pre-Hearing Conference:	August 3, 2011
Hearing Dates:	August 17, 2011, October 25, 2011 November 8, 2011
Witnesses for Petitioner:	Lewis Broslovsky, M.D. Erika Tejada Serrano, EMT David Kher, EMT
Witnesses for Respondent:	Robert F. Hosty, M.D.
Receipt of Submissions:	December 14, 2011(Department only)
Deliberation Held:	January 5, 2012

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Robert F. Hosty, M.D.,("Respondent") is charged with Seven(7)specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). The charges include negligence on more than one occasion, incompetence on more than one

occasion, failure to appropriately supervise and failure to maintain records. A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order as Appendix I. The Respondent filed a timely Answer and denies the factual allegations and specifications of misconduct contained in the Statement of Charges. Respondent did not file a written submission after the last day of hearing, even though his attorney was allotted additional time.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, the Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on April 4, 1980, by the issuance of license number 141667 by the New York State Education Department. (Dept. Ex.2)

2. Respondent currently has no hospital affiliations and the last time he took any continuing medical education courses was in 2006. (T. 269-278)

3. Respondent maintains a private office on Flatbush Avenue in Brooklyn, New York, where he sees patients and does general gynecology. Respondent is also an independent contractor for at least three offices, including the two on Roosevelt Avenue where he treated Patients A and B. Respondent continues to perform termination of pregnancy procedures, as he did in the care of Patient B. (T.246-247, 280-283)

4. Patient A, a 41 year old woman, saw Respondent on October 26, 2008 for evaluation and treatment related to a Bartholin abscess, at Choice Gynecological Services on Roosevelt Avenue in Queens, N.Y. (T. 21, 181; Dept. Ex. 3p. 5)

5. Bartholin glands are secretory glands found on the right and left distal lateral vaginal opening. If there is an irritation or infection involving the gland or duct, the woman can develop a cyst or an abscess. Symptoms of a Bartholin abscess can include pain, swelling, redness and tenderness. The symptoms can be acute and require emergent treatment. The treatment, referred to as an incision and drainage (I and D) relieves the symptoms immediately. In some cases, a marsupialization is required whereby the gland, or part of it, is removed. If it is an acute emergency, a I and D should be done

but, the marsupialization should wait because removing the abscess or cyst at that time- when it is infected is not appropriate. (T. 21-21, 56-57, 62)

6. An appropriate history includes the patient's story about their presentation and should include questions about the symptoms and any other pre-existing conditions that could relate to the current complaint. When taking a history from a patient regarding complaints that might be related to the Bartholin gland, the physician needs to ask questions pertaining to the onset of symptoms, the duration of symptoms and questions that relate to physical activity, sexual activity and trauma. Respondent did not perform an appropriate history. Although there is a note indicating that the patient has a Bartholin abscess, there is no notation indicating size, location, onset or duration of symptoms. There is no story line as it relates to the complaint. There is no indication if this is an emergency or a chronic condition. There is no indication if this patient was seen before or, if she called before coming to the office to see Respondent. (T. 24-29, 68; Dept. Ex. 3)

7. A thorough physical exam includes looking at the area the patient is complaining about and doing a pelvic exam. When a woman complains of vaginal pain, looking and feeling for swelling is important. By examining the vaginal area, the physician can determine if the Bartholin gland is involved and can describe the

size of the abscess or cyst and the location. Respondent did not perform an appropriate physical exam for Patient A. Although there is a note indicating the patient has a Bartholin abscess, there is no notation indicating size or location. There is no documented physical exam, pelvic exam or rectal exam. (T. 24-29, 68; Dept. Ex.3, p. 5)

8. The absence of a rectal exam in the patient is critical. The medical record includes a notation that the patient had a left Bartholin abscess near the anal area. It is appropriate and necessary to examine the rectal area to determine if the abscess involves the rectum or the septum between the vaginal and rectal wall. (T, 28-29; Dept. Ex. 3,p.8)

9. Patient A reported that she was on Coumadin as a result of a pulmonary embolism associated with a previous surgical procedure. Coumadin, also known as warfarin, is a blood thinner; it helps to prevent blood clots from forming. A person taking a blood thinner has a higher risk for bleeding so when considering surgery, a reasonably prudent physician needs to determine the coagulant status of the patient. In order to check that the person has returned to a normal bleeding time, the person must stop taking the medication (because it takes time to get out of the person's system) and then a blood test referred to as a PT test (pro-thrombin time) needs to be done. Respondent did not test Patient A's coagulant status. There is no mention of a PT test in Patient A's medical record. As a

result, Respondent was unaware of whether Patient A was still anti-coagulated. (T. 30-32; Dept. Ex. 3, pp. 5,8)

10. A certified registered nurse anesthetist (CRNA) is a nurse who has been trained and certified in the use of anesthetics. In New York State, CRNAs are permitted to provide anesthesia in an office-based setting or ambulatory setting.(T. 32-35)

11. The CRNA providing anesthesia for Patient A at Choice Gynecological Services on October 26, 2008, was Herman Lee. There was no anesthesiologist at Choice Gynecological Services that day. Therefore, Respondent was the physician responsible for supervising CRNA Lee.(T. 35)

12. MAC refers to intravenous monitored anesthesia. When providing MAC the CRNA (or anesthesiologist) must monitor the patient with an EKG, blood pressure cuff (or machine) and pulse oximeter. (T. 35-36)

13. It is unclear from the medical record what Respondent did to/for Patient A on October 26, 2008. The medical record indicates that Respondent did some sort of surgical opening related to a cyst and then sutured the patient. The autopsy report demonstrates that there was a surgical procedure on the posterior wall of the vagina requiring suturing, approximately 4 centimeters long. However, the location of the suturing does not conform with the Bartholin gland. The suturing was on the posterior wall but the Bartholin gland is

found in the lateral wall of the vagina. (T. 36-38); Dept. Ex.5)

14. Sometime towards the end of the surgical procedure, Patient A had a respiratory arrest. The anesthesia record indicates "respiratory arrest, intubated, oxygenated, transferred to Elmhurst Hospital via ambulance." (T. 43; Dept. Ex. 3, p.7)

15. CPR refers to cardio-pulmonary resuscitation. Specifically, it means resuscitating a patient both in terms of their breathing and heartbeat, Although Patient A was intubated (pulmonary resuscitation) there were no cardiac resuscitative efforts made by Respondent or the CRNA or other staff members. (T. 45-48; Dept. Ex.3,p.7; Dept. Ex. 4, p.13)

16. A reasonably prudent physician who is faced with a patient who goes into cardiac or respiratory arrest should give a full attempt at CPR which includes making sure the airway is open, that oxygen is being administered and that chest compressions are done. Respondent failed to immediately perform chest compressions on Patient A when she went into arrest. (T. 47-48, 50)

17. The failure to perform chest compressions (cardiac resuscitation) leads to lack of oxygen getting to organs throughout the body. A person who does not have oxygen flowing throughout the body becomes ischemic- the tissue dies. As a result of no chest compressions being done on Patient A, she became ischemic or, brain dead. (T.46-48; 50-51; Dept. Ex.5, p.1)

18. 911 should be called as soon as an event occurs requiring immediate medical assistance including when a patient arrests. Patient A had likely been in cardiac arrest for a minimum of ten minutes before EMS was called since the CRNA reported to the paramedics that the patient had been out for that long. It is likely that the patient was in cardiac arrest even longer since the anesthesia report indicates that the procedure began at 2 p.m. Respondent did not call EMS in a timely manner.(T. 48,181, 183,191,198, Dept. Ex.6)

19. EMS was called at 3:07 p.m. The paramedics arrived in four minutes. Once at the office, no one identified themselves as doctors. The paramedics thought the person at the head of the bed ventilating the patient (the CRNA) was the doctor. The CRNA reported, "She's dead. She has no pulse." When the paramedics asked Respondent if he was a doctor, he said "Yes." When they asked "How come you are not doing chest compressions?" He shrugged his shoulders. No one provided any information about the patient and when Respondent was asked if the patient was given medication he said "No." The CRNA interrupted and clarified that the patient had been given propofol. (T. 181-183, 188, 193- 196; Dept. Ex. 6)

20. From the time EMS arrived, Respondent was not near the patient. EMS stated that Respondent did not provide any information or assistance. (T. 182-183,205-206)

21. Patient A was not being monitored with anything other than a pulse oximeter. (T. 185-186, 195-205)

22. EMS transported Patient A to Elmhurst Hospital where she was pronounced brain dead. (T. 186, 197; Dept. Exs.4 and 5)

23. Medical reports are intended to document all events that occur in regard to caring for a patient. They should help a physician recall what was done by them in caring for a patient and, they provide documentation for subsequently treating physicians regarding care and treatment. (T. 48-49)

24. Respondent's medical record for Patient A does not include an operative report. An operative report should be written within 24 hours of the surgical procedure and is supposed to outline step-by-step what the surgeon did and encountered during the procedure including suturing and what type of material was used. (T. 39-40, 70)

25. Respondent's medical records do not meet minimally accepted standards of care. They do not include an adequate history or physical exam, they do not clearly indicate what transpired when the patient underwent the surgical procedure, they do not document what happened when the patient arrested, they do not include an operative report and they do not include a consent for surgery. (T. 4-50, 67-68; Dept. Ex. 3)

26. Patient B, a 37 year old woman, saw Respondent on January

25, 2010, at A-1 Women's Center in Queens, NY, for a second trimester termination of pregnancy (TOP). She was 16-17 weeks pregnant, confirmed by sonogram. (T. 75-76, 79; Dept. Ex.7, p. 9)

27. A TOP done up to week 12 or 13 of a pregnancy is referred to a first trimester TOP. A second trimester TOP is one done beyond 13 weeks and is legally allowable up to 24 weeks of pregnancy. TOP procedures can be done with medications that cause the uterus to contract and evacuate the pregnancy or, they can be surgical where suction is used. In the first trimester a dilation and curettage (D and C) is done with suction. In the second trimester a dilation and evacuation (D and E) is done with suction and possibly instruments, to remove fetal parts. (T. 76-78)

28. There are two facts in Patient B's past medical history that are significant as they relate to Respondent's decision to perform a TOP in a non-hospital setting. Patient B had an anterior wall placenta and, a history of two previous C-sections. (T. 79,82)

29. After a C-section, a woman will have scarring on her uterus. In general, that scar area is thinner than the rest of the wall of the uterus. Since Patient B had two C-sections, each surgery would have been in the same operative field. There is an affinity of placental attachment in patients with previous C-sections to attach in the area where the scar is made. This is important because there is the possibility that since the anatomy

is not normal, the placenta will embed itself deeper than it would in a regular pregnancy. (T. 79-82)

30. Ordinarily, the placenta attaches to the uterine wall which enables the fetus to gain blood supply. When it attaches too deeply into the uterine wall, it is referred to as placenta accreta, increta or percreta. The differential is a pathological diagnosis. The autopsy report confirms that Patient B had placenta increta. This type of placenta invasion is through most of the wall of the uterus but not completely through it. (t. 82-82, 93-94; Dept. Ex. 9, p.1)

31. A reasonably prudent physician must carefully analyze a situation that involves the following: the increased likelihood that the placenta will attach to a scarred area of the uterus in a woman who had two previous C-sections thereby increasing the scarring of the uterus and, the anterior wall placement of Patient B's placenta. The physician must think ahead of time about the possibility that there will be an issue with getting the placenta out.(T. 83-84, 108-109)

32. When faced with the medical history of Patient B, a reasonably prudent physician should consider whether the facility in which the surgery was planned had the capability to switch emergently from a TOP to an abdominal exploratory laparotomy if a complication (such as excessive bleeding or inability to remove the

placenta) occurred. There would have to be blood, cross-match and transfusion capability. In an outpatient setting, there is no transfusable blood available, should it be needed. In addition, it is possible that the patient would need an emergency hysterectomy. In which case, the physician would want to be in a setting that can handle such procedures. (T. 84-85,99-100, 107-108)

33. On January 25, 2010, Respondent began a D&E on Patient B, with monitored anesthesia administered by CRNA Theresa Mitchell, at 3:45 p.m. The surgical procedure began at 3:50 p.m. and ended at 3:59 p.m.(T. 86; Dept. Ex. 7)

34. The medical record indicates that at the end of the procedure, Patient B began to bleed uncontrollably. Under these circumstances, a reasonably prudent physician would need to try to determine the cause of the bleeding and institute resuscitative efforts. In this case, tonics were used to try to control the bleeding and CRNA Mitchell intubated Patient B. Although the CRNA began breathing for the patient, no chest compressions were performed. (T. 87-90; Dept. Ex.7)

35. Respondent was the responsible supervisor for CRNA Mitchell during the surgical procedure since there was no anesthesiologist on site.(T. 92)

36. When there is a catastrophic event- like a person going into shock- all persons capable of assisting in resuscitative

efforts should do so. Respondent did not assist in performing any resuscitative efforts.(T. 92-93)

37. When engaged in surgery in an office based setting, when excessive bleeding occurs, 911 should be called as soon as the bleeding cannot be controlled. The medical record indicates that the TOP ended at 3:59 p.m. EMS was called at 4:47p.m. Respondent did not call 911 timely. (T. 93, Dept. Ex.7, and Ex.10, p. 1,5)

38. Paramedics arrived at A-1 Women's Center on Roosevelt Avenue at 4:58 p.m. (almost one hour after the surgery ended.) They saw Patient B on an exam table/chair with her legs open. They saw blood on the floor and blood coming from Patient B. They also saw bloody clothes in the corner. They noted that Patient B was grey and ashen meaning that she was likely dead. She was cold to the touch. (T. 213-214, 224, 234, 237; Dept. Ex. 10)

39. Paramedics observed a female at the head of the bed, ventilating the patient. No one identified themselves as a doctor. EMS assumed that this person was a doctor because she was the one giving them information about what happened. At no time did Respondent offer information or assistance. Respondent may have walked into the room briefly and then left. In fact, on cross-examination, when asked if he recognized Respondent, the paramedic said no-because he had not seen or interacted with Respondent. (T. 213,215-216,225,229,235-238)

40. No one was doing chest compressions. Patient B was not monitored with anything except a pulse oximeter. She was in cardiac arrest. The paramedics started CPR and transported Patient B to Elmhurst Hospital where she was pronounced dead. (T.214-218, 228, 238; Dept. Exs. 8-10)

41. Respondent's medical records for Patient B do not meet minimally accepted standards of care. The physical examination does not include any documentation of a gynecologic exam. There is no documentation indicating that the risks and benefits of the procedure were discussed with Patient B or, any alternatives to this procedure. In addition, there should be more information documented about what transpired during and after the procedure-understanding that during a crisis, there might be less documented than usual. (T. 94-96, 105, Dept. Ex. 7)

42. Patient C, a 37 year old woman, was seen by Respondent in October 2004, with a history of fibroids and endometriosis. (T. 114-115; Dept. Ex. 12)

43. Fibroids are benign tumors that form within the wall of the uterus and can grow to be very big. They can cause pain and/or cause an enlarged uterus. (T. 117-118)

44. Endometriosis is a condition whereby the normal cells that line the internal cavity of the uterus(endometrium) can be found outside the cavity of the uterus. They can be implanted on the

external surface of the uterus, ovaries or on any internal structure in the abdominal cavity. These cells undergo menstruation just as if they were the normal lining of the uterus. They reproduce and grow more cells. They can cause cysts and can cause a great deal of pain. The can cause infertility and in some cases, the only treatment is a complete hysterectomy. (T. 115-117)

45. At some point in time (the medical record is not clear), Respondent's plan for Patient C was a total abdominal hysterectomy with bilateral salpingo-oophorectomy. In other words, a complete hysterectomy including removal of the cervix, uterus, tubes and ovaries.(T. 118-119)

46. Patient C entered St. Mary's Hospital in Brooklyn through the emergency room (the medical record is unclear why) and on December 3, 2004, Respondent performed surgery on her. (T. 119, 125; Dept. Ex. 13, p. 103)

47. A pre-operative admission history and physical exam is important to determine the exact condition of a patient including past medical history and a plan of action. The medical record for Patient C is wholly incomplete regarding the pre-admission history and physical exam. There is no information about the reason for the patient's admission. Even if the notes regarding Patient C's admission were made by a resident or other staff, Respondent would have been responsible for reviewing them and counter-signing them,

indicating that they are adequate. This was not done.(T. 121-124, Dept. Ex. 13)

48. On December 3, 2004, Respondent supervised the resident performing the surgery on Patient C that consisted of a supracervical abdominal hysterectomy including removal of the uterus, tubes and ovaries. The cervix was left intact.(T. 125, 128; Dept. Ex. 13 pp. 152,159)

49. An operative report is a report written by the responsible surgeon that details what was done and what was encountered during a surgical procedure.(T. 126)

50. The operative report in Patient C's medical record is only partial and was dictated five months after the December 3, 2004 surgery. Even if a resident was initially responsible for dictating the operative report, the ultimate responsibility that the report is complete and done timely, falls to the attending. In this case, that means Respondent. Moreover, the report itself does not describe the dissection of the pelvic anatomy. It does not include any findings or explain why the intended operation (complete hysterectomy) was not done and converted to a supracervical hysterectomy. An incomplete operative report leaves one without knowledge of the interoperative findings.(T. 125-129,,139-140,157-158; Dept. Ex. 13)

51. Patient C developed a fever on post-operative day three. A

post-operative fever can be related to a pulmonary issue from anesthesia or, it can be related to an inflammatory response. Patient C's fever spiked and would go from normal to 102 degrees. This type of sawtooth fever is more indicative of an inflammatory response. (T 130-131, 148-149; Dept. Ex. 13)

52. A reasonably prudent physician faced with a post-operative patient with a sawtooth type fever should perform a complete physical exam, order blood tests and administer antibiotics. This was done. However, when the fever persisted, Respondent should have ordered a chest x-ray and some radiologic diagnostic testing such as an abdominal and pelvic ultrasound or sonogram or CT scan of the abdomen and pelvis. The radiologic tests would assist in evaluating the patient for fluid collection-formation of an abscess. The chest x-ray could determine something in the lungs. Although a chest x-ray was ordered, it was ordered on the day of her discharge and the results were not reviewed prior to Patient C's discharge home. The other diagnostic tests were not ordered by Respondent. (T. 131-134,145–147, 155-156, 163-164; Dept. Ex. 13)

53. Respondent discharged Patient C on December 8, 2004, even though she still had a fever of 102 degrees twelve hours earlier.(Dept. Ex. 13)

54. On December 13, 2004, Patient C was re-admitted to St. Mary's Hospital in Brooklyn, NY due to the post-operative fever.

Again, it is not clear from the record how Patient C returned to the hospital whether directed by Respondent or through the emergency department. There is no thorough physical exam documented by Respondent for this second hospital admission. It would be important to have done and documented a physical exam especially since Patient C had a hysterectomy. An exam would indicate if there were any masses felt or any suggestion that there was an abscess in the area of the pelvic anatomy. An exam would also indicate that the incision site was clean and intact. However, none of this was done or documented. (T. 137-138, 152-154,160-161; Dept. Ex. 13, p. 7)

55. Respondent's medical record for Patient C is wholly inadequate especially as it relates to the history and physical exam and the operative report. The gynecological exam was not done and documented. In addition, the operative report, which is only partial, was dictated five months after the surgery. This is inappropriate.(T. 137-139, Dept. Ex. 13)

CONCLUSIONS OF LAW

Respondent is charged with seven specifications alleging professional misconduct within the meaning of Education Law §6530. Education Law §6530 sets forth a number and variety of forms or types of conduct which constitute professional misconduct, However,

Education Law §6530 does not provide definitions or explanations of some of the misconduct charged in this matter. During the course of their 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.

Negligence on More Than One Occasion

Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by the Respondent caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

Incompetence on More Than One Occasion

Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more

than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession, the word "incompetence" is to be interpreted by its everyday meaning. These factors may include the Hearing Committee's impression of Respondent's technical knowledge and competence of the various issues and the charges under consideration.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded by a preponderance of the evidence that all seven specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of the deliberations, the Hearing Committee made a determination as to the credibility of all witnesses presented by the parties. The Committee must determine the credibility of the witnesses in weighing each witness's testimony, First, the Hearing Committee must consider whether the testimony is supported or contradicted by other independent objective evidence. When the evidence is conflicting and presents a clear-cut issue as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and base its inference on what it accepts as the truth. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness's

testimony and, at the same time reject another. The Hearing Committee also understood that they had the option of completely rejecting the testimony of a witness where they found that the witness testified falsely on a material issue.

With regard to the testimony presented, the Hearing Committee evaluated all witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credential and demeanor.

The Department offered the testimony of Lewis Broslovsky, M.D. as its expert. Dr. Broslovsky is board certified in obstetrics and gynecology. He has over 30 years of experience and recently retired from a private practice that was located in Middletown, New York.(T.17-19;Ex.15) The Hearing Committee found Dr. Broslovsky to have excellent credentials and to be a credible and very objective witness. They gave his testimony great weight.

The Department also offered the testimony of Erika Serrano,EMT a paramedic employed by FDNY who responded to the 911 call for Patient A. The Hearing Committee found EMT Serrano to be a very credible witness who had a good recollection of the events when she arrived at the Choice Gynecological Services office. David Kher, EMT, a paramedic, employed by FDNY testified regarding the 911 call for Patient B. The Hearing Committee notes that Mr. Kher's testimony was supported by the report that he filled out (Ex. 10). They found

him to be a very credible witness.

Respondent testified on his own behalf. The Hearing Committee found that Respondent was not a credible witness. He misrepresented his credentials implying at first that he was board eligible when he has not been eligible for a long time. His statements were inconsistent and he often contradicted himself. He could not provide the Hearing Committee with a timeline of events for Patients A and B. He could not adequately explain why he believed Patient B developed DIC (disseminated intravascular coagulation) after he performed the TOP. As a result, the Hearing Committee gave little weight to Respondent's testimony.

Factual Allegations

Based upon the Findings of Fact set forth above, the Hearing Committee makes the following unanimous determinations regarding the factual allegations contained in the Statement of Charges:

Paragraph A and A.1	Sustained
Paragraph A and A.2	Sustained
Paragraph A and A.3	Sustained
Paragraph A and A.4	Sustained
Paragraph A and A.5	Sustained
Paragraph A and A.6	Sustained
Paragraph B and B.1	Not Sustained
Paragraph B and B.2	Sustained
Paragraph B and B.3	Sustained
Paragraph B and B.4	Sustained
Paragraph B and B.5	Sustained

Paragraph C and C.1	Sustained
Paragraph C and C.2	Sustained
Paragraph C and C.3	Sustained
Paragraph C and C.4	Sustained
Paragraph C and C.5	Sustained
Paragraph C and C.6	Sustained
Paragraph C and C.7	Sustained

NEGLIGENCE ON MORE THAN ONE OCCASION

The Hearing Committee notes the history and physicals for both Patients A and B are woefully inadequate. They further find that it is difficult to ascertain what specifically went wrong in the cases of Patient A and B because the surgical procedures were not documented and Respondent's answers at the hearing were inconsistent. It is however crystal clear to the Hearing Committee that Respondent failed to assume responsibility and perform basic expected care that any reasonable physician would perform in the face of catastrophic events like those faced by Patients A and B. Respondent's failure to assume any responsibility for either patient is corroborated by the testimony of the EMTS who credibly testified that Respondent offered no information or assistance when they arrived on the scene. With respect to Patient C the Hearing Committee finds that Respondent, who was the attending physician, demonstrated a clear lack of respect and responsibility for Patient C. Respondent implied that he had limited responsibility for Patient C's care because she was a "service" patient that belonged to the hospital and was primarily cared for by

the staff. (T. 379, 403-410)

The Hearing Committee notes that they would have found Respondent's care of Patients A and B to be conspicuously bad and would have sustained gross negligence if it had been charged. Nonetheless the Hearing Committee sustains negligence for all three patients under the First Specification.

INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee finds that Respondent demonstrated a clear lack of knowledge about the underlying conditions of his patients and the medications they were taking. He operated on patients without having the benefit of an adequate history and physical. Respondent operated on Patient A without knowing her anti-coagulant status. The Hearing Committee further finds that Respondent failed to identify the point where Patients A and B encountered life threatening situations. Respondent failed to call for back up assistance at the time when it would have made a difference in the outcome. The Hearing Committee sustains the Second Specification.

FAILURE TO APPROPRIATELY SUPERVISE

The Hearing Committee finds that there is no information in the record to support Respondent's interaction with either of the CRNAS for the procedures performed on Patients A and B. The Hearing Committee concludes that Respondent was the responsible supervisor for both CRNAS during the surgical procedure since there was no

anesthesiologist on site. As a result, the Hearing Committee sustains the Third and Fourth Specifications.

FAILURE TO MAINTAIN RECORDS

The Hearing Committee finds Respondent's recordkeeping for all three patients to be wholly inadequate. The Hearing Committee sustains Specifications Five through Seven.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee, by unanimous vote, determines that Respondent's license to practice medicine in New York State should be revoked.

The Hearing Committee believes that Respondent exhibited a wanton disregard for basic medical practice in his failure to obtain adequate histories and physicals of patients before initiating surgical procedures. When life threatening complications arose, Respondent failed to act responsibly. Two patients who had come to Respondent for routine medical procedures died unnecessarily. Respondent showed no remorse and the Hearing Committee believes that he has not learned anything from these two horrific experiences.

The Hearing Committee is deeply troubled when considering the number of other impoverished patients who may have been

jeopardized by Respondent's poor medical practices. The Hearing Committee is revoking Respondent's license to practice medicine because he is a present day danger to patients in this State. 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.

ORDER

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

1. The First through Seventh Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED**; and

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

3. This Determination and Order shall be effective on personal service on Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. Section 230(10)(h).

DATED: New York, New York
FEB 2, 2012

REDACED SIGNATURE

GREGORY FRIED, M.D. (CHAIR)

CASSANDRA HENDERSON, M.D.
RUTH HOROWITZ Ph.D

TO: Leslie Eisenberg, Esq.
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APPENDIX I

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

IN THE MATTER

OF

ROBERT F. HOSTY, M.D.

STATEMENT

OF

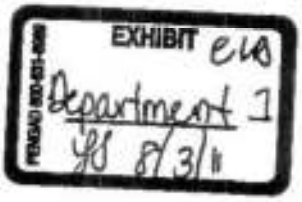
CHARGES

ROBERT F. HOSTY, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 4, 1980, by the issuance of license number 141667 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about October 26, 2008, at Choice Gynecological Services, P.C., Jackson Heights, New York, Respondent performed a surgical procedure regarding a Bartholin abscess on Patient A, a 41 year old woman. (Patient names are identified in the appendix). Patient A had been taking Coumadin but stopped 48 hours prior to the procedure. CRNA Herman Lee administered Propofol IV under the supervision of Respondent. At the conclusion of the procedure, Patient A became pale and had no obtainable blood pressure. CRNA Lee ventilated Patient A and EMS was called. When EMS arrived, the technicians initiated CPR treatment. Patient A's cardiac rhythm was restored and she was transferred to Elmhurst Hospital. Patient A was pronounced brain dead. Respondent's care and treatment of Patient A deviated from minimally accepted standards of care in that Respondent:

1. failed to perform a pre-operative laboratory evaluation of Patient A's coagulation status.
2. failed to perform and/or document an appropriate history and physical



examination of Patient A.

3. failed to call EMS in a timely manner.
4. failed to immediately perform chest compressions and to follow ACLS procedures.
5. failed to adequately supervise the CRNA.
6. failed to maintain appropriate records that reflect the care and treatment of Patient A including but not limited to failing to record an operative record, failing to record the patient's history and physical examination and, verify findings and actual surgical procedure performed.

B. On or about January 25, 2010, at A-1 Women's Center, Jackson Heights, New York, Respondent performed a Dilation and Evacuation termination of pregnancy procedure on Patient B, a 37 year old woman, at 16-17 weeks gestation. CRNA Theresa Mitchell administered Propofol IV, under the supervision of Respondent. Towards the end of the procedure, Patient B began to bleed profusely. CRNA Mitchell appreciated the excess bleeding and administered other medications in an effort to address the bleeding. EMS was called and EMS transferred Patient B to Elmhurst Hospital, where Patient B was pronounced dead. Respondent's care and treatment of Patient B fell below minimally accepted standards of care in that Respondent:

1. inappropriately elected to perform surgery for Patient B in an outpatient facility in view of her past medical history.
2. failed to call EMS in a timely manner.
3. failed to adequately supervise the CRNA.
4. failed to ensure continuous monitoring of Patient B.

5. failed to maintain a record that accurately reflects the care and treatment rendered to Patient B.

C. On or about December 3, 2004, Respondent admitted Patient C, a 37 year old woman, to St. Mary's Hospital in Brooklyn, NY, planning to perform a total abdominal hysterectomy. Respondent performed a supracervical hysterectomy on Patient C on December 3, 2004. On or about December 8, 2004, Respondent discharged Patient C despite a note indicating spiking fevers and elevated white blood count. On or about December 13, 2004, Patient C was re-admitted to the hospital with post-operative fever. Respondent's care and treatment of Patient C deviated from minimally accepted standards of care in that Respondent:

1. failed to perform and/or note an appropriate pre-operative admission history and physical examination.
2. failed to properly monitor/investigate/assess Patient C post-operatively including but not limited to ordering appropriate laboratory assessment or radiologic testing.
3. failed to adequately evaluate and/or treat Patient C's post-operative fever.
4. failed to timely document an operative note.
5. inappropriately discharged Patient C with an unresolved post-operative fever.
6. failed to perform a thorough physical examination on Patient C related to her 2nd hospital admission.
7. failed to maintain a record that accurately reflects the care and treatment rendered to Patient C including but not limited to failing to

document an adequate history, physical examination, admission note, timely and adequate operative note.

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. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs.

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. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs.

THIRD - FOURTH SPECIFICATIONS

FAILURE TO APPROPRIATELY SUPERVISE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(33) by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, as alleged in the facts of:

3. Paragraph A and A (5).
4. Paragraph B and B (3).

FIFTH-SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

5. Paragraph A and A (6).
6. Paragraph B and B (5).
7. Paragraph C and C (7).

DATE: July 7, 2011
New York, New York

REDACTED SIGNATURE

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct