

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:

GEORGE AMBROSIO, M.D.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of a report from the Medical Practitioner Review Panel (the "Panel"), which detailed findings and recommendations made by the Panel upon its conclusion of an investigation of reported information regarding the settlement of a civil malpractice action brought against respondent George Ambrosio, M.D. Specifically, the Panel commenced an investigation upon receipt of a report from respondent's medical malpractice insurer, detailing that a payment of \$100,000 was made in June 2012 to settle an action brought by the estate of patient L.B. In the civil case, it was alleged that respondent failed to recognize a mass that was apparent on a chest x-ray taken on April 4, 2008, which in turn led to an approximate nineteen month delay in the diagnosis and initiation of treatment for lung cancer.

The Panel reviewed available information regarding this matter, to include copies of medical records maintained by

respondent's practice group for patient L.B., copies of x-ray films taken at respondent's office in April 2008 and September 2009, and expert reports prepared during the course of the civil malpractice action. The Panel additionally considered written statements provided by respondent and sworn testimony offered when respondent appeared before the Panel on January 24, 2015, represented by Thomas Ambrosio, Esq. Respondent is presently represented by Svetlana Ros, Esq., of Kern Conroy Augustine & Schoppmann.

The Panel found that respondent provided medical care, along with other physicians at his practice group (First Care Medical Group), to patient L.B. from February 2005 through September 2009. On April 4, 2008, L.B., then 53 years old, presented to respondent's office after having fallen the previous evening and having sustained an injury to her chest. Respondent was the only physician in the office that date.

L.B. was seen by a physician assistant, S.D., who ordered x-ray imaging. X-rays, to include two views of the ribs (AP and oblique) and a single frontal view of the chest were taken at respondent's office by a radiologic technician. A mass in the right lung is clearly visible on those x-ray films. The records for the office visit, however, include a notation "xr-negative." The records for the April 4, 2008 visit were electronically signed by both S.D. (as physician assistant) and respondent.

When appearing before the Panel, respondent testified that it was his responsibility, as the physician on site, to have read all x-rays. Respondent speculated that he must have been shown x-rays taken of a patient other than L.B., as he conceded that the mass visible on L.B.'s x-rays was "obvious." Respondent accepted responsibility for the error made.

L.B. was treated at First Care on multiple occasions after April 4, 2008. On September 28, 2009, L.B. presented to the office complaining of chest pain for 5 days. She was seen by another physician at First Care, who ordered a chest x-ray. The chest x-ray revealed a large lung mass (the same mass that was visible on the x-ray performed on April 4, 2008). L.B. was then referred to a pulmonary specialist and diagnosed with lung cancer.

The Panel found that respondent's failure to have identified the lung mass evident on L.B.'s x-ray films of April 4, 2008 constituted gross negligence. The Panel noted that its conclusion was not dependent on a finding whether respondent in fact reviewed L.B.'s x-rays on April 4, 2008. Rather, the Panel found that gross negligence would be established if respondent in fact reviewed L.B.'s x-rays and failed to recognize the mass thereon, or, in the alternative, if he failed to ensure that the x-rays were reviewed by a physician, as it was his singular, non-delegable responsibility to have ensured that physician review occurred. The Panel further concluded that, immediately upon

reviewing the x-rays, respondent should have ordered appropriate follow-up studies and referrals.

The Board has adopted all of the above delineated findings and conclusions of the Panel. Based thereon, the Board concludes that cause for disciplinary sanction against respondent exists pursuant to N.J.S.A. 45:1-21 (c) (engaging in gross negligence). The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board being satisfied that, subsequent to the events that are the basis for this action and prior to the commencement of the Panel's investigation, respondent instituted corrective measures at his medical office to seek to prevent any recurrence(s), and that good cause exists for the entry of this Order:

IT IS on this 13th day of January, 2016

ORDERED and AGREED:

1. Respondent George Ambrosio, M.D. is hereby formally reprimanded for having engaged in gross negligence in his care of patient L.B., for the reasons detailed above.

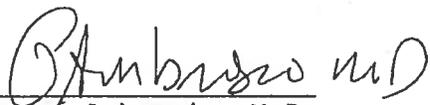
2. Respondent is assessed a civil penalty in the amount of \$10,000, which penalty shall be due and payable in full at the time of entry of this Order.

NEW JERSEY STATE BOARD OF
MEDICAL EXAMINERS

By:


Stewart A. Berkowitz, M.D.
Board President

I represent that I have carefully read and considered this Order, understand its terms, agree to comply with said terms and consent to the entry of the Order by the Board.


George Ambrosio, M.D.

Dated:

1/11/2016

Consent to the form of Order.


Svetlana Ros, Esq.
Counsel for Respondent

Dated:

1/11/2016

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.