STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

August 9, 1994

RECEIVED
AUG 12 1994
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gregory Stamm, Esq.
5555 Main Street
Williamsville, New York 14221

Kevin Donovan, Esq.
Associate Counsel
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

Not Appealed
Effective Date: 8/16/94

RE: In the Matter of Lawrence M. Sherman, M.D.

Dear Mr. Stamm and Mr. Donovan :

Enclosed is the Hearing Committee's Supplemental Determination. Either party may request an administrative review of the Hearing Committee's Supplemntal Determination by filing a Notice of Review with the Review Board within fourteen days of receiving it.

Sincerely,

[redacted]

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER	:	HEARING
OF	:	COMMITTEE'S
LAWRENCE M. SHERMAN, M.D.	:	SUPPLEMENTAL
	:	DETERMINATION

----------X

MICHAEL R. GOLDING, M.D., Chairperson, **MARGARET H. McALOON, M.D.**, and **MARY P. MEAGHER**, duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **GERALD H. LIEPSHUTZ, ESQ.**, served as Administrative Officer for the Hearing Committee.

Pursuant to the Remand Order of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board") received by the Committee during the week of July 4, 1994, the Committee issues this Supplemental Determination following its deliberations on July 29, 1994 held by telephone conference call.

QUESTIONS PRESENTED BY THE REVIEW BOARD

The Review Board in its Remand Order directed the Committee to answer the following questions raised by Respondent's attorney in his letter dated May 19, 1994 to Tyrone T. Butler, Director, Bureau of Adjudication. The Committee's response follows each question:

1. Under Paragraph 1 (p.32) of the Order, may Respondent participate in percutaneous gastrostomies where he does not participate in the endoscopic portion of the procedure and where no laparoscopy is involved?

RESPONSE: Yes, but the Committee emphasizes that Respondent may not participate in the endoscopic portion of the procedure.

2. Under Paragraph 2a of the Order, when must Respondent be assisted by a physician board certified or board eligible in surgery? Is an assistant required for certain types of surgery such as minor excisions, biopsies, carpal tunnel repairs, laser treatments and hemorrhoid removal or treatment?

RESPONSE: Minor surgery which is accepted by the profession as normally done in an office setting need not be assisted. Applying this general rule, minor excisions and hemorrhoid removal or treatment do not require an assistant. Superficial biopsies and superficial laser treatments do not require an assistant. Non-superficial biopsies, non-superficial laser treatments, and carpal tunnel repairs require an assistant under Paragraph 2a of the Order.

3. What are the Category 1 Continuing Medical Education requirements under Paragraph 2b of the Order?

RESPONSE: The Committee adds the following to its Order as clarification on how the CME requirements may be met: Respondent must attend both the Annual October meeting and the Spring April meeting of the American College of Surgeons during each of the five years. He must successfully complete a minimum of two courses per meeting. The remainder of the sixty hour per year requirement, if any, must be successfully completed each year in a university sponsored surgical CME program such as found at the University of Buffalo.

4. Under Paragraph 2c of the Order, may Respondent periodically make up a meeting at another facility if he has a conflict in schedule on the date the principal facility chosen has its surgical morbidity and mortality conference?

RESPONSE: Yes.

5. Do Paragraphs 2a, b, and c apply only if Respondent chooses to return to the operating room as a general surgeon? That is, if he chooses not to continue as a general surgeon, but to practice only within the purview of the present summary suspension, would he be required

to undergo the requirements of Paragraphs 2b and c?

RESPONSE: The requirements of Paragraphs 2b and c apply regardless of Respondent's intentions. At least technically, a license which has not been revoked may give a licensee the right to perform the procedures which the Committee wishes to restrict pursuant to its Order. If Respondent wants to retain his license to practice medicine, he must comply even if he plans not to practice as a general surgeon.

DATED: New York, New York
August , 1994

[redacted]

MICHAEL R. GOLDING, M.D.
Chairperson

MARGARET H. McALOON, M.D.
MARY P. MEAGHER

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

June 26, 1994

Gregory Stamm, Esq.
5555 Main Street
Williamsville, New York 14221

Lawrence Sherman, M.D.
350 Alberta Drive
Suite 107
Amherst, New York 14226

Kevin J. Donovan, Esq.
Rm 2438 Corning Tower
Empire State Plaza
Albany, New York 12203

Re: Lawrence Sherman, M.D.

Dear Parties:

The Administrative Review Board for Professional Medical Conduct has issued the enclosed Determination and Order remanding this case to the Original Hearing Committee, for the reasons stated in the Determination.

The Procedures for the Remand are set out in the Determination. Any penalty imposed by the Hearing Committee in this case shall remain stayed during the course of the Remand, until the Hearing Committee issues a Supplemental Determination.

Sincerely,

[redacted]

Tyrone T. Butler
Director
Bureau of Adjudication

Enclosure

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

IN THE MATTER

OF

LAWRENCE SHERMAN, M.D.

ADMINISTRATIVE REVIEW BOARD REMAND ORDER ARB NO. 94-66

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on June 24, 1994, at which time the Review Board considered Dr. Lawrence Sherman's May 24, 1994 Notice of Review. In the Notice, Dr. Sherman (Respondent) requested clarification of the terms of the penalty which the Hearing Committee for Professional Medical Conduct imposed as part of a May 10, 1994 Determination and Order. Dr. Sherman had requested the clarification directly from the Hearing Committee by letter dated May 19, 1994. The Office of Professional Medical Conduct (Petitioner), by letter dated May 25, 1994, opposed any request to the Hearing Committee for clarification, unless the case is remanded to the Hearing Committee by the Review Board. Following a conference call among the Respondent's and Petitioner's attorney and our Administrative Officer Mr. Horan, the parties consented to submit the request for clarification to the Review Board in an expedited fashion, as a request that the Board remand the case to the Hearing Committee.

Now, following our review of the Respondent's May 19, 1994 and May 24, 1994 requests for clarification of the Hearing Committee's penalty and the Petitioner's May 25, 1994 letter opposing any clarification of the penalty except by the Review Board or by remand to the Hearing Committee, the Review Board votes to **remand** this case to the Hearing Committee so that the Committee can clarify the penalty which they imposed in their May 10, 1994 Determination. The Review Board directs the

Committee to answer the specific questions which the Respondent poses concerning the penalty in the Respondent's May 19, 1994 letter, which we attach to this Determination. The Committee should provide their answers to the parties in a Supplemental Determination, signed by the Committee's Chair. The Hearing Committee may hold any additional deliberations by conference call, if they feel that will expedite the matter. The Hearing Committee's Penalty shall be stayed during the remand. Either party may request an Administrative review of the Hearing Committee's Supplemental Determination by filing a Notice of review with the Review Board, within fourteen days of receiving the Supplemental Determination.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

REMAND ORDER

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the remand of Dr. Sherman's case.

DATED: Albany, New York
June 24, 1994

[redacted]
ROBERT M. BRIBER

REMAND ORDER

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the remand of Dr. Sherman's case.

DATED: Malone, New York

6/24, **1994**

[redacted]

MARYCLAIRE B. SHERWIN

REMAND ORDER

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the remand of Dr. Sherman's case.

DATED: Brooklyn, New York

_____, 1994

WINSTON S. PRICE, M.D.

REMAND ORDER

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the remand of Dr. Sherman's case.

DATED: Roslyn, New York
June 24, 1994

[redacted]

EDWARD C. SINNOTT, M.D.

REMAND ORDER

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the remand of Dr. Sherman's case.

DATED: Syracuse, New York
24 June , **1994**

[redacted]

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

May 10, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin Donovan, Esq.
Associate Counsel
NYS Department of Health
Empire State Plaza
Corning Tower, Room 2438
Albany, New York 12237-0032

Gregory Stamm, Esq.
5555 Main Street
Williamsville, New York 14221

Lawrence M. Sherman, M.D.
350 Alberta Drive
Suite 107
Amherst, New York 14226

RE: In the Matter of Lawrence M. Sherman, M.D.

Dear Mr. Donovan, Mr. Stamm and Dr. Sherman:

Enclosed please find the Determination and Order (No. BPMC 94-66) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 than 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he 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 all action 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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

Very truly yours,

[redacted]

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn
Enclosure

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

IN THE MATTER

OF

LAWRENCE M. SHERMAN, M.D.

HEARING COMMITTEE'S FINDINGS OF FACT, CONCLUSIONS, DETERMINATION AND ORDER NO. BPMC 94-66

MICHAEL R. GOLDING, M.D., Chairperson, **MARGARET H. McALOON, M.D.**, and **MARY P. MEAGHER**, duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **GERALD H. LIEPSHUTZ, ESQ.**, served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee issues its Findings of Fact, Conclusions, Determination and Order.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the **STATEMENT OF CHARGES** attached hereto.

1. Practicing the profession of medicine with negligence on more than one occasion pursuant to New York Education Law Section 6530(3) (FIRST SPECIFICATION)

2. Practicing the profession of medicine with incompetence on more than one occasion pursuant to New York Education Law 6530(5) (SECOND SPECIFICATION)

3. Practicing the profession of medicine with gross negligence pursuant to New York Education Law Section 6530(4) (THIRD THROUGH NINTH SPECIFICATIONS)

4. Practicing the profession of medicine with gross incompetence pursuant to

New York Education Law Section 6530(6) (TENTH THROUGH SIXTEENTH SPECIFICATIONS)

SUMMARY ORDER

This matter was initiated on December 2, 1993, by service on Respondent of a COMMISSIONER'S ORDER AND NOTICE OF HEARING and a STATEMENT OF CHARGES issued by the New York State Commissioner of Health summarily suspending Respondent's license to practice medicine in New York State pursuant to Public Health Law §230(12).

On January 14, 1994, the hearing committee issued a recommendation on the record at the hearing to the Commissioner of Health that his ORDER served on December 2, 1993 summarily suspending Respondent's license be modified consistent with the terms of the committee's recommendation (see transcript of January 14, 1994). The Commissioner accepted the committee's recommendation by INTERIM ORDER dated January 19, 1994. By SECOND INTERIM ORDER dated March 4, 1994, the Commissioner modified his INTERIM ORDER dated January 19, 1994. By THIRD INTERIM ORDER dated April 7, 1994, the Commissioner further modified his INTERIM ORDER dated January 19, 1994.

RECORD OF PROCEEDINGS

Service of Commissioner's ORDER AND NOTICE OF HEARING, and STATEMENT OF CHARGES:	December 2, 1993
Department of Health (Petitioner) appeared by:	Kevin P. Donovan, Esq. Assistant Counsel Bureau of Professional Medical Coduct

Respondent appeared by:	Gregory Stamm, Esq. Stamm and Murray 5555 Main Street Williamsville, NY 14221
Pre-hearing conference:	None held by stipulation of parties due to impossibility of scheduling and conference not necessary
Hearing dates:	1993: December 9 1994: January 5, 6, 7, 12, 13, and 14
Hearing Committee absences:	Dr. Golding was not present during approximately the final seventy minutes of the hearing day of December 9, 1993. Dr. McAloon was not present during approximately the final forty minutes of the morning session of the hearing day of January 13, 1994. Ms. Meagher was not present during the hearing days of January 7, 1994 and January 14, 1994. The three hearing committee members affirm that they have read and considered evidence introduced at, and transcripts of, the times of their absences.
Witnesses called by Petitioner:	Edward Armen Kent, M.D. Raymond J. Lanzafame, M.D.
Witnesses called by Respondent:	Lawrence M. Sherman, M.D., Respondent Robert Alan Milch, M.D. Ursula Falk, Ph.D. Sigmond H. Nadler, M.D. Miguel A. Rainstein, M.D. David Brian Doyle, M.D. H. John Rubinstein, M.D. Stephen Welk, M.D.
Post-hearing written submissions received from	
Petitioner:	February 18, 1994
Respondent:	February 22, 1994
Dates of hearing committee's deliberations:	March 2, 1994 March 3, 1994

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while numbers or

letters preceded by "Ex." refer to an exhibit in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited evidence. All findings of fact were made by a unanimous vote (3-0) of the hearing committee.

1. Lawrence M. Sherman, M.D., Respondent, was authorized to practice medicine in New York State on February 4, 1977, by the issuance of license number 129824 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. His registered address is 350 Alberta Drive, Suite 107, Amherst, New York 14226 (Ex. 2).

PATIENT A: FIRST, SECOND, THIRD AND TENTH SPECIFICATIONS

Paragraphs A and A(1) of the Statement of Charges (hereinafter "The Charges"):

2. Patient A was an 83 year old female with a diagnosis of Alzheimer's disease and dementia, and who had executed a power of attorney (Ex. 4, p. 2).

3. The problem with Alzheimer's patients is one of recollection and interpretation, not comprehension (T. 272). The patient with Alzheimer's can have different levels of functioning on a daily or weekly basis as mentation waxes and wanes (T. 304). This was demonstrated in this case as Respondent explained the procedures to the patient (T. 566-567, 576), yet the patient did not know the reason for her hospitalizations (Ex. 4, p. 15; T. 29).

4. Patient A was admitted to Intercommunity Memorial Hospital, Newfane, New York, on August 19, 1992, for endoscopy (Ex. 4, p. 2). She signed a consent form two days earlier (Ex. 4, p. 21).

5. On the day of her admission, when asked about her understanding of the

reason for the hospitalization, she was "unsure" and "confused to all but self today," and "Patient very confused this a.m." (Ex. 4, p. 15).

6. The surgeon, Respondent in this instance, is the responsible person to obtain appropriate consent prior to a surgical procedure (T. 227). Respondent had obtained adequate consent for the endoscopy two days prior to the surgery (T. 566).

Paragraphs A and A(2) of The Charges:

7. On August 19, 1992, panendoscopy was performed on Patient A by which a lighted fiber optic was passed into the patient to observe her stomach (T. 228-229). In his report on this panendoscopy, Respondent noted edema along the greater curvature and a polypoid tumor with central ulceration and necrosis (Ex. 4, p. 11; T. 229).

8. Respondent then proceeded to obtain multiple biopsy samples from what he referred to as the "tumor" (T. 230; Ex. 4, p. 11).

9. Respondent did not observe any bleeding at the site of the ulcer (T. 230). His reference to "minimal bleeding" in his operative report refers to the site from which the biopsies were taken (T. 230).

10. The biopsy samples submitted by Respondent contained no atypia (abnormal cells), no malignancy (carcinoma), and no neoplastic cells (carcinoma) (T. 231; Ex. 4, p. 12). The biopsy samples submitted showed acute and chronic gastritis (T. 230; Ex. 4, p. 12).

11. The history of the patient as recorded by Respondent noted that the patient had mild senile dementia and, among other things, heme positive stools (Ex. 5, p. 8; T. 231-232). Heme positive stools can be caused by many things including, but not limited to, bleed, medications, ulcer disease, tumors in the alimentary tract, trauma and eating undercooked meat (T. 232).

12. The patient was noted to have adjustment reaction with mixed emotional features and mild Alzheimer's disease (Ex. 5, p. 156). She was also noted to have impaired mentality and a forgetful, confused mental status (Ex. 5, pp. 156-157).

13. The signature of Patient A on a consent for the endoscopy, possible gastrectomy, is dated September 16, 1992, at 10:00 a.m. (Ex. 5, p. 338). However, Respondent was contacted by telephone about the patient's ability to consent on the day of surgery, and although he was not there viewing or examining the patient himself (T. 624), he told the staff that the patient could sign her own consent (Ex. 5, p. 42; T. 577). That conversation took place at 11:35 a.m. (Ex. 5, p. 42). Prior to the nurse's 11:35 a.m. telephone conversation with Respondent, the patient had been given Versed at 10:55 a.m. (Ex. 5, p. 38), which is a drug used for conscious sedation and which produces a cooperative patient with no short-term memory (T. 234). Respondent had not reviewed the nursing notes at the nursing home or the nursing home transfer document (T. 605-607, 619; Ex. 5, pp. 156-157).

14. Respondent had discussed the pending second surgery two days earlier with the patient. That discussion, however, was superficial, and it did not adequately cover the risks, benefits and possible alternate course of action (T. 575-577).

Paragraph A(3) of The Charges:

15. Four weeks after the endoscopy, Respondent again admitted Patient A to Intercommunity Memorial Hospital on an ambulatory basis on September 16, 1992 (Ex. 5, p. 2). His stated plan was that there had been a previous scoping of a tumor in the stomach with negative biopsies, that appropriate therapy had been instituted for four weeks, and that he intended to rescope and resect if there was a persistent lesion. The patient was in no acute distress and was asymptomatic (Ex. 5, p. 8; T. 232).

16. During the scoping, Respondent reported little change in the tumor, and he wrote that he needed to proceed to gastrectomy (T. 239; Ex. 5, pp. 4, 46).

17. Respondent proceeded to perform a proximal gastrectomy, an en bloc splenectomy and a pyloroplasty. His preoperative and postoperative diagnoses were gastric carcinoma (Ex. 5, p. 46).

18. Frozen section is a technique for examining tissue samples by pathology at the time of surgery. This is routinely done during the course of an operation (T. 256), but it was not done in this case (T. 645-646). The gastrectomy and splenectomy were not done on an emergent basis (T. 582-583).

19. In this case, the pathology report from the gastrectomy and splenectomy found no cancer, but only the acute penetrating ulcer with an unremarkable spleen (T. 255; Ex. 5, pp. 48-49).

20. Respondent wrote on the hospital chart that even assuming benign disease, this operation needed to be performed (Ex. 5, p. 4; T. 257). This is not accurate, and this extensive an operation did not need to be performed. The procedures performed by Respondent did not meet acceptable standards of medical care (T. 257). Procedures that involve removing less of the stomach would include removing portions of the distal stomach that produces acid with or without removing the ulcer itself. Vagotomy would be the standard operation (T. 258-259).

Paragraph A(4) of The Charges:

21. The patient should have had a complete blood count with differential, blood chemistry, and then typed and screened or typed and cross-matched for potential transfusion (T. 246-248). The lack of timely type and cross-match on the patient preoperatively resulted in a situation in which the patient's blood pressure dropped during the operation due to blood loss, while blood could not be immediately transfused because Respondent had brought the patient into the operating room without a cross and type match for blood (T. 41). The surgeon is the one responsible for assuring that tests are done so that blood transfusions can take place as necessary (T. 41-42).

22. Respondent did not meet acceptable standards of medical care because he did not permit an adequate trial of medical management, reevaluation, and rebiopsy prior to

performing the gastrectomy and splenectomy (T. 255-256). The patient should have been allowed a minimum of six to eight weeks of therapy and should have been rebiopsied (T. 255-256, 300, 309). Ecotrin may be ulcerogenic and it is not part of an anti-ulcer regimen (T. 237, 243).

Paragraph A(5) of The Charges:

23. It is apparent from the hospital record that Respondent thought he was dealing with metastatic carcinoma on September 16, 1992 (T. 250; Ex. 5, p. 46), as he reported finding small tumor nodules in the liver and the serosa had large nodal metastases (Ex. 5, p. 46). This would indicate to a reasonably prudent surgeon an advanced cancer with metastatic disease (T. 250-251). Metastases are ominous, particularly hepatic (liver). The patient's survival will be measured normally in months (T. 251-252).

24. Assuming this patient had cancer, as Respondent did, the gastrectomy and splenectomy he performed did not meet acceptable standards of medical care as the gastrectomy was too extensive, and there was no need to remove the spleen (T. 252-253). The objective in this procedure would be palliation, to avert obstruction, perforation, or bleeding. In any event, the amount of tissue removed would not change this patient's long-term survivability (T. 253-254). The objective would be to choose the procedure that has the least risk involved but which would solve the problem (T.254). The reason a lesser rather than a greater operation is important is that, generally, the bigger the operation that is performed the greater the possibility that there will be complications (T. 322).

25. The hearing committee repeats Finding of Fact #19 herein.

26. The hearing committee repeats Finding of Fact #20 herein.

27. The mortality rate for gastric resection is from six to twenty-five percent (T. 310). Splenectomy makes the surgery bigger and increases the likelihood of complications, specifically post-splenectomy abscess (T. 311).

Paragraph A(6) of The Charges:

28. The hearing committee repeats Finding of Fact #22 herein.

Paragraph A(7) of The Charges:

29. The hearing committee repeats Finding of Fact #20 herein.

PATIENT B: FIRST, SECOND, FOURTH AND ELEVENTH SPECIFICATIONS

Paragraph B of The Charges:

30. Patient B was a sixty year old female admitted to DeGraff Memorial Hospital on July 31, 1989 by a physician whose impression of the patient was pelvic abscess with sigmoid diverticulosis (Ex. 7, pp. 2, 7). This physician's plan was to obtain a surgical consult, which he did from Respondent (Ex. 7, pp. 7, 12). Respondent's finding was that there was a large pelvic abscess relating to perforated diverticulitis, and he proposed a plan of diverting colostomy and draining the abscess (T. 167; Ex. 7, p. 12).

31. At the operation the abscess was huge and lay behind the sigmoid colon so that the abscess lay in a retroperitoneal position, which was somewhat unusual. The abscess extended medially towards the midline and became adherent to the anterior abdominal wall in the midline. There was no intraperitoneal contamination. Drainage transrectally was originally considered but did not appear feasible, so an anterior approach was required (Ex. 7, p. 58).

32. The best place to drain the abscess was where pus could be kept from contaminating the peritoneal cavity. In Patient B this was in the lower midline where the abscess was adherent to the anterior abdominal wall (T. 917).

33. Therefore, a small incision was made over the most fluctuant spot. A trocar

was inserted and 1100cc's of pus was drained and cultured. This incision was then enlarged, and the wall of the abscess was marsupialized onto the anterior abdominal wall . An Abramson sump tube was inserted, tested to be sure that it was functional (saline could be flushed into the abscess cavity and pus could be aspirated out), and a transverse loop colostomy was created to divert fecal flow. On closing the abdomen, a small umbilical hernia was repaired as part of the closure (Ex. 7, p. 58).

34. The site chosen for sump tube placement was deliberate, being a place in the abdomen where drain insertion would not produce intraperitoneal contamination by leakage of pus around the tube (T. 918). Despite the relative proximity of bladder to anterior abdominal wall at this site, it still was a relatively safe and effective location to place a drain (T. 919).

35. In testing the Abramson sump in the operating room there was no evidence of bladder perforation. Otherwise urine would have been aspirated from the sump, and pus and irrigation fluid would have been noted in the Foley catheter (T. 942-943). The recovery room record indicates that the sump functioned independently of the bladder for at least two hours, with the Foley catheter draining 100cc's of dark amber urine (Ex. 7, p. 101), while the Abramson sump drained 75cc's of reddish purulent material (Ex. 7, p. 98).

PATIENT C: FIRST, SECOND, FIFTH AND TWELFTH SPECIFICATIONS

Paragraph C of The Charges:

36. Respondent treated Patient C, a 70 year old female who was admitted to DeGraff Memorial Hospital on April 6, 1993 (T. 317; Ex. 8, pp. 48, 63).

37. The patient was admitted due to constipation, diarrhea, abdominal pain, and a twenty-five to thirty pound weight loss (Ex. 8, p. 63). She was diagnosed as having obstruction of the splenic flexure of the colon which was confirmed by colonoscopy (T. 317; Ex. 8, pp. 63-66).

38. Respondent noted that during the procedure he found liver metastases extensively, hard nodules in the liver consistent with metastic disease, and ascites (T. 318-319; Ex. 8, p. 73). Liver metastases and ascites mean that this patient's cancer condition was more severe than that of Patient A as ascites with liver metastases may indicate severe derangement of liver function and intraperitoneal tumor cells (T. 318-319).

39. Respondent performed a partial colectomy on Patient C, removing the mid-transverse colon to the distal sigmoid colon (T. 320). He, therefore, removed the proximal part of the sigmoid colon (T. 952).

40. The pathology report confirmed Respondent's suspicion of cancer and metastases to the liver and lymph nodes (T. 320; Ex. 8, p. 117).

41. The blood supply to the splenic flexure is a notoriously treacherous area, because it is not constant or universally intact, so that often one must take a larger portion of colon than what may be theoretically indicated (T. 795).

42. Important considerations in doing the resection are "can I relieve the obstruction and is the gut viable at both ends" (T. 327-328).

43. When dealing with lesions of the splenic flexure, one must be certain that there is an adequate blood supply to the remaining ends of the specimen to assure adequate healing. The amount of colon resected is dictated by safety, not by concerns of palliation. The operative record reflects that the specimen was resected at sites where one would normally expect the most secure and safest blood supply (T. 794).

PATIENT D: FIRST, SECOND, SIXTH AND THIRTEENTH SPECIFICATIONS

Paragraph D of The Charges:

44. Patient D, a 29 year old female who had two episodes of biliary colic and documented gallstones, was admitted to Kenmore Mercy Hospital on August 27, 1990 for an

elective laparoscopic cholecystectomy (Ex. 9, p. 4; T. 330-331).

Paragraph D(1) of The Charges:

45. During this procedure the patient developed hypotension and was found to have a tear of the inferior vena cava. Four units of blood were transfused (T. 331).

46. Respondent was the primary surgeon for this laparoscopic cholecystectomy on Patient D (Ex. 9, p. 22; T. 332).

47. Laparoscopic cholecystectomy is contrasted with removal of the gallbladder by an open procedure. During the open procedure, the abdomen is entered through a right subcostal incision which is an upper abdominal incision on the right side of the abdomen below the ribs (T. 333). During a laparoscopic cholecystectomy, four puncture wounds are made in the patient's abdomen. Trocars are placed in these openings which become the portals for entry into the patient's abdomen for the camera and instruments to dissect and remove the gallbladder (T. 333-334). In this case, the initial puncture was by a Verres needle through which gas was pumped to create pneumoperitoneum which aids visualization (T. 334). A camera was then placed through the area of the incision which created the pneumoperitoneum (T. 334-335). The second entry point is in the upper midline where the surgeon would work, and the assistant surgeon works through two entry points created on the patient's right side (T. 334-335). In this case the trocars which were inserted were sharp, as was the Verres needle (T. 336).

48. Although more than one surgeon is involved in operating the equipment during a laparoscopic cholecystectomy, the primary surgeon is the one responsible for the case, and would direct the placement and maneuvering of instruments within the abdomen (T. 335).

49. During this procedure hypotension was noted which did not respond quickly to fluid replacement (T. 337).

50. After this occurred, Respondent examined the gallbladder bed but could see

no major hemorrhage, so he converted the procedure to an open one (T. 338; Ex. 9, p. 23). He noted that the gallbladder was relatively free of bleeding, and he finished removal of the gallbladder. He then found a huge clot in the pelvis from an obvious retroperitoneal hematoma. He opened the retroperitoneum and found a laceration of the anterior surface of the inferior vena cava (Ex. 9, p. 23; T. 338). Respondent reported the laceration to be the likely result of one of the instruments or the Verres needle (Ex. 9, p. 23; T. 338). He then repaired the inferior vena cava (T. 338).

51. The laceration of the patient's inferior vena cava did not meet acceptable standards of medical care (T. 340). The inferior vena cava is the main venous conduit from the lower extremities and the abdomen to the heart, and it is about two to three centimeters in diameter (T. 341). While this complication can occur, it is preventable if appropriate technique is used (T. 341). Appropriate technique is to insert the Verres needle toward the pelvis as opposed to inserting it straight front to back (T. 342). This injury occurs when the surgeon inserts the Verres needle or trocar in the patient in an anterior to posterior direction (T. 342). The Verres needle and first trocar are inserted blindly (T. 342). All the trocars and instruments thereafter should be inserted and operated under direct visualization (T. 334, 361-362).

52. Due to the size of the laceration this injury probably was created with the trocar, although it could have been created with the Verres needle (T. 357). The diameter of the Verres needle is about 1.5 millimeters. The end of the trocar is cone-shaped with a maximum diameter of ten millimeters (T. 357-358). While the laceration could have been created by the trocar, it would not necessarily be pushed all the way to the ten millimeter diameter (T. 358).

53. This is a deviation from accepted standards of medical care because it can only occur when a needle or trocar is inserted at the wrong angle (T. 359-360). The laceration can occur unseen with instruments inserted without visualization, namely the Verres needle or the initial trocar. Following insertion of the camera, any injury should be seen unless there is use of instruments where the camera is not looking, which does not meet acceptable standards as laparoscopic work must be done under direct visualization (T. 361-362).

54. The danger of laceration of the inferior vena cava is exsanguinating hemorrhage, or bleeding to death (T. 342). In this case, the laceration most likely occurred early in the procedure, but the tamponade created by the pneumoperitoneum reduced the rate of bleeding (T. 343). This is due to the pressure of the gas that created the pneumoperitoneum exceeding the pressure in the vena cava (T. 343-344).

Paragraph D(2) of The Charges:

55. Respondent appropriately converted the procedure. The initial step was to complete the cholecystectomy which was accomplished with a "quick snip" (T. 1239). The next step was to locate the bleed (T. 1239).

56. A laparoscopic surgeon would be unaware of a patient developing tachycardia or hypotension unless the anesthesiologist told him (T. 1078-1079).

57. Dr. Rubenstein confirmed that within a five minute period from the time of the anesthesiologist's announcement of hypotension, laparotomy commenced (T. 1171). This was an appropriate timeframe (T. 1087).

58. Receiving transfusions at 2:45 (30 minutes after BP drop) was appropriate (T. 357).

59. From the time that the anesthesiologist noted hypotension until the first unit of blood was given took twenty-five minutes. This response was timely and appropriate (T. 1053-1054).

PATIENT E: FIRST, SECOND, SEVENTH AND FOURTEENTH SPECIFICATIONS

Paragraph E of The Charges:

60. Respondent treated Patient E, a twenty-eight year old female admitted to

Kenmore Mercy Hospital on March 13, 1991 (Ex. 10, p. 4; T. 366).

61. Patient E had a history of several months of right upper quadrant abdominal pain, and work-up demonstrated a large gallstone at the neck of the cystic duct. She was admitted for an elective laparoscopic cholecystectomy (Ex. 10 , pp. 9-10; T. 366).

62. During the attempted laparoscopic cholecystectomy, Respondent found a tremendous amount of edema around the gallbladder (T. 368; Ex. 10, p. 34). Respondent reported locating what appeared to be the triangle of Calot and what appeared to be a normal small sized cystic duct. He followed it to what appeared to be the entrance of the gallbladder, clipped it, and then divided it (Ex. 10, pp. 34-35). He then found another duct but this raised a question as to precise anatomy, and he performed a cholangiogram (T. 368; Ex. 10, pp. 34-35).

63. During laparoscopic cholecystectomy, the cystic duct, which connects the gallbladder to the common bile duct, is cut. The common bile duct, common hepatic duct, and intrahepatic bile ducts are not cut (T. 369).

64. The identification of the cystic duct versus the common bile duct is classically done by careful dissection so that structures are completely dissected, i.e., skeletonized, and identified (T. 370, 387). The presumed cystic duct must be followed to the gallbladder and back to the junction of the cystic duct and common bile duct (T. 370). Absolute identification can occur by following the common bile duct to both of its ends at the cystic duct and gallbladder (T. 370). If this cannot be done, cholangiography, or x-ray, of the area should be performed (T. 371).

65. Respondent's laparoscopic cholecystectomy of this patient was videotaped. That videotape was viewed by three surgeons who described their findings individually (Ex. 15, p. 3). They noted considerable errors in technique. Specifically, the common duct was approached immediately, the ampullary area and the junction with the cystic duct and common duct were not appreciated, and clips were applied without completely dissecting structures. Following transection of the common duct, two lumens appeared and the transection should have been recognized immediately. However, dissection continued in an unsafe area and caused

continued trauma to the common duct (T 371-372, Ex. 15, p. 3).

66. It is important not to cut the common bile duct as it can result in permanent or life-threatening complications such as biliary stricture, sepsis and death (T. 373-374). Biliary stricture can cause obstructive jaundice, hepatic failure and death (T. 376). It can also result in continuing need for revision or repair of the duct, and the morbidity and mortality related to those procedures (T. 376).

67. The duct was transected before it was identified with certainty (T. 373, 386). The appropriate steps to take in laparoscopic cholecystectomy are to completely dissect structures and identify where they are going and coming from (T. 386). Dissection should continue until the structure is skeletonized (T. 387). In this case it is also obvious that Respondent was dissecting close to the duodenum which would be an unusual location for the cystic duct to be entering the common duct (T. 387).

68. If anatomy cannot be identified by dissection, either a cholangiogram must be done, or the operation must be converted to an open one (T. 387). Converting to open would be helpful as it would permit the surgeon to directly visualize, palpate, and manipulate the structures (T. 388).

69. Respondent did not take appropriate steps in accordance with accepted standards of medical care to identify the common bile duct and cystic duct before transecting (T. 372).

PATIENT F: FIRST, SECOND, EIGHTH AND FIFTEENTH SPECIFICATIONS

Paragraphs F and F(1) of The Charges:

70. Respondent treated Patient F, a sixty-one year old female who was admitted to Kenmore Mercy Hospital on March 5, 1993, for abdominal pain (T. 397; Ex. 11, p. 8). A sonogram of the patient showed cholelithiasis, or gallstones (Ex. 11, p. 8; T. 398), and

Respondent undertook performances of a laparoscopic cholecystectomy on this patient on March 5, 1993 (Ex. 11, p. 8).

71. In the operative report Respondent noted considerable adhesions consistent with chronic cholecystitis, and difficult dissection and removal of the gallbladder due to dense adhesions (T. 399-400; Ex. 11, pp. 261-262). Respondent performed much of the dissection and gallbladder removal using electrocautery (Ex. 11, p. 261).

72. In the first day postoperative, March 6, the patient was noted to have "severe" pain along her lateral stab wound site (Ex. 11, p. 10; T. 400). On the morning of March 7, Respondent noted that the patient had a temperature of 102.9 the night before but was "afebrile now, complains of severe pain, unable to breath well, rales in right chest" (T. 400; Ex. 11, p. 10).

73. On March 7 the respiratory therapist noted at 7:40a.m. that the patient was having a hard time doing breathing exercises and was confused over technique. The therapist made a similar notation at 11:15 that morning as well (T. 401, Ex. 11, p. 353).

74. At 5:34p.m. on March 7, Respondent was contacted by a nurse and was told that the patient had a grossly distended abdomen, that the house officer was notified, and that flat and upright of abdomen ordered, results pending (T. 404; Ex. 11, p. 552).

75. In the evening of March 7 at 7:15p.m., there was a note by the house officer who was called to see the patient and who called Respondent concerning the patient. He found the patient's abdomen tender in all four quadrants and reported after an x-ray had been taken that there were large amounts of free abdominal air (T. 401-402; Ex. 11, p. 10). Although the report of that x-ray may not have been available until March 8 (Ex. 11, p. 216), it is clear that the house officer had the information about what this x-ray showed and passed this information along to Respondent in a telephone call (Ex. 11, p. 11; T. 404). Respondent felt that the air was due to delayed emptying of air from the laparoscopic cholecystectomy (Ex. 11, p. 11).

76. Postoperatively, the patient required medication around the clock, including intramuscular injection on March 6 and 7, the first and second postoperative days (T. 406-408).

77. There were multiple calls from the hospital staff to Respondent during the

day and early evening of March 7, but Respondent stated it was not until around 10:50 p.m. that he decided to come in (T. 1308; Ex. 11, p. 553), and the nurses recorded 11:30 p.m. as the time they were aware that Respondent was coming to the hospital (Ex. 11, p. 553).

78. For a patient that had laparoscopic cholecystectomy, it is not the usual course to have this severe degree of abdominal pain in the second postoperative day (T. 410-411). Furthermore, free air noted in the house officer's note of 7:15 p.m. on March 7 would indicate to a reasonably prudent surgeon the possibility of an untoward event, particularly this amount of air two days postoperatively (T. 411). While it is true that carbon dioxide is used for insufflation during laparoscopic cholecystectomy, it is released after the procedure. While a small amount may be left a few days later, large amounts of free abdominal air would not be (T. 412-413).

Paragraph F(2) of The Charges:

79. The hearing committee repeats Finding of Fact #75 herein.

80. The hearing committee repeats Finding of Fact #77 herein.

81. Respondent failed to appropriately evaluate and treat this patient in a timely manner on March 7, 1993 (T. 411-412). This patient should have been evaluated and treated at a time earlier than Respondent did so (T. 414). During the course of the telephone conversation with the house officer, Respondent had the following facts: a patient with a difficult dissection with a lot of electrocautery and dissection, a patient with evidence of increasing abdominal pain, evidence of ileus such as emesis, nausea, poor intake, a febrile postoperative course, inability to take deep breaths, and an x-ray series showing significant free air (T. 411-412). This information should have prompted a contrast study of the stomach and the duodenum to rule out the possibility of perforation (T. 412). In fact, Respondent should have been suspicious and alert to the possibility of a complication when he evaluated the patient on the morning of March 7 (T. 444). The diagnosis should have been established at the time of the x-ray after 7:00 on March 7 (T. 450). This is an extremely difficult diagnosis to miss (T. 451).

82. Respondent should have been alert to a concern on the morning of March 7 (T. 444), and he should have ordered and received a chest x-ray that morning when respiratory difficulties had been noted (T. 441).

83. That afternoon the nurse called to say that the patient's abdomen was distended and that she had not had a bowel movement, so a Fleet's enema was ordered. At 8:20 p.m. the house doctor called. He had been called to see the patient at 7:15 p.m. and had ordered an abdominal x-ray. The abdominal x-ray demonstrated a lot of free air which Respondent interpreted as too much retained CO^2 from her previous surgery (T. 1295, 1297).

84. In the early hours of March 8, the Respondent did take the patient to the operating room and found a perforation of the duodenum, but no signs of trauma or burn (T. 417; Ex. 11, p. 269).

85. During the initial procedure, Respondent noted taking down adhesions by blunt dissection and electrocautery (T. 418; Ex. 11, p. 261). Perforation of the duodenum can occur with blunt dissection, by traction and by tearing (T. 418). When dissecting bluntly, the surgeon should be aware of any perforation (T. 418).

86. Perforation when dissecting with electrocautery can occur as the result of transmural injury from the application of the current by the electrode, or by stray sparking (T. 418-419).

87. Spark injury is preventable by using the minimum amount of current for coagulation, using the minimum amount of dwell time, that is the time of contact of electrode on the site, by taking care to ensure that the electrode contacts only areas of interest, and by modifying the electric current if there is any evidence of sparking (T. 448).

88. Respondent caused injury to the patient's duodenum before closure (T. 421). This represents a serious, life threatening complication of an elective surgical procedure (T. 421). Respondent failed to recognize in a timely manner that he had caused the injury (T. 422).

PATIENT G: FIRST, SECOND, NINTH AND SIXTEENTH SPECIFICATIONS

Paragraphs G and G(1) of The Charges:

89. Respondent treated Patient G, an eighty-six year old female who was admitted to DeGraff Memorial Hospital on January 30, 1993, after having been found by her family in an unresponsive state (T. 456; Ex. 12, pp. 5, 10).

90. Upon being contacted for surgical consultation, Respondent noted Patient G to have diabetes mellitus, to be status post-cerebral vascular accident, to be unresponsive and on oral hypoglycemic agent (Ex. 12, p. 29; T. 457-458). Respondent recommended performance of jejunostomy, which is a surgically created connection to the jejunum through the abdominal wall for a feeding tube (T. 458; Ex. 12, p. 29). Respondent wrote in the chart that he would follow the patient, meaning that he would continue to evaluate, examine and offer suggestions (Ex. 12, p. 29; T. 458).

91. On February 19, Respondent performed the jejunostomy (T. 459; Ex. 12, p. 37). Between February 15 and March 9, the patient had a low grade fever with spikes (T. 460-461). Respondent wrote on the chart that he should be recalled as needed (Ex. 12, p. 43).

92. Respondent again saw the patient on February 27 to evaluate the peg site (Ex. 12, p. 46).

93. On March 7, Respondent's office was called about leaking of a large amount of yellow drainage around the tube. Respondent came and adjusted the tube and wrote "No further suggestions" (T. 461-462; Ex. 12, pp. 55-56).

94. Respondent was called in to see Patient G for the very limited purpose of establishing a route of enteral alimentation, yet he noted that the patient had been febrile almost since the moment of admission, with evidence of pneumonitis. He therefore ordered appropriate testing including the performance of a barium swallow (Ex. 12, p. 29). The results of that test demonstrated a large hiatal hernia with considerable reflux into the proximal esophagus (Ex. 12, p. 109), leading him to recommend a feeding jejunostomy since the standard approach of gastrostomy was rendered inappropriate (Ex. 12, p. 34). It also established the patient's cause of

fever. Following the jejunostomy on February 19, the patient remained afebrile from February 21 until after Respondent signed off of the case on February 25 (Ex 12, pp. 383-385).

95. From February 20 until March 5, the patient ran a normal temperature curve (T. 460) with surgically significant fever classified at 101.5 (T. 461).

96. There were several doctors involved in the care of Patient G from the time of admission forward including an internist, cardiologist, renal doctor, gastroenterologist, neurologist, and infectious disease consultant (T. 477-478). Respondent was not responsible for treatment of the fever sustained for the twelve days prior to being consulted (T. 480) and the jejunostomy was appropriate (T. 482).

97. It was appropriate for a surgeon to sign off the case on February 25, given there was six other doctors involved in her care (T. 483). On March 7, Respondent was recalled to assist in the care of the jejunostomy stoma (Ex. 12, pp. 55-56). He assessed the situation, recognized it as minor and not contributory to her problems of occult infection or fever (T. 808, 972-973). The jejunostomy was not the source of fever (T. 810). There was no need to order contrast studies at that time (T. 812).

98. Between February 28 and March 22, the patient had three sets of urine cultures, three sets of blood cultures, a stomal culture, a throat culture, two C. dificile titers, stool for pathogens, three chest x-rays, an abdominal sonogram, a paranasal sinus study, a CT scan, and gallium scan all ordered by the other physicians involved in Patient G's care (T. 485-486).

Paragraph G (2) of The Charges:

99. On March 5, Patient G had ultrasound of the kidneys which demonstrated gallstones. The report made no mention of a thick-walled gallbladder which would be indicative of infection (Ex. 12, p. 111). A CT scan reported a thickened gallbladder wall, and Respondent was reconsulted on March 18 (Ex. 12, p. 70). At that time, he ordered a hepatobiliary scan to determine if the cholelithiasis might have clinical significance (Ex. 12, p. 70). Gallstones in an otherwise healthy diabetic are themselves indications for elective cholecystectomy (T. 975-976).

100. Respondent, in his preoperative note, mentions both open and laparoscopic cholecystectomy as potential approaches in Patient G, and he recommends an attempt at laparoscopic surgery as the better tolerated procedure. He states that he will discuss this with the family (Ex. 12, p. 76).

101. The decision to perform laparoscopic cholecystectomy rather than an open procedure in this patient was not acceptable (T. 466). That is because this ill patient had recent upper abdominal surgery with a surgically fixed small intestine which would make exposure much more difficult. Further, there was evidence of ongoing cholecystitis (T. 466). While it may have been an acceptable option to assess the situation laparoscopically, the decision to go ahead with a laparoscopic cholecystectomy in this case was not appropriate (T. 467).

102. With the prior upper abdominal surgery (the recent jejunostomy), there would be expected changes such as adhesions at the surgical site and distortion of anatomy, particularly with the ostomy created. This would make positioning of the instruments and visualization at the surgical site for laparoscopic surgery difficult at best (T. 469). The jejunostomy would also complicate the laparoscopic cholecystotomy as the jejunum would be adherent in the area of the camera or surgeon's trocar, and it would be expected that there would induration or swelling and firm fibrotic tissue at the site of the previous surgery (T. 470). As this patient was intended to be in the hospital for quite a period of time, the usual reasons to perform laparoscopic cholecystectomy such as smaller scars, shorter stay, more rapid recovery, and more rapid return to normal activity would not apply (T. 467-468). While the other possible benefit of fewer pulmonary complications may exist, it does not outweigh the complicated situation which would be presented for laparoscopic cholecystectomy in this patient (T. 468-469).

103. What would be expected to be found in this patient was verified in Respondent's operative report in which he noted finding dense adhesions and that the gallbladder was tremendously thickened and erythematous, consistent with subacute cholecystitis (T. 472-473; Ex. 12, p., 306). Further, Respondent reported finding tremendous dense adhesions around the area of the triangle of Calot (T. 473).

Paragraph G(3) of The Charges:

104. It was during this dissection that Respondent noted the hole in the common bile duct (T. 474), and converted the procedure to open.

105. Respondent's laceration of this patient's common bile duct was the result of an attempt to perform or continue the laparoscopic operation with very difficult dissection in this very ill patient (T. 474). The operative note which indicates the difficult dissection, the dense adhesions in the right upper quadrant, the tissue around the gallbladder, the "tremendously thickened gallbladder" and the difficult dissection in the area of the triangle of Calot with "tremendous dense adhesions" all support the difficulty of a closed approach (T. 474-475; Ex. 12, p. 306).

106. While a cholangiogram was performed in this case, it should have been performed before dividing any duct given the degree of difficulty of dissection and identification (T. 475).

107. Some studies indicate that laceration of the common bile duct occurs about one in a thousand operations. Other studies identify this complication in two to five percent of operations. It has been established that in acute or difficult gallbladder cases the incidence of injury increases dramatically, and that with subacute gallbladder one would expect a higher incidence of these complications (T. 506). One would also expect more dense adhesions in patients with a recent acute event or several episodes of colic (T. 507-508).

108. Once the laparoscope was inserted and the surgeon saw dense adhesions, whether to continue or to convert would depend on the surgeon's judgement and experience (T. 508).

LEGAL DETERMINATIONS SUBMITTED BY THE ADMINISTRATIVE OFFICER

The administrative officer reviewed the parties' written arguments regarding the

definitions of professional misconduct to be applied in this matter. Also reviewed was the memorandum dated February 5, 1992 distributed by Peter J. Millock, General Counsel, New York State Department of Health. This memorandum was prepared to inform the members of the Board for Professional Medical Conduct and others during hearings concerning the Department's position on the definitions of misconduct. All Board members, Health Department prosecutors and administrative officers were provided a copy of the memorandum in 1992. At the commencement of each hearing, the existence of the memorandum is noted by the hearing committee chairperson and the Respondent is offered a copy. Respondent is also notified at this time of Respondent's right to contest the definitions in writing prior to the closing of the hearing. The Department of Health provided Respondent herein with a copy of the February 5, 1992 memorandum.

Pursuant to the review of the above-mentioned documents and the applicable judicial determinations, the administrative officer directed the hearing committee herein to apply the following definitions of professional misconduct as a matter of law:

1. Negligence is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

2. Gross negligence is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and the act or omission must be of an egregious or conspicuously bad nature manifesting a disregard of the consequences which may ensue from the act and indifference to the rights of others. There must, therefore, be evidence of a consciousness on the part of the physician of impending dangerous consequences if he persists in his conduct. Proof of actual injury is not an element of gross negligence.

3. Incompetence is a lack of the skill or knowledge necessary to perform an act undertaken by the physician in the practice of medicine.

4. Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the physician in the practice of medicine. There must be a total and flagrant lack of necessary knowledge or ability.

The administrative officer also instructed the hearing committee that the statutory definitions of negligence and incompetence for professional misconduct purposes require proof of negligence or incompetence "on more than one occasion". "Occasion" has been defined by New York's highest court to mean "an event of some duration, occurring at a particular time and place, and not simply...a discrete act... which can occur in an instant." Rho v. Amabach, 74N.Y.2d 318, 322 (1989).

Regarding the above definition of gross negligence, the administrative officer has reviewed the decision of the Administrative Review Board (ARB) submitted by Petitioner herein and previously issued by the ARB in the Matter of Henry Herrera, M.D. In that decision, the ARB rejected the administrative officer's definition of gross negligence and stated that the ARB "did not consider consciousness as an element of gross negligence, because consciousness is not an element in the definition of gross negligence in professional misconduct cases as that definition has been established recently by the courts, Rho v. Ambach, 74 NY2d 318(1989); Spero v. Board of Regents, 158 A.D. 2d763, 551 N.Y. S. 2d 352 (Third Dept. 1990)."

The administrative officer has rejected the ARB's opinion and he has instructed the hearing committee herein that consciousness is indeed an element of gross negligence in medical misconduct in New York due to the conclusion that the ARB is legally and procedurally incorrect for the following reasons:

1. Petitioner's argument in this case, and that by his colleagues in several other recent cases, ignores the fact that Petitioner's clear written position is and has been that consciousness is an element of gross negligence for professional misconduct purposes. Its widely distributed memorandum of February 5, 1992 states that (underling added)

> There must be evidence of a consciousness on the part of the (licensee) of impending dangerous consequences if he persists in his conduct...", as well as failure to desist. Id. The requisite knowledge or consciousness may, however, be inferred from the

relevant conduct and other facts found by the hearing committee.

In spite of its own language, Petitioner has argued in Herrera and other matters that the consciousness element it writes about arose out of a case other than a professional medical conduct matter, and that it was not meant to apply to our hearings. That argument loses all persuasiveness in light of the above underlined language which speaks of the requisite knowledge or consciousness which may be inferred by the hearing committee. What "hearing committee" could it possibly be referring to other than a professional medical conduct hearing committee?

2. The ARB when rejecting the element of consciousness in gross negligence in the Herrera matter stated that it did so because it believed that consciousness was not established as an element of the definition of gross negligence as that definition has been established recently by the courts. The Rho and Spero cases were then cited by the ARB. The administrative officer submits that the ARB's legal analysis was incomplete and, thus, incorrect. Rho stated that negligence becomes gross when it is "egregious". Spero later provided that egregious means "conspicuously bad". Nothing further relevant to the matter herein was offered by either court regarding the definition of gross negligence. What does "conspicuously bad" mean? "Conspicuous"has been defined as "obvious to the eye or mind: plainly visible: manifest" (Webster's Third New International Dictionary, Unabridged, p. 485; 1981). Additionally, Black's Law Dictionary (Sixth Edition, 1990, pp. 1033-1034) defines gross negligence as "The intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another..." Black's recognizes, as does the administrative officer and the definition given to the hearing committee, that gross negligence differs from wilful and intentional conduct, but it still "consists of conscious and voluntary act or omission which is likely to result in grave injury when in face of clear and present danger of which alleged tortfeasor is aware" (underling added). Those plain definitions and Petitioner's clear pronouncement in its memorandum submitted to all participants in this hearing that

consciousness is a requisite to be dealt with by a hearing committee when considering gross negligence constitute the administrative officer's primary basis for determining that the ARB was incorrect in concluding that recent court decisions have precluded consciousness as an element of gross negligence. Rho and Spero are consistent with the definitions of gross negligence given to the hearing committee. If somehow one accepted the unsupported argument that the February 5, 1992 memorandum did not itself accept that consciousness is a necessary element of gross negligence for medical misconduct purposes, the proper legal response would be that the memorandum was deficient for not doing so pursuant to current judicial opinions in conjunction with long-settled legal definitions.

3. Petitioner's February 5, 1992 memorandum incorporating consciousness as an element of gross negligence for Professional Medical Conduct matters has been institutionalized. It is distributed by the Department of Health to all Board members as part of their training even prior to their selection as members of a particular hearing committee to serve as impartial finders of fact. It is again highlighted as the Department's position regarding definitions at the commencement of each hearing. It would be the most basic of due process denials to allow the prosecution to lull a Respondent into believing that it, the prosecution, willingly accepts the legal burden of proving a particular element of professional misconduct only to suddenly declare that burden unnecessary.

4. Even if one disagrees with the administrative officer's legal determination that consciousness is an element of gross negligence for medical misconduct purposes in New York, it is beyond the ARB's statutory authority to reverse that determination. Section 230(10)(e) of the Public Health Law provides that the administrative officer is responsible for all legal determinations during a professional medical conduct proceeding. Section 230-c, which created the ARB, limits that Board's review of a hearing committee's determination to "whether or not the determination and the penalty are consistent with the findings of fact and conclusions of law and whether or not the penalty is appropriate..." It is not given the authority to reverse legal determinations. That is the prerogative of the courts under existing statutory procedure.

Therefore, even if an administrative officer rendered an "incorrect" legal determination, it would be legally and procedurally unacceptable for the ARB, without authority, to impose its view.

Finally, a word about Respondent's position that although he accepts Petitioner's definition of misconduct as set forth in its memorandum of February 5, 1992, he believes that the use of certain jury instructions regarding negligence utilized in medical malpractice actions would be appropriate here. That view was rejected by the administrative officer inasmuch as this administrative proceeding is not bound by the procedures in a courtroom, and because there are indeed definitional differences between malpractice and medical misconduct. An example of a difference is the need for actual injury in order to sustain a malpractice action. In any event, Respondent's stated concerns are covered by the definition of negligence used by the hearing committee which incorporates an "under the circumstances" element.

CONCLUSIONS

The hearing committee's conclusions were reached pursuant to the findings of fact herein and the legal instructions from the administrative officer regarding the definitions of professional misconduct. In those instances where the committee concluded that Respondent's actions constituted gross negligence, it inferred the necessary element of consciousness of impending dangerous consequences inasmuch as an experienced surgeon would necessarily be aware of the risk of his conduct in relation to the specific act in question. All conclusions resulted from a unanimous vote (3-0) of the hearing committee.

Regarding Patient A:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph A(1)	2-6	not sustained
Paragraph A(2)	7-14	sustained
Paragraph A(3)	15-20	sustained

Paragraph A(4)	21-22	sustained
Paragraph A(5)	23-27	sustained
Paragraph A(6)	28	sustained
Paragraph A(7)	29	sustained

It is concluded that Respondent's actions constituted negligence regarding each of paragraphs A(2) through A(7) of the Charges, but not incompetence or gross incompetence because a lack of skill or knowledge was not proved. Gross negligence was proved regarding paragraphs A(3) and A(6). The factual allegations regarding paragraph A(1) are not sustained.

Regarding Patient B:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph B	30-35	not sustained

It is concluded that Respondent's actions did not constitute professional misconduct became the underlying factual allegations have not been sustained.

Regarding Patient C:

Factual Allegations Charged	Findings of Fact	Factual Allegations
Paragraph C	36-43	not sustained

It is concluded that Respondent's actions did not constitute professional misconduct because the underlying factual allegations have not been sustained.

Regarding Patient D:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph D(1)	44-54	sustained
Paragraph D(2)	55-59	not sustained

It is concluded that Respondent's actions constituted negligence, gross negligence, incompetence and gross incompetence regarding paragraph D(1) of the charges. Paragraph D(2) was not factually sustained.

Regarding Patient E:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph E	60-69	sustained

It is concluded that Respondent's actions constituted negligence, gross negligence, incompetence and gross incompetence.

Regarding Patient F:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph F(1)	70-78	sustained
Paragraph F(2)	79-88	sustained

It is concluded that Respondent's actions constituted negligence, gross negligence, incompetence and gross incompetence regarding paragraph F(1) of the charges. It is concluded that Respondent's actions constituted negligence and gross negligence, but not incompetence or gross incompetence, regarding paragraph F(2) of the Charges.

Regarding Patient G:

Factual Allegations Charged	Findings of Fact	Factual Conclusions
Paragraph G(1)	89-98	not sustained
Paragraph G(2)	99-103	sustained
Paragraph G(3)	104-108	sustained

The factual allegations in paragraph G(1) are not sustained. It is concluded that

Respondent's actions constituted negligence, incompetence and gross incompetence, but not gross negligence regarding paragraph G(2) of the Charges. It is concluded that Respondent's actions constituted negligence, gross negligence, incompetence and gross incompetence regarding paragraph G(3).

DETERMINATION AND ORDER

Pursuant to the hearing committee's findings of fact and conclusions herein,

IT IS HEREBY DETERMINED THAT THE FOLLOWING SPECIFICATIONS ARE SUSTAINED:

1. **FIRST SPECIFICATION** (NEGLIGENCE ON MORE THAN ONE OCCASION) in relation to paragraphs A(2) through A(7), D(1), E, F(1), F(2), G(2) and G(3) of the charges.
2. **SECOND SPECIFICATION** (INCOMPETENCE ON MORE THAN ONE OCCASION) in relation to paragraphs D(1), E, F(1), G(2) and G(3) of the charges.
3. **THIRD SPECIFICATION** (GROSS NEGLIGENCE) in relation to paragraphs A(3) and A(6) of the charges.
4. **SIXTH SPECIFICATION** (GROSS NEGLIGENCE) in relation to paragraph D(1) of the charges.
5. **SEVENTH SPECIFICATION** (GROSS NEGLIGENCE) in relation to paragraph E of the charges.
6. **EIGHTH SPECIFICATION** (GROSS NEGLIGENCE) in relation to paragraphs F(1) and F(2) of the charges.
7. **NINTH SPECIFICATION** (GROSS NEGLIGENCE) in relation to paragraph G(3) of the charges.
8. **THIRTEENTH SPECIFICATION** (GROSS INCOMPETENCE) in relation to paragraph D(1) of the charges.

9. **FOURTEENTH SPECIFICATION** (GROSS INCOMPETENCE) in relation to paragraph E of the charges.

10. **FIFTEENTH SPECIFICATION** (GROSS INCOMPETENCE) in relation to paragraph F(1) of the charges.

11. **SIXTEENTH SPECIFICATION** (GROSS INCOMPETENCE) in relation to paragraphs G(2) and G(3) of the charges.

AND IT IS DETERMINED THAT THE FOLLOWING SPECIFICATIONS ARE NOT SUSTAINED:

1. **FOURTH SPECIFICATION** (GROSS NEGLIGENCE)
2. **FIFTH SPECIFICATION** (GROSS NEGLIGENCE)
3. **TENTH SPECIFICATION** (GROSS INCOMPETENCE)
4. **ELEVENTH SPECIFICATION** (GROSS INCOMPETENCE)
5. **TWELFTH SPECIFICATION** (GROSS INCOMPETENCE)

AND

IT IS HEREBY ORDERED THAT

1. Pursuant to Section 230-a(3) of the Public Health Law, Respondent is permanently prohibited from performing any endoscopic procedures, either diagnostic or therapeutic, including, but not limited to, laparoscopic cholecystectomy.

2. Pursuant to Section 230-a(2) of the Public Health Law, Respondent's license to practice medicine in the State of New York is suspended with said suspension stayed and Respondent being placed on probation with the following conditions of probation:

a. For the period of two years, whenever Respondent performs general surgery other than that prohibited herein, he must be

assisted in the operating room by a physician Board Certified or Board Eligible in surgery.

b. Respondent must successfully complete sixty hours per year for five years of Category 1 Continuing Medical Education courses in general surgery sponsored by the American College of Surgeons. Respondent is required to provide documentation of his compliance with this requirement to the Board.

c. Respondent must, for the period of the next five years, attend 80% of the grand rounds sponsored by the University of Buffalo Department of General Surgery, and he must also attend, for the period of the next five years, 80% of the surgical morbidity and mortality conferences held at one of the major affiliated institutions of the Department of General Surgery at the University of Buffalo, ie., Buffalo General Hospital, Erie County Medical Center, or Millard Fillmore Hospital. Respondent is required to provide documentation of his compliance with this sub-paragraph 2(c) to the Board.

Upon successful completion of these conditions of probation, the stayed suspension of Respondent's license to practice medicine shall be vacated, and said license shall be fully restored except as limited by paragraph 1 of this **ORDER.**

DATED: New York, New York
4/28, **1994**

[redacted]

MICHAEL R. GOLDING, M.D.
Chairperson

MARGARET H. MCALOON, M.D.
MARY P. MEAGHER

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
LAWRENCE M. SHERMAN, M.D.	:	CHARGES

----------X

LAWRENCE M. SHERMAN, M.D., the Respondent, was authorized to practice medicine in New York State on February 4, 1977, by the issuance of license number 129824 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993, through December 31, 1994, with a registration address of 350 Alberta Drive, Suite 107, Amherst, New York 14226.

FACTUAL ALLEGATIONS

A. Respondent admitted Patient A, an 83 year old female, to Inter-Community Memorial Hospital, Newfane, New York, on August 19, 1992, for endoscopy, and on September 16, 1992, for ambulatory surgery of panendoscopy and "possible gastrectomy".

1. Respondent failed to obtain appropriate consent for the endoscopic procedure of August 19, 1992, when the patient was noted to be "very confused" and "unsure" of the reason for the hospitalization.

2. On September 16, 1992, Respondent failed to obtain appropriate informed consent for the panendoscopy, gastrectomy, and splenectomy.

3. Following the panendoscopy on September 16, 1992, Respondent inappropriately performed the gastrectomy and splenectomy on an emergent basis although biopsies from the August 19, 1992, procedure were reported to be benign.

4. Respondent inappropriately performed the gastrectomy and splenectomy on an emergent basis without adequate pre-operative evaluation and preparation.

Amended by Petitioner. No objection. 12-9-93 GHL

5. Respondent inappropriately performed more than a palliative procedure when he stated he observed liver, ~~peritioneal,~~ and probable nodal metasteses.

6. Respondent performed the gastrectomy and splenectomy when the patient had not undergone an adequate trial of medical management, re-evaluation and re-biopsy.

Amended by Petitioner. Allowed over Respondent's objection. GHL 1-13-97

7. Respondent inappropriately performed an extensive gastrectomy ~~in a high-risk patient~~ when a more limited acid reduction surgery would have been appropriate.

B. Respondent treated Patient B, a 60 year old female admitted to DeGraff Memorial Hospital, North Tonawanda, New York, on July 31, 1989, for pelvic abscess.

Amended by Petitioner. No objection. 12-9-93 GHL

During a surgery on July 31, 1989, Respondent placed the Abramson sump at an inappropriate location (lower midline) in the ~~Patient B's~~ Patient's abdomen.

C. Respondent treated Patient C, a 70 year old female admitted to DeGraff Memorial Hospital on April 6, 1993, for adenocarcinoma of the colon.

During a colectomy performed on Patient C on April 9, 1993, Respondent removed an excessive amount of the patient's colon rather than performing a more palliative procedure.

D. Respondent treated Patient D, a 29 year old female admitted to Kenmore Mercy Hospital, Kenmore, New York on August 27, 1990, for removal of her gallbladder.

1. Patient D's vena cava was inappropriately lacerated during a laparoscopic cholecystectomy performed on August 27, 1990.

2. Respondent failed to respond in a timely manner to a rapid drop in Patient D's blood pressure during the cholecystecomy.

E. Respondent treated Patient E, a 28 year old a female admitted to Kenmore Mercy Hospital on March 13, 1991, for removal of her gallbladder.

During a laparoscopic cholecystectomy performed on Patient E on March 13, 1991, Respondent failed to appropriately identify the cystic duct and common bile duct before transecting what he believed to be the cystic duct.

F. Respondent treated Patient F, a 61 year old female admitted to Kenmore Mercy Hospital on March 5, 1993, for abdominal pain.

1. During laparoscopic cholecystectomy performed on Patient F on March 5, 1993, Respondent inappropriately caused and/or failed to recognize that he caused injury to the patient's duodenum.

2. Respondent failed to appropriately evaluate and treat Patient F in a timely manner on March 7, 1993, when there was evidence of significant post-operative pain, ~~shoulder strap discomfort,~~ and significant free air in the abdomen.

Amendment by Petitioner allowed over Respondent's objection.
GHL
1-6-94

G. Respondent treated Patient G, an 86 year old female admitted to DeGraff Memorial Hospital on January 30, 1993, after having been found unresponsive at her home.

1. Following a jejunostomy performed on February 19, 1993, Respondent failed to adequately assess causes of fever in Patient G, a known diabetic.

2. Respondent inappropriately performed a laparoscopic cholecystectomy on Patient G on March 24, 1993, rather than an open cholecystectomy.

3. Respondent failed to appropriately identify and inappropriately lacerated the Patient G's common bile duct during the laparoscopic cholecystectomy.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of New York Education Law §6530(3)(McKinney Supp. 1993), in that Petitioner charges two or more of the following:

1. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, B and B.1, C and C.1, D and D.1, D and D.2, E and E.1, F and F.1, F and F.2, G and G.1, G and G.2, and/or G and G.3.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE
ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than once occasion within the meaning of New York Education Law §6530(5)(McKinney Supp. 1993) in that Petitioner charges two or more of the following:

2. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, B and B.1, C and C.1, D and D.1, D and D.2, E and E.1, F and F.1, F and F.2, G and G.1, G and G.2, and/or G and G.3.

THIRD THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of New York Education Law §6530(4)(McKinney Supp. 1993) in that Petitioner charges:

3. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6 and/or A and A.7.

4. The facts of paragraphs B and B.1.

5. The facts of paragraphs C and C.1.

6. The facts of paragraphs D and D.1 and/or D and D.2.

7. The facts of paragraphs E and E.1.

8. The facts of paragraphs F and F.1 and/or F and F.2.

9. The facts of paragraphs G and G.1, G and G.2 and/or G and G.3.

TENTH THROUGH SIXTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of New York Education Law §6530(6) (McKinney Supp. 1993) in that Petitioner charges:

10. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6 and/or A and A.7.

11. The facts of paragraphs B and B.1.

12. The facts of paragraphs C and C.1.

13. The facts of paragraphs D and D.1 and/or D and D.2.

14. The facts of paragraphs E and E.1.

15. The facts of paragraphs F and F.1 and/or F and F.2.

16. The facts of paragraphs G and G.1, G and G.2 and/or G and G.3.

DATED: Albany, New York
November 29, 1993

[redacted]

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct