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

April 2, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Gerald Moss, M.D.
Climer Circle
Box 296
West Sand Lake, New York 12196

Thomas Gleason, Esq.
Gleason, Dunn, Walsh & O'Shea
11 North Pearl Street
Albany, New York 12207

Kevin P. Donovan, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237

RE: In the Matter of GERALD MOSS, M.D.

Dear Dr. Moss, Mr. Gleason and Mr. Donovan:

Enclosed please find the Determination and Order (No. BPMC-93-52) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

New York State Department of Health
Office of Professional Medical Conduct
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,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER	: DETERMINATION AND
OF	: ORDER OF THE
GERALD MOSS, M.D.	: HEARING COMMITTEE

Order No. BPMC-93-52

The undersigned Hearing Committee consisting of JOSEPH K. MYERS, JR., M.D., F.A.C.S, Chairperson, ROBERT A. MENOTTI, M.D., F.A.C.S., and GEORGE F. COUPERTHWAIT, JR., was duly designated and appointed by the State Board for Professional Medical Conduct. DAVID A. SOLOMON, ESQ., Administrative Law Judge, served as Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230, subdivision 10, of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by GERALD MOSS, M.D.(hereinafter referred to as the "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the Hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its' decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	August 5, 1992
Affidavit of Service:	August 7, 1992
Ammendment of Paragraph A.3:	September 10. 1992
Withdrawal of Paragraphs C.1 & E.3 of Statement of Charges on stipulation of Parties with the concurrance of the Chairperson:	November 12, 1992 January 21, 1993
The State Board for Professional Medical Conduct appeared by:	Kevin P. Donovan, Esq. Assistant Counsel Bureau of Professional Medical Conduct 2429 Corning Tower Bldg. Empire State Plaza Albany, NY 12237
Respondent appeared in person represented by:	Gleason,Dunn.Walsh & O'Shea 11 North Pearl Street Albany, NY 12207 by: Thomas Gleason, Esq., of Counsel
Locations and dates of Hearing and Conferences:	
All Hearings and Conferences were Conducted at:	Hearing Dates:
Professional Medical Conduct Assigned Hearing Rooms Corning Tower & Justice Bldgs. Empire State Plaza Albany, New York 12237	August 28, 1992 September 10, 1992 October 29, 1992 November 12, 1992 November 13, 1992

	November 17, 1992
	December 8, 1992
	December 14, 1992
	December 23, 1992
	January 6, 1993
	Conference Dates:
Pre-Hearing Conference:	August 19, 1992
Intra-Hearing Conference:	September 10, 1992
Intra-Hearing Conference:	November 12, 1992
Submission by the Respondent of an Affidavit of his Expert Witness for Inclusion in the Record only:	February 3, 1993
Submission by the Petitioner of a Letter/Memorandum in Reply to the Respondent's Affidavit Request:	February 9, 1993
Determination of the Administrative Officer Denying Inclusion of the Expert's Affidavit in the Record:	February 10, 1993
Request by the Petitioner that the Hearing Committee be instructed at the February 10, 1993 Deliberations Meeting not to consider page 74 through the first four lines of page 79 entitled Dismissal of Charges Due to Delay and Lack of Due Process:	February 9, 1993
Submission of Findings of Fact by the Parties:	February 5, 1993
Deliberations of the Hearing Committee: State Department of Health, South Salina St., Syracuse, NY	February 10. 1993
Closing of the Record	February 10, 1993
Letter Orders of the Administrative Officer on Affidavit of Expert Witness and Laches & Due Process:	February 15, 1993
Letter Order re Reply Ammendment:	February 22, 1993

NOTE: Respondent waived the 120 and 60 day time limits set forth in Sec.230(10)(f),(h). T.1789-1791.

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges inappropriate, inadequate or otherwise deficient treatment of five patients by the Respondent. It is alleged Patient A, B and C were inappropriately discharged from the hospital and inadequately evaluated and treated after discharge and that Respondent's post-operative hospital and office notes were inadequate. Inappropriate hospital discharge of Patient D is alleged. Inadequate pre-operative preparation of Patient E's bowel is alleged, as is improper use of Vivonex and several inadequacies of Respondent's operative note.

In his opening statement, the Respondent denied premature discharge in each case. He also spoke to "...substantial predjudice as a result of the delay" despite denial of his motions based on the same objection at the pre-hearing conference that preceded the hearing. T. 10; Pre-hearing Conference T.63-64.

Ammendments to the Statement of Charges on stipulation of the parties were to allegation A.3 to read:

> Respondent's post-operative hospital and office notes for Patient A are inadequate. T.405-406,633.

And allegations C.1 and E.3 were withdrawn. T.632-633, 1/21/93 Letter to the Parties.

The respondent did not file a written answer or an affirmative defense related to his time delay objection. See,10 NYCRR 51.5(c), 51.11(d)(10).

The allegations are set forth more particularly in the Statement of Charges attached hereto as Appendix I. The above noted ammendments are referred to in the margins.

At the Pre-Hearing Conference, the Respondent questioned concerning the possible bias of the Chairperson who had informed the Administrative Officer of the Petitioner's expert witness being an acquaintance. Subsequently, the Respondent filed two affidavits requesting replacement of the Chairperson. The Administrative Officer filed a Determination on November 12,1992:

> It is determined that the facts presented do not meet the substantial liklyhood threashold of bias required for the disqualification of Dr. Myers as a member of the Hearing Committee. ALJ Exs.1,2

The Ruling on Bias Request is attached as Appendix II.

As late as the last day of the hearing the Respondent cross examined witness Dr. Guest on factual matters related to his rejected affirmative defense of a time delay. And he included it as well in his Findings of Fact and Conclusions of Law. On the request of the Petitioner, the Administrative Officer informed the Hearing Committee that they should not consider the pertinent pages of Respondent's proposed findings in preparing their own. Department rules are explicit in prohibiting consideration of any time delay less that one year; herein, the "delay" is 21 days. 10 NYCRR 51.11(d)(01).

"Petitioner's Motion to Instruct the Hearing Committee Not to Consider Pages 74 through 78 of the Respondent's Proposed Findings" was filed on February 15, 1993. The Administrative Officer's notice to the attorneys had a like date. Both, with any Reply received from the Respondent, are attached hereto as Appendix III.

The notice to the parties on the Committee's instruction notes that the Respondent did not meet the Rule requirement that it be in the form of an affirmative defense. The three day notice prior to the initial hearing date was met by making the motion at the Pre-Hearing Conference. Regardless of the mandated proceedure the burden of proof is on the Respondent. It was not met.

The Respondent submitted an affidavit of a medical expert witness, Edward Saltzstein, M.D.,for inclusion in the record only. The Administrative Officer denied the request and returned the affidavit and the reply letter to the attorneys. The decision is Appendix IV.

The State called the following witnesses:

Patient B	Fact Witness
Mrs. B	Fact Witness
Mr. B	Fact Witness

Patient A's Son-A	Fact Witness
Patient A's Daughter-in-law-A	Fact Witness
Patient A's Son-B	Fact Witness
Patient A's Stepdaughter	Fact Witness
Patient A's Husband	Fact Witness
Patient C	Fact Witness
Mrs. C	Fact Witness
Richard D. Eberle, M.D.	Expert Witness
Patient A's Daughter-in-law-B	Fact Witness
C. Maynard Guest, M.D.	Fact Witness

Respondent testified in his own behalf and called the following witnesses:

Arthur D. Stein, M.D.	Expert Witness
Robert J. Suozzo, M.D.	Expert Witness
James M. Gavin, M.D.	Fact Witness
Edward C. Saltzstein, M.D.	Expert Witness
Mary Ellen Regal, R.N.	Fact Witness

SIGNIFICANT LEGAL RULINGS

Official Notice was taken by the Administrative Officer, with the concurrence of the Hearing Committee, that the phrase "vital signs" consists of temperature, blood pressure and respiration. Such facts are within the specialized knowledge of the New York State Department of Health. 10 NYCRR 51.11(d)(4).

During the course of the Hearing, the Hearing Committee had access to and consulted a memorandum dated February 5, 1992, entitled "Definitions of Professional Misconduct under the New York Education Law" by Peter J. Millock, Esq., General Counsel for the Department of Health. This document contains suggested definitions for gross negligence and negligence on more than one occasion. Negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances or deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that Petitioner establish that injury actually resulted from the deviation. Gross negligence has been defined by New York's highest court to be "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct" Roh v. Ambach, 74 NY2d 318,322(1989). Egregious means conspicuously bad. Spero v. Board of Regents, 158 AD2d 763,764 (3rd Dept. 1990).

Concerning the charges of failure to maintain adequate medical records, the Committee adopts the standards set forth by the court in Schwartz v. Board of Regents, 89 AD2d 711(3rd Dept. 1982). That case established the definition of what constituted adequate medical records well in advance of the cases at issue here. In Schwartz the court rejected a physician's contention that records are accurate if they can be interpreted by the treating physician. The court stated that records are adequate if they would provide meaningful medical information to other practicioners should the patient transfer to a new physician or the treating physician be unavailable for any reason (Schwartz at 712). The court referred to the standard as requiring "objectively meaningful medical information" (Id.).

FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise. The findings and conclusions of the Petitioner and Respondent submitted herein were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings of fact were made after review of the entire record. Numbers following a finding refer to page numbers of the transcript (T.___). Numbers and letters following a finding preceded by a reference to exhibits (Ex.___) refer to exhibits in evidence. The citations represent evidence the Committee found persuasive in arriving at a particular finding. All findings of fact were established by at least a preponderance of the evidence. Evidence which conflicted with any finding of the Hearing Committee was considered and rejected. The extent that one expert or witness's opinion was given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. Respondent Gerald Moss, M.D. was authorized to practice medicine in New York State on July 20, 1962, having been issued license number 087923 by the New York State Education Department. The Respondent is currently registered with the NYS Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 with a registered address of Climer Circle, Box 296, West Sand Lake, New York 12196. Ex. 2.

2. Respondent was personally served with the Notice of Hearing, Statement of Charges, and Summary of Department of Health Hearing Rules on August 7, 1992. Ex.1. He personally appeared in this proceeding and was represented by Counsel. T.6.

3. Evidentiary hearings were held in this matter on the following dates in 1982: August 28,September 10,October 29,November 12,13 and 17,December 8,14 and 23 and on January 6,1983.

4. The Statement of Charges was amended on September 10, 1992, so that paragraph A.3 would read: "Respondent's post-operative hospital and office notes for Patient A are inadequate." T. 405-406, 633. Two further amendments withdrew allegations C.1 and E.3. T. 632-633 and ALJ Letter dated 1/21/93, respectively.

A. PATIENT A.(Gross Negligence, Negligence)

5. Patient A was an 85 year old female when she visited the Respondent's office on June 8, 1983, complaining of a ventral hernia. Ex. 5,p.1; see,Ex. 3,p.1.

6. Patient A was admitted by Respondent to Samaritan Hospital, Troy, New York, on July 7, 1983. An operation to repair her ventral hernia was performed from 9:50 a.m. to noon on July 8, 1983. Ex.3,pp. 1,28,29. A ventral hernia is the weakness or separation of the fascia with a herniation through the defect. T. 484-485. The hernia was the

result of prior surgery in her abdomen, and was about 8 inches long and about 4 inches wide and extended from her xiphoid to pubis. Ex.3,p. 29; T.877-878. The hernia was fully reducible, meaning that all of the abdominal contents could be contained in the abdominal wall flat and the abdomen could be closed. T. 879.

7. During the course of the July 8 surgery to repair the ventral hernia, Respondent inadvertently lacerated the Patient's small bowel. Ex. 3,p.29. As a repair, Respondent removed a section of the small intestine and closed the opening in the small bowel with a stapling instrument. Ex. 3,pp. 29-30; T. 882-883.

8. Respondent agreed that discharge criteria for Patient A would be eating, drinking and keeping it down. T. 938-939. He then tried to qualify this statement by stating that for this Patient that would mean net nutrients and liquid taken in and kept down. T. 939.

9. By 8:00 p.m. on July 8, the date of the operation, Patient A's temperature had risen to 101.9 degrees; at midnight, it was 101.4; it fell to 98.8 at 4:00 a.m. on July 9, rose to 101.4 at 8:00 a.m. and 102.1 at noon, and then fell to 98 degrees at 4:00 p.m. No temperature readings are recorded after 4:00 p.m. Ex. 3, p.9. Patient A was not discharged until 7:00 p.m. Ex 4,p. 3.

10. On the date of discharge, Patient A vomited 350 cc's of brown fluid during the 7:00 a.m. to 3:00 p.m. shift, and 150 cc's of undigested food at about 6:00 p.m.. Ex.3, p.37.

11. The laceration of the small bowel changed the way this case should be considered using acceptable standards of medical care,from one of only ventral hernia repair to one of ventral hernia repair and lacerated small bowel. Such changes the case because of the possibility of complications from contamination from the lacerated bowel and possible leak from the repair. T.379.

12. Before discharge, Patient A was still vomiting. Before discharge, there was a questionable stability of Patient A's temperature. Dr. Eberle concluded that Patient A was not stable at the time of discharge. T. 449-451, 508-510; Ex. 3, pp. 9, 37.

13. Dr. Eberle's opinion was that the discharge of Patient A on July 9, 1983 did not meet acceptable medical standards because the Patient was not stable and therefore not in approppriate discharge condition. T. 385.

14. A reasonably prudent surgeon being aware of persistent complaints of pain and vomiting in the post-operative period would be concerned that something was going on in the abdomen.Dr. Eberle could not state exactly what was occurring without examining the abdomen; it could be a perforation, an obstruction or a number of things that can occur after repair of a small bowel. T. 427-429. Dr. Eberle clearly stated that the decision to discharge Patient A was inappropriate. T.436. Dr. Eberle explained that the advantages of monitoring an inpatient versus an outpatient are that vital signs can be taken more frequently on a surgical floor, the patient's intake and output can be measured, bowel can be evaluated for functioning, and a patient is examined by a physician one or two times a day. T. 436.

15. Respondent attempted to explain Patient A's first vomiting episode of 350 cc's of brown fluid on the date of discharge by asserting that the naso-gastric tube stimulates a gag reflex, but it was a large amount of liquid and the brown color indicated it could be bile. T. 901. Respondent stated he did not know whether 350 cc's of brown liquid would reasonably be expected. T. 902.

16. As an explanation for the second incident of vomiting 150 cc's of undigested food at 6:00 before discharge an hour later, Respondent stated he was concerned, but he would expect it, as the hernia repair meant the patient could not accommodate her normal eating and drinking habits. T. 904.

17. A cause of post-operative fever in Patient A could be atelectasis, a collapse of a portion of the lung. It is a common cause of fever within 24 to 36 hours of surgery; other causes of fever include urinary tract infections, intraabdominal infection, peritoneal infection, bleeding, acute pulmonary infections, and others. T. 442-443. A prudent practicioner would consider causes for fever other than atelectasis. T. 1495.

18. While it is a reasonable deduction that coughing of the Patient could have reduced atelectasis and apparently cause a fever to come down, only one normal temperature was recorded prior to discharge and the Patient was not watched long enough to assure the temperature did not go back up. Patient A's temperature was last taken at 4:00 p.m.; her discharge temperature was not known. T. 448.

19. A prudent general surgeon would have watched the temperature of Patient A for a period of time before being able to conclude that atelectasis had caused the fever and that the coughing had cleared the atelectasis to permit the temperature to stay down. T. 509-510.

20. Respondent testified that he thought some of the 350 cc's of vomit Patient A had on the day of discharge was due to the fact that she had just eaten; however, when it was pointed out there was no indication of food in the vomit, he stated it might have been only liquid. T. 949.

21. While the Respondent wished to tie the Patient's first episode of vomiting on the day of discharge to the Moss tube being removed, there was no specific statement as to when Patient A vomited other than that it was on the 7 to 3 shift; the tube would have been removed shortly after 6:30 a.m.. T. 953. The notations of vomiting are written at the midpoint of the 7 to 3 shift narrative. Ex. 3,p. 37.

22. Respondent admitted that a patient who had a small bowel laceration during surgery with fever, nausea and vomiting within 24 to 36 hours of surgery, could have an intestinal obstruction. T. 950-951.

23. Dr. Saltzstein, presented as the Respondent's expert witness, candidly testified that he had a concern about Patient A's case, that he would not have fed and discharged her as Respondent did. T. 1410-1411. When asked to discuss both the fever and vomiting, Dr. Saltzstein stated he believed the fever

was pulmonary, that he would have been concerned about it and the vomiting, that he would not have discharged Patient A, and that he was not trying to defend the Respondent under these circumstances. T. 1460. Dr. Saltzstein refused to believe a resident under his supervision would discharge Patient A; but, when asked to assume a resident had done so, he stated there would have been an "education process" for that resident. T.1478-1479. Dr. Saltzstein testified that if he were presented with the facts on this patient in an examination, the best answer would be not to send the patient home. T. 1481. He would expect most practicing general surgeons to keep the patient in the hospital. He would not have sent Patient A home; he would have instructed his residents not to do so. T. 1484. In short, Dr. Saltzstein repeatedly implied that the discharge of Patient A was inappropriate.

24. In Respondent's videotape he set forth discharge criteria, which included that the patient must be eating and drinking and keeping it down, must show bowel function by passing gas and moving bowels, and must be afebrile. Ex. F-1; T. 1114; Appendix to 11/17/92 Transcript at 13.

25. The records state the 350 cc's that Patient A vomited did not contain any food; it was a brown fluid. The Respondent stated that it could have contained bile. He also stated that any excess, undigested food vomited never contained bile. T. 1115.

26. Despite Respondent's contention that the discharge criteria he set forth for cholecystectomy patients did not apply to Patient A, the transcript of Respondent's tape demonstrates that after his discussion of discharge criteria, he stated: "Cholecysectomy is not the only abdominal procedure to which this is applicable." T. 1116; Appendix to 11/17/92 transcript at 13-15.

27. The Respondent's medical expert witness, Dr. Saltzstein, stated that if the patient continued to vomit after being fed, the patient needs to be evaluated for the reasons why. T. 1460. Vomiting can be a response to a lot of things, including problems with the gastrointestinal tract. T. 1459.

28. Two days after hospital discharge, on July 11, the Patient was taken to Respondent's office Respondent was told the Patient was in a lot of pain and was vomiting. A daughter-in-law and a stepdaughter of the Patient, both of whom were present during the entire visit, testified no temperature, blood pressure or pulse was taken, and there was no use of a stethoscope or touching of the Patient's abdomen. T. 140-142, 185.

29. Respondent did not perform an adequate physical examination of Patient A at the office visit on July 11, 1983. T.396. To meet acceptable standards of medical care, a temperature should have been taken, pulse and respiration recorded. The Respondent should have examined the chest and lungs, and the abdomen by palpation and auscultation (feeling and listening), and with his stethoscope. T. 396. A lung examination should have included palpation, thumping on the chest, and listening with a stethoscope. T. 396-397. Dr. Saltzstein agreed that the usual course for a patient who had an abdominal procedure is to examine the abdomen by palpation. T. 1485.

30. On July 12, 1983, the day after the office visit, the Respondent was informed by two of Patient A's sons that she was in a lot of pain. T. 116-117, 165, 187. Respondent's response to the information did not meet acceptable standards of care in view of the previous events. T. 398-400

31. Respondent's response was not adequate because it was now the third day post-operatively and the Patient was still having problems, pain and trouble for some reason. One still has to worry about the sutured bowel as a possible source of the symptoms.T. 399. An appropriate response to the phone calls would

have been to have seen the Patient that very day even though she had been seen just the day before; upon seeing her on July 12th, the Respondent should have adequately examined her. T. 399-400.

32. Respondent did acknowledge that there were multiple telephone calls by Patient A's relatives to him complaining of Patient A's pain and that his suggestion was that the Patient be walked. T.917 Respondent stated: " I was getting calls and making calls relatively continuous, more so than the average patient. For the average patient it would be about three or four phone calls maximum." T. 919.

33. Later in the evening of July 12, 1983, at about 9: p.m., Patient A's other son , who was aware a call had already been made that evening to Respondent, called Respondent. T. 164-165. The son told Respondent that Patient A was in a lot of pain, and that while the Patient can stand a lot of pain, this is beyond that, and that something should be done. T. 165. Respondent told the son that there was nothing wrong with the Patient and that she could do anything but drive a car; the son replied that the Patient could not even get out of bed. T. 165-166. Respondent stated Patient A had to get out of bed and walk in order to get rid of the gas. T. 166. Patient A's son stated she was in so much pain she could not get out of bed and asked what Respondent recommended for gas; he recommended Mylanta. T. 166.

34. Petitioner's expert stated that this was not an adequate response to the information given to the Respondent. T. 401. He now has the additional information that Patient A is weak and cannot walk; she has persistent pain not relieved by enema. T.401 Respondent should have seen her that day and adequately examined her. T. 401.

35. Later that night, at approximately 3:00 a.m. on July 13th, Patient A's step-daughter called Respondent and told him that the Patient was crying with pain, was really bad off. T. 188. The step-daughter also suggested possibly returning Patient A to the hospital. T. 192. Respondent replied that he would give her an appointment to see him at 8:30 in the morning. T. 192.

36. Respondent's response to such information did not meet acceptable medical standards. T. 402. He should have seen the Patient as soon as he possibly could given all of her symptoms and lack of response to suggested treatment. T. 403. He should have seen her himself by meeting her at the office or in the emergency room. T. 403. Even though Respondent did schedule an appointment for only 5 1/2 hours later, the delay between the telephone call and the appointment was unacceptable because of everything that had happened since Patient A left the hospital. It suggested something bad was going on and she should be seen as soon as

possible. T. 404. The Patient should have been seen immediately particularly when there were two or more phone calls within a short time of each other. T. 404.

37. Within a few hours after the 3:00 a.m. call to Respondent on July 13, 1983, Patient A collapsed, was taken to the hospital by ambulance, and died. Exs. 6, 7.

38. Respondent admitted he was told Patient A was continuously vomiting small amounts of food after she ate and drank. T.915-916. Respondent preferred to attribute this vomiting to his assumption she was consuming large amounts of food and the fact she was obese T. 916 , whereas Patient A's daughter-in-law, who was with Patient A, testified that in fact she was "eating" tea and toast and not keeping it down. T. 191.

39. Respondent remembers having perhaps a total of four conversations with Patient A's family on October 12, more than usual for a post-operative patient ,coinciding with the testimony of Patient A's family. T. 965, 971.

40. When presented with the facts that Respondent himself testified to, namely multiple complaints that Patient A was vomiting after eating on more than one occasion and was having

pain, Dr. Saltzstein testified that he would not be as concerned about the pain as the vomiting, both from the standpoint of whether Patient A was appropriately nourished and also whether she could have bowel obstruction and whether her gastrointestinal tract was intact. T. 1462-1463. Dr. Saltzstein would want to evaluate the patient personally; he would either see the patient at her home or in the hospital. T. 1463.

A. PATIENT A., CONT'D. (Inadequate Records)

41. Dr. Eberle stated that Respondent's second hospital progress note for July 9, 1983 was not adequate. Ex. 3 at 4; T. 407.

42. Adequate physician notes are important in the hospital record as they should indicate the thought processes of the physician concerning the patient at the time the note is written. The physician should have a record of his thought processes at a later time. If another physician takes over care, the physician can determine what the treating physician thought at the time the note was written. In addition, it is an indication of the quality of care being rendered. T. 408-409; and see, Significant Legal Rulings, supra, p. 8.

43. Respondent's office record does not contain an adequate post-operative record of Patient A in view of acceptable medical standards because it should reflect the examination performed. The vital signs including temperature, and adequate lung and abdominal examination would need to be recorded.Ex.5; T. 409-410.

44. Concerning the adequacy of Respondent's hospital notes, Dr. Saltzstein stated they were "a little scanty," that he would have liked to see more information, and that the positive finding of vomiting was not recorded by Respondent. T. 1465. Dr. Saltzstein stated, that for a patient who had fever and vomiting after abdominal surgery, he would like to see those events noted by the physician and explanations for why, nonetheless, the patient was discharged. T. 1465-1466.

45. Dr. Saltzstein's opinions on the adequacy of Respondent's notes were based on his opinion that, though the notes were relatively cryptic and it was difficult to determine what was meant, that no standard existed for office notes. T. 1432. As noted in this determination , the case law in New York State does, and did in 1982, establish a standard. Dr. Saltzstein stated the notes were written for the purposes of the person caring for the patient. T. 1432-1433. New York Law requires "objectively meaningful medical information" to other practicioners should the patient transfer to a new physician or the treating physician is unavailable for any reason. Significant Legal Rulings, supra, p.8.

B. PATIENT B (Gross Negligence, Negligence)

46. Patient B was a 47 year old male when he entered Albany Memorial Hospital, in Albany, New York, on October 2, 1983, to have a cholecystectomy or gall bladder removal performed by the Respondent. Ex. 8 at 1.

47. During the operation, dissection of the gall bladder was difficult as it required "digital exploration," and Respondent noted that it was difficult to identify "planes and structures." T. 524-525, 1020-1022.

48. The surgery was performed on the patient on October 3, 1983, and he was discharged at about 6:30 p.m. the next day,October 4th. Ex. 8 at 18,45.

49. Between the conclusion of the surgery on October 3 and discharge of the patient on October 4, his temperature, pulse, and respirations became and remained elevated. The patients rectal temperature became elevated to 101 degrees beginning at midnight after the operation of October 3 and remained at that level until the last reading prior to discharge demonstrated an oral temperature of 100.2 degrees at 4:00 p.m. on October 4th. The patient's pulse elevated post-operatively to 120 and

had decreased to 90, and the patient's respirations elevated to 40 post-operatively and had dropped to 30 at 4:00 p.m. on October 4. Ex. 8 at 31.

50. Dr. Saltzstein, confirmed the vital signs of Patient B were consistent with a reasonable medical decision to discharge Patient B on October 4th. Ex. 8, p. 31. The discharge of the Patient on the day after surgery was appropriate, the record confirming that a normal progression of recovery was in progress. T. 1498-1501; Ex. 8, pp. 12, 22.

B. PATIENT B. (Records)

51 A post-operative physical examination should include the patient's temperature as a part of the follow-up of the patient. There is no indication whether such was or was not done. T. 1532-1533; Ex. 9.

52. Respondent's post-operative hospital progress notes did not mention signs of instability in Patient B's vital signs. T 530-531.

53. Respondent's hospital progress notes contain no indication that Respondent was aware of Patient B's elevated respirations pulse or temperature. T. 1137-1138.

54. Respondent admitted his post-operative hospital and office notes are inadequate measured against 1992 standards. He does not believe that 1984 standards were not met. T. 1148. The case law and regulatory requirements of 1992 were in effect in 1984. Significant Legal Rulings, supra., p. 8.

55. On the day after discharge from the hospital,October 5, Patient B's wife called Respondent stating the Patient did not look good, that he was very pale with a yellowish tinge and that she was concerned about his color. She is not a trained medical observor; jaundice and pallor were not established to the satisfaction of the Committee. T. 69, 75.

56.Both Patient B and his wife identified soaking sweat as a characteristic of Patient B's condition prior to his office visit with Respondent on October 9th. T. 62,70-71.

57. Patient B, his wife and son stated severe pain was also a second problem reported on the October 9th visit to the Respondent T. 27,34,70-72,92.

58. Following the office visit of October 6th and before the next visit on October 9th, Patient B's wife called and told the Respondent that her husband's color was bad. T. 70. Early Sunday

morning, October 9th, Patient B's wife called the Respondent again and told him Patient B had been up most of the night, was in severe pain, a profuse cold sweat, and was cold and clammy. T.71. Respondent told the Patient's wife to have Patient B at his office within the hour. T. 71.

59. Patient B's son drove him to Respondent's office on October 9. During the drive the Patient asked his son not to hit bumps or go around corners fast, and he complained of pain when the car hit a bump. T. 92. The Patient's son helped his father in and out of Respondent's office; his father was hunched over when walking. T. 92, 93. The son waited in the waiting room; following the visit, Respondent stated to Patient's son "Everything is going pretty good, right on schedule." T. 93.

60. Dr. Saltzstein stated that based on the medical record, he felt post-surgical care by the Respondent was acceptable. T.1511. He also stated the office entry October 9 contained no statement of what Respondent did or did not due at the office visit. T.1519. He stated it just was not possible for him to interpret the notes of the Respondent. T.1519. After being informed that New York Law required a physician to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, Dr. Saltzstein stated the records did not indicate to him what Respondent did or did not do. T.1520. He stated the notes do not reflect an evaluation either done or not done. T. 1521.

61. Dr. Eberle testified that Respondent did not take an adequate history or perform an adequate examination of Patient B at the office visit on October 9. T. 537. Based on the fact that Patient B was in distress, on the information provided by his family, and knowing the difficult dissection, Respondent should have asked the Patient how he felt, what was bothering him, whether he had pain, whether there was anything that the Patient was complaining about that was normal or abnormal. He should have examined the abdomen and indicated in the note that he did examine by palpation, ausculation and observation. T. 537. There is no evidence from Respondent's office record that an adequate physical examination of the Patient was performed at the office visit of October 9. T. 537, 539-540.

62. Petitioner's expert further testified that Respondent's office record entries for October 6 and 9, 1983, do not meet acceptable standards of medical record keeping because they do not give evidence of the exact condition of the Patient and do not address complaints that were apparently present. T.542. Considering the fact that the Patient had a difficult cholecystectomy and the possibility of complications, acceptable standards of medical care require evidence that the abdomen was examined and what the examination showed, rather than just a statement that the wound is clean and the hematoma drained T.542

C. PATIENT C.

63. Patient C was 53 years old when he was admitted to Samaritan Hospital in Troy, New York, on April 13,1984, by Drs. Sullivan and Moss for evaluation of a possible gall bladder problem. Ex.11, pp. 2-5. He was diagnosed as having acute cholecystitis, and a cholecystectomy was performed on April 13,1984. Ex. 11,p.32. The pathology report found that: "The patient had acute suppurative cholecystitis with focal necrosis and much hemorrhage." Ex.11,p.33.

64. Over the course of Patient C's stay at the hospital and before his discharge, his red blood count, hemoglobin and hematocrit declined. T.598. The last hematology report prior to the Patient's discharge showed a white blood cell count of 12,500, with polys of 81 and stabs of 9. T. 599; Ex. 11,p.18. Stabs are immature and polys mature white blood cells. T. 646-677.

65. The change from two to nine stabs is called a "left shift" which indicates immature forms of white cells which means an inflammatory or infectious process. T. 1591..

66. The Patient was discharged at 7:30 p.m. on April 14,1984. Ex. 11,p. 39.

67. Dr. Saltzstein stated that waiting for a patient to have a bowel movement is not a valid reason to keep a Patient in the hospital. It could take a day or two or more. If there is

evidence that the patient has gastrointestinal function, tolerating liquids, that they can be discharged, one doesn't have to wait for a bowel movement. T. 1588.

68. Respondent's post-operative progress note dated 4/14/84 does not meet acceptable standards of record keeping because it does not address the issues presented by the contents of the hematology reports and by the comments in the nursing notes concerning not having a BM, and a distended abdomen. T.601-602. If the Respondent had made that progress note in the morning prior to the events noted in the nurse's notes, he should have addressed those items in a later note. T.603.

69. On April 15, the Respondent saw Patient C at his office. T. 232. Respondent looked at the Patient's abdomen and touched around the incision area, but did not take the Patient's temperature, blood pressure or use a stethoscope. T. 233.

70. Respondent's notes do not indicate that he adequately addressed the complaints concerning the Patient. T.604.

71. On April 16, Respondent was called and told that Patient C was in pain in his side around the right arm; Respondent stated that was expected with surgery. T.278. On April 17,Respondent was called again and told by Patient C's wife that the Patient had

pain further down his right side and that he was not eating right. T. 278-279. Respondent replied that pain was to be expected with surgery and he would see the Patient on the 18th, the next day, for a previously scheduled appointment. T. 279

72. Dr. Eberle stated that with these continued complaints of pain, Respondent should have seen the Patient earlier than the scheduled appointment on the next day. T. 605

73. At the office visit on April 18, 1984, Respondent was told that the Patient was not feeling well, that he had pain in his right side, and that he was having hiccoughs. T.279. He was told also that the Patient was only eating Jello and a little toast, but nothing else, and that the Patient was not sleeping well T 279. Further, the Respondent was told at the office visit of the 18th that the Patient felt bloated and could not go to the bathroom. T.280 Respondent gave the Patient Maalox to take, and indicated that these things went along with the surgery. T. 280. He did not take the patient's temperature or blood pressure. T. 281.

74. Petitioner's expert testified that Respondent did not adequately evaluate the Patient at the office visit on April 18; it would be necessary to examine the chest and abdomen. There would be concern about diaphragmatic irritation with the hiccoughs. T. 606.

75. Respondent described his examination of Patient C at the office visit of April 15. It included only looking at the Patient as he walked to observe his breathing pattern, touching his hand to feel a pulse rate and noting his general appearance. When the Patient lay down on the examining table it was only to examine the wound and apply general pressure to see if there were tenderness. T.1160-1161. Respondent testified to a similiar examination being performed on April 18. T.1161-1162. Notably absent were the elements of an examination which Dr. Eberle testified should have been performed, such as examination of the abdomen and chest. T. 606.

76. In the early morning hours of Sunday, April 20, Respondent was called by Patient C's wife and told that her husband was vomiting, that he had a fever, that he was trying to go to the bathroom but couldn't, that he felt he had gas but could not relieve it. T.280-282. Respondent stated that the Patient should be brought to his office at 8:00 a.m.. T. 282.

77. Respondent recalls receiving the phone call from Patient C at 5:00 or 6:00 a.m.on April 20 complaining of a fever and pain in the lower part of his right chest when he took a breath. T.1166.

78. Respondent told Dr. Gavin's staff to take a chest x-ray. T. 1168.

79. At the office visit on the 20th the Patient complained about pain when he took a deep breath, severe pain at the rib margin on the right. T.1170. Respondent was again told the Patient had vomited through the night, had a temperature, felt like he had to go to the bathroom but couldn't, that the pain was still in the right hand side of his body, that his stomach was starting to get larger, and that he was having hiccoughs and they were quite evident. T.282.

80. Respondent diagnosed the Patient as having atelectasis. Ex. 12,p. 4.

81. A chest x-ray of Patient C demonstrates that the right diaphragm is high and there may be some of atelectasis and/or interstitial, interlobar effusion. T.609-610; Ex. 13A A reasonably prudent surgeon seeing that x-ray of a patient who had had a cholecystectomy seven days before should consider the causes of the elevation of the right diaphragm, which could be atelectasis, or something below the diaphragm pushing it up. T.610. The elevated diaphragm needs an explanation. T.611.

82. Given the information provided to Respondent at the office visit on the 20th and the information provided before then, considering what is shown on the x-ray of the Patient, and the facts noted in Respondent's office record (Ex. 12), Respondent did not perform a complete evaluation of the Patient as there is no indication in the office record concerning his findings about the Patient's abdomen. T. 607, 612-613. Given an operation that was below the diaphragm, with a Patient who has pain, elevated diaphragm, a fever, there is need to look at and evaluate the abdomen before deciding that the problem was in the chest. T.613.

83. Looking at the x-ray (Ex. 13A), Dr. Saltzstein stated that an elevated right hemi-diaphragm would make one consider the possibility of something going on under the diaphragm. T.1615. He also testified that the other x-ray (Ex.13B), shows that the right diaphragm is higher than usual and that there was some blunting of the costophrenic angle which indicates that there may be some fluid in the lung T.1616. The pleural effusions on this Patient's x-ray would indicate the possibility of something going on below the diaphragm. T.1628.

84. Petitioner's expert stated that Respondent diagnosed atelectasis which is unusual by the seventh post-operative day. There is no record of abdominal examination although this was an

intra-abdominal operation, and the elevated diaphragm as shown by the chest x-ray is more likely to have been caused by something below the diaphragm. T. 625.

85. The Patient had lower chect pain which can be caused by something below the diaphragm, particularly when the diaphragm is elevated. T.626.

86. Respondent stated the x-ray would indicate to him the possibility of something beneath the diaphragm (T.1251, Ex.13A), but he rejected that because the patient's complaints related only to respiratory problems in the right chest .T.1251. He did testify that there could be a sterile irritating collection even in the absence of fever and signs of inflammation. T. 1252.

87. The physician who evaluated Patient C on April 21 at the emergency room for a second hospitalization noted that Patient C had hiccoughs, and the physician who performed his admitting history and physical also noted that the Patient had a complaint of hiccoughs. Ex. 11, pp.49,51.

88. Respondent's stated plan of treatment for the Patient on April 20, 1984 does not meet acceptable standards of medical care. T. 623-625. The plan of care was for the Patient to take Ampicillin, steam, encourage coughing, and call Dr. Gavin in 3 days if symptoms persist. Ex. 12,p. 4.

89. Dr. Eberle testified that the office records of Respondent for the office visits of April 18 and 20 do not meet acceptable standards of medical care for record keeping because of a lack of notation of an abdomenal examination other than an observation that the wound was clean. Too, no physical findings of a chest examination on April 20th is noted, only a diagnosis. T.622-625, 626-627; Ex. 12.

90. Respondent's office records for April 20 does not contain adequate information for Dr. Gavin to take over care of this Patient, nor does it contain any information about any problems that the Patient had earlier than one day before the 20th. T. 685-686.

91. Respondent testified that he would not have considered an abscess with his Patient as he thought it would be too soon with this Patient's history. T. 1253. Respondent said that if the abscess raising the diaphragm were the result of infection, the Patient would have a temperature, but then acknowledged that his own office record demonstrates the Patient had a one day history of a 101 degrees temperature by the 20th. T. 1255. Respondent also stated that there is a high incidence, about five percent, of infection after acute cholecystitis. T. 1255.

92. Respondent agrees that post-operative care is directed at preventing and promptly recognizing and treating complications after cholecystectomy, such as subphrenic abscess. T.1256-1257. One of the reasons the right diaphragm may be elevated on the x-rays is an abscess. T. 1257.

93. Dr. Saltzstein agrees that, while the majority of patients might lend themselves to early discharge, a prudent physician must keep in his mind that complications could develop with a patient; it is reasonable to assume that some patients are not going to do well. T. 1631,1632. There is no indication in the office record for the 20th that the Respondent considered a subphrenic abscess, bleeding or other complications. T. 1639.

94. Petitioner's expert criticized Respondent's plan of treatment that directed the Patient to call Dr. Gavin in three days; he should have been seen tne next day even if he had only atelectasis and a 101 degree temperature. T. 661-662.

95. When pressed as to when specifically he felt that he no longer had any legal or medical responsibility for the Patient,the Respondent said he always felt responsible for him. T. 1248.

96. When Dr. Eberle stated that there would not be a need to take immediate action after the office visit of April 20, it was based on the assumption that Respondent had done an evaluation that indicated only slight tenderness to palpation predominantly in the upper right quadrant. T. 660-661.

97. Following the conclusion of cross-examination of Dr. Eberle, he stated that it was still his opinion that he agreed with the criticisms of Respondent's care and records in paragraphs C.3 and C.4 of the Statement of Charges. T. 682-683.

98. Dr. Eberle stated the Respondent's post-operative and office notes for Patient C were inadequate. T. 682; Ex. 12.

D. PATIENT D.

99. Patient D was a 9 year old girl when she was admitted to Albany Memoprial Hospital on December 6,1985. Ex. 14, p.1.

100. Patient D was admitted with abdomenal pain and fever; she was diagnosed by Respondent as having appendicitis,; on the date of admission, her appendix was removed. T. 704; Ex. 14, pp.5,20. Patient D was discharged on December 13, 1985, one week after the operation. T. 704.

101. During her hospitalization, Patient D's white blood count increased from 9,300 to 14,400 between December 11th to 13th, and the Patient's temperature was almost consistently elevated above normal. Ex 14, Ex. 14, opp. 26, 44-45. Respondent noted these temperature elevations as well as white blood count elevations. T. 707; Exs 14,15.

102. Patient D's white blood count is of concern because the total white blood count is increasing whereas with Patient C the immature cells were increasing; either one raises concern. T. 722-723.

103. Petitioner's expert stated Respondent's discharge of Patient D on December 13, 1985 did not meet acceptable standards of medical care because the Patient had a gangrenous appendix with a positive culture, had a persistently elevated temperature, and had an elevated white blood count that was actually increasing at discharge rather than decreasing. Respondent had not established the reason after a week in the hospital. T. 709.

104. Respondent should have, but did not, perform a rectal examination before discharge of the Patient. A rectal would be one of the first examinations if one is considering a possibility of a complication following removal of a gangrenous appendix with positive cultures. T. 709. A rectal examination would be

important as the pelvis is an area of frequent localization of persistent infection and abscess after this procedure. T.710. A rectal examination after a week post-operatively could show some induration, or tenderness, or a mass. T. 711.

105. Petitioner's expert witness stated a prudent physician would not discharge the Patient without performing a rectal examination as no adequate answer had been found for the sustained fever and increasing white counts which indicate a brewing infection. T.719. Such is the case even though there was an ability to follow Patient D as an outpatient. T. 718-719.

106. Petitioner's expert stated it would have been acceptable to discharge the Patient if she had been assessed before hand to assure that there was a focus of infection, including the performance of a rectal examination. T. 725,1659,1675,1661-1662.

107. Petitioner's expert stated that no reasonably prudent physician would defer the rectal examination of Patient D to be performed on an outpatient basis. T. 730.

108. While it is true that the abscess this Patient developed was according to Respondent's later operative report to drain the abscess, out of reach of the probing finger, Respondent stated that the most likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum. T. 1314, 1328.

108. While it is true that Respondent stated in a later operative report to drain the abscess that it was out of reach of a probing finger, Respondent stated on questioning that the mosty likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum. T. 1314, 1328.

109. Respondent attributed the Patient's continued fever in the hospital to a viral infection, but he did not note viral infection anywhere in the hospital record, even in his listing of diagnoses. T. 1319. Respondent also stated that it was conjecture as to whether a blood count of 30,300 was evidence of viral enteritis. T. 1319, 1330.

110. Dr. Saltzstein, stated that Respondent's hospital records do not reflect any indication why the Patient may be having problems post-operatively. T. 1659. Respondent's expert would have done diagnostic studies such as a rectal exam to try and determine the cause of the problems before discharge. T. 1661-1662.

111. The Respondent's expert would not rely on a plain x-ray to rule out an abscess; he would have tried to find an intraabdominal abscess with other studies. T. 1675.

112. There is no indication in the record that the Respondent wanted to perform a rectal examination but the Patient or family refused to permit it. T. 1667.

E. PATIENT E.

113. Patient E was a 70 year old female when she was admitted to Albany Memorial Hospital on January 13, 1986 for an intestinal obstruction. T. 744; Ex. 15,p.1.

114. A barium enema revealed that Patient E's obstruction was a lesion tumor of the proximal sigmoid colon. T. 744.

115. The Patient had a carcinoma which grew circumferentially around the bowel, closing down until there was only a relatively small opening. The obstruction was at the end of the decending colon and the beginning of the sigmoid colon, which ends at the rectuim. T. 1342. Surgical removal of the tumor was planned. T. 1343.

116. To prepare Patient E's bowel for surgery, Respondent wanted to have it as clean as possible so that there would be minimum contamination. T. 1344. Due to the obstruction they could not give her a large amount of saline material from above so they tried primarily with saline enemas and antibiotic. T. 1345. The saline enema orders of Respondent were an effort to mechanically cleanse much of the stool and bacteria containing material in the colon, to remove that which was below the obstruction and also to some extent, to go above it and wash down as much as possible. T. 1346; Ex. 15,p. 42.

117. Respondent stated the preparation prior to the procedure was not the best that could be given because the Patient had a partial bowel obstruction. Without the obstruction, there could have been a more thorough cleansing of the bowel. T. 1348.

118. During the surgical procedure on January 16, Respondent removed the portion of the colon that contained the obstructing lesion . Ex. 15, p.168. He then reattached the bowel by an end-to-end reanastamosis. T. 749; Ex.15, p. 168.

119. Respondent then created a colostomy by bringing out a loop of right transverse colon, opened it on the table, then stapled shut the top of the distal portion of colon, which contained the anastamosis. T. 749-750. He used a suction tube in the proximal end of the colon and evacuated a large volume of liquid feculent material. T. 749; Ex. 15, p.168.

120. Dr. Saltzstein, the Respondent's expert, reviewed the preoperative preparation for surgery of Patient E by the Respondent, oral neomycin, rectal saline enemas until clear , some systemic antibiotics. Ex. 15,p.42. He stated the preparation was the best that could be done under the circumstances. T. 1680. The Respondent gave as good a preoperation preparation with antibiotics and cleansing as could be done. T. 1696.

121. Beginning a few days after surgery, a series of x-rays over many days demonstrated that the Patient had a persistent small bowel obstruction. T. 753-755; Ex.15, pp. 152-160.

122. While the Patient had such small bowel obstruction, Respondent ordered, and the Patient was fed, Vivonex by a tube that entered her stomach or small bowel. Ex. 15, p. 52-53,84-86. Vivonex is an elemental nutrient. T. 758. The Patient could not tolerate Vivonex without suction. T. 1358.

123. A barium enema performed on January 29, 1986 revealed an extra-colonic barium collection at the site of the sigmoid anastomosis, indicating that there was a leak at the anastomosis. T. 759-760.

124. A second procedure was performed on Patient E on January 31, 1986 in which adhesions were lysed, multiple resections were performed on the bowel, and the colonic anastomosis was revised. Ex. 15, p. 177-178.

125. Respondent reviewed the January 31st operation stating that there were adhesions throughout the entire abdominal cavity. T. 1374.

126. During the Respondent's testimony about the second procedure, he did not provide the details of the revision of the colonic anastomosis. T. 1374-1376. Respondent's expert implied that the description of the revision of the anastomosis was not

complete, and he confirms that the required revision of the anastomosis is not explicitly described.T.1690; Ex.15,p.177.

127. The Respondent specifies the dense site of many adhesions, and the probable obstruction, was at the previous colon anastomatic site;and,multiple adhesions between small intestine and abdominal wall between the adjacent loops were lysed. Multiple resections were performed and anastomosed functionally. The adhesions were secondary to very dense. The bowel injuries and entry in several sections and the resection and functional anastomoses end-on-end with a staple machine are mentioned. The operative report, in general, does comment on the most important elements of complications of surgery that had to be faced. The location of each adhesion, the specific resections performed, the location of the extra-colonic barium may represent ideal notations, but the entries made do note the complexities of the surgery performed. They are minimally adequate. T. 760-761, 1689-1690; Ex. 17, p. 177.

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

A. Patient A

The Hearing Committee concludes that Respondent treated the 85 year old female Patient A at his office in June and admitted her to Samaritan Hospital, Troy , New York on July 7, 1983. On July 8, 1983, the Respondent performed surgery on the Patient to repair her ventral hernia, inadvertently lacerating the Patient's small bowel. Findings 5,6,7.

A.1. The Petitioner alleges the Respondent inappropriately discharged the Patient from the hospital on July 9th when she was both febrile and had vomited twice that day and her bowel had been lacerated during surgery. The Respondent stated the Patient's temperature had dropped, that her first vomiting of about 250 cc's.of brown fluid was due to a gag reflex from the naso-gastric tube, and that the second vomiting of about 150 cc's of undigested food shortly before discharge at about 6:00 p.m. was due to over eating Findings 10, 15.

Respondent agreed that discharge criteria for Patient A would include eating, drinking and keeping it down. Finding 8. Respondent's videotape includes the three criteria noted along

with the moving of the bowel and being afebrile.Findings 24,26. The Patient's first vomiting episode on the day of discharge took place after 7:00 a.m.; the tube was removed at 6:30 a.m. Finding 21. The Patient's first vomiting did not contain food despite Respondent's attribution of it to her having just ate. Findings 20,25. Finally, Respondent attributed the second vomiting to undigested food because Patient A could not accommodate her normal eating and drinking habits. Finding 16.

Dr. Saltzstein, the Respondent's expert witness, stated that,if the Patient continued to vomit after being fed, the Patient needs to be evaluated for the reasons why. Vomiting can be a response to a lot of things, including problems with the gastro-intestinal tract. Finding 27.

The temperature of Patient A at 4:00 p.m. prior to the 7:00 p.m. discharge on July 9 was 98 degrees. On the same day, temperatures were 102.1 at noon and 101.4 at 8:00 a.m. It cannot be concluded the temperature remained afebrile at the time of discharge. Finding 9.

During the first procedure a small bowel laceration changed the surgery from a hernia repair alone to one of a ventral hernia and a lacerated small bowel repair with possible bowel contamination being added to a possible leak from the hernia

repair. Finding 11. The Respondent stated that a patient with a bowel laceration during surgery with fever, nausea and vomiting 24 to 36 hours after surgery could have an intestinal obstruction. Finding 22. Patient A had a fever 24 hours after surgery and vomiting during the period noted by the Respondent. Findings 6,9 Respondent and Dr. Saltzstein both concluded that problems with the gastro-intestinal tract should have been considered.

The Respondent's criteria for discharge were eating, drinking and keeping it down. Finding 8. They were not met on the day of discharge.

The Hearing Committee confirms Petitioner's expert judgement that Patient A was not stable at the time of discharge. and that the discharge did not meet acceptable medical standards. Findings 12,13,14. A prudent physician would have considered the many causes other than the atelectasis chosen by the Respondent as an explanation of the fever. Findings 17,18. A prudent physician would have watched the Patient's temperature for a period of time before reaching the conclusion of the Respondent. Finding 19. The expert witness of the Respondent, Dr.Saltzstein, confirms that discharge of Patient A on July 9th was inappropriate in that he was concerned about the fever and vomiting. Findings 23,27.

The Hearing Committee unanimously concludes that Allegation A-1. is Sustained.

A.2. The Petitioner alleges the Respondent inadequately evaluated and treated Patient A after discharge from Samaritan Hospital because he did not perform an adequate office physical examination and did not properly respond to reports of Patient's vomiting, inability to keep liquids or solids down, and severe pain. No formal reply was entered.

On July 11, two days after discharge from the hospital, Patient A was taken to Respondent's office. She was in a lot of pain and vomiting. No temperature, blood pressure or pulse was taken and Respondent did not use a stethoscope or touch Patients abdomen. Finding 28. An adequate physical exam was not given by the Respondent. Temperature, pulse and respiration should have been recorded; the chest, lungs and abdomen palpated and auscultated (feeling and listening) and a lung and chest examination should have been completed. Dr. Saltzstein agreed the a palpation of the abdomen was indicated. Findings 28,29.

The next day, two of Patient A's sons separately called the Respondent reporting a lot of pain. An appropriate response would have been to see the Patient that day and adequately examine her. Findings 30, 31.

Respondent stated that in response to multiple calls he recommended the Patient be walked. The number of calls were more than for the average patient, more than three or four calls per day.. Findings 32,39.

At about 9:00 p.m. the same day, a son called the Respondent to tell him something had to be done about the pain. The Respondent replied the Patient could do anything except drive a car, that nothing was wrong with the Patient. Respondent was told the Patient could not even get out of bed. Respondent insisted so she could get rid of gas and recommended Mylanta. Finding 33. Petitioner expert stated the response was not adequate and the Respondent should have seen the Patient that day. Finding 34.

Later that night, at about 3:00 a.m. on July 11th Patient's step-daughter called the Respondent and told him Patient A was crying in pain, was really bad off. Respondent gave her an appointment to see him at 8:30 a.m.. Finding 35. Given the symptoms, Respondent should have seen the Patient as soon as possible. The five and one-half hour delay before appointment was not acceptable, particularly considering the short times between the calls. Again Respondent's response to the information did not meet acceptable medical standards. Finding 36.

Within a few hours after the 3:00 a.m. call to the Respondent on July 13th, Patient A collapsed, was taken to the hospital by ambulance, and died. Finding 37

Respondent was told the Patient was vomiting small amounts of food continuously after she ate and drank. He attributed it to her consuming large amounts of food and being obese whereas she was only swallowing tea and toast. Finding 38 .

When presented with the facts Respondent testified to, Dr. Saltzstein stated he would want to evaluate the Patient personally, at her home or in the hospital. Finding 40.

The Hearing Committee unanimously concludes that Allegation A.2 is Sustained.

A.3. The Petitioner alleges that Respondent's post-operative hospital and office notes for Patient A are inadequate. No formal reply was entered.

Adequate physician notes are important to indicate the thought processes of the physician at the time of treatment. Another physician taking over care can determine what the thoughts of the treating physician were. Finding 42. Respondent's expert Dr. Eberle stated that Respondent's second hospital progress note for July 9, 1983 was not adequate. Finding 41.

Dr. Saltzstein stated he would like to see the findings of vomiting and fever recorded as well as an explanation of why the Patient was discharged. Finding 44. Objectively meaningful medical information for other practicioners is required. Finding 45.

Respondent's office record does not contain an adequate post-operative record of Patient A Acceptable medical standards must reflect the examination performed. None of the vital signs are recorded. Finding 43.

The Hearing Committee unanimously concludes that Allegation A.3 is Sustained.

B. Patient B

The Committee concludes that the Respondent treated Patient B, a 47 year old male, at Albany Memorial Hospital in Albany, New York, and at Respondent's office in October and November, 1983. Respondent performed a cholecystectomy on Patient B on October 3, 1983, at Albany Memorial Hospital. Findings 46,48.

B.1. The Petitioner alleges the Respondent inappropriately discharged Patient B from the Hospital on October 4, 1983, when his vital signs had not sufficiently returned to normal following a difficult cholecystectomy. No formal reply was entered.

During the surgery, dissection of the gall bladder was difficult Finding 47. Patient B was discharged the following day,October 4, 1983 at about 6:30 p.m. Finding 48.

The last temperature reading before discharge was 100.2 (oral) degrees at 4:00 p.m. At 4:00 p.m. Patient B's pulse was 90;, his respirations, 30. Finding 49.

Dr. Saltzstein confirmed the vital signs of Patient B were consistent with a reasonable medical decision to discharge him on October 4th. There was a normal progression of recovery in progress. Finding 50.

The Hearing Committee unanimously concludes that Allegation B.1 is Not Sustained.

B.2. The Petitioner alleges the Respondent inadequately evaluated and treated Patient B after discharge from Albany Memorial Hospital because he did not perform an adequate physical examination at his office and did not properly respond to reports of patient pallor, jaundice, soaking sweat, and severe pain. No formal reply was entered.

The day after discharge from the hospital, the wife of Patient B told the Respondent that he was pale, with a yellowish tinge. Finding 55. She again called the Respondent

after the first post-hospital office visit and before the next visit on October 9 to report that her husband's color was bad. Finding 58. She was not a trained medical observor. The Respondent had seen and evaluated the Patient twice. Jaundice and pallor were not established by a preponderance of the evidence to the satisfaction of the entire Hearing Committee. Finding 55.

Soaking sweat was characteristic of Patient B's physical condition prior to the October 9 visit. Finding 56. Severe pain, a profuse sweat and feeling cold and clammy were reported to the Respondent on October 9. Finding 57.58. The Respondent directed Patient B's wife to bring the Patient to his office within the hour Finding 58.

Following the visit ,the Respondent reported to the Patient's son who was in the waiting room during the visit that everything was going pretty good, right on schedule. Finding 59.

The Repondent's expert, Dr. Saltzman, reported he was not able to determine what was done or not done from the Respondent's office notes, including the absence of an evaluation of the Patient. The Petitioner's expert, Dr. Eberle, reported the same conclusions, itemizing what should be in the office notes of the October 9th visit. Findings 60,61.

The Hearing Committee unanimously concludes that a preponderance of evidence has not been established to affirm the allegation.

Allegation B.2 is Not Sustained.

B.3. The Petitioner alleges the Respondent's post-operative hospital and office notes for Patient B are inadequate. Respondent admitted his post-operative hospital and office notes are inadequate, but he believes that 1984 standards were met. Finding 54. The Committee has adopted the standards set forth in Schwartz v. Board of Regents, requiring in 1982 that objectively meaningful medical information be the standard of adequacy for medical records. See, Significant Legal Rulings, supra, p.8.

Respondent's expert, Dr. Saltzstein, stated the records do not indicate what the Respondent did or did not do and do not contain an evaluation of the Patient. Finding 60. Dr.Eberle, Petitioner's expert, states the Respondent did not take an adequate history and did not perform an adequate physical exam. He summarized by stating that the Responmdent's office records do not meet acceptable standards of medical record keeping. Findings 61,62.

The Hearing Committee unanimously concludes that Allegation B.3 is Sustained.

C. Patient C.

The Committee concludes the Respondent treated Patient C, a 53 year old male, at Samaritan Hospital, and at Respondent's office on or about April, 1984. Respondent performed a cholecystectomy on Patient C on April 13, 1984 at Samaritan Hospital. Finding 63.

C.1. Allegation C.1 was withdrawn.

C.2. The Petitioner alleges Respondent inappropriately discharged Patient C from the hospital on April 14,1984, because the patient's abdomen was distended, he had not moved his bowels adequately, he did not wish to be discharged until he had adequate bowel movement, his red blood cell count, hemoglobin and hematocrit were declining, and he had a white blood cell count of 12,500 with polys of 81, stabs of 9. No formal reply was entered.

Patient C was admitted to Samaritan Hospital on April 13, 1984.He was diagnosed as having acute cholecystitis, and a cholecystectomy was performed the same day by the Respondent. The pathology report found the Patient had acute suppurative cholecystitis with focal necrosis and much hemorrhage. Finding 63.

Patient C was discharged at 7:30 p.m. on April 14th. The pre-discharge blood counts of the Patient are consistent with post-surgery inflammation. The Respondent's expert, Dr.

Saltzstein, stated that waiting for a bowel movement is not a reason to keep a patient in a hospital; evidence of gastrointestinal function, tolerating liquids, is adequate. Findings 64,65,66,67.

The Hearing Committee unanimously concludes that Allegation C.2 is Not Sustained.

C.3 The Petitioner alleges the Respondent inadequately evaluated and treated Patient C after discharge from Samaritan Hospital because he did not perform an adequate physical examination at his office, he did not properly respond to reports of patient fever, hiccoughs, vomiting, difficulty in keeping solids down, abdominal distension, and severe pain. No formal reply was entered.

The Respondent saw Patient C at his office on April 15, looked at the abdomen, touched around the incision area, but did not take the Patient's vital signs. Finding 69. On April 16th Respondent was called and told Patient C was in pain in his side around the right arm; Respondent stated such was expected. On April 17th, respondent was called to report the Patient had pain further down his right side and was not eating properly. The Respondent's reply was that such was expected and he would see the Patient the next day at the scheduled visit. Finding 71. The

Petitioner's expert witness, Dr. Eberle, stated that with the complaints of pain, the Respondent should have seen the Patient earlier that the scheduled appointment. Finding 72.

At the April 18th office visit, the Respondent was told the Patient was not feeling well, had a pain in his right side, had hiccoughs, was only eating jello and a little toast, was not sleeping well, felt bloated,and could not go to the bathroom. Respondent gave Maalox and indicated the complaints went along with the surgery. He did not take vital signs. Finding 73. Dr. Eberle stated the Respondent did not adequately Patient C on April 18th. The chest and abdomen should have been examined. With hiccoughs, there would be concern about diaphragmatic irritation. Finding 74.

Respondent's examinations on April 15th and 18th consisted of observing the Patient walking and breathing, touching his hand to feel the pulse, noting his general appearance, examining the wound, and applying general pressure to see if there was tenderness. Absent were examinations of the abdomen and chest that Dr. Eberle stated should have been performed. Finding 75

Early on April 20th, a call to the Respondent informed him that the Patient was vomiting, had a fever, tried to

go the the bathroom and couldn't, felt he had gas but could not relieve it. Respondent said the Patient should be brought to his office at 8:00 a.m. Finding 76. Respondent recalls the complaints were of fever and pain in the lower part of the right chest when he took a breath. Finding 77.

At the office visit on April 20th, the Patient complained of severe pain at the right rib margin when he took a deep breath and again repeated the symptoms reported a few hours earlier on the phone. Finding 79. Respondent diagnosed the Patient had atelectasis. Finding 80.

Two chest x-rays were taken. One demonstrates the Patient's right diaphragm is high and there may be some atelectasis and/or interstitial, interlobular effusion. A reasonably prudent surgeon,on viewing the x-ray of a patient who had a cholecystectomy a week earlier, would consider the causes of the elevation of the right diaphragm. They could be atelectasis or something below the diaphragm pushing it up. Finding 81.

Given the information provided to the Respondent and the facts shown in the Respondent's office record, no complete evaluation of the Patient was performed; no findings were made about the Patient's abdomen prior to decidinng that the problem was in the chest. Finding 82.

Dr. Saltzstein stated the Patient's x-ray with an elevated right hemi-diaphragm would make one consider the possibility of something happening under the diaphragm. The other x-ray indicates there may be some fluid on the lung; the pleural effusions indicate the possibility of something going on below the diaphragm. Finding 83. Dr. Eberle stated the diagnosis of atelectasis is unusual the seventh day after surgery. There is no record of an abdominal examination, and the elevated diaphragm is likely to be caused by something below the diaphragm. Finding 84. The Patient's lower chest pain can be caused by something below the elevated diaphragm. Finding 85.

Respondent stated the x-ray would indicate something beneath the diaphragm. Such was rejected because the Patient's complaints related only to respiratory problems in the right chest. There could be a sterile irritating collection even in the absence of fever and signs of inflammation. Finding 86.

Respondent's plan of treatment on the 20th was for the Patient to take Ampicillin, steam, encourage coughing, and call Dr. Gavin in three days if symptoms persist. The plan does not meet acceptable standards of medical care. Finding 88.

Respondent stated he believed an abscess would be premature for Patient C; and, if it were the result of infection,

the Patient would have a temperature. On April 20th the office record of the Respondent evidences a one day history of a 101 degree temperature. Respondent also stated there is a 5% incidence of infection after acute cholecystitis. Finding 91.

Respondent agrees that post-operative care is directed at preventing and promptly recognizing and treating complications after cholecystectomy, such as subphrenic abscess. One reason the right diaphragm may be elevated is an abscess. Finding 92.

Dr. Saltzstein agrees that with early patient discharge, a prudent physician knows that complications could develop; some patients are not going to do well. There is no indication in the office record for the 20th that Respondent considered a subphrenic abscess, bleeding or other complications. Finding 93.

Dr. Eberle criticized Respondent's treatment plan that directed the Patient to call Dr. Gavin in three days; even if he only had atelectasis with a 101 degree temperature. Finding 94. The Respondent stated he always felt medical and legal responsibility for Patient C. Finding 95.

Dr. Eberle stated that his original opinion that it was not necessary to take immediate action at the April 20th visit had assumed an evaluation of only slight tenderness to palpation in

the upper right quadrant. Finding 96 He agreed with the criticisms of the Respondent's care set forth in Paragraph C.3. Finding 97.

Two physicians who admitted the Patient in the Emergency Room on April 21st noted hiccoughs. Finding 87.

The Hearing Committee unanimously concludes that Allegation C.3 is Sustained.

C.4 The Petitioner alleges the Respondent's post-operative hospital and office notes for Patient C are inadequate. No formal reply was entered.

Respondents post-operative progress note of 4/14/84 does not meet acceptable standards of medical note keeping because it does not address the issues presented by the contents of the hematology reports and by comments in the nursing notes concerning not having a BM, and a distended abdomen. If the Respondent's note was made prior to the nurse's note, they should have been addressed in a later note. Finding 68

Respondent's notes do not indicate he adequately addressed the complaints of Patient C. Finding 70. Respondent recorded no examination of the chest or of the abdomen. Findings 75,82,84,89.

Respondent's office records for April 20th do not contain adequate information for Dr. Gavin to take over care of the Patient. There is no information about any problems the Patient had earlier than one day before the 20th. Finding 90.

Petitioner's expert testified he agreed with the criticisms of Respondent's records as set forth in paragraph C.4 of the Statement of Charges. Finding 97. Dr. Eberle stated the Respondent's post-operative and office notes for Patient C were inadequate. Finding 98.

The Hearing Committee unanimously concludes that Allegation C.4 is Sustained.

D. Patient D

The Respondent treated Patient D, a 9 year old female, at Albany Memorial Hospital, and at Respondent's office on or around December 1985. Respondent performed an appendectomy on Patient D on or about December 6, 1985 at Albany Memorial Hospital. Findings 99, 100.

D.1 The Petitioner alleges the Respondent inappropriately discharged Patient D from the hospital on December 13, 1985, when the cause of her fever had not been adequately assessed, she had an elevated blood count, and Respondent had not performed a rectal examination before discharge. No formal reply was entered.

During her hospitalization, Patient D's white blood count increased from 9,300 to 14,400 between December 11th to 13th, and the Patient's temperature was almost consistently elevated above normal. Respondent noted both the temperature and white blood count elevations. Finding 101.

Patients D's white blood count is of concern because both the total and the immature cell count were increasing. Finding 102.

Petitioner's expert, Dr. Eberle, stated the discharge of Patient D on December 13th did not meet acceptable standards of medical care because the Patient had a gangrenous appendix with a positive culture, had a persistently elevated temperature, and had an elevated blood count that was actually increasing at discharge, rather than decreasing. Respondent had not established the reason after a week in the hospital. Finding 103.

Dr. Eberle stated Respondent should have , but did not,perform a rectal exam before the discharge of the Patient. It would be one of the first exams considered in Patient C's type of case where the pelvis is an area of frequent localization of infection and abscess. A week after an operation, a rectal could show some induration, or tenderness, or a mass. A prudent physician would not discharge the Patient without performing a

rectal exam because no adequate answer had been found for the sustained fever and increasing white counts indicating a brewing infection even if there was an ability to follow the Patient as an outpatient. Finding 104, 105.

If the Patient had been assessed before hand to assure there was a focus of infection, including the performance of a rectal examination, it would have been accepatble to discharge her. No reasonable physician would defer the rectal examination to be performed on an outpatient basis. Finding 106.

The Respondent's later operative report to drain Patient D's abscess stated it was out of reach of a probing finger. The Respondent also stated the most likely site of drainage from the appendectomy for this Patient would be somewhere near the rectum Finding 108.

Respondent attributed the Patient's continued fever in the hospital to a viral infection. He did not note viral infection anywhere in the hospital record, even in his listing of diagnosis. He also stated it was conjecture as to whether a blood count of 30,300 was evidence of viral enteritis. Finding 109.

Dr. Saltzstein stated that Respondent's hospital records do not reflect any indication why the Patient was having problems post-operatively. Respondent's expert would have done diagnostic studies such as a rectal exam to try to determine the cause of the problems prior to discharge. Finding 110

Dr. Eberle would not rely on a plain x-ray to rule out an abscess; he would have tried to find an intraabdominal abscess with other studies. Finding 111.

There is no indication in the record that the Respondent wanted to perform a rectal examination but the Patient or family refused to permit it. Finding 112.

The Hearing Committee unanimously concludes that Allegation D.1 is Sustained.

E. Patient E

Respondent treated Patient E, a 70 year old female, at Albany Memorial Hospital from on or about January 13, 1986, through February 2, 1986. Patient E was admitted to Albany Memorial Hospital due to intestinal obstruction and Respondent performed surgery on Patient E on January 16, 1986 and January 31, 1986. Findings 113,118,124; Ex. 15, p. 2.

E.1 The Petitioner alleges pre-operative preparation of the bowel for the operation on or about January 16, 1986 was inadequate. No formal reply was entered.

Patient E was hospitalized for an intestinal obstruction, identified as a lesion tumor of the proximal sigmoid colon. Surgical removal of the tumor was planned. Findings 113, 114,115.

Respondent prepared Patient E for surgery with saline enemas and antibiotic. Without the bowel obstruction there could have been a more thorough cleansing. Findings 116,117.

On January 16, Respondent removed the colon portion containing the lesion and reattached the bowel by an end-to-end reanastamosis, followed by a colostomy created by bringing out a loop of right transverse colon, opening it, stapling shut the top distal portion of the colon containing the anastamosis. A suction tube was used to evacuate a volume of liquid feculent. Findings 118, 119.

Dr.Saltzstein, the Respondent's expert, reviewed the preoperative preparation of oral neomycin, rectal saline enemas until clear, some systemic antibiotics. He stated the preparation was the best that could be done under the circumstances. Finding 120

The Hearing Committee unanimously concludes that Allegation E.1 is Not Sustained.

E.2 The Petitioner alleges the Respondent instilled Vivonex into Patient E despite evidence that her small bowel was partially obstructed. No formal reply was entered.

Several post-surgery x-rays identified a persistent small bowel obstruction. The Respondent ordered feeding with Vivonex through a tube that entered her stomach or small bowel. The Patient could not tolerate Vivonex without suction. Vivonex is an elemental nutrient. Findings 121, 122.

The Hearing Committee, noting that the Vivonex was able to be absorbed in some part before and during the suction process, determined that the bowel obstruction did not obviate its use.

The Hearing Committee unanimously concludes that Allegation E.2 is Not Sustained.

E.3 Allegation E-3 was withdrawn.

E.4 The Petitioner alleges the Respondent's operative note for the operation on January 31, 1986, was inadequate because it does not mention the location of the adhesions, the multiple resections of the bowel, the presence of the extra colonic barium collection, and the details of the revision of the colonic anastamosis. No formal reply was entered.

A barium enema on January 29th indicated there was a leak in the anastamosis. A second procedure was performed on January 31st. Adhesions were lysed, multiple resections were

performed on the bowel and the colonic anastamosis was revised. The Respondent stated there were adhesions throughout the entire abdominal cavity. Findings 123, 124 125.

The Respondent did not provide details of the revision of the colonic anastamosis. Dr. Saltzstein, Respondent's expert implied the description of the revision was not complete. He confirmed that the required revision of the anastamosis is not explicitly described. Although the Respondent's expert finds the operative report comments on "...the most important elements. .." of the surgery, the location of the adhesions, the resections performed,and the location of the extra-colonic barium are not specified. The Respondent testified concerning all of these. Findings 126, 127.

The Hearing Committee,noting that the testimony of the Respondent substantially fills in the gaps of the operative report, concludes that such was available and should be in the report to meet the minimum New York standard of objectively meaningful medical information. Significant Legal Rulings, supra, p. 8.

The Hearing Committee unanimously concludes that

<u>Allegation E.4 is Sustained.</u>

CONCLUSIONS WITH REGARD TO SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS:
Practicing with Gross Negligence

FIRST SPECIFICATION: Having sustained allegations A.1, and A.2 , the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in both hospital discharge of Patient A on July 9, 1983 and in post-discharge treatment of Patient A thereafter.

SECOND SPECIFICATION: Having failed to sustain allegations B.1 and B.2, the Hearing Committee unanimously concludes that the Respondent did not practice with gross negligence either in hospital discharge of Patient B on October 4, 1983 or in the post-discharge evaluation and treatment of Patient B thereafter.

THIRD SPECIFICATION: Having withdrawn allegation C.1,and having failed to sustain allegation C.2, and having sustained allegation C.3 , the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in inadequately evaluating and treating Patient C after hospital discharge on April 14, 1984, but that the hospital discharge was appropriate.

FOURTH SPECIFICATION: Having sustained allegation D.1, the Hearing Committee unanimously concludes that the Respondent practiced with gross negligence in hospital discharge of Patient D on December 13, 1985.

FIFTH SPECIFICATION: Having failed to sustain allegations E.1 and E.2 and having withdrawn allegation E.3, the Hearing Committee unanimously concludes that the Respondent did not practice with gross negligence either in pre-operative preparation of Patient C's bowel on or about January 16, 1986 or in instilling Vivonex into Patient C.

SIXTH SPECIFICATION:
Practicing with negligence on more than one occassion

SIXTH SPECIFICATION: Having sustained allegations A.1, A.2, C.3 and D.1 as heretofore set forth, despite having failed to sustain or withdrawn the other negligence allegations cited, the Hearing Committee unanimously concludes that the Respondent practiced with negligence on Patients A,C and D on four occassions.

SEVENTH THROUGH TENTH SPECIFICATIONS
Inadequate medical records
(NOTE: The First Specification No. 7 repeats Specification No. 6; herein, Specifications numbered "8..9.,10.,and 11." have been renumbered to conform to the caption:"7.,8.,9.,and 10.")

SEVENTH SPECIFICATION: Having sustained allegation A.3 , the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient A being inadequate.

EIGHTH SPECIFICATION: Having sustained allegation B.3, the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient B being inadequate.

NINTH SPECIFICATION: Having sustained allegation C.4 , the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his post-operative hospital and office notes for Patient C being inadequate.

TENTH SPECIFICATION: Having sustained allegation E.4 , the Hearing Committee unanimously concludes that the Respondent maintained inadequate medical records, his operative note for the operation on January 31, 1986 being inadequate.

CONCLUSIONS WITH REGARD TO RESPONDENT'S CREDIBILITY

An example of the equivocation characteristic of the Respondent is provided in his statements concerning Patient A's two episodes of vomiting on the day of discharge the day after

surgery. First it was the naso-gastric tube removal stimulating a gag reflex(Finding 15), then it was due in part to having just eaten (Finding 20). Finally, he acknowledged that 350cc's is a large volume of liquid, that it was brown in color indicating bile, and that there was no indication of food in the vomit. Finding 25. And the 150cc's of vomit somewhat before discharge were the result of not being able to accommodate normal eating and drinking habits. Finding 16.

The Respondent managed to avoid the conclusions of both medical experts that pain and vomiting post-operatively dictated an abdominal examination prior to discharge at the least. Findings 14,23. More incredulous, verging on the bizarre, is the ability of the Respondent to avoid the application of his own discharge criteria: eating,drinking,keeping it down.Finding 24. At the least, acceptable standards of medical care were breeched by the Respondent. T. 394; Ex. 5. And Respondent's position on the critical discharge of Patient A demonstrated his capacity to mold facts to fit his view that Patient A cannot be having problems needing resolution prior to discharge.

In response to a question by a member of the Hearing Committee, the Respondent stated he was still in active practice. The Respondent, however, has no surgical privileges at any

hospital in the Albany area. He is a consultant at Harlem Center Hospital, but was not practicing operative surgery at the time of the hearing. T. 998.

SUMMARY OF CONCLUSIONS

As set forth in Significant Legal Rulings on page 7 the Hearing Committee has applied the following definitions in formulating its conclusions:

> Negligence is a deviation from the acceptable standard of care.
>
> Negligence on more than one occasion is proved by acts of negligence on more than one event of some duration.
>
> Gross negligence is proved by a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct.

The Hearing Committee finds that Respondent placed Patients A, C and D,because of his inappropriate hospital discharge of Patients A and D,and his post-discnarge evaluation and treatment of Patients A and C.despite the repetitive reports he received on their condition, at substantial risk. The discharges and lack of treatment of patients after discharge each constitute gross negligence, egregious and multiple.

Respondent's medical records for Patients A,B,C, and E do not meet the mandated requirement of objectively meaningful information. Neither expert witness was able to determine what

the Respondent did or did not do related to essential elements of hospital and post-discharge evaluation and treatment. If an expert is not able to determine essential information on both, a physician filling an emergency or succeeding another physician is not able to provide the evaluation and treatment needed with dispatch. The patient records are a lifeline to continuity of care. The testimony of the experts is the best evidence of the records meeting the standard of acceptability.

In essence, the Hearing Committee has grave misgivings about the continuation of surgical practice by the Respondent. His apparent efforts to embellish the results of early discharge of patients to their detriment, his lack of remorse or insight into his problems, and his denial of wrongdoing despite the candid testimony of objective experts representing the Petitioner and the Respondent largely contribute to the Committee's conclusions. The Respondent's inability to focus on the questions and to answer them directly contributed to the conclusions as well.

ORDER

IT IS HEREBY ORDERED that the license number 087923 issued by the New York State Education Department to GERALD MOSS.M.D. be and and hereby is limited to the area and type of practice of consultation to the exclusion of all other types of medical practice.

DATED: Syracuse, New York
March 24, 1993

BY: _____
JOSEPH K. MYERS, JR., M.D., F.A.C.S.

ROBERT A. MENOTTI, M.D., F.A.C.S.

GEORGE F. COUPERTHWAIT

APPENDICES

Appendix	I.	Statement of Charges (with ammendments noted)
Appendix	II.	Ruling on Bias Request
Appendix	III.	Petitioner's Motion to Instruct the Hearing Committee Not to Consider Pages 74 through 78 of Respondent's Proposed Findings; Administrative Officer's Notice re the Subject Hearing
Appendix	IV.	Affidavit of Respondent's Expert Witness in Lieu of Rejected Conclusory Statement at the Hearing, submitted for the record only, Denied by the Administrative Officer