STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 13, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

John Bell-Thomson, M.D.
Dept. of Cardio-Thoracic Surgery
Erie County Medical Center
462 Grider Street
Buffalo, New York 14215

Kevin C. Roe, Esq.
NYS Department of Health
Corning Tower Room 2503
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3400 Marine Midland Center
Buffalo, New York 14203

RE: In the Matter of John Bell-Thomson, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-177) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

JOHN BELL-THOMSON M.D.

DETERMINATION

AND

ORDER

BPMC 98 - 177

JOHN H. MORTON, M.D., (Chair) **JOHN P. FRAZER, M.D.** and **GEORGE C. SIMMONS, Ed.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE ("ALJ"), served as the Administrative Officer.

The Department of Health appeared by **HENRY M. GREENBERG, ESQ.**, General Counsel, by **KEVIN C. ROE, ESQ.**, Associate Counsel.

Respondent, **JOHN BELL-THOMSON M.D.**, appeared personally and was represented by **PHILLIPS, LYTLE, HITCHCOCK, BLAINE & HUBER, LLP**, by **JOSEPH V. SEDITA, ESQ.** and **KIMBERLY A. FERRIS, ESQ.**, of counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

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

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" or "**Department**") pursuant to §230 of the P.H.L. JOHN BELL-THOMSON M.D. ("**Respondent**") is charged with twenty-one specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with: professional misconduct by reason of practicing the profession with gross negligence on six occasions[1]; professional misconduct by reason of practicing the profession with gross incompetence on six occasions[2]; professional misconduct by reason of practicing the profession with negligence on more than one occasion[3]; professional misconduct by reason of practicing the profession with incompetence on more than one occasion[4]; six charges of professional misconduct by reason of conduct in the practice of medicine which evidences moral unfitness to practice medicine[5]; and one charge of practicing the profession fraudulently[6].

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[1] Education Law §6530(4) and Specifications First through Sixth in Department's Exhibit # 1.

[2] Education Law §6530(6) and Specifications Seventh through Twelfth in Department's Exhibit # 1.

[3] Education Law §6530(3) and Specification Thirteenth in Department's Exhibit # 1.

[4] Education Law §6530(5) and Specification Fourteenth in Department's Exhibit # 1.

[5] Education Law §6530(20) and Specifications Fifteenth through Twentieth in Department's Exhibit # 1.

[6] Education Law §6530(2) and Specification Twenty-First in Department's Exhibit # 1.

These charges concern the medical care, treatment and services provided by Respondent to five patients and interaction with five medical personnel[7].

Respondent admits to being licensed to practice medicine in New York and admits that he treated the five patients in Buffalo, New York. Respondent denies any gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion , any moral unfitness and any fraudulent practice of the profession and asserts that his actions were, in all respects, consistent with applicable accepted standards of medical care.

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

The Hearing consisted of 13 separate days. The Department called 14 witnesses. The Respondent called 17 witnesses, including himself.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. **Where there was conflicting evidence or testimony, the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence.** All Findings and Conclusions herein were unanimous unless otherwise indicated. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

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[7] Patients and certain medical staffs are identified in an Appendix to the Statement of Charges, Department's Exhibit # 1.

1. Respondent was licensed to practice medicine in New York State on August 1, 1974 by the issuance of license number 121353 by the New York State Education Department (Department's Exhibit # 1)[8]; (Uncontested).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the Administrative Officer; Respondent had no objection regarding personal service effected on him); (P.H.L. § 230[10][d]); (Department's Exhibit # 1); [P.H.T-10-12][9].

3. Lori Ann Larson has been a Surgical Technician for ten years and was employed at Erie County Medical Center ("**ECMC**") in Buffalo, New York, on May 12, 1995 [T-27-29]. She was called by the Department and testified on March 19, 1998 [T-27-76].

4. Nurse C was licensed as a Registered Nurse ("**R.N.**") in October 1978. She has been employed by Millard Fillmore Hospital ("**MFH**") since 1989. On June 30, 1995, Nurse C was the charge nurse on the Open Heart Unit ("**O.H.U.**") at MFH [T-78-80]. She was called by the Department and testified on March 19, 1998 [T-76-149].

5. Dr. Frederick Blacman Parker, Jr., a board certified cardiothoracic surgeon, has practiced medicine in New York for 30 years. Dr. Parker is also board certified in general surgery and is presently the Chair of the Surgery Department at the State University of New York ("**SUNY**") Health Science Center in Syracuse, New York [T-152-153]; (Department's Exhibit # 13). He was called by the Department and testified on March 19 and March 31, 1998 [T-150-243, 618-866].

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[8] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit) or submitted by Dr. John Bell-Thomson (Respondent's Exhibit).

[9] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

6. Nurse B, an R.N. since 1975, is employed by ECMC as an assistant head nurse. She was recruited by Respondent to work with him in the O.H.U. at ECMC from her position with General Surgery Services at ECMC [T-262-265]. She was called by the Department and testified on March 20, 1998 [T-262-360].

7. Nicole Rickard, an R.N., has been a nurse investigator with the New York State Health Department, Office of Professional Medical Conduct for three years [T-361-363]. She was called by the Department and testified on March 20, 1998 [T-360-409].

8. Nurse D, an R.N. for 25 years, is presently employed as a staff nurse in the O.H.U. at MFH. Nurse D has been employed with MFH for 11 years and was working at MFH on June 30, 1995 [T-411-412]. She was called by the Department and testified on March 20, 1998 [T-410-449].

9. Rosanna T. Schultz, an R.N. since 1983, was employed as a staff nurse on the O.H.U. of MFH from July 1989 through June 1997. Ms. Schultz was working at MFH on August 31, 1995 [T-451-453]. She was called by the Department and testified on March 20, 1998 [T-450-500].

10. Patricia Wopperer, an R. N., was the Director of Surgical Services at ECMC in 1995 [T-509-511]. She was called by the Department and testified on March 30, 1998 [T-508-553].

11. Dr. Bradley T. Truax, board certified physician in Internal Medicine and Neurology, was the Medical Director at ECMC from 1992 to 1996 [T-555-556]. He was called by the Department and testified on March 30, 1998 [T-553-602]; (Department's Exhibit # 12).

12. Dr. LuJean Jennings, a cardiothoracic surgeon, went to medical school at Albert Einstein in Bronx, New York and did her cardiovascular surgery fellowship at Stanford in California [T-874-875]. She was called by the Department and testified on April 3, 1998 [T-872-968].

13. Dr. A. went to medical school at Temple University. He did a surgical residency at the Albert Einstein Medical Center in Philadelphia, Pennsylvania ("**AEMC**"). Dr. A did a fellowship in solid organ transplantation in the University of Pittsburgh, and is currently practicing medicine in Florida. Dr. A's practice consists of general vascular and thoracic surgery [T-975-1007]. He was called by the Department and testified on April 6, 1998 [T-975-1007].

14. Michele Mutchler, an R.N. since 1974, was employed by AEMC from December 1987 through June 1993. She was the scrub nurse in the operating room ("**OR**") at AEMC on the date of the alleged incident described in Factual Allegation B of the Statement of Charges [T-1009-1010]. She was called by the Department and testified on April 6, 1998 [T-1008-1055].

15. Rita Suhr, an R.N. since 1991, has been employed by MFH since 1983. She was working at MFH on June 27, 1995 [T-1058-1059]. She was called by the Department and testified on April 6, 1998 and April 23, 1998 [T-1057-1099, 1170-1204].

16. Sharon A. McNamara, an R.N., is the Director of Surgical Services at MFH. She obtained her B.S. degree from Daemen College and her Master's Degree in Nursing from D'Youville [T-1124]. She was called by the Department and testified on April 23, 1998 [1122-1169].

17. Paul J. Candino, a Certified Public Accountant since 1985, has been Chief Executive Officer of the ECMC since 1994 [T-1206-1207]. He was called by the Respondent and testified on April 23, 1998 [T-1205-1273].

18. Dr. Roger K. Kaiser, Jr., a board certified anesthesiologist, has been the Clinical Director of the Anesthesiology Department at ECMC since 1989 [T-1275-1276]. He was called by the Respondent and testified on April 23, 1998 [T-1274-1303].

19. Dr. Joseph A. Zizzi, Sr., a cardiologist, is the Director of Clinical Cardiology at ECMC and professor of medicine at the University of Buffalo [T-1314-1316]. He was called by the Respondent and testified on April 24, 1998 [T-1313-1373].

20. Patient E's daughter holds a Master's Degree in Public Administration. She resides in Dublin, Ohio and did so in 1995 [T-1374-1376]. She was called by the Respondent and testified on April 24, 1998 [T-1374-1393].

21. Bonnie L. Hawes is an R.N. employed in the OR at ECMC. She has worked as a nurse with the O.H.U. Team for 8 years [T-1393-1396] She was called by the Respondent and testified on April 24, 1998 [T-1393-1416].

22. Rosemary Shriber, has been an R.N. since 1976 and is certified as an OR nurse. She is employed by ECMC as the Nursing Team Leader in the cardiothoracic OR [T-1418-1419] She was called by the Respondent and testified on April 24, 1998 [T-1417-1441].

23. Dr. Joseph Louis Gelormini is a physician specializing in cardiology since 1987. Dr. Gelormini was Patient's B physician in 1995 [T-1450-1451]. He was called by the Respondent and testified on April 27, 1998 [T-1448-1487].

24. Jo Ann B. Cole was employed as Associate Director of Surgical Services by ECMC in 1995 [T-1488-1489]. She was called by the Respondent and testified on April 27, 1998 [T-1487-1491].

25. Dr. Margaret Paroski graduated from SUNY Buffalo in 1980 and did her residency as a neurologist from 1980 to 1984. From 1991 to 1996 she was Chief of Neurology at ECMC and currently is Medical Director at ECMC [T-1493]. She was called by the Respondent and testified on April 27 and 28, 1998 [T-1491-1560, 1690-1726].

26. Dr. Robert G. Somers graduated from Jefferson Medical College in 1958. Dr. Somers has been the chairman of the Department of Surgery at AEMC for the past 14 years [T-1562-1563]. He was called by the Respondent and testified on April 27, 1998 [T-1561-1630].

27. Michael T. Rumschik was employed by Respondent as a cardiac physician assistant ("**P.A.**") at ECMC [T-1632]. He was called by the Respondent and testified on April 27, 1998 [T-1630-1635].

28. Dr. Kenneth Eckhert, Jr. graduated from SUNY Buffalo in 1968, and did his surgical residency at the Meyer Hospital, Deaconess Hospital, Childrens Hospital Consortium in Buffalo. In 1987 he was Chief of Surgery at Sisters of Charity Hospital and is currently Chief of Surgery and Director of the Breast Care Center at Sisters of Charity Hospital [T-1643-1644]. He was called by the Respondent and testified on April 28, 1998 [T-1641-1657].

29. Jane M. Becht, an R.N., has a B.S. degree from Niagara University. She has been employed by MFH since 1978 and has been in the O.H.U. since 1989 [T-1659-1661]. She was called by the Respondent and testified on April 28, 1998 [T-1657-1690].

30. Daniel R. Zayac was trained as a corpsman (medic) by the military and as a P.A. In 1993 he separated from the military after receiving additional medical training as a perfusionist. He has been employed by Respondent since 1994 [T-1718-1730, 1732]. He was called by the Respondent and testified on April 28, 1998 [T-1727-1785].

31. Julie Ann Luczak is a certified cardiovascular perfusionist at ECMC and has been so employed since 1993. She also worked part-time at MFH on Respondent's cases [T-1786-1789]. Ms. Luczak is married to the Respondent [T-1793]. She was called by the Respondent and testified on April 28, 1998 [T-1786-1797].

32. Dr. Roger Seibel is the Chief of Surgery at ECMC and has been for approximately nine years. He is also the director of the Trauma-Burn Center at ECMC and Professor of Surgery and Orthopedics at SUNY, Buffalo Medical School [T-1807-1809]. He was called by the Respondent and testified on May 18, 1998 [T-1804-1824].

33. Dr. John Bell-Thomson was educated in medicine and received his degree in medicine in Argentina. He did his residency at Lennox Hill Hospital in New York. He is board certified as a general surgeon and as a thoracic surgeon [T-1837-1838]. Respondent testified on May 18, 19 and 21, 1998 [T-1824-2357].

PATIENT A

34. Patient A, a 40 year old male, was admitted from the Emergency Department of ECMC for surgical repair of a traumatically transected aorta. Respondent was the attending surgeon and the surgical procedure took place between 21:30[10] (March 28) and 3:30 on March 29, 1995 (Department's Exhibit # 3 @ pp. 4, 130, 132); [T-629-630].

35. A double-lumen endotracheal tube had been used intraoperatively so that ventilation could be maintained on one lung and thereby permit the surgeon greater operating room in the contralateral chest [T-1384].

36. After the conclusion of the main surgical procedure, Respondent and Dr. Roger Kaiser, discussed the ventilation problems facing Patient A and determined that the best course of action was to perform a tracheostomy and replace the double-lumen endotracheal tube [T-1285-1286; 2073-2076].

37. Respondent and Dr. Kaiser determined that, due to Patient A's extremely edematous condition, the double-lumen endotracheal tube could not be safely replaced with a single-lumen endotracheal tube through the mouth [T-1285-1287].

38. The tracheostomy performed on Patient A permitted replacement of the double-lumen endotracheal tube employed for anesthesia and respiratory support intraoperatively with a single-lumen tracheostomy canula (Department's Exhibit # 3 @ pp. 26, 126,130,132,145,146); [T-2073-2076].

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[10] Military time will be used throughout this Determination and Order.

39. Under the circumstances presented by Patient A, the decision to proceed with the tracheostomy was medically justified [T-1285-1300; 1814-1817; 2073-2076].

40. Nurse B was the circulating nurse during Patient A's surgery. When Respondent determined that a tracheostomy was going to be undertaken, Nurse B informed him that she would obtain the necessary supplies, including Betadine (Department's Exhibit # 3 @ p. 126); [T-284].

41. The performance of a tracheostomy was not urgent or an emergency situation [T-160, 285, 1302].

42. Instead of waiting for Nurse B to return with the Betadine, Respondent assisted in prepping the neck area of Patient A by pouring alcohol over a sponge stick held by the resident who thereupon painted the patient's neck (Department's Exhibit # 23); [T-2074-2075].

43. When electrocautery was applied to Patient A's neck, a fire ignited on the patient's neck, face and the operative drapes (Department's Exhibit # 23); [T-286, 2075, 2079].

44. In a non-emergent situation electrocautery should not be applied while alcohol used for sterilization is still present [T-162-163, 632-635, 2079]; (Department's Exhibit # 23).

PATIENT B

45. Patient B, a 65 year old female, had a history of hypertension, Addison's disease, diabetes mellitus, adrenal insufficiency treated with steroids and recurrent angina pectoris. Patient B had undergone coronary artery bypass graft ("**CABG**") surgery prior to June 1995 (Department's Exhibit # 4 @ pp. 10, 33); [T-1453].

46. Patient B was admitted to MFH after a number of episodes of congestive heart failure or "flash pulmonary edema" (Department's Exhibit # 4 @ pp. 33-35); [T-1453-1454].

47. On May 15, 1995, Alan W. Meholick, M.D. performed cardiac catheterization and angiography at the cardiac catheterization lab of MFH. The May 15th study showed mildly elevated left ventricular and diastolic pressure at rest, mild to moderate reduction in the left

ventricular ejection fraction at rest, and triple vessel coronary artery disease with old occlusion of the saphenous vein graft to the LAD and circumflex marginal, and new occlusion of the saphenous vein graft to the RCA which had undergone coronary intervention on August 30, 1994. Mitral regurgitation was estimated at approximately 3 + [11] (Department's Exhibit # 4 @ pp. 33-35).

48. Dr. Meholick recommended a trial of medical therapy, consideration to be given for transesophageal echocardiography ("**TEE**") to further assess the degree of mitral regurgitation, and consideration of mitral valve repair or replacement with re-do CABG surgery. (Department's Exhibit # 4 @ pp. 33-35).

49. On June 27, 1995, Respondent admitted Patient B at MFH for mitral valve repair or replacement with re-do CABG surgery (Department's Exhibit # 4); [T-165-166, 1788].

50. A preoperative TEE was not done or ordered for Patient B (Department's Exhibit # 4); [T-165-168].

51. On June 27, 1995 Patient B was taken to the operating room and received general anesthesia. At that time, a TEE was performed. The TEE showed mild degenerative changes in the mitral valve leaflets with normal motion; mild mitral regurgitation at some angles with no reversal flow in the left upper pulmonary vein. In view of these findings, including no significant V wave on the Swan-Ganz and Patient B's general improved clinical status after re-initiation of medical therapy, Respondent canceled the planned surgery for Patient B (Department's Exhibit # 4 @ pp. 10-11); [T-165-168, 2097-2100].

52. Prior to surgery and initiation of general anesthesia, a TEE should have been performed on Patient B (a high-risk patient) to evaluate the degree of mitral regurgitation and determine whether or not surgery was the appropriate therapy. Patient B was unnecessarily exposed to the risks of general anesthesia and infection [T-166-168, 695-713].

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[11] Mitral regurgitation is a leakage of the mitral valve. Mitral regurgitation is graded on a scale of 1-4 in which 4 is the most severe manifestation of the disease [T-1456, 1459].

53. Respondent ordered preoperative antibiotics (Ancef, one gram intravenously) for Patient B (Department's Exhibit # 4 @ pp. 97, 102); [T-2106-2108].

54. Respondent did not insert into Patient B's femoral artery a guidewire which had fallen to the floor (Respondent's Exhibit # H-1); [T-2108-2109].

55. Neither the testimony of Nurse Suhr, nor the documentary evidence provided regarding a contaminated femoral line guidewire involved Patient B. The testimony conflicts with the documentary evidence and indicates different operating rooms; different dates; different surgical procedures [events]; the identity of the patient is not confirmed; the identity of the physician is not confirmed (Department's Exhibit # 4); (Respondent's Exhibit # H-1); [T-1066, 1090-1091, 1097, 1175].

PATIENT C

56. Patient C, a 73 year old male with a past medical history of arrhythmias, was admitted to MFH on June 16, 1995, for elective CABG surgery after coronary and angiography showed severe three vessel coronary artery disease. Patient C had a good ejection fraction and was a good risk for surgery (Department's Exhibit # 5 @ pp. 8, 148); [T-175]

57. On June 30, 1995, Respondent performed CABG surgery on Patient C. The procedure terminated at 11:50 and Patient C was transferred to the O.H.U. at 12:30 (Department's Exhibit # 5 @ pp. 194, 215)

58. Respondent left MFH and went to ECMC (Department's Exhibit # 5 @ p. 215); [T-877-878, 1682].

59. At 13:35, Lynette Lusch[12], a P.A., working for Respondent, was informed that the cardiac index had fallen to 1.79 with decreased blood pressure and cardiac output. PA Lusch ordered 40 mg. KCL IV and increased doses of Dobutamine and Epinephrine (Department's Exhibit # 5 @ pp. 116, 215); [T-1667-1668].

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[12] a/k/a Luksch or Lukash.

60. At 14:30, the cardiac index was 1.86 with continued decreased blood pressure and cardiac output. At approximately 14:30 Respondent was notified of the patient's condition and he ordered increased Epinephrine to achieve a mean arterial pressure greater than 70 (Department's Exhibit # 5 @ p 116 {time indicated that medication was given per Respondent's order 14:55}); [T-1669-1671].

61. At 15:00, Daniel Zayac, a P.A. working for Respondent (who was present with Respondent at ECMC), was contacted, informed of the patient's condition, and he ordered increased Dobutamine to 5 micrograms per kilogram per minute and initiation of Albumen (Department's Exhibit # 5 @ pp 116, 215); [T-1672-1674].

62. At 15:15 Dr. Conti came in the O.H.U. and evaluated Patient C whose heart rate had dropped to 60 and spontaneously recovered to the 80's (Department's Exhibit # 5 @ p. 215); [T-1673, 1680].

63. Between 15:00 and 15:50, attempts were made by the nursing staff to reach Respondent without success (Department's Exhibit # 5 @ pp. 116, 215); [T-81, 176-179, 413-414, 878-879, 1659-1689].

64. At 15:50, Patient C suffered cardiac arrest and a code was called (Department's Exhibit # 5 @ p. 215); [T-1675].

65. At 15:50, P.A. Lusch was paged and Respondent was called and updated about Patient C's condition (Department's Exhibit # 5 @ pp. 215-216); [T-1675].

66. At 15:55, Respondent issued a telephonic order for $NaHCO_3$ (Sodium Bicarbonate) after being informed of the patient's condition and Respondent indicated that he would respond. At 15:57, Respondent was with Patient C and opened the patient's chest at 16:30 (Department's Exhibit # 5 @ pp. 116, 215); [T-1677].

67. Patient C was pronounced dead at 16:40 or 16:50 (Department's Exhibit # 5 @ pp. 8-9, 143, 215-216); [T-675-678].

68. While Respondent was reopening the chest of Patient C, he discarded a clamp which was not working to his satisfaction. Respondent threw the clamp away from the sterile field in the direction of Nurse D [T-416-418, 420, 425, 432-433].

69. The thrown clamp landed on the bed without touching Nurse D [T-435].

70. Respondent did not deliberately throw a clamp at Nurse D [T-416-435, 726].

71. After Patient C expired, Respondent and Nurse C were on opposite sides of the bed facing each other. Respondent requested that the suction used to drain the patient's chest be turned off. As Nurse C reached to turn off the suction, Respondent snapped the chest tubes apart, splattering Nurse C in the face and chest with a couple drops of blood [T-84-86, 105-109]; (Department's Exhibit # 18-C). VOTE 2-1

72. Nurse C asked Respondent why he did that. Respondent replied that it was poetic justice. Respondent never apologized to Nurse C [T-84-86, 137-138]. VOTE 2-1

PATIENT D

73. On August 31, 1995, Patient D, an 83 year old female with a past medical history of coronary artery disease, diabetes mellitus, hypertension and recent (January 1995) coronary atherectomy of the proximal, diagonal, and mid-right coronary, was admitted to MFH to Respondent's care (Department's Exhibit # 6 @ p.7); [T-175].

74. On August 31, 1995, Respondent performed CABG surgery on Patient D (Department's Exhibit # 6 @ pp. 7-9).

75. Prior to surgery, the attending surgeon should document his/her evaluation and assessment of the patient, nature and extent of the proposed surgery and the rationale for the proposed surgery [T-181-184, 775-776].

76. Patient D's medical record does not contain adequate preoperative notes or assessments (Department's Exhibit # 6).

77. The admission history and physical examination of this patient was not an adequate preoperative assessment (Department's Exhibit # 6 @ pp 117-118); [T-181-184, 775-776].

78. After surgery, Patient D was transferred to the O.H.U. at 13:30. At 15:45 Respondent was contacted regarding Patient D's deteriorating condition and stated that he would have a P.A. evaluate the patient (Department's Exhibit # 6 @ p 459); [T-463-466].

79. Michael Rumschik, a P.A. employed by Respondent, came to the patient's bedside and attempted unsuccessfully to clear the sump with a Fogarty. Patient D continued to deteriorate. P.A. Rumschik opened the lower end of the incision and attempted to suction out the mediastinum with little change in the patient's condition (Department's Exhibit # 5 @ p. 459); [T-466].

80. Dr. Kerr, a cardiothoracic surgeon not associated with Respondent and not previously involved in the care and treatment of Patient D, arrived and continued opening the chest (Department's Exhibit # 5 @ p. 459); [T-466-467].

81. At 16:05 Respondent arrived, completed opening of the chest, removed clots from the mediastinum, inserted an intra-aortic balloon pump, and engaged in other resuscitative efforts on Patient D (Department's Exhibit # 6 @ pp. 459-460); [T-453-462, 2223].

82. During the resuscitative efforts shortly after Respondent arrived, his gloves became contaminated. Respondent was offered a fresh pair of sterile gloves but refused. Respondent used the same contaminated gloves to remove clots from the patient's open chest (Department's Exhibit # 28); [T-459-463, 2230-2231].

83. Shortly after arriving, Respondent was offered a mask and head cover but refused (Department's Exhibit # 28); [T-454-455, 495-497, 2230-2231].

84. Sterile gloves, a mask and a head covering are basic infection precautions which should be used during any invasive procedure unless the emergent nature of the circumstance dictates otherwise [T-185-188].

85. The resuscitative efforts by Respondent for Patient D was of an emergent nature and "in such an emergency situation, you make do" [T-185-187].

86. Respondent did not use a clamp (sterile or contaminated) to stimulate the myocardium of Patient D [T-1633, 2228-2230].

87. The attending surgeon should document in the medical record, by way of a procedure or progress note, the reopening of a patient's chest and resuscitative efforts made. The only documentation by Respondent of the procedures undertaken and resuscitative efforts is contained in a discharge summary dictated by Mr. Rumschik two months after the events in question (Department's Exhibit # 6 @ pp. 7-9); [T-183-184, 188-189].

PATIENT E

88. Respondent treated Patient E, a 57 year old female, at ECMC from April 23, 1997, until May 9, 1997. Patient E was admitted to ECMC with a right pleural effusion. Patient E was a long term smoker who suffered coronary artery disease (Respondent had performed CABG surgery in August 1995), hypertension, diabetes, hypercholesterolemia and rheumatic arthritis (Department's Exhibits # 10 & # 11)

89. Patient E, complaining of shortness of breath, was seen by Dr. Zizzi on April 23, 1997. Dr. Zizzi ordered a chest x-ray and thoracentesis, which was performed by Dan Zayac, Respondent's P.A. (Department's Exhibits # 10 & 11); [T-1321-1322].

90. Mr. Zayac noted that the chest x-ray showed mild to moderate right pleural effusion. He was not able to enter the effusion with a thoracentesis needle and admitted Patient E to Respondent's service for flouroguided tap of the pleural effusion with cytology of the appropriate specimen (Department's Exhibit # 11 @ pp. 5, 14).

91. If cytology of a specimen of the pleural effusion had shown malignancy, surgery would be contraindicated (Department's Exhibit # 52); [T-204-205].

92. A CAT scan of the chest was performed on April 24, 1997, which revealed a right hilar mass. The CAT scan showed the tumor and an enlarged regional subcarinal lymph node, without evidence of enlarged peritracheal or anterior mediastinal nodes (Department's Exhibit # 11); [T-2265-2266]

93. On April 28, 1997, Patient E underwent bronchoscopy and bronchial biopsy with bronchial washings. Cytology from the bronchial washings showed squamous cell carcinoma of the right main stem bronchus (Department's Exhibit # 11 @ pp. 5, 23-24).

94. Following bronchoscopy, Patient E received an oncological work up including CAT scans of the head, chest, abdomen and pelvis, and a bone scan. Pulmonary function tests showed Patient E to be a marginal candidate for a pneumonectomy (Department's Exhibit # 11); [T-824, 861].

95. Prior to performing a pneumonectomy, every effort must be made to determine whether the tumor is operable, including testing to determine whether the tumor had spread and testing to determine the patient's ability to tolerate the procedure (Department's Exhibit # 52); [T-192, 792-800, 803-808].

96. Preoperative stress tests, modified stress tests, and/or angiogram should be undertaken to evaluate cardiac function prior to subjecting a patient to a major and debilitating operation. [T-196-197, 797-799].

97. Respondent did not perform a preoperative mediastinoscopy on Patient E (Department's Exhibit # 11); (Admitted).

98. Although prior to a pneumonectomy, sampling of the lymph nodes by a mediastinoscopy, should generally be undertaken to evaluate the nature and extent of the cancer, under all of the circumstances present in Patient E, and on the basis of the results of the CAT scan, mediastinoscopy was not going to be helpful in further assessment of Patient E [T-191-196, 206, 818-821, 856, 2266-2268].

99. Respondent did not perform preoperative stress tests to evaluate the cardiac function of Patient E (Department's Exhibit # 11); (Admitted).

100. In light of Patient E's very active and asymptomatic lifestyle, her successful rehabilitation following CABG surgery in 1995, a successful stress test slightly more than a year prior, and her stable cardiac status, to have foregone this particular test as part of her preoperative workup was not inappropriate [T-1319-1326, 1332, 1367, 1376-1378, 2286-2287].

101. The medical record of Patient E for the period of time prior to surgery on May 2, 1997, does not contain any notation by Respondent regarding his evaluation of Patient E. There is no credible evidence that Respondent reviewed the CAT scan of the chest prior to surgery. There is inadequate history of Patient E's symptoms with respect to her chest (Department's Exhibit # 11 @ pp.14-31, 309); [T-197-198, 857-858].

102. Prior to surgery, Respondent did not discuss the use of chemotherapy and/or radiation with Patient E or her family. No consultation was obtained from an Oncologist (Department's Exhibit # 11); [T-1391-1393].

103. On May 2, 1997, Respondent took Patient E to surgery for a planned right pneumonectomy. After stapling, ligating and transecting the right pulmonary veins and arteries, Respondent attempted to remove the right lung and discovered that the hilar tumor invaded the esophagus with impingement on the major hilar structures. Respondent left the operating room to confer with the family and with Dr. Zizzi (Department's Exhibit # 10 @ pp. 15-16).

104. Respondent performed a right pneumonectomy, an esophageal gastrectomy with anastomosis of proximal esophagus to distal stomach (a gastroesophagogectomy) and a jejunostomy with tube placement ("**combined procedure**") (Department's Exhibits # 10 @ pp. 15-16 & # 11 @ pp. 5, 320-321); [T-198-199, 836-841, 2309-2310].

105. Seven days post-surgery Patient E expired (May 9, 1997) (Department's Exhibit # 10).

106. The combined procedure performed by Respondent on Patient E was too extensive and dangerous. The right pneumonectomy and the esophageal gastrectomy were too massive for Patient E to tolerate and were not medically justified (Department's Exhibit # 52); (Respondent's Exhibit # K, L, M); [T-198-199, 206-207, 837-842, 849-851].

ALLEGATION A

107. Respondent was employed at AEMC, Philadelphia, Pennsylvania from 1987 to 1992 [T-1846-1847].

108. Dr. A was a trauma surgeon at AEMC from 1987 to 1994 [T-978].

109. In 1989 or 1990, Dr. A was called to a meeting in the office of Robert G. Somers, Chief of Surgery at AEMC. Present during this meeting were Dr. A, Dr. Somers, Dr. Stan Carrol (Assistant Chief of Surgery and Director of AEMC's trauma program), and Respondent. A discussion of the events of the prior evening ensued in which Respondent accused Dr. A of calling in the bypass team without calling the surgeon. Dr. A called Respondent a liar. Both Respondent and Dr A stood up, approached each other, pushed each other and a physical altercation occurred (Respondent's Exhibit # A); [T-978-981, 997-1000, 1569-1571, 1858, 1866-1868].

110. During the altercation between Respondent and Dr. A., Respondent caused the dislocation of Dr. A's shoulder [T-981].

111. Immediately after the altercation, Respondent was asked to leave the room. An orthopedic surgeon was called to treat Dr. A's dislocated shoulder. Ultimately, Dr. A's injuries required surgical repair [T-994-1002, 1573, 1869].

ALLEGATION B

112. In 1989 or 1990, with a patient under anesthesia and awaiting surgery, Respondent entered an operating room, at AEMC, without a mask [T-1011].

113. Nurse A was the circulating nurse. As Respondent crossed the room, Nurse A tapped Respondent on the shoulder and told him that he needed to put on a mask [T-1011, 1047].

114. Respondent then hit Nurse A in the stomach with his hand causing her to fall to the floor [T-1011-1012, 1018, 1046-1047].

115. Respondent proceeded through the operating room to a scrub sink area, neither apologizing to Nurse A nor offering assistance [T-1018, 1036, 1046].

ALLEGATION C

116. ECMC Form CH-17, entitled Pre-Operative Notes, contains the following statement directly above the signature bar for the attending surgeon: "I have reviewed the above and verify that this patient is ready for surgery" (Department's Exhibit # 7).

117. The attending surgeon's signature signifies that the patient is prepared for surgery, and that preoperative lab reports, EKG, X-Ray, history and physical has been reviewed by the surgeon (Department's Exhibits # 7 & 20); [T-556-558].

118. On or before March 13, 1995, Respondent signed 24 blank Pre-Operative note forms (ECMC Form CH-17) and instructed his P.A.'s to complete the form (Department's Exhibits # 7 & 7-A); (Respondent's Exhibit # A); [T-155-157, 559, 561-563, 565].

ALLEGATION D

119. Nurse B was the Assistant Head Nurse in the Open Heart Team at ECMC from 1992 until October 1995. She is presently employed as an Assistant Head Nurse in the OR for another surgical service [T-262-263].

120. Respondent recruited Nurse B to her position in the Open Heart Team in 1992 [T-265].

121. On May 12, 1995 Respondent arrived at the operating room at ECMC to perform CABG surgery on Patient M.K. (Department's Exhibit # 2); [T-274].

122. When Respondent entered the operating room, at ECMC, Lori Larson, Operating Room Technician, handed him a towel with which to dry his hands. While drying his hands, Respondent stated "I am in the mood to abuse someone today. I am in a really bad mood and I think today it is going to be ...(pause) ... Nurse B." [T-274, 279].

123. Respondent then threw the wet towel at Nurse B, hitting her in the face and/or head and/or shoulder [T-279-280, 317, 570-571] (Department's Exhibit # 8).

124. Nurse B reported the above incident to her supervisor, Nurse Patricia Wopperer [T-281, 511-512].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. Unless otherwise noted, all conclusions as to the allegations contained in the Statement of Charges were by unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the February 2, 1998, Statement of Charges, are **SUSTAINED:**[13]

Paragraph A.	(in part)	:	(107 - 111)
Paragraph B.	(in part)	:	(112 - 115)
Paragraph C		:	(116 - 118)

[13] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee.

Paragraph D	:	(119 - 124)	
Paragraphs E. & E.2.	:	(34, 40 - 44)	
Paragraphs F. & F.1.	:	(45 - 52)	
Paragraphs G. & G.1.	:	(56 - 67)	
Paragraphs G. & G.3. (in part)	:	(56, 66 - 67, 71 - 72)	VOTE 2-1
Paragraphs H., H.1 & H.5.	:	(73 - 77, 81, 87)	
Paragraphs H.2. & H.4.	:	(73 - 74, 81 - 85)	
Paragraphs I.1. & I.2.	:	(88 - 100)	
Paragraphs I., I.3 & I.4	:	(88 - 106)	

The Hearing Committee concludes that the following Factual Allegations, from the February 2, 1998 Statement of Charges, are **NOT SUSTAINED:**

Paragraphs E.1.	:	(34 - 39)
Paragraphs F.2. & F.3.	:	(45, 53 - 55)
Paragraphs G.2.	:	Withdrawn by the Department
Paragraphs G.4.	:	(56, 66, 68 - 70)
Paragraphs H.3.	:	(73 - 74, 81, 86)

Based on the above and the complete Findings of Fact, the Hearing Committee unanimously (except for Specification # nineteenth) concludes that the following Specifications contained in the February 2, 1998, Statement of Charges are **SUSTAINED:**[14]

SIXTH SPECIFICATION (GROSS NEGLIGENCE):
(Paragraph: I.4.)
THIRTEENTH SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASION):
(Paragraphs: E. & E.2.; F. & F.1.; G. & G.1; H. & H.1 & H.5.; I. & I.3 & I.4)
SIXTEENTH SPECIFICATION (MORAL UNFITNESS):
(Paragraph: B.)

[14] The citations in parentheses refer to the Factual Allegations which support each Specification.

SEVENTEENTH SPECIFICATION (MORAL UNFITNESS):
(Paragraph: C.)
EIGHTEENTH SPECIFICATION (MORAL UNFITNESS):
(Paragraph: D.)
NINETEENTH SPECIFICATION (MORAL UNFITNESS):
(Paragraphs: G. & G.3.) VOTE 2-1
TWENTY-FIRST SPECIFICATION (FRAUD):
(Paragraph: C.)

Based on the above, the Hearing Committee unanimously concludes that the following Specifications contained in the February 2, 1998, Statement of Charges are **NOT SUSTAINED:**

FIRST THROUGH FIFTH SPECIFICATIONS: (GROSS NEGLIGENCE)
SEVENTH THROUGH TWELFTH SPECIFICATIONS: (GROSS INCOMPETENCE)
FOURTEENTH SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION)
FIFTEENTH SPECIFICATION: (MORAL UNFITNESS)
TWENTIETH SPECIFICATION: (MORAL UNFITNESS)

DISCUSSION

Respondent is charged with twenty-one specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of the type of misconduct charged in this matter.

The ALJ provided to the Hearing Committee the definitions of medical misconduct as alleged in this proceeding. These definitions were obtained from a memorandum, prepared by Henry M. Greenberg, General Counsel for the New York State Department of Health, dated January

9, 1996[15]. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"), sets forth suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion; and (5) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of her conduct.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

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[15] A copy of this memorandum, was made available to Respondent [P.H.T-8]; [T-4].

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

The Misconduct Memo does not contain a discussion of moral unfitness. The Hearing Committee determined that to sustain an allegation of moral unfitness, the Department must show that Respondent committed acts which "evidence moral unfitness". There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Hearing Committee is asked to decide if certain conduct is suggestive of, or would tend to prove, moral unfitness. The Hearing Committee is not called on to make an overall judgment regarding a Respondent's moral character. The Department is not required to prove that a physician is morally unfit to practice medicine. The Department must prove that a physician committed an act which shows a lack of moral fitness to practice medicine. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgment or other temporary aberration.

The standard for moral unfitness in the practice of medicine has two separate and independent possibilities. First, there may be a finding that the accused has violated the public trust which is bestowed by virtue of his or her licensure as a physician. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based on the fact that they are physicians. Hence, it is expected that a physician will not violate the trust the public has bestowed on him or her by virtue of his or her professional status. Second, moral unfitness can be seen as a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. All findings by the Hearing Committee were established on their own merits and based on the evidence presented. If evidence or testimony was presented which was contradictory, the Hearing Committee made a determination as to which evidence was more believable based on their observations as to credibility, demeanor, likelihood of occurrence and reliability.

The ALJ told the Hearing Committee, that under present law, injury, damages and proximate cause are not essential legal elements to be proved in a medical disciplinary proceeding. The State does not need to present evidence of injury to demonstrate that negligence has occurred or that substandard care was given; Matter of Morfesis v. Sobol, 172 A.D. 2d 897, leave to appeal denied 78 N.Y. 2d 856 (1991); Matter of Loffredo v. Sobol, 195 A.D. 2d 757, leave to appeal denied 82 N.Y. 2d 658 (1993).

Acceptable medical standards are based on what a reasonably prudent physician, possessed of the required skill, training, education, knowledge or experience to act as a physician, would do under similar circumstances (and having the same information, ie: without the benefit of hindsight). Proof that a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances is sufficient to sustain a finding of negligence in a medical misconduct proceeding; Matter of Bogdan v. NYS-BPMC, 195 A.D.2d 86 appeal dismissed and leave to appeal denied, 83 N.Y.2d 901 (1994); Matter of Enu v. Sobol, 171 A.D.2d 302 (3rd. Dep't., 1991) and 208 A.D.2d 1123 (3rd. Dep't., 1994) (expert witness qualifications).

A physician can make a mistake or an error in medical judgment without being negligent. However, a physician's decision or act which is without proper medical foundation or not the product of careful examination or deviates from acceptable medical standards or knowledge is more than a mere error in medical judgment; Krapvika v. Maimonides Medical Center, 119 A.D.2d 801,

805 (2d Dep't., 1986) (dissent- citing Bell v. New York City Health & Hosps. Corp. and Huntley v. State of New York [citations omitted]).

The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Parker, as the State's expert, had no professional association with Respondent. Dr. Parker was considered to be knowledgeable in the area of cardiothoracic surgery. No reason was advanced to show Dr. Parker to have any prejudice against Respondent. Overall, the Hearing Committee found Dr. Parker to be credible, honest, straightforward, and forthright and accepted many of his opinions, as supported by the patients' medical records. Dr. Parker gave detailed impartial testimony regarding areas he believed Respondent's care fell below minimum standards of accepted medical practice and why a reasonably prudent physician would have responded differently given the circumstances at hand. The Hearing Committee did note the mixup with the CAT scans and a few minor other errors made by Dr. Parker and in those instances gave less weight to his testimony.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Although Respondent claimed to assume responsibility for his actions, he actually tried to place some of the blame on others (ie: his residents in the case of Patient A; the cardiologist in the case of Patient B; the nurses in the case of Patient C). Respondent is articulate and is able to explain to himself and others everything he has done and why. Many of Respondent's explanations are rationalizations and justifications for his questionable actions. The Hearing Committee observed an intelligent physician who had a tendency to engage in self deception and well rehearsed justifications.

With regard to a finding of medical misconduct, the Hearing Committee assessed Respondent's medical treatment and care of the patients, without regard to outcome, in a step-by-step assessment of patient situation, followed by medical responses provided by Respondent to each situation.

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

The Department of Health has met its burden of proof as to: one (1) act of gross negligence; five (5) acts of negligence; four (4) acts of Moral unfitness and one (1) charge (24 separate acts) of fraud as charged in the February 2, 1998 Statement of Charges.

The rationale for the Hearing Committee's conclusions is set forth below. The Hearing Committee will first discuss each patient in order (beginning with Factual Allegation E) and then discuss Factual Allegations A through D.

PATIENT A **ALLEGATIONS E. & E.1.**

Factual Allegations E. and E.1. alleges that Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that Respondent performed, ordered, supervised and/or directed a tracheostomy without adequate medical justification. The tracheostomy permitted replacement of the double-lumen endotracheal tube employed for anesthesia and respiratory support intraoperatively, with a single-lumen tracheostomy canula.

Respondent explained that after conclusion of the main operation, he and ECMC's Chief of Anesthesiology, Dr. Roger Kaiser, discussed the ventilation problems which this very edematous patient was certain to have and decided that the best course of action would be to perform a

tracheostomy and replace the double-lumen tube. Dr. Bell-Thomson testified that in the circumstances he believed the decision to proceed in this manner was medically justified.

The Hearing Committee agrees with Dr. Kaiser, Respondent, Dr. Seibel and Dr. Parker that the management of secretions are more readily accomplished with a single lumen tube. In addition, Dr. Kaiser, the person in charge of the airway, indicated that he insisted on the tracheostomy. The Hearing Committee believes that the decision to proceed with a tracheostomy on Patient A was medically justified and the Department has not carried its burden of proof to demonstrate the contrary.

ALLEGATIONS E. & E.2.

Factual Allegations E. and E.2. alleges that Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that Respondent had electrocautery applied to Patient A's neck while alcohol used for sterilization was still present, thereby igniting a fire.

Electrocautery should not be used with alcohol prep. If alcohol is used, then the area should be thoroughly dried before the skin incision is begun with the Bovie. Obviously these precautions did not occur and Respondent was negligent on this occasion. Respondent should have waited for the Betadine solution and the prep tray to be brought to him, especially since there was no emergency to begin the tracheostomy. The "luck" that Patient A was not harmed (although his hair was singed) does not diminish Respondent's negligent conduct. The Hearing Committee concludes that Respondent is responsible for the fire in this no-rush, non-emergent situation case where the patient had adequate airway in place.

Respondent's claim of a mere momentary inattention is not convincing. Respondent helped roll the patient over, Respondent poured the alcohol on a sponge stick; Respondent had agreed to the performance of the tracheostomy.

Respondent is guilty of practicing the profession with negligence on a particular occasion in that he failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Hearing Committee does not find that Respondent's actions as to Patient A were egregious and do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill or knowledge necessary to correctly perform the procedure and does not sustain the charge of incompetence.

The charge of practicing the profession with negligence on a particular occasion is sustained.

PATIENT B **ALLEGATIONS F. & F.1.**

Factual Allegations F. and F.1. charges that Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care because Respondent failed to perform and/or order a preoperative[16] transesophageal echocardiogram ("TEE")

Respondent has confirmed that a preoperative TEE was neither ordered nor performed in this case. Dr. Parker's unambiguous testimony that a TEE should have been done prior to surgery was accepted by the Hearing Committee. Dr. Meholick, who had performed cardiac catheterization and angiography on Patient B, recommended that a TEE be done to further assess this patient. Patient B, a high risk patient, had a plethora of medical problems making anesthesia particularly dangerous. Every effort should have been made to avoid exposing her to the additional risks associated with anesthesia and surgery.

[16] The Hearing Committee notes that Patient B was never surgically operated on and the issue deals with the TEE not being performed prior to bringing the patient to the OR and anesthetizing her.

Although there was no medical record keeping charges, the Hearing Committee was troubled that no proper preoperative evaluation, from a surgeon, was contained in Patient B's medical records. Had Respondent taken the time to do a complete assessment and thorough preoperative review of Patient B, maybe he would have ordered a preoperative TEE or indicated why he believed one was not necessary.

Respondent's argument that in the Buffalo community, it is the cardiologist who does the TEE and not the surgeon is not relevant to the charge. It is the surgeon who makes the ultimate (medical) decision to bring the patient to the OR. In addition, the cardiologist, Dr Meholick recommended on May 15, 1995 that a TEE be done. Patient B was not taken to the OR at MFH until June 27, 1995. There were no critical time pressures. In the case of Patient B, Respondent did not meet acceptable standards of medical care in that he failed to perform and/or ordered a preoperative TEE.

The Hearing Committee agrees with Respondent's decision to cancel the surgery and opt for non-surgical possibilities (as had been suggested by Dr. Meholick on May 15, 1995) for Patient B. The criticism and negligence occurred in the failure to perform the TEE prior to bringing this patient to the OR, and unnecessarily subjecting her to anesthesia, not in the subsequent results or actions of Respondent.

Respondent is guilty of practicing the profession with negligence on a particular occasion in that he failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Hearing Committee does not find that Respondent's actions as to Patient B were egregious and do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill necessary to correctly perform the TEE or to know that the TEE needed to be performed and does not sustain the charge of incompetence.

The charge of practicing the profession with negligence on a particular occasion is sustained.

ALLEGATIONS F. & F.2.

Factual Allegations F. and F.2. charges that Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care because Respondent failed to order preoperative antibiotics.

The medical record of Patient B contains references to the administration of the preoperative antibiotic Ancef. Dr. Parker opined that the reference to Ancef in the medical record indicates that the antibiotic was administered with the IV before the patient was anesthetized.

This Factual Allegation is not supported by the medical record or by any testimony and it is not sustained. The charges of practicing the profession with gross negligence, gross incompetence, negligence, and incompetence on a particular occasion are not sustained.

ALLEGATIONS F. & F.3.

Factual Allegations F. and F.3. charges that Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care because Respondent inserted a contaminated femoral line guidewire after it had dropped to the floor and despite the offer of a replacement guidewire.

Although no credible motive for Ms. Suhr to fabricate her testimony has been suggested, the Hearing Committee can not sustain this allegation. Ms. Suhr's incident report was misdated, did not contain the patient's name, had the incorrect OR, indicated different surgical procedures and did not confirm the identity of the physician involved. These irregularities render the statements contained therein insufficient to sustain a charge of professional misconduct by a preponderance of the evidence.

This Factual Allegation is not sustained. The charges of practicing the profession with gross negligence, gross incompetence, negligence, and incompetence on a particular occasion are not sustained.

PATIENT C **ALLEGATIONS G. & G.1.**

Factual Allegations G. and G.1. asserts that Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care in that he failed to attend Patient C in a timely manner postoperatively.

Patient C received double bypass surgery from Respondent at MFH on June 30, 1995. On completion of the surgery the patient was admitted to the O.H.U. at 12:30 hours. By 13:35, the patient started to deteriorate and one of Respondent's P.A.' s was called. Between 14:30 and 14:55 Respondent was notified and updated as to the patient's condition. The Hearing Committee concludes that upon such notification (between 14:30 and 14:55) Respondent, as the attending and operating surgeon, should have personally attended to the patient at the O.H.U. of MFH.

The Hearing Committee indicates that a surgeon who is so busy with surgery in two separate hospitals with consecutive major cases following immediately one after the other is not in a position to respond properly to post operative emergencies. At the very least, a capable associate or covering cardiothoracic surgeon should be easily available at the hospital where acute post operative care may create an emergency. The operating surgeon is responsible for having adequate competent personnel available if he can not be immediately present. If the individuals who he selects are similarly "busy" or unavailable, the operating surgeon remains responsible and can not disperse the blame onto others.

The Hearing Committee did not need to determine whether between 15:00 and 15:55 "numerous" attempts were made by the nursing staff of the O.H.U. at MFH to reach Respondent without success (although the Hearing Committee does believe that at least some attempts were

made). At 14:30 Patient C's cardiac index was 1.86 up only slightly from the 1.79 reading of 13:35 even though Dobutamine and Epinephrine had been increased. With the patient's blood pressure history and his cardiac output down, (1.86 is too low) Respondent should have personally and physically attended to the patient between 14:30 and 14:55 and not waited until 15:57 after a code was called and the patient had crashed at 15:50.

The Hearing Committee notes that a review of Respondent 's actions subsequent to his arrival at the O.H.U. of MFH tends to demonstrate signs of internal anger for his own failure to be there sooner. Respondent dramatized his internal emotions by throwing a clamp while reopening Patient C's chest, belittling the nursing staff for the loss of his patient and hurriedly, without patience, disconnecting a chest tube splashing a nurse with bloody fluids.

Respondent is guilty of practicing the profession with negligence on a particular occasion in that he failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Hearing Committee does not find that Respondent's actions as to Patient C were egregious and do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill necessary nor know that he should have attended to the patient in a more timely manner and does not sustain the charge of incompetence.

The charge of practicing the profession with negligence on a particular occasion is sustained.

ALLEGATIONS G. & G.3.

Factual Allegations G. and G.3. asserts that while disconnecting chest tubes, Respondent deliberately placed the tubing directly in Nurse C's face, allowing bloody fluid to splash directly on her face and clothing.

Respondent acknowledged that bloody fluid was splashed in Nurse C's face when he disconnected the chest tubes. He admitted that when asked why he did that, he may have responded that it was poetic justice. The Hearing Committee found Nurse C to be credible and accepted her testimony that Respondent snapped the chest tubes apart and splattered her with a couple drops of blood. The Hearing Committee, 2 to 1, determines that this incident occurred because Respondent intended it to occur and that it was not merely an accident. The Hearing Committee does not believe there was evidence which indicated that Respondent directly placed the tubing in Nurse C's face and therefore that portion of the allegation is not sustained.

The Hearing Committee concludes that while disconnecting a chest tube on Patient C, Respondent consciously and voluntarily (ie: deliberately) allowed bloody fluid to splash directly on Nurse C's face and clothing. Respondent's act was committed while in the practice of medicine and is a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent.

Respondent is guilty of conduct in the practice of medicine which evidence moral unfitness on a particular occasion in violation of Education Law §6530(20).

ALLEGATIONS G. & G.4.

Factual Allegations G. and G.4. asserts that Respondent deliberately threw a clamp at Nurse D.

While Respondent was reopening the chest of Patient C, he discarded a clamp which was not working to his satisfaction. Respondent threw the clamp away from the sterile field in the direction of Nurse D. The thrown clamp landed on the bed without touching Nurse D. Based on the evidence presented, the Hearing Committee can not conclude that Respondent deliberately threw a clamp at Nurse D in an (implied) attempt to hit her.

This Factual Allegation is not sustained and therefore this charge of practicing medicine with moral unfitness is not sustained.

PATIENT D **ALLEGATIONS H. & H.1.**

Allegations H. and H.1. of the Statement of Charges asserts that Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care because Respondent failed to perform and/or record a preoperative assessment.

As with the other medical records reviewed during the course of this proceeding, Patient D's medical record does not contain a preoperative intellectual note, handwritten or dictated by Respondent. Minimum standards of acceptable care require not only that the attending surgeon personally evaluate the patient and the preoperative testing, but that such evaluation be documented in the first person. Respondent's initialing of notes made by his physician assistants are not sufficient. The existence of, or non-existence of, a personal preoperative note is especially important considering the charges and the findings of this Hearing Committee regarding Respondent's signing of blank preoperative notes (see discussion of Factual Allegation C). An admission history and physical examination of the patient is not a sufficient preoperative assessment Respondent's claim, of having performed a preoperative assessment of Patient D, is not supported by the medical records of Patient D and is found not credible by the Hearing Committee.

Respondent's failure to have performed and properly record a preoperative note for Patient D makes Respondent guilty of practicing the profession with negligence on a particular occasion under the circumstances presented in this case.

The Hearing Committee does not find that Respondent's actions as to Patient D were egregious and do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill necessary to correctly perform a preoperative assessment or to know that one needed to or should be performed and therefore does not sustain the charge of incompetence.

This Factual Allegation is sustained. The charge of practicing the profession with negligence on a particular occasion is sustained.

ALLEGATIONS H. & H.2. & H.4.

Allegations H., H.2. and H.4. of the Statement of Charges asserts that Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care because Respondent used contaminated gloves during an attempted resuscitation, despite an offer of new gloves and failed to wear a hat and mask during an attempted resuscitation.

As to these two allegations, the Hearing Committee believed the testimony of Nurse Schultz and the incident report she prepared on the day after the incidents. Nurse Schultz had nothing to gain or lose by her testimony. She promptly reported what she perceived to be breaks in sterile techniques and even saved her raw notes of the events in question. Respondent has put forth no credible motive for Nurse Schultz to fabricate or embellish.

Since the resuscitative efforts by Respondent for Patient D were of an emergent nature, the Hearing Committee determines that under the specific circumstances presented, Respondent's break in sterile techniques was not a breach of acceptable medical care. The Hearing Committee agrees with Dr. Parker (@ T-185):

> Q. Is it appropriate to use contaminated gloves when attempting resuscitation when a chest is open?
> A. No, no, but in that setting, this is truly an emergency setting and although the procedure is started with sterile gloves, one has to be as sterile as one can be. During the course of a resuscitation, it is not uncommon that sterility conditions are broken.

The Hearing Committee sustains Factual Allegations H.2. and H.4. but determines that these facts do not result in a finding that Respondent committed gross negligence, gross incompetence, negligence or incompetence under the specific circumstances of the resuscitative efforts in the care and treatment of Patient D.

ALLEGATIONS H. & H.3.

Allegations H. and H.3. of the Statement of Charges asserts that Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care because Respondent used a contaminated clamp to attempt stimulation of the myocardium.

Although the Hearing Committee generally believed the testimony of Nurse Schultz, we found that the use of a clamp (contaminated or sterile) to attempt stimulation of the myocardium was unlikely to have occurred in this instance and can not sustain this allegation and its related charges.

In this situation, the Hearing Committee believed Respondent when he said that it was very unlikely that he would use a clamp to stimulate the patient's myocardium. Respondent further indicated that when a patient is asystolic he normally taps the heart with his finger and he would use a Kelly clamp to reach outside of the sterile field and would use one specifically to adjust a balloon pump. Respondent also said that regardless of how many times he would do this, he would put the clamp outside the sterile field and in fact, the very reason for using a clamp rather than his fingers to adjust the console is to maintain sterility. Using the clamp to touch the myocardium would defeat the entire purpose for using it to adjust the console.

The Hearing Committee does not sustain Factual Allegation H.3. and therefore can not find that Respondent committed gross negligence, gross incompetence, negligence or incompetence under the specific circumstances of the resuscitative efforts in the care and treatment of Patient D.

ALLEGATIONS H. & H.5.

Allegations H. and H.5. of the Statement of Charges asserts that Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care because Respondent failed to document reopening of Patient D's chest and resuscitative efforts in the Intensive Care Unit ("ICU").

The Hearing Committee does not credit Respondent's assertion that he was not involved in the reopening of the chest and resuscitative efforts in the ICU of MFH for Patient D. Respondent essentially admits to being present for the reopening of the chest but denies actually being involved in the reopening of Patient D's chest. The Hearing Committee regards this assertion as being so out of character as to be incredible. Patient D was Respondent's patient and Respondent's responsibility. Respondent's nature would be to take over as soon as he arrived at the scene.

Respondent indicated that Patient D's "problem seemed to be an arrhythmia. She had developed atrial fibrillation and then it deteriorated into ventricular fibrillation and this became a major resuscitative effort which went on for quite some time.". A search of Patient D's medical records for notes or documentation of the extensive and lengthy efforts made by Respondent on this patient turns up nothing by the Respondent. A very brief mention, of the 8/31/95 incident, of the patient's sternum being re-explored is made at page 8 (discharge summary); a very brief nursing note at page 127; and the nursing notes at pages 459-463.

In the final analysis there is little relevancy to whether Respondent did or did not reopen Patient D's chest. There is no question that he was involved in a lengthy resuscitative effort. It was Respondent's responsibility to document what was done to Patient D in the ICU of MFH on August 31, 1995. The failure to do so was practicing the profession with negligence on a particular occasion under the circumstances presented in this case.

The Hearing Committee does not find that Respondent's actions as to Patient D were egregious and do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill necessary to correctly document what transpired or to know that it should have been documented and therefore does not sustain the charge of incompetence.

This Factual Allegation is sustained. The charge of practicing the profession with negligence on a particular occasion is sustained.

PATIENT E **ALLEGATIONS I. & I.1. & I.2.**

Factual Allegations I., I.1. and I.2. asserts that Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that Respondent failed to perform a preoperative mediastinoscopy and failed to perform preoperative stress tests to evaluate the cardiac function of the patient.

Respondent admits that Patient D's preoperative workup did not include a mediastinoscopy or cardiac stress tests. Patient E came to Dr. Zizzi's office on April 23, 1997, complaining of shortness of breath. Dr. Zizzi ordered a chest x-ray and thoracentesis, which was performed by P.A. Zayac. This procedure did not succeed in acquiring any pleural fluid. However, it did result in a pneumothorax which was treated by Respondent with insertion of a chest tube.

A CAT scan of Patient E's chest was performed on April 24, 1997, which revealed a right hilar mass. Bronchoscopy was performed on April 28, 1997. In the course thereof a biopsy was taken. Subsequent analysis revealed the presence of a squamous cell carcinoma of the right mainstem bronchus. Following confirmation of the cancer, Patient E was worked up for metastatic disease. The workup included CAT scans of the head, chest, abdomen, pelvis and liver as well as a bone scan.

Patient E's pulmonary function was evaluated by Dr. Sheriff. It was determined, by Respondent and Dr. Sheriff that Patient E could survive a pneumonectomy. Prior to a pneumonectomy, sampling of the lymph nodes, by mediastinoscopy or other method, should be undertaken to evaluate the nature and extent of the cancer. However, under all of the circumstances present in Patient E, including the results of the CAT scan, the pulmonary evaluation, the patient's past CABG surgery and her subsequent history of being asymptomatic for heart disease, the Hearing Committee agrees with Respondent that a mediastinoscopy was not going to be tremendously helpful in further assessment of Patient E. Similarly, not performing preoperative stress tests to

evaluate cardiac function was not totally inappropriate in light of Patient E's very active and asymptomatic lifestyle, her successful rehabilitation following CABG surgery in 1995, a successful stress test slightly more than a year prior, and her stable cardiac status.

The Hearing Committee sustains Factual Allegations I.1. and I.2. but determines that these facts do not result in a finding that Respondent committed gross negligence, gross incompetence, negligence or incompetence under the specific circumstances of the individual preoperative stress tests and the individual mediastinoscopy in the care and treatment of Patient E.

Therefore the charges are not sustained.

ALLEGATIONS I. & I.3.

Factual Allegations I. and I.3. asserts that Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that Respondent failed to adequately evaluate Patient E preoperatively.

The Hearing Committee agrees with Dr. Parker's (T-197-198) assessment and specific criticism regarding the overall evaluation of Patient E preoperatively. In addition to no mediastinoscopy and no stress tests to evaluate cardiac function, there is no indication in the medical records of this patient that Respondent actually reviewed the CAT scan, no preoperative note by Respondent, inadequate history of Patient E's symptoms with respect to her chest and no indication that Respondent discussed alternatives to surgery, such as chemotherapy and/or radiation. Taken comprehensively (as opposed to individually) the above omissions by Respondent results in a failure to evaluate Patient E preoperatively.

Factual Allegations I. and I.3. are sustained and result in a finding that Respondent was negligent in his preoperative evaluation of Patient E in that he failed to exercise the care that a reasonably prudent board certified thoracic surgeon would under similar circumstances.

The Hearing Committee does not find that Respondent's actions as to Patient E were egregious and does not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that Respondent did not lack the skill or knowledge necessary to perform and record a proper preoperative evaluation for a pneumonectomy and therefore does not sustain the charge of incompetence.

The charge of practicing the profession with negligence on a particular occasion is sustained.

ALLEGATIONS I. & I.4.

Factual Allegations I. and I.4. asserts that Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that Respondent performed a right pneumonectomy and an esophagectomy without adequate medical justification.

On May 2, 1997, Respondent took Patient E to surgery for a planned right pneumonectomy. After stapling, ligating and transecting the right pulmonary veins and arteries, Respondent attempted to remove the right lung and discovered that the hilar tumor invaded the esophagus with impingement on the major hilar structures. After consultation with the patient's family and Dr. Zizzi, Respondent performed a right pneumonectomy, an esophageal gastrectomy with anastomosis of proximal esophagus to distal stomach (a gastroesophagogectomy) and a jejunostomy with tube placement. The right pneumonectomy by itself is a very extensive major surgical procedure. As it was, Patient E was only "a little better than a marginal candidate for a pneumonectomy" [T-861]. Respondent should have known that fact and would have known it had he done an adequate preoperation evaluation. The combined procedure performed by Respondent on Patient E was too extensive and dangerous. The Hearing Committee determines that the evidence overwhelmingly indicates that the right pneumonectomy and esophagectomy was too massive for Patient E to tolerate and was not medically justified.

Dr. Parker was unequivocal regarding this patient's ability to tolerate this operation: [@ T-205-206].

> Q. Just before on page 27 and 28 there is a consultation note from somebody named Dr. Sheriff. And Dr. Sheriff, I presume he must be a pulmonary medicine person from the tone of this note, but what he suggests was that she was at some risk of being able to tolerate a pneumonectomy and he thought that she should have a lung perfusion and quantitative perfusion scan done prior to anybody undertaking the kind of operation that was done here, would you agree with that?
> A. I think that's one way to evaluate these patients.
> Q. Would the evaluation that you found there give you information that might lead you to say, "no, I'll not operate on this patient"?
> A. No, I think she was operable from the point of view of pulmonary function. In other words, if her lung came out, she probably could have tolerated -- a little borderline but I would have operated on that patient.
> Q. When you opened the chest to do this operation or you were planning to do a pneumonectomy, what would you do before you started the actual pneumonectomy itself?
> A. I would again evaluate, the lymph node sampling we referred to previously, I would do lymph node sampling in that chest and I would take lymph nodes and I would send lymph nodes for frozen section to the pathologist to see if there is any cancer out in these lymph nodes.
> Q. Would you expect to be able before you started the pneumonectomy to find out whether or not the esophagus was invaded?
> A. I think you probably could and I think you could and I think before you do any ligation of vessels or bronchus, you want to make sure that that tumor is going to come out and that it is what we call operable, so you have to sample the lymph nodes and make sure the tumor is removable.
> Q. If you were doing such an operation and found that there was invasion of the esophagus, what would you have done?
> A. In this setting, I would have either not done anything -- if I couldn't shave it off the esophagus, if I couldn't -- if there was really invasion of the esophagus, I wouldn't have done anything on this lady.
> Q. Why?
> A. Because the chance of cure is so low. I mean it's a 57-year-old lady with not particularly good lung function. The chance of cure, I would say, is close to nonexistent.

Respondent urges the Hearing Committee "to decline to 'second guess' the reasonable judgment of a practitioner ...". However, based on the medical record of Patient E and the testimony of the witnesses, the Hearing Committee concludes that Respondent did not use good

judgment nor reasonable judgment in the care and treatment of Patient E. In fact, Respondent's conduct in performing the combined procedures was egregious and constitutes gross negligence.

Respondent's gross negligence occurred even though Respondent had a full understanding of the risks attendant to and inherent in the situation he confronted. Respondent failed to exercise careful professional judgment in a reasoned attempt to save his patient's life. Instead, there is little doubt that the combined procedures led to Patient E's premature death.

Additional factors which point to Respondent's gross negligence are discussed by Dr. Hoover, professor and chairman of the department of surgery at the University of Buffalo, in his letter dated December 11, 1997 (Department's Exhibit # 52) and are as follows:[17]

> Most thoracic surgeons would have taken a different approach when it was discovered on the day after admission that this patient had a right hilar mass in the setting of a pleural effusion. These are usually malignant in origin, and these patients are inoperable. Once this mass was discovered, most practitioners would have made a diligent attempt to recover an aliquot of pleural fluid for cytology.
>
> A pneumonectomy is considered by most thoracic surgeons to be a disease in and of itself. It is technically an easy operation with the new stapling devices, but is poorly tolerated by most elderly patients. Therefore, it is not the standard practice in this country to perform "palliative" pneumonectomies. When these findings were discovered intraoperatively, most practitioners would simply have closed without consulting the referring physicians and/or family about the issue. This is a surgical decision and not an emotional quorum.
>
> I am a member of a NIH oncology subcommittee which reviews all program project grants for multi-modality cancer regimens. <u>There is nobody in America doing combined palliative pneumonectomies and synchronous esophageal gastrectomies even under protocol conditions.</u> (emphasis added).

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[17] The Hearing Committee notes that these additional factors are not needed for its conclusion that Respondent committed gross negligence. The Hearing Committee also notes that Dr. Hoover's conclusions would point to some negligence by Respondent commencing as early as the day after admission of Patient E.

The Hearing Committee acknowledges that it is reasonable to assume that Respondent may not or could not have known of the existence of the tumor's involvement of the esophagus until the time of thoracotomy. Respondent recognized the dangers in going forward with the combined procedure and even indicated to Patient E's family that this would be like putting the patient through three surgeries at once. Respondent admitted that the expanded procedure would expose the patient to a much higher risk of morbidity and mortality and complications. Respondent also acknowledged that he had never performed this operation previously. Respondent explained that in the past he had encountered lung cancers involving the mediastinal organs and had simply backed out. Yet, with all of the above, Respondent's "I can do anything" attitude overcame reason and sound medical judgment.

A finding of gross negligence also includes a finding of negligence on a particular occasion. Therefore, the Hearing Committee sustains the charges of gross negligence and negligence.

The Hearing Committee does not find that Respondent's conduct constituted either gross incompetence or incompetence. Respondent recognized that his "heroic surgical intervention to excise the entire tumor ... would impose a great deal of stress on a patient whose health is otherwise less than robust." (Department's Exhibit # 52). Dr. Parker confirmed that there is nothing in the medical record to suggest that the combined right pneumonectomy and esophagectomy undertaken by Respondent as a result of the discovery of esophageal involvement was in any way technically deficient. The Hearing Committee similarly recognizes that Respondent had the skills to do the procedure but failed to realize that he should not do it. Therefore the Hearing Committee does not find that Respondent's care of Patient E rose to the level of incompetence.

Respondent is guilty of professional misconduct under the laws of the State of New York. The charge of practicing the profession with gross negligence on a particular occasion, within the meaning of §6530(4) is sustained. The charge of practicing the profession with negligence on a particular occasion is sustained.

ALLEGATION A

There is no doubt or dispute that an altercation occurred between Respondent and Dr. A. The Hearing Committee concluded that Respondent engaged in a physical altercation and contributed to the dislocation of Dr. A's shoulder. Both Respondent and Dr. A should be ashamed of themselves for this incident and apparently are. The Hearing Committee did not need to determine who initiated the altercation. The Hearing Committee found that there was insufficient evidence to conclude that Respondent attempted to strangle Dr. A.

Although the altercation clearly occurred, the Hearing Committee determines that the incident was not "in the practice of medicine". Therefore the Factual Allegation is, in part, sustained but the Charge of moral unfitness, as defined in Education Law §6530(20) is not sustained.

The Hearing Committee also indicates that Pennsylvania, where the incident occurred in 1990, would have been the more appropriate venue to make a determination of the conduct which occurred. A more timely proceeding in Pennsylvania would have been more appropriate.

ALLEGATION B

Whether Respondent punched Nurse A with a closed fist or an open hand or hit her with a closed hand or an open hand is not the relevant issue. What occurred between Respondent and Nurse A was an unprovoked assault by Respondent. The assault on Nurse A was intentional and deliberate. The assault on Nurse A caused her to fall backwards onto a laundry cart and then onto the floor. The wind was knocked out of her and she could not catch her breath. Respondent proceeded through the operating room (which he should not have been in under the circumstances)

into a scrub sink area, without apologizing to Nurse A or offering to assist her. As Nurse A was on the floor crying, Respondent opened the door from the scrub area and told another Nurse to get him a new circulating nurse (Nurse A was the circulating nurse for this particular procedure). Nurse A continued crying and begged Respondent not to replace her. Ultimately, Nurse A was replaced and the surgery went forward.

Respondent's conduct in the OR of AEMC was clearly abusive behavior (physical as well as emotional) towards Nurse A. The long term "relationship" between Respondent and Nurse A, both before and after this incident, appears to the Hearing Committee to be an abusive relationship, not unlike spousal abuse. Respondent demonstrated to the Hearing Committee the classic signs of this type of abuse, ie: it really was just an accident; I didn't really mean to do it; but she's my friend and continued to be thereafter; subsequent reconciliation; it was her fault. On these issues, Respondent's testimony was transparent and not credible. Another troublesome aspect of the event which underlies this charge is Respondent's attempt to blame Nurse A for trying to impede Respondent's forward progress into a sterile field. It is not difficult to comprehend why a nurse would do this. It is difficult to comprehend why a board certified thoracic surgeon with a claim of excellent infection control would continue his walk thru a sterile field rather than turn around as appeared to have been wisely suggested by Nurse A.

Respondent's conduct in the OR of AEMC was conduct in the practice of medicine which evidences moral unfitness to practice medicine. The assault on Nurse A by Respondent was committed while in the practice of medicine and is a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent. Therefore the Factual Allegation is, in part, sustained and the Charge of moral unfitness, as defined in Education Law §6530(20) is sustained.

ALLEGATION C

The signing of blank preoperative history forms is unacceptable. Much time was wasted, both by the Department and the Respondent, during the Hearing attempting to prove or disprove the establishment of hospital policy and knowledge of such policy by Respondent. An educated teenager knows that it is dangerous to sign a blank form/contract. Regardless of hospital policy, Respondent knew that it was improper to sign even one blank preoperative form. Whether Respondent's claim that he did so to expedite matter is true or not, signing these blank forms suggests that Respondent did not perform a history and physical on his patients before the patient was operated on by him. The signing of even one blank form, under the circumstance present, is an intentional misrepresentation with the intention to mislead the patient, his/her family and anyone else who reviews the particular patient's medical record. The signing of 24 of these preoperative forms is fraudulent practice of medicine. The signing of 24 preoperative forms also indicates moral unfitness to practice medicine.

Respondent admitted that he had a problem with the preoperative forms when he first arrived at ECMC. Respondent claims that he believes that the patient should not be held up from entering the OR because a surgeon has to sign a preoperative note containing information that the surgeon had already reviewed. This is one of numerous example of Respondent's arrogance and egotistical attitude. These types of forms are commonly used in most hospitals for patient and physician protection. Yet Respondent knows, or believes he knows, better what is best for his cases.

Respondent claims that the preoperative note is duplicative of several other documents in the patient's chart, namely the consultation reports, the cath conferences, the history and physical, and other examination notes elsewhere in the chart. Respondent also claims that he always reviews the patient information contained in the patient's chart before taking the patient into surgery. The

evidence presented to the Hearing Committee on all five patients does not support Respondent's assertions. The preoperative note form is only redundant if Respondent is too busy (which he appears to be). For a thoracic surgeon to be too busy to review preoperative notes prior to taking a patient to the OR is a dangerous condition which is unacceptable to the Hearing Committee.

The Hearing Committee does not find that the signing of preoperative forms constitutes egregious conduct and we do not sustain the charges of gross negligence or gross incompetence. The Hearing Committee also believes that the signing of these forms does not constitute a lack of the skill or knowledge necessary to practice medicine nor that there was a failure to exercise proper care as to any particular patient and therefore does not sustain the charge of negligence or incompetence.

The signing of the 24 blank preoperative forms by Respondent was committed while in the practice of medicine and is a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent. Therefore the Factual Allegation is sustained and the charges of moral unfitness and fraud, as defined in Education Law §6530(2) and (20) are sustained.

ALLEGATION D

Respondent acknowledged that Nurse B may have been hit in the face with a towel but claimed he did not remember the incident/accident. Nurse B testified in a clear and straight forward manner. She was not evasive nor less than candid. This is another troubling example of Respondent's abusive and assaultive behavior towards his fellow workers.

The Hearing Committee was astounded by the obvious dishonest and unscrupulous testimony provided by Lori Ann Larson, a health care professional, on the first day of the Hearing in regards to this particular Charge. Either Ms. Larson gave false statements to hospital personnel during an investigation or she gave false statements to the Department during its investigation or committed perjury before the Hearing Committee or all of the above.

Mr. Zayac's testimony was not believable, having surfaced some extended period of time after the incident.

Respondent deliberately threw a towel at Nurse B. The towel hit Nurse B in the face. Nurse B reported the incident to her supervisor. Before throwing the towel at Nurse B, Respondent stated "I am in the mood to abuse someone today. I am in a really bad mood and I think today it is going to be ...(pause) ... Nurse B.".

The verbal and physical assault on Nurse B by Respondent was committed while in the practice of medicine and is a violation of the moral standards of the medical community which the Hearing Committee, as delegated members of that community, represent. Therefore the Factual Allegation is sustained and the Charge of moral unfitness as defined in Education Law §6530(20) is sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines as follows:

Respondent's license to practice medicine in New York State should be SUSPENDED for five (5) years; four (4) years of said suspension should be STAYED, if Respondent complies with the conditions of probation; one (1) year of said suspension should be actual and full SUSPENSION.

Respondent should be placed on probation for a period of five (5) years from the effective date of this Determination and Order; Respondent's probation should be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct ("**OPMC**"); and Respondent must comply with the terms and conditions of probation contained in Appendix II.

In addition, Respondent should obtain psychiatric treatment and provide psychological evidence of his fitness to practice medicine to the OPMC before the SUSPENSION is lifted. Respondent shall cause the psychiatrist or therapist to submit a proposed treatment plan and quarterly reports to OPMC certifying whether Respondent is in compliance with the treatment plan. The treatment should continue as long as the psychiatrist or therapist determines it is necessary. Respondent should provide a copy of this Determination and Order to his psychiatrist or therapist and provide proof thereof to the OPMC. The period of probation should be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State (except for the first year of suspension).

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

Once the Hearing Committee arrived at a finding of one (1) act of gross negligence; five (5) acts of negligence (professional misconduct by reason of practicing the profession with negligence on more than one occasion - Education Law §6530[3]); four (4) acts of Moral unfitness and one (1) charge (24 separate acts) of fraud, the three members voted unanimously for the penalty indicated above. In Respondent's defense, the Hearing Committee agreed that: Respondent is capable of providing good and adequate medical care; that Respondent is not incompetent; that Respondent did serve a need in his community; and that Respondent can be helped to recover from being his own worst enemy.

The Hearing Committee believes Respondent is capable of continuing to contribute to medicine. The Hearing Committee has considered the extensive support that Respondent has produced within and among accomplished professionals in highly responsible positions within the Buffalo medical community. No less than five department heads or chiefs of surgery, as well as the medical director and the chief executive officer of ECMC testified on Respondent's behalf. The Hearing Committee also appraised the fact that all of these individuals are acquainted with Respondent, have professional interactions with him, and most of them have economic or financial interests at stake.

Based on all of the evidence presented, the Hearing Committee determines that license revocation would be disproportionate, inappropriate and excessive. The Hearing Committee is convinced that Respondent has done a good job in the past and can do so again. There is no question that his skills are held in high regard within the Buffalo medical community. Respondent needs to attend to his behavior and attitude predicaments.

Given the above, the Hearing Committee does not believe that censure and reprimand is sufficient to address Respondent's failure to have personal insight, true remorse or lack of admission that he really did anything wrong. Since there was insufficient evidence to sustain any findings of incompetence, the Hearing Committee finds that limiting Respondent's practice is not an available penalty. Similarly the Hearing Committee does not believe that re-training or attendance at CME seminars is appropriate because of the lack of any proof of incompetence.

The Hearing Committee does not find that public service is indicated or will provide any learning benefits to Respondent. Similarly, the imposition of monetary penalties is not indicated.

The Hearing Committee does not believe that monitoring would be beneficial because Respondent was not found to be incompetent. As previously discussed, Respondent knows what to do but needs to apply himself and carefully think about and document his actions. Monitoring is more of an after the fact remedy.

The Hearing Committee, in the course of a long and intense hearing process, had an opportunity to learn and observe Respondent, both through extensive contact and dialogue with the physician himself, and through the words of many of the people with whom he has interacted on a personal and professional basis over many years. The Hearing Committee believes that Respondent has been placed in such demand that he has a difficulty controlling his actions. Respondent has placed tremendous pressures on himself.

The Hearing Committee found it difficult to arrive at an appropriate penalty under the law, but unanimously believes that the penalty imposed above is an appropriate balance between adequately safeguarding and protecting the public and sufficiently sending Respondent a wake up call that his unprofessional conduct can not and will not be tolerated. Respondent's behavioral troubles in Buffalo are not unique to him. Most of Respondent's medical negligence resulted from lack of documentation and from being too busy with too many cases.

The Hearing Committee does strongly believe that overall Respondent is capable of providing medically acceptable care and treatment. However, Respondent has an arrogant attitude and a "I'm the best, don't question me" view of himself, which needs to be addressed. Respondent has an explanation for everything. Respondent's explanations almost invariably pass blame onto others and have a "not my fault" intonation.

The Hearing Committee believes that a 5 year period of Probation with psychiatric intervention will help Respondent attack both his behavioral problems and his occasional medical inattention, as well as adequately safeguard and protect the public. The Hearing Committee believes Respondent does not have a physical or supervisory type problem which might be rectified by probation alone, but rather a problem which requires intensive professional guidance.

The intent of the Hearing Committee in regard to requiring psychiatric treatment is not to punish Respondent but to aid Respondent in gaining insight to appropriately deal with his problems and to reestablish his position within the medical community. In addition, the Hearing Committee believes that an actual 1 year suspension plus 4 years of stayed suspension will send a sufficiently sobering message to Respondent and will better benefit society than revocation or other penalty. In the event that psychiatric treatment is refused, the Hearing Committee believes that revocation would be appropriate.

The Hearing Committee believes that any treating therapist will be aided, in treating Respondent, by receiving a copy of this Determination and Order because of Respondent's inability to acknowledge responsibility for his behavioral conduct and his continual attempts to place the blame on others without being cognizant of his role. The Hearing Committee recognizes that Respondent claims to accept responsibility, but these claims are mere verbal fabrications for the benefit of the Hearing Committee. Respondent's acts and conduct does not show his claimed acceptance. In the past, Respondent has indicated his willingness to apologize for some of his abusive behavior but has yet to do so. Respondent has indicated that he does not need counseling after it was suggested on several occasions by others within his respected peers. Respondent's behavior and misbehavior have gone beyond the allowable limits of acceptability within an operating room. It was clear to the Hearing Committee that the nature of the incidents and the number of them showed that Respondent is in need of some meaningful external support.

The Hearing Committee realizes that Respondent came to Buffalo and helped with the improvement of a cardiac surgery service at ECMC that had been in danger of collapse. This type of accomplishment requires learning, intellect, determination and passion. Such qualities are found in conjunction with a strong ego and a powerful personality. However, Respondent's strong ego and powerful personality can not remain unchecked when it begins to cause substantial harm to others.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanctions under the circumstances. The Hearing Committee unanimously concludes that the sanctions imposed strike the appropriate balance between the need to punish Respondent, deter future misconduct and protect the public.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

ORDER

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

1. The Sixth Specification (Gross Negligence); the Thirteenth Specification (Negligence on more than one occasion); the Sixteenth, Seventeenth, Eighteenth and Nineteenth Specifications (Moral Unfitness); and the Twenty-First Specification (Fraud) of professional misconduct contained in the Statement of Charges (Department's Exhibit #1) are **SUSTAINED**, and

2. The First through Fifth Specifications (Gross Negligence); the Seventh through Twelfth Specification (Gross Incompetence); the Fourteenth Specification (Incompetence on more than one occasion); and the Fifteenth and Twentieth Specifications (Moral Unfitness) of professional misconduct contained in the Statement of Charges (Department's Exhibit #1) are **NOT SUSTAINED**, and

3. Respondent's license to practice medicine in New York State is **SUSPENDED for five (5) years** from the effective date of this Order; and

4. **A maximum of four (4) years of the SUSPENSION is STAYED** as long as Respondent complies with the terms of probation (specifically item # 10); and

5. Respondent's license to practice medicine in New York State is **ACTUALLY SUSPENDED for a minimum of one (1) year** from the effective date of this Order; and

6. Respondent shall be on **PROBATION** in New York State for a period of **five (5) years** from the effective date of this Order; and

7. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein; and

8. Respondent's probation shall be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct ("**OPMC**"); and

9. In the event that Respondent leaves New York to practice outside the State, the above periods of suspension and probation shall be tolled until Respondent returns to practice in New York State; and

10. Respondent shall obtain psychiatric treatment in compliance with P.H.L. §230(18)(a)(viii), starting within 30 days of the effective date of this Order, and provide psychological evidence of his fitness to practice medicine to the OPMC before the above one (1) year SUSPENSION is lifted; and

11. Respondent shall cause the psychiatrist or therapist to submit a proposed treatment plan and quarterly reports to OPMC certifying whether Respondent is in compliance with the treatment plan; and

12. The psychiatric treatment shall continue as long as the psychiatrist or therapist determines it is necessary; and

13. Respondent shall provide a copy of this Determination and Order to his psychiatrist or therapist and provide proof thereof to the OPMC; and

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

DATED: Albany, New York
August 10, **1998**

John H. Morton

JOHN H. MORTON, M.D., , (Chair),
JOHN P. FRAZER, M.D.
GEORGE C. SIMMONS, Ed.D.

To:

John Bell-Thomson, M.D.,
Department of Cardio-Thoracic Surgery
Erie County Medical Center
462 Grider Street
Buffalo, New York 14215

Kevin C. Roe, Esq.
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Bureau of Professional Medical Conduct
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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER :

OF :

JOHN BELL-THOMSON, M.D. :

STATEMENT

OF

CHARGES

----------X

JOHN BELL-THOMSON, M.D., the Respondent, was authorized to practice medicine in New York State on August 1, 1974 by the issuance of license number 121353-1 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Sometime after approximately May 1, 1988, and prior to August 28, 1990, in the office of the Chief of Surgery at Albert Einstein Medical Center, Philadelphia, Pennsylvania, Respondent initiated, provoked and/or engaged in a physical altercation with Dr. A (all persons are identified in the attached appendix) during which Respondent caused and/or contributed to the dislocation of Dr. A's left shoulder and thereafter attempted to strangle Dr. A by placing his hands around Dr. A's neck.

B. Sometime after approximately May 1, 1988, and prior to August 1990, in an operating room in Albert Einstein Medical Center with a patient under anesthesia and awaiting surgery, Respondent punched Nurse A in the stomach.

C. On or before March 13, 1995, Respondent signed blank preoperative note forms at the Erie County Medical Center, Buffalo, New York (ECMC) and instructed physician assistants to complete the forms.

D. On or about May 12, 1995, at ECMC, Respondent deliberately threw a towel at Nurse B, hitting her in the face.

E. On or about March 29, 1995, Respondent provided care and treatment to Patient A at ECMC. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that:

1. Respondent performed, ordered, supervised, and/or directed a tracheostomy without adequate medical justification.
2. Respondent had electrocautery applied to Patient A's neck while alcohol used for sterilization was still present, thereby igniting a fire.

F. On or about June 27, 1995, Respondent treated Patient B at the Millard Fillmore Hospital, Buffalo, New York (MFH). Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care in that:

1. Respondent failed to perform and/or order a preoperative transesophageal echocardiogram.
2. Respondent failed to order preoperative antibiotics.

3. Respondent inserted a contaminated femoral line guidewire after it had dropped to the floor and despite the offer of a replacement guidewire.

G. On or about June 30, 1995, Respondent treated Patient C at MFH. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care in that:

1. Respondent failed to attend Patient C in a timely manner postoperatively.
2. Respondent applied contaminated internal paddles to the heart muscle after banging the paddles on a console in an attempt to get the attention of medical personnel.
3. While disconnecting chest tubes, Respondent deliberately placed the tubing directly in Nurse C's face, allowing bloody fluid to splash directly on her face and clothing.
4. Respondent deliberately threw a clamp at Nurse D.

Withdrawn w/ prejudice 3/19/98

H. On or about August 31, 1995, Respondent treated Patient D at MFH. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent failed to perform and/or record a preoperative assessment.
2. Respondent used contaminated gloves during an attempted resuscitation, despite an offer of new gloves.
3. Respondent used a contaminated clamp to attempt

stimulation of the myocardium.

4. Respondent failed to wear a hat and mask during the attempted resuscitation.

5. Respondent failed to document reopening of the chest and resuscitative efforts in the ICU.

I. From on or about April 23, 1997, to on or about May 9, 1997, Respondent treated Patient E at the Erie County Medical Center. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that:

1. Respondent failed to perform a pre-operative mediastinoscopy.

2. Respondent failed to perform pre-operative stress tests to evaluate cardiac function.

3. Respondent failed to adequately evaluate Patient E pre-operatively.

4. Respondent performed a right pneumonectomy and an esophagectomy without adequate medical justification.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4)(McKinney Supp. 1998) in that, Petitioner charges:

1. The facts in Paragraph C.
2. The facts in Paragraphs E and E.1 and/or E.2.
3. The facts in Paragraphs F and F.1, F.2 and/or F.3.
4. The facts in Paragraphs G and G.1 and/or G.2.
5. The facts in Paragraphs H and H.1, H.2, H.3, H.4 and/or H.5.
6. The facts in Paragraphs I and I.1, I.2, I.3, and/or I.4.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6)(McKinney Supp. 1998) in that, Petitioner charges:

7. The facts in Paragraph C.
8. The facts in Paragraphs E and E.1 and/or E.2.
9. The facts in Paragraphs F and F.1, F.2 and/or F.3.
10. The facts in Paragraphs G and G.1 and/or G.2.
11. The facts in Paragraphs H and H.1, H.2, H.3, H.4 and/or H.5.
12. The facts in Paragraphs I and I.1, I.2, I.3, and/or I.4.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3) (McKinney Supp. 1998) in that, Petitioner charges two or more of the following:

13. The facts in Paragraphs C; E and E.1, E.2; F and F.1, F.2, F.3; G and G.1, G.2; H and H.1, H.2, H.3, H.4, H.5; and/or I and I.1, I.2, I.3, I.4.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5) (McKinney Supp. 1998) in that, Petitioner charges two or more of the following:

14. The facts in Paragraphs C; E and E.1, E.2; F and F.1, F.2, F.3; G and G.1, G.2; H and H.1, H.2, H.3, H.4, H.5; and/or I and I.1, I.2, I.3, I.4.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice the profession in violation of New York Education Law §6530(20)(McKinney Supp. 1998) in that, Petitioner charges:

15. The facts in Paragraphs A.
16. The facts in Paragraphs B.
17. The facts in Paragraph C.
18. The facts in Paragraph D.
19. The facts in Paragraphs G and G.3.
20. The facts in Paragraphs G and G.4.

TWENTY-FIRST SPECIFICATION

FRAUD

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530(2)(McKinney Supp. 1998) in that, Petitioner charges:

21. The facts in Paragraph C.

DATED: February 2, 1998
Albany, New York

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

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit all written notifications to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Troy, New York 12180. Notifications shall include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled on Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. On receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

8 Respondent shall comply with any request from OPMC to obtain an independent psychiatric evaluation by a health care professional proposed by Respondent and approved, in writing, by the Director of OPMC.

9. Except for the first year of suspension, the period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. In the event that Respondent leaves New York to practice outside the State, the above period of suspension shall be tolled until Respondent returns to practice in New York State.

10. Starting within 30 days from the effective date of the Order, Respondent shall begin psychiatric treatment by a qualified health care professional selected by Respondent and approved by the Director of OPMC. Respondent shall provide psychological evidence of his fitness to practice medicine to the director of OPMC before the one (1) year SUSPENSION is lifted.

11. Respondent shall cause and authorize the psychiatrist or therapist to submit (a) a proposed treatment plan and quarterly reports to OPMC certifying whether Respondent is in compliance with the treatment plan; (b) an immediate report to OPMC if Respondent leaves treatment against medical advise; (c) report to OPMC any significant pattern of absences.

12. The psychiatric treatment shall continue as long as the psychiatrist or therapist determines it is necessary.

13. Respondent shall provide a copy of the complete Determination and Order to his psychiatrist or therapist and provide proof thereof to the OPMC.

14. Respondent shall submit the name of a proposed successor, within ten (10) calendar days of learning that the approved psychiatrist or therapist is no longer willing or able to serve.