STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

September 14, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Susan L. Bogdan, M.D.
Wood Street
Katonah, New York 10536

Anthony Z. Scher, Esq.
Wood & Scher
14 Harwood Court
Suite 512
Scarsdale, New York 10583

Michael A. Hiser, Esq.
Assistant Counsel
NYS Department of Health
Tower Building - Room 2429
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Susan L. Bogdan, M.D.

Dear Dr. Bogdan, Mr. Scher and Mr. Hiser:

Enclosed please find the Determination and Order (No. BPMC-92-72) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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

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

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER OF SUSAN L. BOGDAN, M.D.	DETERMINATION AND ORDER ORDER NO. BPMC 92-72

A Notice of Hearing and Statement of Charges, both dated March 2, 1992, were served upon the Respondent, Susan L. Bogdan, M.D. **THERESE G. LYNCH, M.D. (Chair), GEORGE C. SIMMONS, Ed.D.**, and **LEO FISHEL, JR., M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. A hearing was held commencing on April 7, 1992. The Department of Health appeared by Michael A. Hiser, Esq., Assistant Counsel. The Respondent appeared by Wood & Scher, Anthony Z. Scher, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges against Respondent:	March 9, 1992
Date of Amended Statement of Charges:	March 31, 1992
Answer to Statement of Charges:	None
Pre-Hearing Conference:	March 25, 1992

Dates of Hearing:	April 7, 1992 May 4, 1992 May 28, 1992 May 29, 1992 June 4, 1992 June 5, 1992 June 11, 1992
Witnesses for Department of Health:	Paul G. Kleinman, M.D. Scott R. Messenger, M.D. Patrick A. Fantauzzi, M.D. Florence V. Vinour, R.N.
Witnesses for Respondent:	Susan L. Bogdan, M.D. Paul M. Goldiner, M.D. Henrix Holt Bendixen, M.D. Paul J. Candino Bernard Fagin, M.D.
Received Department's Proposed Findings of Fact, Conclusions of Law and Recommendation:	July 15, 1992
Received Respondent's Summation, Proposed Findings of Fact and Conclusions of Law :	July 15, 1992
Deliberations Held:	July 24, 1992

STATEMENT OF CASE

The Department has charged Respondent, a board-certified anesthesiologist with professional misconduct regarding the anesthesia management of six surgical patients. More specifically, the Department has accused Respondent with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, failing to maintain accurate medical records and abandonment or neglect of a patient. Respondent denied the allegations.

Pursuant to Respondent's motion for a more definite,

detailed Statement of Charges, which was granted by the Administrative Officer at the March 25, 1992 pre-hearing conference, an amended Statement of Charges was received into evidence as Petitioner's Exhibit #1-A. All conclusions reached by the Hearing Committee were based upon the allegations contained within the amended Statement of Charges.

Marilyn M. Kritchman, M.D. was originally delegated to serve as the Chair of the Hearing Committee. Dr. Kritchman recused herself following the April 7, 1992 hearing date, due to the possibility of a conflict of interest. She was replaced as Chair by Therese G. Lynch, M.D. Dr. Lynch certified, on the record, that she has read the transcript of the April 7, 1992 proceedings.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Susan L. Bogdan, M.D. (hereinafter "Respondent") was authorized to practice medicine in New York State on August 13, 1982 by the issuance of license number 151235 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992, from

Wood Street, Katonah, New York 10536. (Not Contested).

Patient A

2. Patient A, an 83 year old female, was admitted to Peekskill Community Hospital, 1980 Crompond Road, Peekskill, New York, 10566 (hereinafter "Hospital") on or about March 6, 1989 with a fractured hip. (Pet. Ex. #3, pp. 4-5).

3. On or about March 7, 1989, Patient A underwent open reduction and internal fixation of the right hip. Respondent administered the anesthesia for this procedure. (Pet. Ex. #3, pp. 104-105).

4. Patient A weighed eighty kilograms. (Pet. Ex. #3. p. 104).

5. The responsibility for fluid management of a patient, both as to type and amount, rests with the anesthesiologist. (951).

6. The surgeon's estimate of blood loss for the patient was approximately 1500cc. Respondent testified that she estimated the blood loss to be 1200-1300cc. She did not enter an estimated blood loss on the anesthesia record. (30, 31, 609-610).

7. Patrick Fantauzzi, M.D., the Department's expert witness, estimated that Patient A lost over twenty percent of her blood volume. (191).

8. A 500cc bag of D5 1/2 NS (5% Dextrose in 1/2 normal saline), administered intravenously, was in place when the patient was brought to the operating room. Respondent finished this bag and then hung an additional 1500cc of D5 1/2 NS. In addition,

Respondent hung 1000cc of Ringer's lactate. Another 500cc of Ringer's Lactate was hung at or about 4:30 P.M. This last bag of IV fluid is not noted on the anesthesia record. (Pet. Ex. #3, pp. 104, 207).

9. D5 1/2 normal saline is hypotonic. It will not provide needed extracellular fluid replacement. However, Patient A had already received two units of packed red blood cells during the twelve hours prior to surgery. In addition, Ringer's Lactate, a replacement for extracellular fluid, was administered intra-operatively. (184-185, 187, 191-192, 234).

10. Respondent's conduct in infusing the patient with 2000cc D5 1/2 NS was controversial. Dr. Fantauzzi testified that it was contrary to accepted standards of practice. However, Henrix Holt Bendixen, M.D., a witness for Respondent, testified to the contrary. (189-190, 261, 1270-1272).

11. The anesthesia record is the document used by the anesthesiologist to describe the condition of the patient during the administration of anesthesia. (201).

12. The anesthesia record provides information to other physicians who want to review the patient's medical care. The anesthesiologist is responsible for maintaining the anesthesia record. (955-956).

13. The anesthesia record is intended to be a companion document to the surgeon's description of the operation, as well as a record of the administration of drugs, fluids, anesthetic agents, and other relevant events. (1340).

14. Paul M. Goldiner, M.D., a witness for Respondent, testified that good record-keeping is part of good practice. (1190).

15. There is no way to tell from the anesthesia record that Respondent had estimated blood loss on the day of surgery. (653).

16. The estimate of blood loss is an essential element of good practice and a very useful clinical tool. Respondent admitted that she was taught to estimate blood loss and to document the estimate. (204-205, 653).

17. The space on the anesthesia record for estimated blood loss was left blank. (Pet. Ex. #3, p. 105).

18. The failure of the anesthesia record to contain the estimated blood loss was contrary to generally accepted standards of practice. (204-205).

19. Patient A received spinal anesthesia. The level of spinal anesthetic achieved was not documented on the anesthesia record. (Pet. Ex. #3, p. 104).

20. The level of spinal is extremely important to note because it tells you the level of sensory, motor and autonomic anesthesia achieved. (206-207).

21. A level of spinal is documented on an anesthesia record to record the effect of a given dose of anesthetic agent on the patient. It is one part of patient care. (1247).

22. Dr. Fantauzzi testified that Respondent's failure to record the level of spinal on the anesthesia record was contrary

to generally accepted standards of practice. (205-206, 262).

23. Patient A was in the operating room from 12:30 p.m. until 4:55 p.m. The operation stared at 1:55 p.m. and ended at 4:37 p.m. (Pet. Ex. #3, p. 112).

24. The last recorded blood pressure noted on the anesthesia record is timed at approximately 4:20 p.m. (Pet. Ex. #3, p. 107).

25. Respondent desired to leave the hospital promptly following the end of the surgery on Patient A due to pressing personal reasons. An emergency had arisen concerning the provision of care for her nine year-old son upon his return from school. (603; Pet. Ex. #4, Pet. Ex. #5).

26. Patient A was taken directly to her room, rather than to the recovery room. Respondent exercised her judgment not to request that emergency after-hours recovery room services be made available for Patient A. (677).

27. At Peekskill Community Hospital, floor nurses were not as well-trained in recovery room and ICU care as recovery room and ICU nurses. (1455).

28. At 4:55 p.m., the patient was brought directly back to a nursing unit on the third floor by Respondent and Dr. Kleinman. Dr. Kleinman then left to find a nurse to provide care to the patient. (33-34; Pet. Ex. #3, p. 112).

29. Respondent waited until the nurse came, told the nurse of the patient's anesthesia, how much fluid the patient had, and then left. When Respondent left, the vital signs had not yet

been taken. Respondent advised Dr. Kleinman that she was leaving, and he indicated that he would check on the patient. Respondent and Dr. Kleinman then said good-bye to each other. (35; Pet. Ex. #5, pp. 1417-1418).

30. Respondent went to the nurse's changing room on the first floor of the hospital to change her clothes. This is approximately two flights below the patient's room. Respondent changed her clothes and left, and did not thereafter check on Patient A. (64-65, 62221, 626).

31. Shortly thereafter, the nurse informed Dr. Kleinman that she could not get a blood pressure reading on the patient. Because he felt that someone other than an orthopedic surgeon should care for this patient, Dr. Kleinman tried twice to contact Respondent - once through the hospital paging system, and once by phone call to the operating room suite. He was informed that Respondent was no longer there. Dr. Kleinman and a Dr. Stievelman thereafter provided immediate medical care to Patient A from 5:00 p.m. until 8:00 p.m., consisting of IV fluids including dextrose, 1/2 normal saline, albumin, blood, and dopamine; administration of digoxin, and EKG studies. The patient was constantly attended by a physician from 5:00 p.m. through 7:00 p.m., and transferred to the step-down unit at approximately 7:00 p.m. (36, 41; Pet. Ex. #3, pp. 12-13).

32. The American Society of Anesthesiologists ("ASA") standards for post-anesthesia care, effective as of October 12, 1988, reflect the general standards of care applicable in the

practice of anesthesiology. The ASA standards were applicable to anesthesia care rendered in March, 1989. ASA standard IV(3) states that "general medical supervision and coordination of patient care in the PACU [Post-Anesthesia Care Unit] should be the responsibility of an anesthesiologist. (208; Pet. Ex. #8).

33. Respondent had the responsibility to make sure that the patient was stable. The vital signs should be taken in the anesthesiologist's presence, and the anesthesiologist should remain with the patient until the nurses have recorded the data. (253, 270).

34. Respondent's conduct in taking the patient to the floor and leaving the patient post-operatively without insuring that the vital signs were checked was not in accordance with accepted standards of practice. (211-212).

Patient B

35. Patient B, a 2 1/2 year-old female, was admitted to the hospital on or about March 29, 1989 for a bilateral myringotomy with tube insertion and adenoidectomy, which were performed on that day. Respondent provided general anesthesia for this procedure. (Pet. Ex. #6, pp. 3, 18).

36. Generally accepted standards of practice require that concentrated succinylcholine be present in the operating room when an anesthesiologist is anticipating inducing general anesthesia. (292-293).

37. Succinylcholine is a depolarizing muscle relaxant. (292).

38. Respondent did not have concentrated succinylcholine in the operating room during the surgery performed on Patient B. (542).

39. Respondent had succinylcholine in the amount of 4 mg/cc in an IV bag prepared for intravenous use. (460-461).

40. The operating surgeon, Dr. Messenger, unsuccessfully attempted to start the patient's IV. Respondent then attempted to intubate the patient without the IV in place. Her initial attempt at intubation was unsuccessful and the patient went into laryngospasm. Respondent instructed a nurse to draw 8cc of succinylcholine from the IV bag and inject it into the patient intramuscularly - 4cc into each thigh. (90, 459-460).

41. Patient B experienced two episodes of laryngospasm, . In both instances, succinylcholine from the IV bag was injected into the patient. The saturation reading on the pulse oximeter for Patient B read in the 40's during the first laryngospasm. (91, 105, 479, 558, 561).

42. Generally accepted standards of practice require notation in the anesthesia record where there is difficulty with intubation. (298-301).

43. Difficulty with intubation includes circumstances where a patient experiences a laryngospasm necessitating action by the physician to break the laryngospasm. (300).

44. Respondent failed to record the episodes of laryngospasm Patient B experienced during the surgery of March 29, 1989. (Pet. Ex. #6, p. 18).

45. The dose and method of injection of drugs is something that should be recorded in the medical record. (301-301).

46. Respondent failed to record the method of injection and specific doses of drugs which were administered to Patient B. (Pet. Ex. #6, p. 18).

47. Respondent failed to record the estimated blood loss experienced by Patient B. (Pet. Ex. #6, p. 18).

48. Generally accepted standards of practice require documentation on the anesthesia record concerning an oxygen saturation level in the 40's. (307).

49. Respondent failed to record accurate oxygen saturation levels for Patient B. (Pet. Ex. #6, p. 18).

50. The nature of the breathing circuit used should be noted on the anesthesia record. (354).

51. The nature of the breathing circuit used was not documented on the anesthesia record for Patient B. (Pet. Ex. #6, p. 18).

Patient C

52. Patient C, a 69 year-old male, was admitted to the hospital on November 5, 1987 for a transurethral resection of the prostate ("TURP") and anal fissurectomy, which were performed on November 6, 1987. Respondent provided spinal anesthesia for this procedure. (Pet. Ex. #9, p. 5-6, 31).

53. Patient C was 5' 8 1/2"" tall. (Pet. Ex. #9, p. 12).

54. There is no standard dose of Tetracaine given to all

patients. The range of appropriate doses varies, depending on the site of the surgery and the height of the patient. (374-375).

55. Respondent usually seeks a T8 to T10 level for a TURP patient. (741-742).

56. Respondent administered 16 mg of Tetracaine with epinephrine to Patient C. (Pet. Ex. #9, p. 31).

57. Dr. Fantauzzi testified that the dose of 16 mg Tetracaine for Patient C, considering the patient's age and height and the surgical procedure performed, was not in accordance with generally accepted standards. (378).

58. Dr. Goldiner testified that a range of dosage of 14 mg - 16 mg Tetracaine would be appropriate for Patient C, given the surgical procedure performed. (1159).

59. Patients undergoing TURPs receive irrigating solution in the bladder that may be absorbed by the patient. Patients can take on a big fluid load and become hyponatremic. Hyponatremia is a decrease in serum sodium. The patient's serum sodium will decrease due to the absorption of the fluid. (379-380).

60. The irrigation fluid used during a TURP is a very hypotonic solution. Absorption of the fluid through the veins in the bladder can cause their electrolyte balance to be shifted in a negative direction, with lowering of sodium and electrolytes in general. That can lead to significant and serious complications. (732).

61. D5 1/2 normal saline is a hypotonic solution. There is no valid reason to give a hypotonic solution to patient who is

already getting hypotonic solution through the venous sinuses. (383).

62. There is a conflict between the anesthesia record, recovery room, and IV admixture records, as to what fluids were given to Patient C. The anesthesia record indicates that Patient C received 1000cc of Ringer's lactate, then a 1000cc bag of D5 1/2 normal saline was hung. The recovery room record indicates that no Ringer's lactate was given, but that 1000cc of D5 1/2 normal saline was given in the OR, followed by the hanging of a second bag of D5 1/2 normal saline, of which 300cc had been absorbed when the patient came to the recovery room at 12:00 p.m. The IV admixture sheet for Patient C indicates that 2000cc of D5 1/2 normal saline were administered to the patient. (Pet. Ex. #9, pp. 31, 37, 63).

63. Florence V. Vinour, R.N., the operating room clinical nurse manager at Peekskill Community Hospital, testified as the procedures followed by the circulating nurse to document the fluids given in the OR. The nurse documents the administration of fluids by the anesthesiologist through the use of a two-layered tab. The top layer of the tab is affixed to the IV bag. The bottom tab is affixed to a summary sheet entitled "IV admixture sheet". The nurse looks at the IV fluid bag when the tab is affixed. According to the procedures followed at the hospital, the nurse is not supposed to rely on the anesthesiologist's statement as to the fluid administered. (1416-1417, 1432, 1434, 1472-1473).

Patient D

64. Patient D, an 81 year-old male, was admitted to the hospital on or about October 15, 1988 with severe vascular disease, chronic obstructive pulmonary disease, and cirrhosis. Patient D was scheduled for a left femoral-popliteal bypass on or about October 31, 1988, for which Respondent provided spinal anesthesia. (Pet. Ex. #10, pp. 9-10, 84).

65. The anesthesiologist is responsible for determining what fluids are to be given to a patient, both as to type and amount of fluid. (951).

66. Three pre-operative blood studies, collected on 10/28/88, 10/29/88, and the morning of surgery, 10/31/88, respectively, reveal that Patient D had low sodium levels. More specifically, the sodium levels on 10/28/88, 10/29/88 and 10/31/88 were 135, 130, and 132, respectively. The normal range, as noted on the laboratory reports, was 136-148. (Pet. Ex. #13).

67. Respondent's pre-anesthesia evaluation documented that the patient's electrolytes were within normal limits. (1497-1498; Pet. Ex. #13, pp. 6-8).

68. The fluid summary contained in the anesthesia record for Patient D indicates that Patient D received 4000cc of D5 1/2 normal saline during the course of the operation. (Pet. Ex. #10, pp. 84, 200).

69. According to Dr. Fantauzzi, patients who have low sodium levels should not receive a hypotonic solution, due to the risk of water intoxication. Therefore, using a hypotonic solution

to replace an extracellular fluid loss is incorrect. One should use a balanced salt solution to replace extracellular fluid in a patient with low sodium and low albumin. Dr. Fantauzzi further testified that Patient D should have received a balanced salt solution, such as Ringer's lactate, which has the electrolyte composition of extracellular fluid. (953, 999, 1020-1021).

70. Dr. Goldiner testified that Respondent's use of D5 1/2 normal saline did not constitute a deviation from accepted standards of practice. He stated that, given a long operation such as the operation performed on Patient D, with an estimated blood loss of only 300cc, it is appropriate to use a maintenance fluid, such as D5 1/2 normal saline, rather than a replacement fluid. (1162-1163).

71. Dr. Fantauzzi testified that the volume of fluid given to Patient was too large. By administering 3000cc to 4000cc of D5 1/2 normal saline to a patient with heart disease runs the risk of pushing the patient into congestive heart failure. (953-954).

72. Dr. Goldiner testified that 4000cc of D5 1/2 normal saline would be perfectly adequate fluid management for Patient D, given the patient's history of cirrhosis and vascular disease. (1162-1163).

73. A Foley catheter was in place in Patient D during the surgery. It is accepted practice to measure and document the urine output, when a Foley catheter is in place. (959-960; Pet. Ex. #10, p. 89).

74. The purpose of a Foley catheter is to compress the bladder and to record the volumes of urine produced on an hourly or half-hourly basis. It is important to measure the urine output because it indicates the adequacy of renal function. It is an indicator of the adequacy of perfusion, i.e., whether the patient's cardiac output is adequate to meet the tissue demands. This is reflected in the hourly urine output. (957-960).

75. The measurement of urine output in an 81 year-old patient with chronic obstructive pulmonary disease is a relevant consideration. (958).

76. Dr. Bendixen acknowledged that it is considered good practice to record the urine output. (1320).

77. Dr. Goldiner testified that good practice carries with it the obligation to put down the level of anesthetic, blood loss and urine output. (1184-1185).

78. The anesthesia record for Patient D did not document the urine output. (Pet. Ex. #10, p. 84).

79. The level of spinal anesthesia is something that is normally documented in the medical record. The anesthesiologist needs to know the level of sensory, motor and autonomic anesthesia. Higher levels of spinal anesthesia can produce profound blood pressure changes. Generally accepted standards of practice require documentation of the level of spinal anesthesia. (961-962, 1319).

80. Respondent failed to document the level of spinal anesthesia on Patient D's anesthesia record. (Pet. Ex. #10, p.

84).

81. The operating surgeon estimated Patient D's blood loss to be 300cc. (Pet. Ex. #10, pp. 86-87).

82. Dr. Fantauzzi testified that generally accepted standards of practice require documentation of a 300cc blood loss on the anesthesia record. However, Respondent failed to record the estimated blood loss on Patient D's anesthesia record. (965; Pet. Ex. #10, p. 84).

83. Respondent's failure to accurately record the surgical procedure performed, by not indicating that the intended procedure (left femoral-popliteal bypass) had been cancelled, and that a different procedure (left profundoplasty) was performed, was not contrary to accepted standards of practice. (966-968).

Patient E

84. Patient E, a 58 year-old male, was admitted to the hospital on or about May 28, 1986. Patient E underwent debridement and split thickness skin graft of the right foot on or about June 26, 1986, for which Respondent provided spinal anesthesia. During the procedure, Patient suffered cardiac arrest, and was resuscitated. (Pet. Ex. #11, pp. 5-8, 103-105).

85. Patient E had a Foley catheter in place during the surgery. (Pet. Ex. #11, p. 101).

86. Respondent's anesthesia record did not document urine output. (Pet. Ex. #11, p. 105).

87. Respondent's failure to document Patient E's urine output was contrary to generally accepted standards of medical

practice, (1031-1032, 1319-1320).

88. Respondent's anesthesia record for Patient E did not record the level of spinal anesthesia. (Pet. Ex. #11, p. 105).

89. Respondent's failure to document the level of spinal anesthesia on the anesthesia record for Patient E was not in accordance with generally accepted standards of medical practice. (1033, 1272).

90. Respondent's anesthesia record for Patient E did not document any estimated blood loss. The failure to record the blood loss was not in accordance with generally accepted standards of medical practice. (1035-1036; Pet. Ex. #11, p. 105).

91. Patient E experienced bradycardia and asystole at approximately 3:30 p.m. Resuscitative measures were undertaken. The patient was intubated and given epinephrine, lidocaine, sodium bicarbonate and DC electrocardioversion. The patient's cardiac function returned, and the patient was extubated after approximately one hour. (Pet. Ex. #11, p. 8).

92. There would be no need to intubate Patient E during spinal anesthesia, unless a complication, such as a cardiac arrest, arose during the procedure which required securing the patient's airway. (1036).

93. The intubation of the patient was a significant event. Generally accepted standards of practice require documentation of the intubation on the anesthesia record, because it was unplanned and indicated that a problem arose which required securing the airway. The etiology of the problem, the corrective

measures taken, including the drugs employed and the route of administration, as well as the outcome, should also be recorded in the patient chart. (1037-1038, 1040-1044).

94. Respondent failed to note the fact or method of intubation on the anesthesia record. (Pet. Ex. #11, pp. 105, 114).

95. The admixture record for Patient E indicates that 2000cc of D5 1/2 normal saline were administered to Patient E. (Pet. Ex. #11, p. 254).

96. The anesthesia record states that only 1000cc of D5 1/2 normal saline was given to Patient E. Respondent testified that she could not explain the discrepancy. (845-846; Pet. Ex. #11, pp. 105, 254).

97. A cardiac arrest is a significant event. In 1986, it was accepted practice to document the steps taken to treat a patient experiencing a cardiac arrest. (1041-1042).

98. A resuscitation flow sheet was used in 1986 at Peekskill Community Hospital when there was a code in progress, i.e., whenever a patient had a cardiac or respiratory arrest. (1423; Resp. Ex. B).

99. At Peekskill, either the circulating nurse or one of the floating nurses would fill the chart out. They keep a record during the code of the type and amount of medication given, and the time it was administered. This is indicated on the flow sheet. The person filling out the flow sheet does so only during the resuscitation attempt. They stop making entries once the

patient has been resuscitated or has expired. (1424, 1426-1427).

100. Respondent's description of the circumstances of Patient E's cardiac arrest is contained on the anesthesia record and post-anesthesia note. (Pet. Ex. #11, pp. 105, 114).

101. Respondent's documentation of the circumstances of Patient E's cardiac arrest was not in accordance with generally accepted standards of practice. Generally accepted standards of practice require documentation of the etiology of the arrest, the corrective measures taken, including the drugs employed and the route of administration, as well as the outcome. (1037-1038, 1040-1044).

102. During the period from approximately 3:30 p.m. - the time of the arrest - until approximately 5:10 p.m, when the patient left the operating room, Respondent recorded no information on the anesthesia record which would document urine output, oxygen saturation, diastolic or systolic blood pressure, pulse, respirations, or fluids given to Patient E. (860-862; Pet. Ex. #11, pp. 105, 114).

103. Dr. Fantauzzi testified that failing to make any entries in the anesthesia record during the period from 3:30 p.m. through 5:10 p.m. was not acceptable. Even assuming there was a delegation of authority to the circulating nurse to record the events during the cardiac arrest, and assuming that the arrest was short-lived, it was not in accordance with accepted practice to have no further information on the chart. (1049).

Patient F

104. Patient F, a 73 year-old female, was admitted to the hospital on or about October 14, 1986, with a fracture of the left patella. Patient F was taken to surgery for an open reduction, internal fixation of the left patella at approximately 12:00 p.m. on October 15, 1986, for which Respondent provided spinal anesthesia. (Pet. Ex. #12, pp. 4, 54).

105. Respondent failed to document the level of spinal anesthesia on the patient's anesthesia record. (Pet. Ex. #12, p. 54).

106. Respondent's failure to document the level of spinal on the anesthesia record for Patient F was not in accordance with accepted standards of practice. (1076).

107. Surgery on Patient F was cancelled prior to an incision having been made. There was no blood loss. (893, 1337).

108. Respondent did not note in the section of the anesthesia record entitled "Operative Procedure" the fact that the planned surgery was cancelled. The failure to make such an entry was not contrary to generally accepted standards of practice. (1076-1077).

109. The nursing notes indicate that Patient F was pre-operatively given an intravenous solution of D5 Ringer's lactate, with KCL. The solution was infused into the patient at the rate of 50cc per hour, beginning at approximately 8:30 a.m. on October 5, 1986. (Pet. Ex. #12, p. 67).

110. The IV admixture record indicates that the patient was given D5 Ringer's lactate with 20cc of KCL, at the rate of

50cc per hour. (Pet. Ex. #12, p. 88).

111. The recovery room record indicates that the patient received 1000cc of 5% Dextrose/lactated Ringer's solution in the operating room. (Pet. Ex. #12, p. 56).

112. Respondent's anesthesia record for Patient F inaccurately indicates that Patient F received 1000cc of D5 1/2 normal saline. (Pet. Ex. #12, p. 54).

113. Dr. Fantauzzi testified that Respondent's failure to accurately document the intravenous fluids administered to Patient F was not in accordance with accepted standards of practice. (1078).

114. Respondent did not record diastolic blood pressure and pulse rates for Patient F. (Pet. Ex. #12, p. 54).

115. Before the surgical procedure actually began, Patient F suffered a respiratory arrest and was resuscitated by Respondent. (Pet. Ex. #12, pp. 14-15; 893-895, 909-910, 1080-1081).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. Numbers in parentheses refer to the specific Findings of Fact which support each conclusion.

FACTUAL ALLEGATIONS

The Hearing Committee concluded that the following Factual Allegations should be sustained:

--Paragraph A: (2);

--Paragraph A.2: (6,11-22);

--Paragraph A.3: (25-26, 28-30, 32-34);

--Paragraph B: (35);

--Paragraph B.2: (36-40);

--Paragraph B.3: (41-51);

--Paragraph C: (52);

--Paragraph D: (64);

--Paragraph D.1: (66, 68-69, 71);

--Paragraph D.2: (73-82);

--Paragraph E: (84);

--Paragraph E.1: (85-90, 93-96, 102-103);

--Paragraph E.2: (91, 97-101);

--Paragraph F: (104);

--Paragraph F.1: (105-106, 110-114).

The Hearing Committee further concluded that the following Factual Allegations should not be sustained:

--Paragraph A.1: (8-10);

--Paragraph B.1: (Withdrawn by Petitioner);

--Paragraph C.1: (53-58);

--Paragraph C.2: (59-63);

--Paragraph F.2: (115).

SPECIFICATION OF CHARGES

The Hearing Committee concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each specification:

--Fifth Specification (Negligence on More Than One Occasion: (A, A.2, A.3, B, B.2, B.3, D, D.1, D.2 E, E.1, E.2, F, F.1); and

--Eighth Specification (Failing to Maintain Records): (A, A.2, B, B.3, D, D.2, E, E.1,E.2, F, F.1).

The Hearing Committee further concluded that the following Specifications should not be sustained:

--First Specification (Gross Negligence);

--Second Specification (Gross Negligence);

--Third Specification (Gross Incompetence);

--Fourth Specification (Gross Incompetence);

--Sixth Specification (Incompetence on More Than One Occasion); and

--Seventh Specification (Abandonment or Neglect).

DISCUSSION

Respondent is charged with eight specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct under the New York Education Law" sets forth suggested definitions for gross negligence, gross

incompetence, negligence on more than one occasion and incompetence on more than one occasion.

The following definitions were utilized by the Hearing Committee as a framework for its deliberations:

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

(2) **Gross Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad;

(3) **Incompetence** is a lack of the skill or knowledge necessary to practice the profession;

(4) **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.

All conclusions reached by the Hearing Committee were made based upon the preponderance of the evidence. The rationale underlying the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made an evaluation of the credibility of the expert witnesses presented by the parties. The Department presented one expert witness - Patrick A. Fantauzzi, M.D. Dr. Fantauzzi is a board-certified anesthesiologist, and a Past President of the New York State Society of Anesthesiologists. He is currently an assistant clinical instructor in anesthesia at the Albany Medical College.

He is an attending anesthesiologist at St. Peter's Hospital, and the chief attending anesthesiologist at the Child's Hospital, Albany, New York.

Respondent presented two expert witnesses - Henrik Holt Bendixen, M.D. and Paul M. Goldiner, M.D. Dr. Bendixen is a board-certified anesthesiologist and the Vice President for Health Sciences and Dean of the Faculty of Medicine at Columbia University. Dr. Goldiner is professor of medicine and chairman of the department of anesthesiology at the Albert Einstein College of Medicine and Montefiore Medical Center. Dr. Goldiner is Vice President of the New York State Society of Anesthesiologists.

None of the expert witnesses presented has any personal stake in the outcome of the proceedings. The Hearing Committee found all three experts to be eminently qualified in the field of anesthesiology. As a result, the Committee found all three experts to be credible witnesses, to varying degrees.

Gross Negligence

The First and Second Specifications allege that Respondent was grossly negligent with respect to the care and treatment of Patient's A and B, respectively.

The First Specification alleged that Respondent transferred Patient A, an 83 year-old female patient who was admitted to Peekskill Community Hospital for an open reduction and internal fixation of the right hip, from the operating room to a nursing unit, rather than to the recovery room. It was further alleged that Respondent left the patient without checking her

vital signs and without ensuring that the patient was stable. (Paragraphs A and A.3).

The record established the fact that Respondent did transfer Patient A from the operating room directly to a nursing unit. At the time of the surgery, the hospital's recovery room was not open on a 24-hour basis. Respondent could have requested that after-hours recovery room services be made available for this patient. She exercised her professional judgment by deciding not to request such coverage in this instance.

The record further established that Respondent desired to leave the hospital promptly following the end of the surgery on Patient A due to a family emergency. Due to a combination of circumstances, Respondent's arrangements for after-school care for her nine-year old son fell through, and she needed to get home before he arrived.

Following the operation, Respondent and Dr. Kleinman (the operating surgeon) brought Patient A to the nursing unit. Respondent briefed a floor nurse regarding the patient's anesthesia course, and the fluids administered. Respondent then advised Dr. Kleinman that she was leaving. Dr. Kleinman indicated that he would check on the patient. Respondent and Dr. Kleinman then said good-bye to each other, and Respondent left the nursing unit. She left before the nurse had taken the patient's vital signs.

Shortly thereafter, the nurse reported to Dr. Kleinman that she could not get a blood pressure reading on the patient.

He then tried to page Respondent, but was informed that she had already left the hospital. Dr. Kleinman and a Dr. Stievelman then rendered immediate medical care to Patient A until the situation was resolved.

The American Society of Anesthesiologists ("ASA") has promulgated standards of practice which reflect the general standards of care applicable to the practice of anesthesiology. ASA standard IV(3) provides that the general medical supervision and coordination of patient care in the post-anesthesia care unit should be the responsibility of an anesthesiologist.

The Hearing Committee concluded that Respondent had made suitable arrangements with Dr. Kleinman to monitor the patient during the immediate post-operative period. Nevertheless, the Committee concluded that a reasonably prudent anesthesiologist would have ensured that the patient's vital signs were stable before turning the patient over to a non-anesthesiologist They therefore concluded that Respondent's conduct constituted negligence. However, the Hearing Committee further concluded that Respondent's conduct did not rise to the level of gross negligence. Respondent delegated the responsibility for the patient to a competent physician (Dr. Kleinman), with his consent. As a result, the Hearing Committee found that Respondent's conduct was neither egregious nor conspicuously bad. Therefore, the First Specification was not sustained.

The second Specification alleged that Respondent was grossly negligent with regard to her care and treatment of Patient

B, a 2 1/2 year-old female admitted to the hospital for a bilateral myringotomy with tube insertion and adenoidectomy. More specifically, the Department alleged that Respondent committed an act of gross negligence by attempting to intubate the patient without having concentrated succinylcholine readily available. (Paragraphs B and B.2).

Succinylcholine is a depolarizing muscle relaxant. Dr. Fantauzzi testified that generally accepted standards of practice require that concentrated succinylcholine be present in the operating room when the anesthesiologist anticipates inducing general anesthesia in a patient. Henrix Holt Bendixen, M.D., an expert witness for the Respondent, acknowledged that concentrated succinylcholine is part of the standard anesthesia set-up at his hospital. (T. 1294).

Respondent conceded that concentrated succinylcholine was not present in the operating room during the surgery performed on Patient B. However, the record clearly established that Respondent had succinylcholine in the amount of 4mg/cc in an IV bag prepared for intravenous use. When the patient experienced laryngospasms on two occasions, Respondent used the dilute succinylcholine to successfully break the laryngospasm. Paul M. Goldiner, M.D., another expert witness testifying on behalf of Respondent, testified that Respondent had available for use a concentration of succinylcholine which was sufficient to successfully break the laryngospasms.

The Hearing Committee concluded that a reasonably prudent

anesthesiologist would have had concentrated succinylcholine readily available in the operating room prior to attempting intubation of the patient. Therefore, Respondent's failure to have the concentrated succinylcholine available constituted negligence. However, the fact that Respondent was able to use the diluted succinylcholine which was available to break the patient's laryngospasms demonstrated that her conduct was not egregious. As a result, the Hearing Committee did not sustain the Second Specification.

Negligence On More Than One Occasion

The Fifth Specification charges Respondent with negligence in regard to her medical care and treatment of Patients A through F. The allegations predominantly concern Respondent's medical records (Paragraphs A.2, B.3, D.2, E.1, and F.1), as well as her management of intravenous fluids for these patients. (Paragraphs A.1, C.2, and D.1).

There is little controversy regarding the quality of the medical records for five of the patients (no records-related allegations were raised concerning Patient C). In each case, significant aspects of the anesthesia management of the patient were omitted. Respondent repeatedly failed to note the level of spinal anesthetic achieved (Patients A, D through F), the urine output (Patients D and E), or the estimated blood loss (Patients A, D and E).

In addition, Respondent failed to record other significant aspects of the anesthesia management of Patient B, including the

difficulty with intubation, the episodes of laryngospasm, accurate oxygen saturation levels and the method of injection and doses of drugs administered. Respondent further failed to properly record the circumstances of Patient E's cardiac arrest. The anesthesia record for this patient omitted key information, such as the etiology of the arrest, corrective measures taken, including the drugs administered and the route of administration, as well as the outcome of the resuscitation efforts.

There was near-unanimity amongst the expert witnesses concerning the quality of Respondent's records. Generally accepted standards of medical practice dictate that the above-mentioned information should be documented in the medical record by the anesthesiologist. The Committee therefore concluded that a reasonably prudent anesthesiologist would have recorded the information in the medical records. As a result, the Hearing Committee concluded that the failure to record the cited information for each patient constituted acts of negligence.

The Department also alleged that Respondent was negligent with regard to her management of intravenous fluids for Patients A, C and D. This was an area of some controversy during the hearing.

Dr. Fantauzzi testified that Respondent's fluid management for Patient A deviated from accepted standards of practice by infusing the patient with approximately 2000cc of D5 1/2 normal saline, together with 1500cc of Ringer's lactate. D5 1/2 normal saline is a hypotonic solution which does not adequately replace

extracellular fluid lost during surgery. Ringer's lactate is used as a replacement for extracellular fluid. Dr. Fantauzzi testified that, given the fact that the patient lost approximately 20 percent of her blood volume during surgery, Respondent should have used more Ringer's lactate instead of the D5 1/2 normal saline. However, Dr. Bendixen testified that there is no significant difference between D5 1/2 normal saline and Ringer's lactate, when used in the amounts administered to Patient A. (T. 1270-1272). The Hearing Committee concluded that the Department failed to prove by a preponderance of the evidence that Respondent's conduct with regard to the fluid management of Patient A constituted a deviation from generally accepted standards of practice.

The Department also alleged that Respondent inappropriately administered D5 1/2 normal saline to Patient C. Patient C was a 69 year-old male admitted to the hospital for a transurethral resection of the prostate ("TURP") and anal fissurectomy. Dr. Fantauzzi testified that patients undergoing TURPs receive a hypotonic irrigation solution through the bladder during the procedure. Absorption of this solution through the veins in the bladder can cause hyponatremia, a decrease in serum sodium levels. This would be a potentially serious complication. The risk of developing hyponatremia would be compounded by the administration of D5 1/2 normal saline.

However, there is a conflict within the medical records regarding the type and amount of intravenous fluids administered to Patient C. The anesthesia record indicates that Patient C

received 1000cc of Ringer's lactate, after which a 1000cc bag of D5 1/2 normal saline was hung. The recovery room record indicates that no Ringer's lactate was given, but that 1000cc of D5 1/2 normal saline was given in the operating room, followed by the hanging of a second bag of D5 1/2 normal saline, of which 300cc had been absorbed when the patient came to the recovery room. The IV admixture sheet for Patient C indicates that 2000cc of D5 1/2 normal saline were administered to the patient.

Due to the confusion in the medical record, the Hearing Committee was unable to determine the type and amount of fluid actually administered to Patient C. As a result, the Hearing Committee concluded that the Department failed to prove by a preponderance of the evidence that Respondent's fluid management for Patient C constituted negligence.

The Department also alleged that Respondent inappropriately administered D5 1/2 normal saline to Patient D. Patient D was an 81 year-old male admitted with a history of severe vascular disease, chronic obstructive pulmonary disease and cirrhosis. Patient D underwent a left femoral-popliteal bypass.

Respondent's pre-anesthesia evaluation stated that the patient's electrolytes were within normal limits. However, three pre-operative blood studies, collected on 10/28/88, 10/29/88 and the morning of surgery on 10/31/88, respectively, document the fact that Patient D had low sodium levels. Dr. Fantauzzi testified that Respondent deviated from accepted standards of practice by administering D5 1/2 normal saline, a hypotonic

solution, to this patient. He further testified that Respondent should have administered a balanced salt solution such as Ringer's lactate.

The Hearing Committee accepted Dr. Fantauzzi's opinion in this regard, and concluded, by a preponderance of the evidence, that Respondent's conduct constituted negligence.

The Department alleged that Respondent administered an excessively high dose of tetracaine with epinephrine to Patient C (Paragraph C.1). The record indicates that Respondent administered 16mg of tetracaine with epinephrine to the patient, a 69 year-old male who was 5' 8 1/2" tall. There is no standard dose of tetracaine for all patients. The range of appropriate doses varies, depending on the site of the surgery and the height of the patient. Dr. Fantauzzi testified that a dose of 16mg of tetracaine was not in accordance with generally accepted standards of practice, as administered to Patient C.

However, Dr. Goldiner testified that a range of dosage of 14mg-16mg of tetracaine would be appropriate for Patient C, given the surgical procedure to be performed. The Hearing Committee concluded that reasonably prudent anesthesiologists may differ as to the appropriate dosage to use. They therefore concluded that the Department failed to prove, by a preponderance of the evidence, that Respondent's use of 16mg tetracaine with epinephrine constituted negligence.

The Department also alleged that Respondent inadequately documented the circumstances of a cardiac arrest during the

surgery performed on Patient F. However, the record demonstrated that the patient did not suffer a cardiac arrest. Patient F did suffer a brief respiratory arrest, which was successfully resolved. As a result, the Hearing Committee did not sustain this allegation.

Based upon the above, the Hearing Committee concluded that Respondent's conduct did constitute acts of negligence on more than one occasion. Therefore, the Committee sustained the Fifth Specification.

Gross Incompetence; Incompetence On More Than One Occasion

The record established during this hearing, especially the testimony of the Respondent, clearly demonstrated that she does not lack either the skill or knowledge necessary to practice the profession of medicine. Respondent's deficiencies arose from a failure to exercise the care that a reasonably prudent physician would have exercised under the circumstances presented in the various cases. As a result, the Committee did not sustain the Third and Fourth Specifications (Gross Incompetence) or the Sixth Specification (Incompetence On More Than One Occasion).

Abandonment or Neglect

The Hearing Committee, as was set forth more specifically in the discussion of the First Specification, above, concluded that Respondent was negligent in not ensuring that Patient A's vital signs were stable prior to turning the care of the patient over to Dr. Kleinman. However, the Committee also concluded that Respondent had made reasonable provisions for the follow-up care

of the patient with Dr. Kleinman. Further, the record established that Dr. Kleinman agreed to assume responsibility for the patient. Therefore, the Hearing Committee did not sustain the Seventh Specification.

Failing To Maintain Records

The record of this hearing clearly established that Respondent failed to meet generally accepted standards of practice in her documentation of her anesthetic management of the cited patients. (Patients A, B, and D through F). Respondent failed to record key aspects of the patients' anesthetic course, such as the level of spinal anesthetic achieved, the estimated blood loss, urine output, and complications related to intubation. Further, Respondent failed to adequately document the circumstances surrounding Patient E's cardiac arrest. The Hearing Committee therefore concluded that Respondent failed to maintain a record for each cited patient which accurately reflects the evaluation and treatment of the patient. As a result, the Hearing Committee sustained the Eighth Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to its Findings of Fact and Conclusions of Law herein, unanimously voted to not impose any penalty on Respondent at this time. This recommendation was reached after due consideration of the full spectrum of available penalties, including suspension, probation, censure and reprimand, or the imposition of monetary penalties.

During the course of its deliberations on this matter, it

became apparent to the members of the Hearing Committee that the deficiencies found in Respondent's medical practice primarily resulted from carelessness, and a willingness to cut corners. Respondent's testimony clearly revealed a thorough knowledge of appropriate anesthesia practices. Under such circumstances, the Hearing Committee would generally impose a period of remediation and re-training, in order to give the Respondent an opportunity to re-qualify herself for the practice of anesthesiology. However, the record established that Respondent has already successfully undertaken such a period of remediation.

Paul M. Goldiner, M.D., professor of medicine and chairman of the department of anesthesiology at the Albert Einstein College of Medicine and Montefiore Medical Center, testified as a witness on behalf of Respondent. He indicated that following her suspension from the medical staff at Peekskill Community Hospital, Respondent approached him and requested that she be permitted to come to Montefiore for a period of evaluation and remediation. (T. 1218-1219). Dr. Goldiner further stated that Respondent then came to Montefiore for a four-week evaluation . He testified that he personally participated in the evaluation of Respondent's practice. He stated that following his evaluation of Respondent's practice, he concluded that she had the technical skills, medical background and the knowledge to practice good, safe, quality anesthesia. (T. 1219-1220). At the end of the evaluation period, Dr. Goldiner and his senior staff further concluded that Respondent did not require a further period of remediation. (T.

1220). Dr. Goldiner subsequently retained Respondent as an assistant attending anesthesiologist. (T. 1221). Respondent remained on the staff of Montefiore through the course of these proceedings. Dr. Goldiner stated to the members of the Hearing Committee that he would recommend Respondent as an anesthesiologist "without reservation". (T. 1230).

The Hearing Committee recognized Dr. Goldiner as a highly regarded member of the profession and placed great weight upon his recommendations regarding Respondent. It was the unanimous consensus of the Hearing Committee that Respondent has already obtained the remediation needed and that no further penalty is warranted.

ORDER

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

1. The Fifth and Eighth Specifications of professional misconduct contained within the amended Statement of Charges (Pet. Ex. # 1-A) are **SUSTAINED**;

2. The First, Second, Third, Fourth, Sixth and Specifications of professional misconduct contained within the amended Statement of Charges are **NOT SUSTAINED**, and

3. No penalty is imposed upon Respondent for the violations set forth herein.

DATED: Albany, New York
[illegible], 1992

Therese G. Lynch M.D.
THERESE G. LYNCH, M.D. (Chair)

GEORGE C. SIMMONS, Ed.D.
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STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

---X

IN THE MATTER	:	STATEMENT
OF	:	OF
SUSAN BOGDAN, M.D.	:	CHARGES

---X

SUSAN BOGDAN, M.D., the Respondent, was authorized to practice medicine in New York State on August 13, 1982, by the issuance of license number 151235 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from Wood Street, Katonah, New York 10536.

FACTUAL ALLEGATIONS

A. Patient A (patients are identified in Appendix A), an 83-year old female, was admitted to Peekskill Community Hospital, 1980 Crompond Road, Peekskill, New York 10566, (hereinafter "Hospital") on or about March 6, 1989 with a fractured hip. On or about March 7, 1989, Patient A underwent open reduction and internal fixation of the right hip, for which Respondent was the anesthesiologist.

1. Respondent provided inadequate fluid management for Patient A during the surgery of March 7, 1989.

2. Respondent failed to record significant aspects of the anesthesia procedure, including estimated blood loss and/or the level of spinal anesthesia.

3. Patient A was transferred from the Operating Room following surgery directly to a nursing unit, i.e., the floor. Following the transfer, Respondent left the patient without checking the patient's vital signs and without ensuring that Patient A was stable.

B. Patient B, a 2 1/2-year old female, was admitted to the Hospital on or about March 29, 1989 for a bilateral myringotomy with tube insertion and adenoidectomy, which were performed on that day. Respondent provided anesthesia for this procedure.

1. Respondent administered an inadequate dose of Halothane to Patient B prior to attempting intubation.

2. Respondent attempted to intubate Patient B without concentrated succinylcholine readily available.

3. Respondent failed to record significant aspects of the anesthesia procedure, including the difficulty with intubation, the episodes of laryngospasm, estimated blood loss, method of injection of drugs, accurate oxygen saturation levels, and/or the doses of drugs administered.

C. Patient C, a 69-year old male, was admitted to the Hospital on November 5, 1987 for transurethral resection of the prostate (TURP) and anal fissurectomy, which were performed on November 6, 1987. Respondent provided spinal anesthesia for this procedure.

1. Respondent administered an excessively high dose of Tetracaine with Epinephrine in light of Patient C's age, height, and/or physical condition.

2. Respondent administered an inappropriate replacement fluid (D5 1/2NS i.e. 5% Dextrose in 1/2 Normal Saline) to Patient C.

D. Patient D, an 81-year old male, was admitted to the Hospital on or about October 15, 1988 with severe vascular disease, chronic obstructive pulmonary disease and cirrhosis. Patient D underwent a left femoral-popliteal bypass on or about October 31, 1988, for which Respondent provided spinal anesthesia. During surgery, Patient D became unresponsive, apneic and had to have cardiopulmonary resuscitation.

1. Respondent administered an inappropriate replacement fluid (D5 1/2NS) to Patient D.

2. Respondent failed to record significant aspects of the anesthesia procedure, including urine output, level of spinal anesthesia, estimated blood loss, and/or the surgical procedure performed.

E. Patient E, a 58-year old male, was admitted to the Hospital on or about May 28, 1986. Patient E underwent debridement and split thickness skin graft of the right foot on or about June 26, 1986, for which Respondent provided spinal anesthesia. During the procedure, Patient E suffered cardiac arrest, and was resuscitated.

1. Respondent failed to record significant aspects of the anesthesia procedure, including urine output, level of spinal anesthesia, estimated blood loss, the intubation of the patient, and/or the method of intubation of the patient.

2. Respondent inadequately documented the circumstances of Patient E's cardiac arrest.

F. Patient F, a 73 year old female, was admitted to the Hospital on or about October 14, 1986 with a fracture of the left patella. Patient F was taken to surgery for an open reduction, internal fixation of the left patella on October 15, 1986, for which Respondent provided anesthesia. During the procedure, Patient F suffered cardiac and respiratory arrest, and was resuscitated.

1. Respondent failed to record significant aspects of the anesthesia procedure, including the level of spinal anesthesia, estimated blood loss, surgical procedure performed, and/or the amount of fluid given to Patient F.

2. Respondent inadequately documented the circumstances of the cardiac arrest.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law Sec. 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

1. The facts in Paragraphs A and A.3.
2. The facts in Paragraphs B and B.1 and/or B and B.2.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law Sec. 6530(6) (McKinney Supp. 1992), in that Petitioner charges:

3. The facts in Paragraphs A and A.3.
4. The facts in Paragraphs B and B.1 and/or B and B.2.

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law Sec. 6530(3) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed two or more of the following:

5. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1 and/or F and F.2.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law Sec. 6530(5) (McKinney Supp. 1992), in that Petitioner charges that Respondent committed two or more of the following:

6. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1 and/or F and F.2.

SEVENTH SPECIFICATION

ABANDONMENT OR NEGLECT

Respondent is charged with professional misconduct under N.Y. Educ. Law Sec. 6530(30) (McKinney Supp. 1992), by abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, in that Petitioner charges:

7. The facts in paragraphs A and A.3.

EIGHTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Sec. 6530(32) (McKinney Supp. 1992), by failing to maintain a record for each Patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

8. The facts in paragraphs A and A.2, B and B.3, D and D.2, E and E.1, E and E.2, F and F.1 and/or F and F.2.

DATED: Albany, New York
March 31, 1992

Peter D Van Buren

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