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

June 19, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
Corning Tower Room 2503
Empire State Plaza
Albany, New York 12237

Zdarsky Sawicki & Agostinelli
K. Michael Sawicki, Esq., of Counsel
404 Cathedral Place
298 Main Street
Buffalo, New York 14202

Dugald T. Lewis, M.D.
100 Memorial Drive
Gowanda New York 14070

Dugald T. Lewis, M.D.
191 North Street, Suite 207
Buffalo, New York 14201

RE: In the Matter of Dugald T. Lewis, M.D.

Dear Mr. Roe, Mr. Sawicki and Dr. Lewis:

Enclosed please find the Determination and Order (No. 97-153) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

DUGALD T. LEWIS, M.D.

DETERMINATION
AND
ORDER
BPMC 97 - 153

GEORGE C. SIMMONS, Ed.D., (Chair), **JOHN H. MORTON, M.D.**, and **JOHN P. FRAZER, M.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, served as the Administrative Officer.

The Department of Health appeared by **KEVIN C. ROE, ESQ.**, Assistant Counsel.

Respondent, **DUGALD T. LEWIS, M.D.**, appeared personally and represented himself at times, and was represented at other times by **ZDARSKY, SAWICKI & AGOSTINELLI, K. MICHAEL SAWICKI, 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.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	January 22, 1997
Date of Service of Notice of Hearing and Statement of Charges:	January 27, 1997
Answer to Statement of Charges:	January 28, 1997
Pre-Hearing Conference Held:	February 7, 1997
Hearings Held: - (First Hearing day):	March 12, 1997 March 26, 1997 April 9, 1997 April 23, 1997
Intra-Hearing Conferences Held:	March 12, 1997 March 26, 1997 April 9, 1997 April 23, 1997 April 23, 1997
Petitioner's Post-Hearing Brief: Received	May 20, 1997
Respondent's Proposed Findings and Conclusions and Closing Argument:	Received May 19, 1997
Witnesses called by the Petitioner, Department of Health:	Duane M. Cady, M.D.
Witnesses called by the Respondent, Dugald T. Lewis, M.D.:	Dugald T. Lewis, M.D. Darlene Schwertfager Patricia Gail Mooney Gretchen Van Alstyne, M.D. Rosemary Harris Ian Laurence Cohen, M.D. Edward Lawrence Bradley, III, M.D. Kristy Kohler, R.N. Richard A. Gowan David Edward Fay, M.D.
Deliberations Held:	June 2, 1997

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**") pursuant to §230 of the P.H.L. DUGALD T. LEWIS, M.D., ("**Respondent**") is charged with eight (8) specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with: (1) professional misconduct by reason of practicing the profession with gross negligence[1]; (2) professional misconduct by reason of practicing the profession with gross incompetence[2]; (3) professional misconduct by reason of practicing the profession with negligence on more than one occasion[3]; and (4) professional misconduct by reason of practicing the profession with incompetence on more than one occasion[4].

The charges concern the medical care, treatment and services provided by Respondent to three (3) patients (A, B & C)[5].

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

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[1] Education Law §6530(4) and First through Third Specifications of Petitioner's Exhibit # 1.

[2] Education Law §6530(6) and Fourth through Sixth Specifications of Petitioner's Exhibit # 1.

[3] Education Law §6530(3) and Seventh Specification of Petitioner's Exhibit # 1.

[4] Education Law §6530(5) and Eighth Specification of Petitioner's Exhibit #1.

[5] Patients are identified in an Appendix to the Statement of Charges, Petitioner's Exhibit # 1.

Respondent admits to being licensed to practice medicine in New York and admits that he treated all the patients at his office and/or at Tri-County Memorial Hospital ("**Tri-County**") and/or at Buffalo General Hospital ("**BGH**"), in Buffalo, New York. Respondent emphatically denies any gross negligence, gross incompetence, negligence or incompetence and asserts that his actions were in all respects consistent with applicable accepted standards of medical care.

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. 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.

1. Respondent was licensed to practice medicine in New York State on September 25, 1985 by the issuance of license number 164025 by the New York State Education Department (Petitioner's Exhibit # 1, Respondent's Exhibits # A[6] & N)[7]; (Admitted).

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[6] This exhibit is Respondent's written answer to the Charges and the allegations. Pursuant to P.H.L. § 230(10), allegations not answered are deemed admitted.

[7] Refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or submitted by Dr. Dugald T. Lewis (Respondent's Exhibit).

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]); (Petitioner's Exhibit # 1, Respondent's Exhibit # A); [P.H.T-6-7][8].

3. Dr. Duane M. Cady is an associate clinical professor of surgery at the State University of New York ("**SUNY**") Health Science Center in Syracuse, NY. Dr. Cady graduated from the Loma Linda School of Medicine in 1959. He is licensed to practice medicine in the States of New York, South Carolina and California. Dr. Cady's specialty is general surgery. He was board certified in 1967 and has been involved in educational contributions, research activities, presentations at professional meetings and publications of professional articles (Petitioner's Exhibit # 9); [T-25-28]. He testified as an expert witness for Petitioner [T-23-283].

4. Dr. Gretchen Van Alstyne is a board certified radiologist currently on staff at BGH. She testified as an expert witness for Respondent regarding the care and treatment provided to Patient A [T-391-409].

5. Dr. Ian Laurence Cohen is a physician, co-director of the surgical intensive care unit ("**ICU**") and director of the intermediate care unit at BGH. He testified as a fact witness for Respondent regarding the care and treatment provided to Patient C. He also testified regarding Respondent's character [T-658-669].

6. Dr. Edward Lawrence Bradley, III is licensed to practice medicine in the States of New York, Georgia and Florida. He obtained his medical degree in 1962 from Temple University Medical School. He was board certified in general surgery in 1970. Dr. Bradley's

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[8] 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 was advised of the relevant legal decisions or rulings made by the ALJ.

most recent position is at SUNY at Buffalo as vice-chairman of the department of surgery and professor of surgery and chief of surgery at BGH. Dr. Bradley has had numerous academic and hospital appointments. He has received a number of honors and awards and belongs to over twenty professional societies. He has had articles published in scientific peer review journals and served as a reviewer for peer-review scientific journals. Dr. Bradley has also written chapters and textbooks on the subject of surgery and pancreatitis. He has been involved in the preparation of abstracts and panel discussions on various types of surgeries. He has made national and international presentations and lectures and has been involved in numerous educational contributions, research activities, presentations at professional meetings and publications of professional articles and books (Respondent's Exhibit # CC). He testified as an expert witness for Respondent regarding all three patients [T-670-716].

7. Dr. Dugald Thomas Lewis, is licensed to practice medicine in the State of New York. Dr. Lewis went to medical school at Universidad de Montemorelos in Nuevo Leon, Mexico from 1979 through 1983. Dr. Lewis did his residency and general surgery training, from 1983 to 1989, through the SUNY teaching hospitals. Thereafter, he began a private practice in general surgery and vascular surgery in the Buffalo area. He was board certified in general surgery in 1991. Dr. Lewis is on active staff at BGH and on courtesy staff at four area hospitals. He has a number of academic appointments, administrative appointments and memberships in professional organizations. He has been involved in clinical research and received a number of honors and awards. He has been involved in continual medical education from 1991 to the present (Respondent's Exhibit # N). Dr. Lewis testified on his own behalf as to the operations performed, treatment and care of Patients A, B & C [T-323-385, 410-548, 574-657].

8. Kristy Kohler, a registered nurse since 1988, is employed by Tri-County and testified as a fact witness for Respondent about Patient B [T-719-730].

9. Dr. David Edward Fay graduated from SUNY Center for Health Sciences medical school (formerly known as Upstate Medical Center) in 1982. Dr. Fay has professional certification in the subspecialty of Gastroenterology (1989). Dr. Fay has a number of academic appointments, hospital affiliations and other faculty service activities. He has been involved in research and development activities, publication of peer review articles, contributions to books and lectured on various gastroenterological topics. Dr. Fay testified as an expert witness for Respondent regarding the care and treatment provided to Patient A [T-735-751].

PATIENT A

10. Patient A was a 62 year old female with a history of unstable angina, hypertension, depression and disability from back disease (Petitioner's Exhibit # 2).

11. On August 11, 1995 Patient A was seen by Respondent at his office. Current complaint, history and physical examination were obtained. Respondent did not obtain and examine the films or typewritten reports of an abdominal ultrasound done August 8, 1995, or an oral cholecystogram done August 10, 1995 (Petitioner's Exhibit # 3); [T-457-458].

12. Respondent did not consult with the radiologist who performed the August 8, 1995 abdominal ultrasound or the attending physician from Olean General Hospital ("**Olean**") (Petitioner's Exhibit # 3); [T-458].

13. On August 11, 1995, Patient A was seen at Tri-County for routine preoperative testing. When the laboratory attempted to type the patient's blood, abnormal antibodies[9] were encountered. Respondent was asked whether he wanted further testing to complete the typing and screening and insure blood availability at the operation. Respondent replied in the negative (Petitioner's Exhibit # 4 @ P. 13);[T-42, 726-727].

14. Patient A was morbidly obese at 5'2" tall and 203 pounds (247 pounds in the anesthesia preoperative notes). Her prior medical history included two previous intra-abdominal operations (Petitioner's Exhibits # 3, 4, 5 & 6); [T-43-44].

15. Respondent should have anticipated, or at least prepared for, the potential complications of the operation, which including bleeding [T-44-45].

16. Prior to the operation, further testing should have been ordered to insure immediate availability of blood products [T-41-44, 96, 108-109, 114, 476-478, 680, 726-727].

17. On the afternoon of August 14, 1995, Patient A was admitted to Tri-County for a planned, elective, laparoscopic cholecystectomy (Petitioner's Exhibit # 4); [T-33-34].

18. The operation began at 5:40 P.M. During the laparoscopic procedure, multiple adhesions were noted. While dissecting these adhesions, there was an injury to the small intestine and the operation was converted to an open procedure. After conversion, the small intestine was repaired and the gallbladder was removed (Petitioner's Exhibit # 4 @ P. 40-42).

19. Blood loss during the operation was estimated at 700 cc's. Because of the blood loss, a Jackson-Pratt drain was placed. The operation was completed at 8:20 P.M. and Patient A was transferred to the recovery room at 8:30 P.M. (Petitioner's Exhibit # 4 @ P. 40-42).

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[9] The presence of antibodies in the serum of the body would mean that it "would be difficult to cross match a unit of blood in case it's needed for a transfusion. It will delay the time that it takes to get the blood cross-matched." [T-42].

20. In the recovery room, Patient A's vital signs were initially stable. Initial post-operative CBC (complete blood count) showed a hemoglobin of 9 and hematocrit of 29, a substantial decrease from the preoperative values, indicating blood loss. 275 cc's of sanguinous fluid was noted from the Jackson-Pratt drain during the first hour (Petitioner's Exhibit # 4 @ P. 46-47, 102); [T-91].

21. At 9:05 P.M., Patient A's blood pressure was 106/71 and her pulse was 101. At 9:27 P.M., her blood pressure was 88/66 and pulse was 105. At 10:00 P.M., her blood pressure was 78/42. At 10:15 P.M., Patient A's systolic blood pressure continued in the 70's. At 10:25 P.M., Respondent ordered typing and cross matching of two units of packed red blood cells to be transfused as soon as available. At 10:30 P.M., blood was drawn and emergency preparations for transport of the blood to the Red Cross were begun (Petitioner's Exhibit # 4 @ P. 62, 102).

22. During the operation, Respondent was aware that there was a problem with the antibodies and that blood products were not available. When bleeding was encountered during the operation, necessitating placement of a Jackson-Pratt drain, typing and cross matching of blood should have been ordered and transfusion arranged depending on blood pressure, hematocrit and hemoglobin. Absent an intraoperative order, cross matching of blood should have been ordered in the immediate post-operative period [T-51-52, 96, 101-105, 109].

23. At 10:50 P.M. a second post operative CBC was ordered and showed hematocrit of 21 and hemoglobin of 6, indicating continued bleeding. The Jackson-Pratt drain had stopped draining and was attached to wall suction to check for clotting (Petitioner's Exhibit # 4 @ P. 16, 102).

24. At 12:15 A.M. on August 15, 1995, transfusion of two units of type specific blood (later determined to be compatible) was begun. Plasma expanders, vasopressors, and increased fluids, previously ordered, continued (Petitioner's Exhibit # 4 @ P. 63, 102).

25. Respondent was at Patient A's bed side at 12:45 A.M. A second unit of blood was started at 1:10 A.M. Patient A was transferred to the ICU at 1:30 A.M. Patient A remained hypotensive with blood pressure noted at 1:30 A.M. to be 80/50. A third unit of blood was started at 2:45 A.M. Her blood pressure was 50/24. At 3:00 A.M., bright red blood was noted to be draining from her dressing. Blood pressure was unobtainable. At 3:30 A.M., Patient A had a cardiac arrest and having no blood pressure, was placed on a ventilator. At 4:20 A.M., her pupils were dilated and nonreactive. Blood gases at 4:30 A.M. showed marked acidosis and 4 amps of sodium bicarbonate were administered. A fourth unit of blood was started at 5:00 A.M. She continued to drain blood through her wound. Her abdomen was distended. She had edema of her face. Her nose was draining blood. There was no urine output and her legs were edematous. She continued on fresh frozen plasma and her abdominal dressings were changed every five to ten minutes because of continued bleeding. At 6:00 A.M., the fourth unit of blood was completed. Between 8:00 A.M. and 11:00 A.M., she remained hypotensive. At 11:00 A.M., she developed a straight line electrocardiogram. Patient A was pronounced dead at 11:15 A.M., fifteen hours after the operation (Petitioner's Exhibit # 4 @ P. 62-66, 97-98, 104-107).

26. Patient A was in shock beginning at 9:30 P.M., one hour after the operation. Blood was not available and was not given until 12:15 A.M. During this period of time, Patient A should have been returned to the operating room for a reexploration in an attempt to control the bleeding [T-50-53, 95, 101-105, 109-111, 674].

27. Acceptable standards of medical practice did not require preoperative or intraoperative cholangiography and postoperative cholangiography was an acceptable option for this patient in the event it was found to be necessary following the operation [T-673, 748-750].

PATIENT B

28. Patient B was a 71 year old female with a history of severe mental retardation, seizure disorder, gastroesophageal reflux, Barretts esophagus and hiatal hernia (Petitioner's Exhibit # 6); [T-124].

29. Patient B was admitted to Tri-County on March 14, 1995, for elective repair of a hiatal hernia by a procedure known as a Nissen fundoplication (Petitioner's Exhibit # 6); [T-125].

30. Patient B was 5 feet tall and weighed 78 pounds. She had a previous operation to repair a hiatal hernia (Petitioner's Exhibit # 6).

31. Given Patient B's prior history, substantial bleeding during this operation or procedure should have been expected or anticipated (Petitioner's Exhibit # 6); [T-127-128].

32. Preoperative orders for this patient included typing and screening of blood. Given the patient's age, relative fragility and previous history, cross matching of at least one unit of blood should have been ordered preoperatively to be available in the operating room [T-126-128, 147, 152-154, 175].

33. On March 14, 1995, Patient B was taken to the operating room at 10:30 A.M. and the operation began at 11:00 A.M. A midline incision was made. Moderate to severe adhesions were found around the gastroesophageal junction which caused bleeding. During mobilization of the stomach, one of the short gastric vessels, close to the hilum of the spleen, began to bleed. Surgicel (an absorbable hemostatic agent) and pressure hemostasis were not successful in controlling the bleeding. Respondent did further dissection around the gastroesophageal junction. The gastric fundus was quite friable and in the process of dissecting, a tear in the stomach occurred which causing bleeding in that area. A Penrose drain was placed around the esophagus. The spleen continued to bleed. Significant blood loss in excess of 700 cc's was noted and removal of the spleen was undertaken. During the splenectomy, Patient B became hypotensive

and fluid resuscitation was started. Two units of packed red blood cells were ordered and transfused. After the spleen was removed, small bleeders from the attachment of the short gastric vessels around the esophagus continued. Pressure hemostasis was applied. At 12:50 P.M., Patient B had cardiac arrest and cardiopulmonary resuscitation was administered (Petitioner's Exhibit # 6 @ P. 36, 41-42, 45); [T- 125-126].

34. Bleeding from the spleen should have been controlled rather than packed and the use of Surgicel. Before proceeding with the operation, the blood vessel in question should have been suture ligated and if not successful, then a splenectomy performed [T-128-129, 133-134, 175, 179-180, 183].

35. After the first cardiac arrest at 12:50 P.M., Patient B remained unstable. Continued bleeding in the splenic bed and the greater curvature of the gastroesophageal junction were noted and control was attempted with sutures and electrocautery. During this attempt, a second cardiac arrest occurred at 2:00 P.M. Patient B developed a coagulopathy. The left upper quadrant was packed and the bleeding slowed. Two Jackson-Pratt drains were placed and the patient was closed (Petitioner's Exhibit # 6 @ P. 41-42); [T-126].

36. The estimated blood loss during the operation was 5,200 cc's. The Jackson-Pratt drained 500 cc's. Patient B received 12,000 cc's of Ringer's lactate, 7 units of packed cells, 2 units of fresh frozen plasma, one unit of platelets and 1,000 cc's of Hespan. Patient B was taken to the recovery room and then to the ICU where she died one hour after the operation (Petitioner's Exhibit # 6 @ P. 36, 45-46, 50, 70); [T-126-127].

37. Because of the amount of the blood loss, the Patient went into hypotensive shock, which led to disseminated intravascular coagulation ("**DIC**") [T-170, 502, 686].

38. The spleen receives its blood supply from several sources, including the main splenic vessel and short gastric vessels. The short gastric vessels which connect the stomach to the spleen are the blood supply to the superior portion of the spleen (Gray's Anatomy, 1977 edition @ P. 949-954).

39. When significant blood loss was encountered during the course of the operation, blood was ordered, but there ensued a delay in its delivery, requiring that the operating room nurse go to the blood bank to obtain it (Petitioner's Exhibit # 6 @ P. 49); [T-500-501, 720-721].

PATIENT C

40. Patient C, a 76 year old female, was admitted to Tri-County on May 1, 1994 with complaints of black tarry stools, light headedness and anemia. Her past medical history was significant for chronic obstructive pulmonary disease ("**C.O.P.D.**"), total abdominal hysterectomy, ruptured appendicitis, sigmoid colon resection for perforated diverticulitis with initial Hartman procedure and subsequent colonostomy closure done ten years previously. Her history also included idiopathic tonic colonic epilepsy and chronic anxiety syndrome. Her hemoglobin had dropped five grams from a previous hemoglobin done as an out patient several months prior to admission (Petitioner's Exhibit # 7 @ P. 4); [T-194-195].

41. Patient C was evaluated by her medical doctor and a surgical consultation was obtained from Respondent. An upper G.I. endoscopy found "kissing ulcers" of the anterior and posterior duodenum which were bleeding. The patient was started on H2 blockers and ulcer treatment. Her hematocrits were followed for several days, and she received two units of packed red blood cells. A colonoscopy on Patient C found a sigmoid stricture at about 20 centimeters. Surgical therapy was considered and the patient was transferred to the BGH on May 13, 1994 (Petitioner's Exhibit # 7 @ P. 4); [T-195-196].

42. On May 16, 1994, Respondent performed a sigmoid resection with end-to-end anastomosis. During the dissection, four enterotomies in the small bowel were made and repaired primarily (Petitioner's Exhibit # 8 @ P. 28); [T-195-196].

43. Post operatively, Patient C was transferred to the ICU for four days where she was stabilized and then transferred to the regular floor. She was started on a clear liquid diet and progressed to a soft diet (Petitioner's Exhibit # 8).

44. On the seventh post operative day (May 23, 1994) at 2:30 A.M., Patient C was found wedged in the door frame of the bathroom on one knee without injury noted (Petitioner's Exhibit # 8 @ P. 295); [T-202].

45. On the eighth post operative day (May 24, 1994) at 6:00 A.M., Patient C complained of vomiting that morning and the night before, mild abdominal tenderness, with no bowel movement the day before or that morning. Vital signs were stable. On examination, the abdomen was found to be soft, non-tender, mildly distended, with positive bowel sounds. Abdominal x-rays were ordered and showed an ileus. A CBC showed a normal white count but a marked shift to the left with about 50% band forms (Petitioner's Exhibit # 8 @ P. 297); [T-196-197].

46. On May 24, 1994, the 11:00 P.M. to 7:00 A.M. nurse noted a potential surgical complication with complaints of nausea and vomiting, and a tender and distended abdomen. Patient C received Reglan for vomiting, and Darvocette for pain (Petitioner's Exhibit # 8 @ P. 297).

47. At 8:00 A.M. on May 24, 1994, Patient C's vital signs were temperature 99.2, pulse 120, respiration 28 and blood pressure 172/100 (Petitioner's Exhibit # 8 @ P. 221).

48. At 4:00 P.M. on May 24, 1994, Patient C's vital signs were temperature 101.8, pulse 120, respiration 22 and blood pressure 110/72. The 3:00 P.M. to 11:00 P.M. shift nurse noted a temperature of 101.9, positive bowel signs, no flatus, no bowel movement, abdomen still distended and tender to touch. Dr. Cardamone (BGH intern) ordered blood, sputum and urine cultures and a CBC at 4:30 P.M. (Petitioner's Exhibit # 8 @ P. 77, 221, 298); [T-211].

49. Between 8:00 P.M. and 8:30 P.M. on May 24, 1994, Patient C was seen by Respondent. A nasogastric tube was ordered by Respondent and inserted by a resident at 8:30 P.M. At 8:15 P.M., Respondent ordered 50 mg's of Demerol for pain. Some time later, Respondent ordered that a repeat abdominal flat plate be done in the morning, to followup patient for small bowel obstruction and Demerol 50 mg every three hours as needed for pain (Petitioner's Exhibit # 8 @ P. 77-78, 177, 298); [T-197, 222-223].

50. On the evening of the eighth post operative day (May 24, 1994), Patient C had sufficient signs of a complication from the May 16, 1994 operation to warrant further evaluation or studies such as an abdominal CAT scan. Depending on the results of the abdominal CAT scan, surgical exploration should have been considered. Based on this patient's past medical history and her signs and symptoms, which included, elevated temperature, white blood count shift to the left, vomiting, nausea, abdominal distention, abdominal tenderness and pain warranting treatment with Demerol, a more aggressive management and workup should have been performed [T-200-204, 260-261, 274, 279-280].

51. Beginning at approximately 5:30 A.M. on the ninth post operative day (May 25, 1994), Patient C rapidly decompensated to a state of untreatable, irreversible, and profound septic shock. Respondent saw Patient C at 9:30 A.M. on this ninth post operative day. As the attending physician, Respondent should have seen Patient C in a more timely manner (Petitioner's Exhibit # 8 @ P. 299-309); [T-199-202, 274].

52. Patient C died at 2:30 P.M. on the ninth post operative day (Petitioner's Exhibit # 8).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. 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 January 22, 1997, Statement of Charges, are **SUSTAINED:**[10]

Paragraphs A. & A.1.	:	(10 - 17)
Paragraphs A. & A.4.	:	(10 - 26)
Paragraphs B. & B.1.	:	(28 - 32)
Paragraphs B. & B.2.	:	(28 - 38)
Paragraphs C. & C.1.	:	(40 - 51)
Paragraphs C. & C.2.	:	(40 - 51)

The Hearing Committee concludes that the following Factual Allegations, from the January 22, 1997, Statement of Charges, are **NOT SUSTAINED:**

Paragraphs A. & A.2.	:	(10 - 27)
Paragraphs A. & A.3.	:	(10 - 27)

[10] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation contained in the Statement of Charges.

Based on the above, the complete Findings of Fact and the entire record, the Hearing Committee unanimously concludes that the following Specifications of Charges are **SUSTAINED:**[11]

FIRST SPECIFICATION:	(Paragraphs: A., A.1. & A.4)
SECOND SPECIFICATION:	(Paragraphs: B., B.1. & B.2.)
THIRD SPECIFICATION:	(Paragraphs: C., C.1. & C.2.)
SEVENTH SPECIFICATION:	(Paragraphs: A., A.1., A.4., B., B.1., B.2., C., C.1. & C.2.)
EIGHTH SPECIFICATION:	(Paragraphs: B., B.1., B.2., C., C.1. & C.2.)

Based on the above, the complete Findings of Fact and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **NOT SUSTAINED**:

FOURTH SPECIFICATION:	(Paragraphs: A., A.1. & A.4)
FIFTH SPECIFICATION:	(Paragraphs: B., B.1. & B.2.)
SIXTH SPECIFICATION:	(Paragraphs: C., C.1. & C.2.)
EIGHTH SPECIFICATION:	(Paragraphs: A., A.1. & A.4.)

DISCUSSION

Respondent is charged with eight 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 types of misconduct charged in this matter.

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

The Administrative Law Judge ("**ALJ**") advised the Hearing Committee of 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[12]. 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.

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

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).

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[12] A copy of this memorandum, was made available to Respondent at the Pre-Hearing [P.H.T-49-50; T-47].

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]).

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 and reliability.

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. Duane Cady as the State's expert, had no professional association with Respondent. No reason was advanced to show Dr. Cady to have any prejudice against Respondent. By his own testimony, Dr. Cady admitted that he had not personally performed all of the operations presented in this case. Nevertheless, the errors alleged by Petitioner were matters which are common to numerous other types of operations.

Dr. Cady's expertise lies in general surgery and the Hearing Committee found him to be qualified, credible, honest and forthright and accepted a number of his opinions, which were supported by the patients' medical records. Dr. Cady gave impartial testimony, based on a fair reading of the medical records, in what respects 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.

Dr. Edward Bradley, Respondent's main expert, presented a credible review of the information which he was provided. Dr. Bradley has impressive credentials. Dr. Bradley did not appear to have had a stake in the outcome of these proceedings and no motive for falsification or fabrication of his testimony was alleged or shown. The Hearing Committee believes that Dr. Bradley testified truthfully and honestly and called it "the way he saw it.". Unfortunately he never reviewed the actual medical records. Dr Bradley's testimony was based on incomplete summaries and unspecified conversations with Respondent. As such, Dr. Bradley's testimony can be discounted and the Hearing Committee gave his testimony less weight and disregarded matters not supported by the medical records. Dr. Bradley's view of the operations were limited because of his acceptance of Respondent's version of what occurred, and the version is not supported by the medical records.

Obviously, Respondent had the greatest amount of interest in the results of these proceedings. Respondent attempted to blame others for omissions that were his responsibility, while putting a positive spin on his own actions. In a number of instances he spoke in hyperbole. Respondent's response to charges regarding Patient A and his explanation of her death are bizarre. The contention that Patient A committed suicide was contradicted by every medical witness and the Medical Examiner of Erie County. In any event, the patient's death and/or manner of death is irrelevant to a finding of misconduct.

Inconsistencies were present in numerous items between Respondent's testimony and the information contained in the medical records. Taking into consideration the above, Respondent's bias, reaching interpretations and at times, obscure perceptions, the Hearing Committee found Respondent's testimony not as credible as the other witnesses.

The other witnesses (fact and medical) were evaluated by the Hearing Committee and found to be generally credible. However, their testimony was found to be mostly not relevant to the issues involved. The character witnesses were found to be credible and the Hearing Committee considered their testimony when assessing the penalty imposed herein.

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 Misconduct Memo and the legal understanding set forth above, the Hearing Committee unanimously concludes 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 the gross negligence charges of misconduct contained in the January 22, 1997 Statement of Charges.

Respondent's care, treatment and management of Patients A, B and C were a significant and egregious deviation of acceptable standards of medical care required of a surgeon.

The Hearing Committee unanimously finds that Respondent was also negligent in the medical care he provided to Patients A, B and C.

Therefore, Respondent was negligent on more than one occasion and is guilty of professional misconduct under the laws of the State of New York.

Respondent was also incompetent in the medical care he provided to Patients B and C. Therefore, Respondent was incompetent on more than one occasion and is guilty of professional misconduct under the laws of the State of New York.

The Hearing Committee unanimously votes not to sustain any of the charges of misconduct as they relate to gross incompetence against Respondent. The Hearing Committee also unanimously votes not to sustain the charge of misconduct as it relates to incompetence regarding the medical care and treatment provided by Respondent to Patient A.

The rationale for the Hearing Committee's conclusions is set forth below.

PATIENT A

I. Gross Negligence (First Specification)

This operation on Patient A was not an emergency. A prudent surgeon does not undertake to do a non emergent laparoscopic cholecystectomy on a patient who is positive for antibodies without knowing that blood products can be available immediately. Patient A was morbidly obese and her prior medical history included two previous intra-abdominal operations. Respondent should have anticipated, or at least prepared for, the potential complications of the operation, which including bleeding.

Respondent created a significant risk to Patient A's health by failing to have blood available prior to bringing Patient A to the operating room. A reasonably prudent physician would have had the blood, at least typed and cross matched under the circumstances presented by Patient A's condition. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that he failed to have appropriate blood products available for transfusion.

During the operation, bleeding was encountered which required the use of a Jackson-Pratt drain. Respondent should have ordered blood at that point, knowing that the patient had antibodies present. Having failed to order blood during the operation, Respondent had another opportunity to do so immediately at the post-operative period. Respondent failed to do so. The patient did not receive blood products until 12:15 A.M. The patient was in hemorrhagic shock from approximately 9:30 P.M. with no blood being given until 12:15 A.M. Since no blood products were being given, Respondent should have returned the patient to the operating room to try to control the bleeding. Respondent failed to order blood transfusions in a timely manner and/or return Patient A to the operating room for reexploration.

Respondent's actions were extreme deviations from accepted standards of care because of the compounding of his actions. First, he failed to have appropriate blood products available and then when it became obvious (to a prudent surgeon) that transfusion was needed, he failed to order blood and then failed to attempt to control the bleeding when no blood was transfused.

In summary, the Hearing Committee determines that Respondent's care, management and treatment of Patient A were well below minimally accepted standards of practice and were egregious. Respondent was grossly negligent in the care and treatment he provided to Patient A. The charge of practicing the profession with gross negligence, within the meaning of § 6530(4) is sustained.

The Hearing Committee determines that the necessity for an endoscopic retrograde pancreatic cholangiography ("**ERCP**") or a cholangiogram was not proven. Dr Cady indicated that he did them about ten (10%) percent of the time. Dr Bradley indicated that performing these procedures was not always needed and it is better to be selective. Dr Fay was in agreement with Dr. Bradley and indicated that a post-operative ERCP could have been done if the information was needed. In this case it was not needed.

Therefore, the Hearing Committee determines that, the failure to perform or order an ERCP or perform a cholangiogram was not a failure to meet acceptable standards of medical care for Patient A.

II. Gross Incompetence (Fourth Specification)

As to Patient A, with regard to the accusation of gross incompetence, there is no evidence that Respondent has a complete lack of ability or a total and flagrant lack of necessary knowledge or ability to practice medicine.

The Hearing Committee believes that Respondent had the knowledge necessary for the proper care and treatment of this patient. However, Respondent did not act on this knowledge. He did not obtain and examine the films or typewritten reports of the abdominal ultrasound done August 8, 1995, or the oral cholecystogram done August 10, 1995. Respondent did not consult with the radiologist that performed the August 8, 1995 abdominal ultrasound or the attending physician from Olean. Most importantly, he did not insure blood availability for the operation, knowing that Patient A was positive for antibodies. The Hearing Committee believes that these failures are negligence rather than incompetence.

Respondent was not grossly incompetent in his care and treatment of Patient A. The charge of practicing the profession with gross incompetence, within the meaning of § 6530(6) is not sustained.

III. Negligence (Seventh Specification)

Having found that Respondent was grossly negligent in the care and treatment he provided to Patient A, the Hearing Committee concludes that Respondent was negligent for the same reasons stated above.

The Hearing Committee determines that Respondent's care, management and treatment of Patient A was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient A.

IV. Incompetence (Eighth Specification)

The Hearing Committee finds that Respondent did not lack the skill or knowledge necessary to perform the operation on Patient A. As stated above, the Hearing Committee believes that Respondent was negligent rather than incompetent in this case.

Respondent was not incompetent in the care and treatment he provided to Patient A.

The charge of practicing the profession with incompetence, within the meaning of § 6530(5) is not sustained.

PATIENT B

V. Gross Negligence (Second Specification)

Given Patient B's prior history, substantial bleeding during this operation or procedure should have been expected or anticipated. Preoperative orders for this patient included typing and screening of blood. Given the patient's age, relative fragility and previous history, cross matching of at least one unit of blood should have been ordered preoperatively to be available in the operating room. Respondent failed to insure that typing and cross matching of blood was completed prior to the operation. This failure was a deviation from acceptable standards of medical care for Patient B.

The Hearing Committee deems the splenic vessel to be an inclusive term. The spleen receives its blood supply from several sources, including the main splenic vessel and short gastric vessels. The short gastric vessels which connect the stomach to the spleen are the blood supply to the superior portion of the spleen. Therefore, the splenic vessel includes the short gastric vessels, as well as, the main splenic vessels. When Respondent was confronted with significant blood loss, he should have attempted to control the bleeding by suture ligation. Control of the bleeding should have been the primary focus before proceeding (or continuing) with the

operation. Blood was ordered to deal with the significant amount of bleeding. However, due to Respondent's prior negligence of not typing and cross matching of blood for this patient, there was a significant delay in the delivery of the blood products. The combination of both factors was egregious in this instance.

In summary, the Hearing Committee determines that Respondent's care, management and treatment of Patient B was well below minimally accepted standards of practice.

Respondent was grossly negligent in the care and treatment he provided to Patient B. The charge of practicing the profession with gross negligence, within the meaning of §6530(4) is sustained.

VI. Gross Incompetence (Fifth Specification)

As to Patient B, with regard to the accusation of gross incompetence, there was no evidence that Respondent had a complete lack of ability or a total and flagrant lack of necessary knowledge or ability to practice medicine.

The Hearing Committee sees Respondent's treatment of Patient B as negligence and incompetence which does not rise to complete lack of skill. In other words, the operation itself was not deficient in how it was done, only some aspects of it.

The Hearing Committee can not find that Respondent was grossly incompetent in his care and treatment of Patient B. The charge of practicing the profession with gross incompetence, within the meaning of § 6530(6) is not sustained.

VII. Negligence (Seventh Specification)

Having found that Respondent was grossly negligent in the care and treatment he provided to Patient B, the Hearing Committee concludes that Respondent was a fortiori negligent for the same reasons stated above.

The Hearing Committee determines that Respondent's care, management and treatment of Patient B was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient B.

VIII. Incompetence (Eighth Specification)

There is evidence that Respondent's actions showed a lack of knowledge in regards to the proper and most effective manner of controlling the bleeding. Also, the failure to insure that typing and cross matching of blood be done for this patient, considering her history, shows a lack of skill and knowledge, at least in this instance.

This leads the Hearing Committee to conclude that Respondent lacked the knowledge, under these circumstances, that a competent surgeon would have.

Respondent was incompetent in the care and treatment he provided to Patient B.

PATIENT C

IX. Gross Negligence (Third Specification)

Respondent knew that he had some problems with this patient during her operation. A prudent surgeon would take that fact into consideration and be even more attentive and suspicious than otherwise. Respondent had indications of problems on the seventh post-operative day when the patient complained of nausea, vomiting, had mild abdominal tenderness, and no bowel movement the day before or that morning.

Clearly, Patient C developed a surgical complication on the eighth post operative day. Respondent's own progress notes indicated that he would follow her closely. Respondents failed to do so. There were signs that the patient was in trouble but Respondent did not adequately evaluate her. On the evening of May 25, 1994, an abdominal CAT Scan should have been ordered and reexploration considered depending on the results.

Whether Respondent lives five minutes or one hour away is irrelevant to proper care. Respondent, as the attending surgeon, is responsible for the patient. Respondent had some information in the morning of May 25, 1994, which he chose to ignore. Thereafter, he had approximately 18 hours to watch the patient and act. Even Respondent's expert, with the limited information he was given, indicated that he would have been concerned with a leak and that the surgeon needs to be there to make the evaluation and do the examination of the patient.

Respondent's actions were extreme deviations from accepted standards of care because of the compounding of his actions. His failure to return the patient for re-exploration was, in part, due to his failure to adequately evaluate the patient. He knew the error made during the operation, diagnosed the problem correctly but then failed to do what a reasonably prudent surgeon would do under the circumstances. These failures were, unsuccessfully, attempted to be explained by blame on others.

In summary, the Hearing Committee determines that Respondent's care, management and treatment of Patient C was well below minimally accepted standards of practice and was egregious

Respondent was grossly negligent in the care and treatment he provided to Patient C.

The charge of practicing the profession with gross negligence, within the meaning of § 6530(4) is sustained.

X. Gross Incompetence (Sixth Specification)

As to Patient C, with regard to the accusation of gross incompetence, there is no evidence that Respondent has a complete lack of ability or a total and flagrant lack of necessary knowledge or ability to practice surgery.

The Hearing Committee sees Respondent's treatment of Patient C as negligence and incompetence which does not rise to complete lack of skill. In other words, some of the skills were there, some of the knowledge was there but Respondent failed to act on them.

The Hearing Committee can not find that Respondent was grossly incompetent in his care and treatment of Patient C. The charge of practicing the profession with gross incompetence, within the meaning of § 6530(6) is not sustained.

XI. Negligence (Seventh Specification)

Having found that Respondent was grossly negligent in the care and treatment he provided to Patient C, the Hearing Committee concludes that Respondent was negligent for the same reasons stated above.

The Hearing Committee determines that Respondent's care, management and treatment of Patient C was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient C.

XII. Incompetence (Eighth Specification)

There is evidence that Respondent's actions showed a lack of knowledge in regards to the proper evaluation of Patient C post-operatively. The failure to timely evaluate and order necessary test, led to the failure to return this patient to the operating room for re-exploration at a time when it was still possible. Considering this patient's history and signals on the seventh and eighth post-operative days, Respondent showed a lack of skill and knowledge.

This leads the Hearing Committee to conclude that Respondent lacked the knowledge, under these circumstances, that a competent surgeon would have.

Respondent was incompetent in the care and treatment he provided to Patient C.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, unanimously determines that Respondent is guilty of professional misconduct under the definitions of § 6530 of the Education Law and under § 230 of the P.H.L.

The Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

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.

The record establishes that Respondent committed professional misconduct by practicing the profession with gross negligence as to Patients A, B and C; by practicing with negligence on more than one occasion (Patients A, B and C); and practicing with incompetence on more than one occasion (Patients B & C).

Respondent does not accept responsibility and blames others for these three patients' complications. In Patient A, he blames the surgical assistant, the hospital blood bank and the patient herself. Respondent's attempt to prove to the Hearing Committee that Patient A's demise was due to suicide was not relevant to the Charges or the outcome of the finding of misconduct. In Patient B, he blames the surgical assistant and hospital personnel. In Patient C, he blames the hospital's residents. Respondent's inability to recognize surgical complications when they occur presents a danger to the patients he treats.

Respondent's explanations to the Hearing Committee were not credible and defied the medical records. The Hearing Committee believes that Respondent knows better but his actions didn't show it. The Hearing Committee believes that Respondent has the intellect and even the skills to do what is correct. However, Respondent has a disregard for the simple rules and shows an arrogance and hubris not deserved. Respondent's superman "I can do no wrong" attitude is unacceptable. Respondent's care and treatment of the three surgical patients failed to meet acceptable standards of medical care.

The Hearing Committee believes that Respondent lacks surgical principals and ethics rather than the specifics of performing an operation or procedure. For example, it is axiomatic that you first control bleeding in one place (area) before going somewhere else.

Given the above, the Hearing Committee does not believe that censure and reprimand is sufficient to address Respondent's failure to have personal insight, remorse or lack of admission that he did anything wrong. Since there was insufficient evidence regarding other areas of Respondent's practice, the Hearing Committee finds that limiting Respondent's practice is not an available penalty. Similarly, the imposition of monetary penalties is not indicated and Respondent's teaching activities provides sufficient public service.

The Hearing Committee does not believe that re-training or attendance at CME seminars is appropriate because Respondent has no insight into his short comings and lacks the ability to recognize errors in judgment and abilities. The Hearing Committee does not believe that monitoring would be beneficial because surgical procedures performed by Respondent need to be viewed before they occur. Monitoring is more of an after the fact remedy.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines revocation to be the appropriate sanction under the totality of the circumstances presented by these three cases. The Hearing Committee unanimously concludes that the sanction imposed strikes the appropriate balance between the need to punish Respondent, deter future misconduct in others 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.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of these proceedings.

ORDER

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

1. Specifications First through Third, Seventh and Eighth of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**,; and

2. Specifications Fourth through Sixth of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED**,; and

3. Respondent's license to practice medicine in New York State is **REVOKED**

DATED: Albany, New York
June, 14 **1997**

George C. Simmons
GEORGE C. SIMMONS, Ed.D., (Chair),

JOHN H. MORTON, M.D.,
JOHN P. FRAZER, M.D.

To:

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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	: STATEMENT
OF	: OF
DUGALD T. LEWIS, M.D.	: CHARGES

----------X

DUGALD T. LEWIS, M.D., the Respondent, was authorized to practice medicine in New York State on September 25, 1985 by the issuance of license number 164025 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached appendix) in August of 1995 at his office, 100 Memorial Drive, Gowanda, New York 14070, and at the Tri-County Memorial Hospital, Gowanda, New York. On August 14, 1995, Respondent attempted a laporascopic cholecystectomy. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to have appropriate blood products available for transfusion.
2. Respondent failed to perform and/or order an ERCP to evaluate abnormalities of the common duct.
3. Respondent failed to perform a cholangiogram.
4. Respondent failed to order blood transfusions in a timely manner and/or return Patient A to surgery for re-exploration.

B. Respondent treated Patient B at the Tri-County Memorial Hospital for severe gastroesophageal reflux and Barrett's esophagitis with chronic gastritis. On March 14, 1995, Respondent attempted a Nissen fundoplication. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to ensure that typing and cross matching of blood was completed prior to surgery.

2. Respondent failed to adequately control bleeding from the splenic vessel during surgery.

C. Respondent treated Patient C in May 1994 for abdominal complaints at the Tri-County Memorial Hospital and at Buffalo General Hospital, Buffalo, New York. On May 16, 1994, Respondent performed surgery at the Buffalo General Hospital. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to adequately evaluate Patient C post-operatively.

2. Respondent failed to return Patient C to surgery for re-exploration.

SPECIFICATIONS

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Laws §6530(4) (McKinney Supp. 1996) in that, Petitioner charges:

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

FOURTH THROUGH SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6)(McKinney Supp. 1996) in that, Petitioner charges:

4. The facts in Paragraphs A and A.1, A.2, A.3, and/or A.4.
5. The facts in Paragraphs B and B.1 and/or B.2.
6. The facts in Paragraphs C and C.1, and/or C.2.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Educaiton Law §6530(3)

(McKinney Supp. 1996) in that, Petitioner charges two or more of the following:

7. The facts in Paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2 and/or C and C.1, C.2.

EIGHTH 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. 1996) in that, Petitioner charges two or more of the following:

8. The facts in Paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2; and/or C and C.1, C.2.

DATED: January 22, 1997
Albany, New York

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