STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

November 1, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Frederick Zimmer, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Edward Woods, M.D.
4 Poinciana Drive
Durham, North Carolina 27707

RE: In the Matter of Edward Woods, M.D.

Dear Mr. Zimmer and Dr. Woods:

Enclosed please find the Determination and Order (No. 95-257) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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 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 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
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

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

IN THE MATTER

OF

EDWARD WOODS, M.D.

DETERMINATION

AND

ORDER

BPMC-95- 257

The undersigned Hearing Committee consisting of **IRVING S. CAPLAN, Chairperson, THERESE G. LYNCH, M.D.** and **ANDREW J. MERRITT, M.D.** was duly designated and appointed by the State Board for Professional Medical Conduct. **DAVID A. SOLOMON, ESQ.,** Administrative Law Judge, served as Administrative Officer.

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

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

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated March 8, 1994 (sic) served personally on Respondent on:		March 5, 1995
Amended Statement of Charges dated May 31, 1995 admitted on:		June 6, 1995
Amended Factual Allegations and Charges dated June 29, 1995 admitted on:		July 11, 1995
The State Board for Professional Medical Conduct appeared by:		Jerry Jasinski, Esq. Acting General Counsel NYS Dept. of Health
	BY:	Frederick Zimmer, Esq. Assistant Counsel NYS Dept. of Health Corning Tower Albany, New York 12237
Respondent's representation:		Anne McKown, Esq. Durham, NC 27702 Withdrew on or about May 5, 1995
		Catherine A. Gale, Esq. Mackenzi, Smith, Lewis, Michell & Hughes P.O. Box 4967 Syracuse, NY 13221-4967 From on or about May 5, 1995 through May 23, 1995
Thereafter Respondent appeared pro se		
Locations and Dates of Hearing and Conferences:		
Pre-hearing Conference:		June 6, 1995 (10:10 am)
Hearing:		June 6, 1995 (12:30 pm)
Hearing		July 11, 1995 (9:15 am)
Deliberations:		August 12, 1995 (9:00 am)
All hearings and conferences held at:		Best Western Syracuse Airport Inn Hancock Airport Syracuse, New York

Submission of Petitioner's Argument, Proposed Findings, Conclusions and Recommendation	August 4, 1995
The Respondent filed "Responses to Statement of Charges" denying the specifications of charges:	May 18, 1995
The Respondent filed an undated "Factual Responses to Allegations":	July 11, 1995
The Respondent filed a request to dismiss the charges:	August 10, 1995
Record Closed:	August 12, 1995

SUMMARY OF PROCEEDINGS

Several requests for adjournment of the hearing were received on behalf of the Respondent. The first was from the Respondent's North Carolina attorney, primarily for the purpose of retaining local counsel. After denial of the request, a local attorney in Syracuse was retained. An extension of time was granted for the new attorney to review the matter and to reschedule the Prehearing Conference. Prior to the Conference, the Syracuse attorney reported the Respondent was to represent himself; she withdrew. See, AO Ex. 1.

The Respondent was urged to consider professional representation. The Respondent chose to represent himself[1]. He filed a general denial and factual responses to the allegations. The Respondent also agreed to attend the second hearing day to testify before the Hearing Committee.

[1]NOTE: The Respondent made several requests for adjournments and objected to amendments to the charges and to factual allegations conforming the charges to the proof. The Department objected to each. The Administrative Officer denied the requests. See A.O. Exhibits 1, II, III: Attachment I.

The Statement of Charges alleges the Respondent provided deficient emergency medical care to seven (7) patients during 1990 at the House of Good Samaritan (Hospital) in Watertown, New York. It is alleged that adequate physical examinations were not provided to five (5) of the patients and that two (2) were inappropriately discharged. A broad range of deficiencies in emergency medical care were also alleged: failure to detect a fracture in a cervical spine X-ray, failure to obtain or record an adequate medical history, failure to investigate or treat hypertension, failure to make a medically acceptable diagnosis, failure to appropriately prescribe Dimetapp, failure to prescribe nitroglycerine and thrombolytic treatments, failure to interpret diagnostic studies, and a failure to administer rabies immunoglobulin and vaccine. A final allegation was the Respondent's issuance of inappropriate discharge instructions.

The allegations are set forth more particularly in the Statement of Charges attached hereto as Appendix I. Dept. Ex, 1A, Amended Statement of Charges; Dept. Ex. 11, Additional Factual Allegations A.3, B.5 and E.3.

The State called the following witnesses:

Michael S. Jastremski, M.D.	Expert Witness
Judith S. Staffer, Department of Health	Fact Witness

The Respondent called the following witnesses:

Edward L. Woods, M.D., Respondent	Fact Witness
Betty R. Woods, R.N., Occupational Health Nurse	Fact Witness

SIGNIFICANT LEGAL RULINGS

During the course of the hearing, the Hearing Committee had access to and consulted a memorandum dated February 5, 1992, entitled "Definitions of Professional Misconduct under the New York Education Law" prepared by the General Counsel for the Department of Health. The document contains suggested definitions for gross negligence and negligence on more than one occasion.

Negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, or deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that there be established that injury actually resulted from the deviation.

Gross Negligence has been defined by New York's highest court to be "...a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct." Roh v. Ambach, 74 NY2d 318, 322(1989). Egregious means conspicuously bad. Spero v. Board of Regents, 158 AD2d 763, 764 (3rd Dept. 1990).

Incompetence: A licensee who does not possess the requisite skill or knowledge to practice medicine is said to be incompetent. The incompetent physician lacks the ability to discharge the physician's required duty to the physician's patients because of a want of a skill or knowledge. Courts have defined incompetence or unskillfulness as meaning a lack of the learning or skill necessary to perform, day in or day out, the characteristic tasks of a given calling in at least a reasonably effective way.

Gross incompetence is when a practitioner shows a complete lack of ability necessary to perform an act in connection with the practice of the profession. Unlike ordinary incompetence, gross incompetence involves a total and flagrant lack of necessary knowledge or ability to practice.

FINDINGS OF FACT

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

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

1. Edward Woods, M.D., the Respondent, was served with a Notice of Hearing and Statement of Charges on April 5, 1995. (Dept.'s Ex. 1)

2. An Amended Statement of Charges was accepted into evidence at the June 6, 1995 hearing and three (3) additional Factual Allegations were accepted at the July 11, 1995 hearing. (Dept.'s Exs. 1A, 11; Prehearing Conference T. 9-10; T. 265)

3. Respondent was authorized to practice medicine in New York State on March 29, 1990 by the issuance of license number 181890. Respondent is not currently registered to practice medicine in New York State. (Dept.'s Ex. 2)

FINDINGS OF FACT AS TO PATIENT A

4. Patient A, a 24 year old female, presented at the House of Good Samaritan emergency room (hereinafter "the emergency room") at 10:51 p.m. on July 22, 1990 and was provided emergency care by the Respondent. (T. 11-12; Dept.'s Ex. 3, pgs. 2-3)

5. Patient A hit her head diving into a pool. She complained of pain in the posterior neck, shoulders and upper chest. She was in a Philadelphia collar. (Dept.'s Ex. 3, pgs. 2-4; T. 12)

6. The Respondent diagnosed a "possible whiplash injury". (Dept.'s Ex. 3, pg. 3)

7. A patient who has hit her head diving into a shallow three (3) foot pool with resultant neck pain is at risk for spinal injury. In such a situation, accepted standards of medical care require that the emergency physician carefully examine the neck while it is stationary to determine if there is pain on palpation, deformity or other signs of injury. (T. 13)

8. With the main concern for Patient A's mechanism of injury being a possible cervical spine injury, a detailed neurological examination, testing all muscle groups; testing the dermatomes for sensation and testing reflexes, is needed to help assure the absence of a spinal cord injury. (T. 13-14)

9. Respondent's physical examination failed to meet acceptable standards of medical care in that he documented no neck examination and merely indicated that hand grasp was good, extremities are moving and the neuro is intact. Such is an inadequate neurologic examination of Patient A. (T. 13-14)

10. Respondent ordered X-rays of Patient A's cervical and thoracic spine and interpreted these as showing no obvious fractures. (T. 14-15; Dept.'s Ex. 3, pg. 2)

11. Patient A was admitted to the emergency room at 10:51 p.m. on July 22, 1990 and discharged at 12:30 a.m. on July 23, 1990 with instructions that she not work for three (3) days, that she wear a soft cervical collar and return if any problems arose. (T. 11-12, 15; Dept.'s Ex. 3, pgs. 2-3, 7)

12. On July 23, 1990, a radiologist detected a fracture of the fourth cervical vertebrae of the neck. (T. 15-16; Dept.'s Ex. 3, pg. 6; Dept.'s Ex. 3f)

13. Respondent's reading of the cross table lateral X-ray of Patient A's cervical spine failed to meet acceptable standards of medical care in that Respondent missed an obvious fracture. The fracture was of a nature such that it should have been obvious to an emergency room physician. (T. 15-22, 141-141; Dept.'s Ex. 3f)

14. Respondent's discharge of Patient A about one (1) hour and forty minutes after admission to the emergency room failed to meet acceptable standards of medical care. While the fracture of Patient A's cervical spine was stable, Respondent failed to have Patient A evaluated by an appropriate specialist who could have determined upon examination whether a C.T. Scan of the spine was necessary to ensure that no unseen fractures were presenting a threat to her spinal cord. (T. 21, 23) * See Note p. 21.

FINDINGS OF FACT AS TO PATIENT B

15. Patient B, a 67 year old male, presented at the emergency room at 4:18 a.m. on August 6, 1990 where he received emergency care from Respondent. (Dept.'s Ex. 4, pgs. 2-3; T. 23-24)

16. Respondent noted that Patient B had a subjective complaint of "left nostril with clogging, had difficulty with passage of air and prior history of bronchitis." (Dept.'s Ex. 4, pg. 2; T. 24)

17. The emergency department nursing flow sheet indicates that Patient B complained of unusual shortness of breath, had lung rales at the bases bilaterally, was unable to lie down and had to sleep in a sitting position. (Dept.'s Exs. 4 pg. 4, 4A pg. 17; T. 24-25)

18. Rales are indicative of extra fluid in the lungs. an inability to lie down is a common symptom of heart failure known as orthopnea which involves shortness of breath in the supine position caused by fluid accumulation in the lungs. (T. 25)

19. Respondent did not document that he was aware of Patient B's hypertension or that he investigated its' cause. Respondent's failure to do so deviated from accepted standards of medical care. (Dept.'s Ex. 4, pgs. 2-3; T. 30)

20. Patient B's blood pressure at 4:20 a.m. was 220/120. A blood pressure of 220/120 is indicative of hypertension requiring immediate treatment. (Dept.'s Ex. 4, pg. 4; T. 25-26)

21. At 4:50 a.m., Patient B's blood pressure was still quite high at 180/110 necessitating immediate treatment. (Dept.'s Ex. 4, pg. 4; T. 26, 32)

22. Patient B was noted upon presentation to be taking medications including Coumadin, an anti-coagulent, and Choledyl and a Vancanese inhaler, both of which are used for obstructed airway disease. Patient B was also taking Lanoxin, used for heart failure or cardiac arrhythmia. (Dept.'s Ex. 4, pg. 2; T. 26-27)

23. Patient B's history recorded by Respondent failed to meet accepted standards of medical care given Patient B's age, condition and history of medication use indicating heart and lung disease. Respondent did not describe adequately Patient B's shortness of breath, that it was postural and whether there were associated symptoms such as fever, cough or chest pain. Respondent failed to document why Patient B was taking the various medications and whether he had previous myocardial infarctions, previous congestive heart failure or hypertension. (T. 27-29)

24. Respondent's physical examination of Patient B indicating the Patient was alert and in no respiratory distress, focused entirely on the Patient's nose and his ear tympanic membranes. The examination failed to meet accepted standards of medical care. Given his condition and medication history, his physical should have included a detailed cardiorespiratory examination focused on seeking a cardiac or lung related cause of patient B's shortness of breath and increased respiratory rate. (Dept.'s Ex. 3, pg. 2; T. 29-30)

25. Respondent diagnosed Patient B as having nasal congestion and sinusitis and prescribed medication including Dimetapp, an over the counter cold remedy.
(Dept.'s Ex. 4, pg. 3; T. 31)

26. Respondent's diagnosis of Patient B failed to meet accepted standards of medical care in that he failed to consider Patient B's hypertension or alternative causes of his breathing difficulties. (Dept.'s Ex. 4, pg. 2; T. 31)

27. Respondent's instruction that Patient B take Dimetapp contravened accepted standards of medical care in that Dimetapp contains phenylephrine, an alpha agonist which can cause acute elevation of blood pressure in hypertensive individuals. (T. 31-32)

28. Respondent took no action to treat Patient B's hypertension. This failure contravened accepted standards of medical care. (Dept.'s Ex. 4, pgs. 2-3; T. 32)

29. Patient B was discharged at 5:02 a.m. on August 6, 1990. (Dept.'s Ex. 4, pg. 3)

30. Respondent's discharge of patient B failed to meet accepted standards of medical care in that Respondent failed to investigate adequately the cause of Patient B's shortness of breath or to treat his hypertension. (T. 33-34)

31. Patient B subsequently returned to the emergency room at 10:20 a.m. on the same day, August 6, 1990, when he was treated by another physician who noted that Patient B had had difficulty breathing for three (3) days. He subsequently receive a thorough examination including an electrocardiogram, chest X-ray and blood tests resulting in a diagnosis of mild congestive heart failure, chronic obstructive lung disease, bronchitis, left maxillary sinusitis and diabetes mellitus. (Dept.'s Ex. 4, pgs. 9-10; T. 33-34)

FINDINGS OF FACT AS TO PATIENT C

32. Patient C, a 72 year old male, presented at the emergency room at 8:34 p.m. on August 3, 1990. Respondent noted Patient C had substernal pressure which had been temporarily relieved by nitroglycerin and that the pressure was not associated with radiation, shortness of breath, diaphoresis, nausea, vomiting, headaches, chills, fever, cough, constipation, peptic

ulcer disease or diarrhea. Respondent diagnosed acute myocardial infarction. (Dept.'s Ex. 5, pgs. 14-15; T. 36-37)

33. A patient with acute myocardial infarction with continued pain should receive nitroglycerin, unless the patient has contraindicating hypotension, both to limit the size of the infarction through restoration of coronary perfusion and to limit the secondary sympathetic effects of pain which can increase the work load and oxygen demands of the heart and cause the infarct to be larger. In the event the pain returns following the administration of nitroglycerin, further treatment with nitroglycerin should be administered.

34. Patient C received two (2) doses of sublingual nitroglycerin while in the ambulance en route to the hospital relieving his chest pain completely. On arrival at the emergency room at 8:34 p.m. he complained of "non-radiating" chest pain with diaphoresis and pain in the teeth. The initial pain had begun at 7:30 p.m. (Dept.'s Ex. 5, pgs. 3, 16; T. 39)

35. Pain in the back teeth of Patient C was a symptom of radiating pain. (Dept.'s Ex. 5, pgs. 14-16; T. 39, 51)

36. An electrocardiogram given when Patient C arrived at the emergency room indicated he was suffering from acute anterior wall myocardial infarction. (Dept.'s Ex. 5, pg. 64; T. 43)

37. Thrombolytic therapy could have minimized the damage to Patient C through intravenous drug administration to dissolve blood clots. The 1990 indications for the therapy were met by the ECG showing S.T. segment elevation and contiguous leads indicating one (1) area of the heart was having an infarction. It should be administered two (2) to four (4) hours from the onset of symptoms. Patient C had no contraindications to thrombolytic therapy and would have been a good candidate for such. Despite the potential the Respondent did not

notify the attending cardiologist, Dr. DeBrown, until 10:10 p.m. Prior to such notice, the Patient complained of pain in the chest at 9:10 p.m., 9:17 p.m. and 10:00 p.m. (Dept.'s Ex. 5, pgs. 14-16; T. 39, 42-44, 50, 52, 147-148)

38. Dr. DeBrown arrived at the hospital at about 10:30 p.m. He treated Patient C with intravenous nitroglycerin and heparin to resolve the chest pain. Dr. DeBrown determined that Patient C had passed the effective period for administration of thrombolytic therapy. Patient C sustained a completed anterior wall myocardial infarction complicated by congestive heart failure and atrial fibrillation. (Dept.'s Ex. 5, pgs. 3-4, 16; T. 39-40, 47)

39. Respondent did not order thrombolytic therapy for Patient C. (Dept.'s Ex. 5, pg. 3, 14-15)

40. Respondent's treatment of Patient C failed to meet accepted standards of medical care in that he failed to treat adequately Patient C's chest pain by giving him sufficient sublingual nitroglycerin. In the event that sublingual nitroglycerin did not succeed in alleviating Patient C's pain, Respondent should have treated Patient C with intravenous nitroglycerine and/or intravenous narcotics. Respondent also failed to administer thrombolytic therapy thereby increasing the risk of cardiac damage to Patient C, damage which Patient C sustained due to a completed infarct. (T. 41, 42-47)

FINDINGS OF FACT AS TO PATIENT D

41. Patient D, a 47 year old female, presented at the emergency room at 12:17 a.m. on August 5, 1990 with right lower quadrant abdominal pain with slight abdominal distension. Patient D was treated by Respondent. (Dept.'s Ex. 6, pgs. 3-4; T. 52-53)

42. Respondent's physical examination included a description of Patient D's abdomen indicating pain and tenderness to palpation in the right inguinal and lower inguinal abdominal area with a finding that bowel sounds were present and that there were no masses or hernias. Respondent did not perform a rectal or pelvic examination. (Dept.'s Ex. 6, pgs. 3-4; T. 54) * See Resp.'s Ex. C for his rationale; T. 213

43. A pelvic examination is routinely indicated for a female with lower quadrant pain presenting to an emergency room in order to assess adequately whether there are problems in the patient's reproductive organs. A rectal examination is similarly routinely indicated to determine if there are masses in the rectum causing abdominal obstruction and whether there is bleeding in the patient's stool. (T. 54-55)

44. Respondent's physical examination failed to meet accepted standards of medical care in that he did not perform rectal and pelvic examinations of Patient D. (T. 54)

45. Respondent ordered blood tests for Patient D consisting of an amylase, pregnancy test, a complete blood count, a chemical profile and a urinalysis which was repeated twice. (Dept.'s Ex. 6; T. 55)

46. Respondent diagnosed Patient D as having "abdominal pain, rule out stone." Respondent ordered the patient to push fluids, a standard treatment for kidney stones. (Dept.'s Ex. 6, pg. 4; T. 55-56)

47. Respondent evaluated the laboratory work as being inconclusive and recommended further evaluation of Patient D. (Dept.'s Ex. 5, pg. 59; T. 221-223)

FINDINGS OF FACT AS TO PATIENT E

48. Patient E, a 15 year old male, presented at the emergency room on July 12, 1990 at 7:37 p.m. with a complaint that he had twisted his left ankle while playing basketball and that he was "now with pain, swelling and decreased motion." Respondent provided emergency room care to Patient E. (Dept.'s Ex. 7, pgs. 2, 4; T. 62)

49. With an ankle injury of this nature, Respondent should have evaluated Patient E's knee and physically described his ankle including the location of swelling and tenderness, performed an evaluation of ankle ligament stability including the Achilles tendon, range of motion and intactness of neurovascular function. (T. 63)

50. Respondent's physical examination of Patient E did not meet accepted standards of medical care in that he did not record a physical examination other than to note "same" for his objective findings. (Dept.'s Ex. 7, pg. 2; T. 62-63)

51. Respondent ordered X-rays of Patient E's ankle and interpreted them as showing "no obvious fracture." (Dept.'s Ex. 7, pg. 4, 6; T. 64)

52. Respondent diagnosed Patient E as having a sprained left ankle and discharged him at 8:50 p.m. He prescribed an Ace wrap, crutches, ice, elevation and gradual weight bearing. (Dept.'s Ex. 7, pgs. 4, 6; T. 64)

53. A fracture of Patient E's ankle involving the superiorlateral corner of the talus was detected on July 13, 1995 by the radiologist who also found avulsion fracture fragments present between the medical aspect of the talus and the medical malleolus. The mortise was found to appear widened indicating probable ligament instability. (Dept.'s Ex. 7, pg. 8; T. 64-69)

54. Patient E's fracture was of a nature that it should have been obvious to an emergency room physician interpreting Patient E's X-rays. (T. 66-67, 71-72)

55. Patient E's discharge instructions failed to meet accepted standards of medical care in that Patient E suffered an injury which should not have been subject to weight bearing. In addition, they included no instructions or prescription for pain medication. (T. 70)

56. Respondent made a belated referral of Patient E to orthopedics on July 14, 1990. (T. 227)

FINDINGS OF FACT AS TO PATIENT F

57. Patient F, a 22 year old female, presented at the emergency room at 4:23 a.m. on September 1, 1990, after having been involved in a motor vehicle accident. Patient F, who was driving the vehicle without a seat belt complained of pain in her head, neck and right knee. She was unconscious when the ambulance reached her and may have undergone a prolonged period of unconsciousness. Patient F received emergency room care from the Respondent. (Dept.'s Ex. 8, pgs. 2-3, 6; T. 74-75)

58. Given the circumstances of Patient F's injury and her complaints of pain, acceptable medical standards require that Respondent should have examined Patient F's neck and performed a neurological examination to detect neurological damage or injuries to the spine or neck. (T. 74-75)

59. Respondent's physical examination of Patient F failed to meet accepted standards of medical care in that there is no evidence that he performed a physical examination of her neck. There is no evidence that he performed a neurological examination other than his notation of the

word "neuro." Respondent's omissions risked his missing signs of serious injury. (Dept.'s Ex. 8, pg. 2; T. 74-75)

60. Respondent discharged Patient F at 6:45 a.m. (Dept.'s Ex. 8, pg. 3)

61. Patient F was ultimately readmitted to the House of Good Samaritan Hospital on September 2, 1990 with a comminuted fracture of the lateral mass of C-2 of the cervical spine. (Dept.'s Ex. 8, pgs. 17-21; T 77-78)

FINDINGS OF FACT AS TO PATIENT G

62. Patient G, a 23 year old male, presented to the emergency room at 10:34 p.m. on August 26, 1990, with a complaint that he had been bitten on his right index finger by a wild raccoon resulting in a small puncture wound. Patient G received emergency room care from the Respondent. (Dept.'s Ex. 9, pgs. 3-4, 6; T. 82)

63. For a raccoon bite of this nature, accepted standards of medical care require the administration of rabies prophylaxis to prevent the patient from catching rabies from a possibly rabid raccoon. Proper administration of rabies prophylaxis involves the administration of human rabies immunoglobulin containing the antibodies. The patient should also receive rabies vaccinations administered in a series of inoculations to stimulate the antibodies beginning on the day of injury followed by an inoculation two (2) or three (3) days later, then seven (7), fourteen and twenty days after the first vaccination. (T. 83-84, 238-239)

64. Patient G was never treated with human rabies immunoglobulin. (Dept.'s Ex. 9, pg. 13; T. 241)

65. Respondent's treatment of Patient G failed to meet accepted standards of medical care in that he failed to treat Patient G with human rabies immunoglobulin. In addition, while Patient G received an initial rabies vaccination, he was advised to return seven (7) days later for his second vaccination, contravening the proper schedule. The failure to treat Patient G with immunoglobulin and administer rabies vaccination on an appropriate schedule risked that Patient G would contract rabies, a fatal disease. Such was a significant deviation from acceptable standards of medical care. (T. 85-86; Dept.'s Ex. 9, pgs. 4, 14)

66. Patient G was advised to return seven (7) days later for his second vaccination. This was a very significant deviation from acceptable standards of medical care. (Dept.'s Ex. 9, pg. 6)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

AS TO PATIENT A

Respondent provided emergency medical care on or about July 22, 1990 to Patient A, a 24 year old female, at Good Samaritan Hospital. She presented after hitting her head while diving into a swimming pool. Finding 4.

1. Respondent failed to perform and record an adequate physical examination. Findings 4, 5, 6, 7, 8, 9, 12, 13.
2. Respondent failed to detect a fracture on Patient A's cervical spine X-rays. Findings 4, 6, 7, 8, 10, 12, 13.
3. Respondent inappropriately discharged Patient A. Findings 4, 11, 12, 13, 14.

AS TO PATIENT B

Respondent provided emergency medical care to Patient B on or about August 6, 1990 at Good Samaritan Hospital. Patient B, a 67 year old male, presented to the Emergency Department with a complaint of difficulty in breathing and with abnormal vital signs. Findings 15, 16.

4. Respondent failed to obtain and record an adequate history and perform and record an adequate physical examination of Patient B. Findings 17, 18, 19, 20, 21, 22, 23, 24.

5. Respondent failed to investigate and treat adequately Patient B's hypertension. Findings 19, 20, 21, 22, 23, 24, 28.

6. Respondent failed to make a medically acceptable diagnosis. Findings 25, 26.

7. Respondent inappropriately prescribed Dimetapp for Patient B. Findings 25, 27.

8. Respondent inappropriately discharged Patient B. Findings 29, 30, 21.

AS TO PATIENT C

Respondent provided emergency medical care to Good Samaritan Hospital to Patient C, a 72 year old male, who presented with chest pain on or about August 3, 1990. Finding 32.

9. Respondent failed to treat adequately Patient C with nitroglycerine. Findings 32, 33, 34, 35, 36, 38, 40.

10. Respondent failed to institute thrombolytic therapy in a timely manner to Patient C. Findings 37, 38, 39, 40.

AS TO PATIENT D

Respondent provided emergency medical care at Good Samaritan Hospital to Patient D, a 47 year old female, who presented with complaints of abdominal pain on or about August 5, 1990. Findings 41, 42.

11. Respondent evaluated the diagnostic laboratory studies ordered as being inconclusive and recommended further evaluation of Patient D. Findings 45, 47.

12. Respondent failed to perform a rectal or a pelvic examination, both accepted standards of Patient D's medical care. Findings 42, 43, 44.

AS TO PATIENT E

Respondent provided emergency medical care on or about July 12, 1990 to Patient E, a 15 year old boy, at Good Samaritan Hospital. Patient E twisted his ankle while playing basketball. Finding 48.

13. Respondent failed to perform and record an adequate physical examination. Findings 49, 50.

14. Respondent failed to interpret adequately the X-rays of Patient E's ankle. Findings 51, 54.

15. Respondent issued inappropriate discharge instructions for Patient E. Findings 52, 53, 55.

AS TO PATIENT F

Respondent provided emergency medical care to Patient F, a 22 year old female, on or about September 1, 1990, at Good Samaritan Hospital, after she was involved in a motor vehicle accident. She complained of head and neck pain. Respondent failed to perform and record an adequate physical examination. Findings 57, 58, 59, 60, 61.

AS TO PATIENT G

Respondent provided emergency medical care to Patient G, a 23 year old male, on or about August 26, 1990, at Good Samaritan Hospital. Patient G had been bitten by a wild raccoon. Finding 62.

16. Respondent failed to initially administer human rabies immunoglobulin. Findings 63, 64, 65.

17. Respondent failed to have vaccine administered to Patient G on an appropriate schedule. Findings 63, 66.

CONCLUSIONS WITH REGARD TO SPECIFICATION FIRST THROUGH SEVENTH

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE:

First Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs A, A.1 and A.2. Two (2) members of the Committee **SUSTAINED** the allegations set forth in Paragraph A.3. One (1) member, however, supported a contrary position, determining that Respondent's discharge directions to Patient A to continue use of the collar, to abstain from work for three (3) days and to return to the hospital should any problem arise, was reasonable based on the information the Respondent had at the time. The Committee concludes that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to perform and record an adequate physical examination of Patient A, failing to detect a fracture on Patient A's cervical spine X-rays and by inappropriately discharging Patient A.

Second Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs B, B.1., B.2., B.3., B.4. and B.5. The Committee concludes that Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to obtain and record an adequate physical examination of Patient B, to investigate and treat adequately Patient B's hypertension, failing to make a medically acceptable diagnosis, by inappropriately prescribing Dimetapp to Patient B and by inappropriately discharging Patient B.

Third Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs C, C.1. and C.2. The Committee concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to treat adequately Patient C with nitroglycerine and failing to institute thrombolytic therapy in a timely manner.

Fourth Specification:

The Hearing Committee unanimously concludes that Allegation D.1. of the charges be **DISMISSED**, confirming the Respondent's evaluation of the diagnostic studies as being inconclusive and supporting his recommendation for further evaluation of Patient D. The Hearing Committee also unanimously concludes that the Allegations in Paragraphs D and D.2. be **SUSTAINED**, and that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to perform a rectal and a pelvic examination of Patient D.

Fifth Specification:

The Hearing Committee unanimously concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4), the Respondent having failed to perform and record an adequate physical examination and to interpret adequately the X-rays of Patient E's ankle as well as issuing inappropriate discharge instructions. The Allegations set forth in Paragraphs E, E.1., E.2. and E.3. are **SUSTAINED**.

Sixth Specification:

The Hearing Committee unanimously **SUSTAINED** the Allegations set forth in Paragraph F, concluding that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to record and perform an adequate physical examination.

Seventh Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraph G , G.1. and G.2. The Committee concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to administer human rabies immunoglobulin to Patient G and failing to have vaccine administered to Patient G on an appropriate schedule.

CONCLUSIONS WITH REGARD TO SPECIFICATIONS EIGHTH THROUGH FOURTEENTH

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE:

Eighth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs A, A.1. and A.2. Two (2) members of the Committee sustained the allegations set forth in Paragraph A.3. One (1) members, however, for the reasons set forth in the First Specification, had a contrary position. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to perform and record an adequate physical examination of Patient A, failing to detect a fracture on Patient A's cervical spine X-rays and by inappropriately discharging Patient A.

Ninth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs B, B.1., B.2., B.3., B.4. and B.5. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to obtain and record an adequate physical examination of Patient B, to investigate and treat adequately Patient B's hypertension, to make a medically acceptable diagnosis, by inappropriately prescribing Dimetapp to Patient B and by inappropriately discharging Patient B.

Tenth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations in Paragraphs C, C.1. and C.2. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to treat adequately with nitroglycerine and by failing to institute thrombolytic therapy in a timely manner to Patient C.

Eleventh Specification:

The Hearing Committee unanimously concludes that allegation D.1. of the charges be **DISMISSED**, confirming the Respondent's evaluation of the diagnostic studies as being inconclusive and supporting his recommendation for further evaluation of Patient D. The Committee also unanimously concludes that the allegations in Paragraphs D. and D.2. be **SUSTAINED**, and that the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to perform a rectal and a pelvic examination of Patient D.

Twelfth Specification:

The Hearing Committee unanimously concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6), the Respondent having failed to perform and record an adequate physical examination and to interpret adequately the X-rays of Patient E's ankle. The Respondent also issued inappropriate discharge instructions. The allegations set forth in Paragraphs E, E.1., E.2. and E.3. are **SUSTAINED.**

Thirteenth Specification:

Despite the Hearing Committee sustaining the Respondent's failure to record and perform an adequate physical examination, the Committee determined that such did not encompass the complete lack of ability, and the total and flagrant lack of necessary knowledge to perform such examination. The Respondent's description of his "three" examinations, in the collar, out of the collar and after viewing the X-rays, was introduced by his notation "neuro" in Patient F's record. (Finding 59; T. 236-237) The Committee concludes the charge of gross incompetence in this Specification should be **DISMISSED.**

Fourteenth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraph G, G.1. and G.2. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to administer human rabies immunoglobulin to Patient G and failing to have vaccine administered to Patient G on an appropriate schedule.

CONCLUSIONS WITH REGARD TO FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Fifteenth Specification:

The Hearing Committee, having determined that the Respondent practiced with gross negligence in the seven occasions set forth in the First through the Seventh Specifications, **SUSTAINED** the charge that the Respondent practiced with negligence on more than one occasion contrary to the provision of New York Education Law Section 6530(3).

CONCLUSIONS WITH REGARD TO SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Sixteenth Specification:

The Hearing Committee, having determined that the Respondent practiced with gross incompetence in the six[2] occasions set forth in the Eighth through Fourteenth Specifications, **SUSTAINED** the charge that the Respondent practiced with incompetence on more than one occasion contrary to the provision of New York Education Law Section 6530(5).

[2]The Committee dismissed the Thirteenth Specification

CONCLUSIONS WITH REGARD TO SEVENTEENTH THROUGH TWENTIETH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Seventeenth Specification:

The Hearing Committee, having concluded in the first specification that the Respondent failed to obtain and record an adequate physical examination of Patient A, concludes that the Respondent did not fail to maintain a record for Patient A which accurately reflected his examination. New York Education Law Section 6530(32) requires that "the record for each patient accurately reflects the evaluation and treatment of the patient". The record for Patient A reflects the inadequate physical examination provided. The Committee concluded that the facts in Paragraphs A. and A.1., A.2. and A.3. spell out a violation of the failure to maintain accurate records of Patient A's examination. Therefore, this specification is **SUSTAINED**.

Eighteenth through Twentieth Specification:

The Committee further concludes that the Paragraphs B. and B.1., B.2., B.3., B.4., B.5., E., E.1., E.2., E.3. and F. encompass violations of failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Therefore, these specifications are **SUSTAINED**.

SUMMARY OF CONCLUSIONS

Patient A:

The Committee sustain the three (3) allegations against the Respondent. An injury frequently resulting in spinal damage was followed by an inadequate physical examination and a diagnosis of a "possible whiplash injury" (Finding 6). Respondent failed to detect an obvious cervical fracture (Finding 13). Respondent ordered a premature discharge of Patient A without a review by an appropriate specialist (Finding 14). The record of the Respondent and the testimony

of the Department's expert witness, Dr. Jastremski, confirms the Committee's conclusions that gross negligence and gross incompetence need to be sustained.

Patient B:

The Committee sustained five allegations:

1. The failure to record an adequate medical history of Patient B, including the history of medications used, shortness of breath and previous heart treatment, among others, was of basic importance (Finding 23). Respondent performed a physical examination centered on the Patient's nose and ear tympanic membranes with no cardiorespiratory examination (Finding 24).

2. The Respondent failed to investigate adequately or treat Patient B's hypertension despite the history of cardiovascular symptoms and treatment and the acute hypertension that required immediate treatment (Findings 19, 20, 21, 28).

3. The Respondent failed to make a medically acceptable diagnosis (Finding 26). It should have included a detailed cardiorespiratory examination seeking a cardiac or lung related cause of Patient B's shortness of breath and increased respiratory rate (Finding 24).

4. The Respondent inappropriately prescribed Dimetapp (Finding 27). It can cause acute elevation of blood pressure in hypertensive individuals (Finding 25).

5. Respondent inappropriately discharged Patient B, without investigating the cause of Patient B's shortness of breath or treating his hypertension (Finding 30). Five and one-third hours later Patient B returned to the emergency room where he received a thorough examination (Finding 31).

Patient C:

The Hearing Committee sustained two (2) allegations. The first is an allegation that the Respondent failed to treat adequately Patient C with nitroglycerine. Sublingual nitroglycerine was needed to alleviate Patient C's continued pain from his acute myocardial infarction. If sublingual nitroglycerine did not resolve the pain, Patient C should have been treated with intravenous nitroglycerine (Finding 40).

The second allegation was the Patient C should have been treated with thrombolytic therapy to dissolve blood clots during the limited time period available to the Respondent. Patient C was an acceptable candidate for the therapy (Findings 37, 40). By failing to utilize the therapy, and by delaying in calling the attending physician, the Respondent increased the risk of the additional cardiac damage that resulted in the acute myocardial infarction sustained by Patient C (Findings 37, 38, 39, 40). Sustained are gross negligence and gross incompetence.

Patient D:

The Department charged two (2) allegations against the Respondent concerning Patient D. The first allegation is the Respondent's failure to interpret adequately Patient D's diagnostic studies. The Respondent evaluated the laboratory work as being inconclusive and recommended further studies; the Committee agrees and does not sustain the allegation (Finding 47).

The second allegation charges a failure of the Respondent to perform rectal and pelvic examinations of Patient D. Both are routinely indicated for female patients to assess adequately potential problems in reproductive organs, abdominal obstructions of the rectum or bleeding in the patient's stool (Finding 43). The Hearing Committee sustains the second allegation as gross negligence only.

Patient E:

The Committee sustained the three (3) allegations charged against the Respondent. The first was a failure to perform or record an adequate physical examination. In lieu of a knee evaluation, a description of the ankle including the location of swelling and tenderness, ankle ligament an Achilles tendon stability, range of motion and intactness of neurovascular function, the Respondent's examination noted "same" as his findings (Findings 49, 50).

The second charge is a failure to interpret adequately the X-rays of Patient E's ankle. The Respondent's interpretation was "no obvious fracture" when the fracture should have been obvious to an emergency room physician (Findings 51, 54).

The final charge was for inappropriate discharge instructions by the Respondent. They should have included an instruction not to subject the ankle to weight bearing and instructions or a prescription for pain medication (Finding 55). Respondent made a belated referral to orthopedics two (2) days later (Finding 56). Sustained are gross negligence and gross incompetence.

Patient F:

The Hearing Committee sustained the single charge of failure to perform and record an adequate physical examination. Patient F, who was driving a motor vehicle without a seat belt at the time of an accident, complained of pain in her head, neck and right knee and may have had a prolonged unconsciousness period (Finding 57). Under these circumstances, acceptable medical standards require that the Respondent should have examined Patient F's neck and performed a neurological examination to detect neurological damage or injuries to the spine or neck (Finding 58).

The only documentation of a neurological examination is the entry of the work (?) "neuro" by the Respondent in the patient record. The Committee concludes the failure to record a summary of any physical examination given does not indicate a complete lack of ability, or a total and flagrant lack of the necessary knowledge to perform the required examination. See, Thirteenth Specification, pg. 25, supra. The Committee concludes the allegation of gross negligence in the performance and recording of any examination is sustained. The allegation of gross incompetence is not sustained.

Patient G:

The Hearing Committee sustains the two (2) allegations of failure to initially administer human rabies immunoglobulin and failing to have vaccinations administered to Patient G on an appropriate schedule. Patient G suffered a small puncture wound from a wild raccoon bite. Findings 63, 64, 65.

The Committee sustains the allegations and the charges of gross negligence and gross incompetence in each allegation.

Four allegations of a failure to maintain records for Patients A, B, E and F were dismissed because the Committee determined the records generally documented the Respondent's evaluation and treatment of the patients. In addition, four (4) dismissed allegations of gross negligence, gross incompetence, negligence on more than one (1) occasion and incompetence on more than one (1) occasion for Patient D were based on the Committee's conclusion that the Respondent had reason to determine the diagnostic studies at issue were inconclusive. The Respondent's recommendation for further evaluation was warranted. One (1) allegation of gross incompetence of patient F was dismissed as well.

The remaining allegations sustained by the Committee consisted of seventeen instances of gross negligence relating to all seven (7) patients, sixteen instances of gross incompetence relating to six (6) of the patients, seventeen instances of negligence on more than one (1) occasion relating to the seven (7) patients, and sixteen instances of incompetence on more than one (1) occasion relating to six (6) of the patients.

It is apparent that gross negligence and gross incompetence required a determination of egregious conduct in each of the seven (7) cases. However, three (3) of the cases are set forth from the others because of the dangers they pose to the patients and the documentation of the Respondent's capabilities:

1. **Patient C:** Shortly after arrival at the emergency room, the Respondent diagnosed Patient C as suffering an acute myocardial infarction confirmed by history and an electrocardiogram. The Patient was in pain. The Respondent did not treat with nitroglycerine. Nor did the Respondent take advantage of the hour or so that remained to use thrombolytic therapy to minimize permanent cardiac damage. Nor did the Respondent call the attending cardiologist until it was too late.

2. **Patient D:** This female patient was admitted with lower quadrant abdominal pain and a slight abdominal distention. The Respondent did not perform a pelvic or a rectal examination. The pelvic is routine for a female patient with lower quadrant pain to assess whether there are problems in her reproductive organs. The rectal is routine to determine

if there are masses in the rectum causing abdominal obstructions and whether there is bleeding in the patient's stool.

3. **Patient G:** Patient G presented with a wild raccoon bite on a finger. Rabies prophylaxis starts with a prompt administration of human rabies immunoglobulin. It is followed by an initial rabies inoculation. Thereafter a series of rabies inoculations two (2) or three (3) days later, then seven (7), fourteen and twenty days after the first is given. The Patient did not receive the immunoglobulin. the Patient was given an initial inoculation by the Respondent. The Patient did not return to the hospital until seven (7) days later, in contravention of the schedule. The failed treatment risked rabies.

The three cases above, and the other four cases that are the subjects of the hearing, speak to the Respondent's deviations from acceptable standards of care in emergency cases. Many of the patients are at critical risk. The Respondent has been practicing emergency medicine for about sixteen years. It can not be anticipated that he will change. His medical skill and judgment are both in question.

ORDER

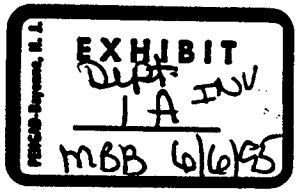
Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

In accordance with the provisions of Sections 230, Subdivision 10, Paragraph (g) and 230-a, Subdivision 4 of the Public Health Law, the Hearing Committee unanimously orders that license number 181809 to practice medicine in the State of New York of **EDWARD WOODS, M.D.** be and hereby is **REVOKED.**

DATED: **Albany, New York**
,1995

IRVING S. CAPLAN, Chairperson

THERESE G. LYNCH, M.D.
ANDREW J. MERRITT, M.D.



ATTACHMENT I

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

----------X

IN THE MATTER : AMENDED STATEMENT
OF : OF
EDWARD WOODS, M.D., : CHARGES
Respondent :

----------X

EDWARD WOODS, M.D., the Respondent, was authorized to practice medicine in New York State on March 29, 1990, by the issuance of license number 181809 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine in New York State.

FACTUAL ALLEGATIONS

A. Respondent provided emergency medical care on or about July 22, 1990 to Patient A, a 24 year old female (all patients are identified in the attached Appendix), at House of the Good Samaritan, Watertown, New York (hereinafter "Good Samaritan Hospital"). Patient A presented after hitting her head while diving into a swimming pool. Respondent's care of Patient A was deficient in the following respects:

1. Respondent failed to perform and/or record an adequate physical examination.

2. Respondent failed to detect a fracture on Patient A's cervical spine x-rays.

3. Respondent inappropriately discharged Patient A.

B. Respondent provided emergency medical care to Patient B on or about August 6, 1990 at Good Samaritan Hospital. Patient B, a 67 year old male, presented to the Emergency Department with a complaint of difficulty in breathing and with abnormal vital signs. Respondent's care of Patient B was deficient in the following respects:

1. Respondent failed to obtain and/or record an adequate history, and/or perform and/or record an adequate physical examination.

2. Respondent failed to adequately investigate and/or treat Patient B's hypertension.

3. Respondent failed to make a medically acceptable diagnosis.

4. Respondent inappropriately prescribed Dimetapp for this patient.

5. Respondent inappropriately discharged Patient B.

C. Respondent provided emergency medical care at Good Samaritan Hospital to Patient C, a 72 year old male, who presented with chest pain on or about August 3, 1990. Respondent's care of Patient C was deficient in the following respects:

1. Respondent failed to adequately treat this patient with nitroglycerin.

2. Respondent failed to institute thrombolytic therapy in a timely manner.

D. Respondent provided emergency medical care at Good Samaritan Hospital to Patient D, a 47 year old female, who presented with complaints of abdominal pain on or about August 5, 1990. Respondent's care of Patient D was deficient in the following respects:

1. Respondent failed to adequately interpret diagnostic studies ordered for Patient D.

2. Respondent failed to perform a rectal and/or pelvic examination.

E. Respondent provided emergency medical care on or about July 12, 1990 to Patient E, a 15 year old boy, at Good Samaritan Hospital. Patient E presented after twisting his ankle while playing basketball. Respondent's care of Patient E was deficient in the following respects:

1. Respondent failed to perform and/or record an adequate physical examination.

2. Respondent failed to adequately interpret the x-rays of this patient's ankle.

3. Respondent inappropriately discharged Patient E. (NS)

F. Respondent provided emergency medical care to Patient F, a 22 year old, on or about September 1, 1990, at Good Samaritan Hospital. Patient F presented after being involved in a motor vehicle accident, with complaints of head and neck pain. Respondent's care of Patient F was deficient in that he failed to perform and/or record an

adequate physical examination.

G. Respondent provided emergency medical care to Patient G, a 23 year old male, on or about August 26, 1990 at Good Samaritan Hospital. Patient G presented after having been bitten by a raccoon. Respondent's care of Patient G was deficient in the following respects:

1. Respondent failed to initially administer human rabies immunoglobulin.

2. Respondent failed to have vaccination administered to Patient G on an appropriate schedule.

SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (4) (McKinney Supp. 1995) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

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

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

3. The facts in Paragraph C and C.1 and/or C.2.

4. The facts in Paragraph D and D.1 and/or D.2.

5. The facts in Paragraphs E and E.1 and/or E.2.

6. The facts in Paragraph F.

7. The facts in Paragraphs G and G.1 and/or G.2.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (6) (McKinney Supp. 1995) by reason of his having practiced the profession with gross incompetence, in that Petitioner charges;

8. The facts in Paragraphs A and A.1 and/or A.2.

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

10. The facts in Paragraph C and C.1 and/or C.2.

11. The facts in Paragraph D and D.1 and/or D.2.

12. The facts in Paragraphs E and E.1 and/or E.2.

13. The facts in Paragraph F.

14. The facts in Paragraphs G and G.1 and/or G.2.

FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (3) (McKinney's Supp. 1995) by reason of his having practiced the profession with negligence on more than one occasion, in that Petitioner charges that the Respondent committed at least two of the following:

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

SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (5) (McKinney Supp. 1995) by reason of his having practiced the profession with incompetence on more than one occasion, in that the Petitioner charges that the Respondent committed at least two of the following:

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

SEVENTEENTH THROUGH TWENTETH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) by reason of his having failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that the Petitioner charges:

17. The facts in Paragraphs A and A.1.

18. The facts in Paragraphs B and B.1.

19. The facts in Paragraphs E and E.1.

20. The facts in Paragraph F.

DATED: May 31, 1995
Albany, New York

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

STATE OF NEW YORK
DEPARTMENT OF HEALTH

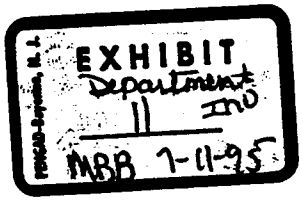
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

June 29, 1995

David Solomon, Esq.
Administrative Law Judge
2366 Algonquin Road
Schenectady, New York 12309



Re: Matter of Edward Woods, M.D.

Dear Judge Solomon:

By this letter, I am making an Application to add three Factual Allegations to the Statement of Charges in this matter. In your ruling on this application, I respectfully request that you consider that 10 NYCRR §51.6 allows any party to supplement a pleading at any time prior to the Hearing Committee' final Determination and Order if there is not substantial prejudice to any other party.

It is my understanding that Dr. Woods has obtained or has had the opportunity to obtain the transcript of the June 6, 1995 hearing date. The additional Factual Allegations are based on Dr. Jastermski's testimony at the June 6, 1995 hearing. Therefore, Dr. Woods will have had ample time to review the prior transcript and will have ample time prior to the next hearing date of July 11 to prepare for the additional charges. The Factual Allegations that I wish to add are as follows:

Factual Allegation A.3 (see transcript, pgs. 20-23)

Respondent inappropriately discharged Patient A. (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (first, eighth, fifteenth and sixteenth specifications).

Factual Allegation B.5 (see transcript, pgs. 34-35)

Respondent inappropriately discharged Patient B. (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (second, ninth, fifteenth and sixteenth specifications)).

Factual Allegation E.3 (see transcript, pgs. 69-73)

Respondent issued inappropriate discharge instructions for Patient E (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (fifth, twelfth, fifteenth and sixteenth specifications)).

Thank you for your attention to these matters.

Very truly yours,

Frederick Zimmer

Frederick Zimmer
Assistant Counsel
(518) 473-4282

FZ:ctt

Edward Woods, M.D.
#4 Poinciana Drive
Durham, North Carolina 27707