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

September 30, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Karen E. Carlson, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Linda C. Laing, Esq.
Notaro & Laing
Rand Building
14 Lafayette Square, Suite 900
Buffalo, New York 14203

George True Simpson, M.D.
130 LeBrun Road
Buffalo, New York 14215

Effective Date: 10/07/96

RE: In the Matter of George True Simpson, M.D.

Dear Ms. Carlson, Ms. Laing and Dr. Simpson:

Enclosed please find the Determination and Order (No. 96-228) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 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
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

COPY

IN THE MATTER

OF

GEORGE TRUE SIMPSON, M.D.

DETERMINATION
AND
ORDER
BPMC 96 - 228

PETER B. KANE, M.D., (Chair), **ERNST A. KOPP, M.D.**, and **IRVING S. CAPLAN** 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 **KAREN EILEEN CARLSON, ESQ.**, Assistant Counsel.

Respondent, **GEORGE TRUE SIMPSON, M.D.**, appeared personally and was represented by **KENNEY, KANALEY, SHELTON, NOTARO, LIPTAK & LAING, LLP, LINDA C. LAING, 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:	May 16, 1996
Date of Service of Notice of Hearing and Statement of Charges:	May 17, 1996
Answer to Statement of Charges:	None filed
Pre-Hearing Conference Held:	June 3, 1996[1]
Hearings Held: - (First Hearing day):	June 10, 1996 June 17, 1996 June 18, 1996 July 18, 1996 July 19, 1996
Intra-Hearing Conferences Held.	June 10, 1996 July 19, 1996 July 26, 1996[1]
Petitioner's Proposed Findings of Fact, Conclusions and Recommendations:	Received August 13, 1996
Respondent's Argument, Proposed Findings of Fact, Conclusions and Recommendations:	Received August 13, 1996
Witnesses called by the Petitioner, Department of Health:	Ann Marie Kakavand, C.R.N.A. Robert Joel Ruben, M.D. Nicole Rickard, R.N. Nancy Donahue, R.N.
Witnesses called by the Respondent, George True Simpson, M.D.:	George True Simpson, M.D. Larry Leonard Myers, M.D. William Ray Panje, M.D. Paul R. Knight, III, M.D.
Deliberations Held: - (Last Hearing day):	August 22, 1996

[1] Via Telephone.

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. GEORGE TRUE SIMPSON, M.D., ("**Respondent**") is charged with one specification of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of practicing the profession with gross negligence on a single occasion[2]. The charge concerns the medical care, treatment and services provided by Respondent to Patient A[3]. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

Respondent admits to being licensed to practice medicine in New York and admits that he treated Patient A at Sisters of Charity Hospital ("**Sisters Hospital**") in Buffalo, New York. Respondent denies any gross negligence and asserts that his actions were in all respects consistent with applicable accepted standards of medical care.

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[2] Education Law §6530(4) and Specification in Petitioner's Exhibit # 1.

[3] Patient A is identified in an Appendix to the Statement of Charges, Petitioner's Exhibit # 1.

FINDINGS OF FACT

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

1. Respondent was licensed to practice medicine in New York State on November 15, 1990 by the issuance of license number 184484 by the New York State Education Department (Petitioner's Exhibits # 1 & # 3, Respondent's Exhibit # C)[4]; (Admitted).

2. Respondent is registered with the New York State Education Department to practice medicine for the period January 1, 1995 through March 31, 1997 (Petitioner's Exhibit # 3); (Admitted).

3. Ann Marie Kakavand is a certified registered nurse anesthetist ("**C.R.N.A.**"). She has a Bachelor of Science degree in nursing from D'Youville College and a Master of Science degree from the University of Buffalo with a specialty in anesthesia and a certification in nurse anesthesia. She has been a CRNA for five years and has worked as such at Sisters Hospital for Parkside Anesthesia Services for five years. Prior to that, she worked at Sisters Hospital as a

[4] Refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or submitted by Dr. George Simpson (Respondent's Exhibit).

registered nurse for 10 years [T-10-11][5]. She was a fact witness for Petitioner about the December 4, 1995 surgery on Patient A [T-9-58].

4. Dr. Robert Joel Ruben is a professor and chairperson of the Department of Otolaryngology at the Albert Einstein College of Medicine. Dr. Ruben graduated from Johns Hopkins University School of Medicine in 1959. He is licensed to practice medicine in the States of New York and Maryland. Dr. Ruben's specialty is Pediatric Otolaryngology. He is board certified in otolaryngology and has been involved in numerous educational contributions, research activities, presentations at professional meetings and publications of professional articles (Petitioner's Exhibit # 9); [T-59-66]. He testified as an expert witness for Petitioner [T-58-173].

5. Nicole Rickard has been a nurse investigator with the New York State Health Department, Office of Professional Medical Conduct for a year. She has worked for the Health Department since 1981. Nurse Rickard interviewed Nurse Stefana Campanella, now deceased. Nurse Campanella was the circulating nurse at the December 4, 1995 surgery on Patient A [T-182-185, 190]. Nurse Rickard testified about her interview with Nurse Campanella [T-182-194].

6. Nancy Donahue has been a registered nurse for 30 years and has worked at Sisters Hospital for the majority of that 30 years. On December 4, 1995, she was working in the pediatric ambulatory admission unit [T-195-197]. She was a fact witness for Petitioner about the December 4, 1995 surgery on Patient A [T-194-215].

7. Dr. Larry Leonard Myers was licensed to practice medicine in the State of New York in October, 1994. Presently he is an otolaryngology/head and neck surgeon, resident in training, at the University of Buffalo Medical School. He is in the second year of **ENT**[6] training, fourth

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[5] Numbers in brackets refer to transcript page numbers [T-].

[6] Abbreviation for ears, nose, and throat Stedman's Medical Dictionary, 25th Edition, 1990, pg. 515.

year of postgraduate training. In December of 1995, Dr. Myers was an otolaryngology resident [T-370-372]. He was a fact witness for Respondent about the December 4, 1995 surgery on Patient A [T-370-419].

8. Dr. William Ray Panje was licensed to practice medicine in the States of Illinois and Iowa in 1971. He went to the University of Iowa College of Medicine and obtained his medical degree in 1971. Dr. Panje did a straight surgical internship, a year of surgical residency and then four years of ENT training in maxillofacial surgery at the University of Iowa until 1976. He obtained an MS in otolaryngology in 1977. Dr. Panje was board certified in otolaryngology in 1977. He was Director of the Head and Neck Surgery Division in Otolaryngology at Iowa and became a full professor with tenure in otolaryngology and maxillofacial surgery at Iowa and remained there until 1984 when he was recruited to Chicago as Chairman of the Division of Otolaryngology in Head and Neck Surgery at the University of Chicago, Department of Surgery. In 1992, Dr. Panje went to Rush Medical College as a full professor and Director of Skull Base and Reconstructive Surgery in its Department of Otolaryngology. Dr. Panje has numerous professional affiliations, been involved in a number of research programs and professional activities. 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. Dr. Panje has authored and had published at least 5 books dealing with major head and neck surgery (Respondent's Exhibit # D); [T-425-442]. He testified as an expert witness for Respondent regarding the care and treatment provided to Patient A [T-425-533].

9. Dr. Paul R. Knight, III was licensed to practice medicine in the States of New York (1992), Pennsylvania (1975) and Michigan (1978). He obtained his medical degree in 1973 from Pennsylvania State University College of Medicine. Dr. Knight also obtained a Ph.D. from

Pennsylvania State University in 1973. Dr. Knight did a surgical residency training for two years and then two years of anesthesiology (1974 to 1977). He became a professor in the Department of Anesthesiology at the University of Michigan Medical Center and was also a research scientist in the Department of Epidemiology in the School of Public Health at the University of Michigan until 1992. In 1992, Dr. Knight came to the State University of New York at Buffalo as Professor and Chairman of Anesthesiology and Professor of Microbiology. Dr. Knight became board certified in anesthesiology in 1978 and was recertified in 1994. He has had articles published in scientific peer review journals concerning the topic of anesthesia and also served as a reviewer for peer-review scientific journals. Dr. Knight has also written chapters and textbooks on the subject of anesthesiology and has been involved in the preparation of abstracts and panel discussions on the subject of anesthesia (Respondent's Exhibit # B); [T-540-551]. He testified as an expert witness for Respondent [T-540-610].

10. Dr. George True Simpson, II, is licensed to practice medicine in the States of New York, Alabama, California and Massachusetts. Dr. Simpson went to medical school at Loma Linda University in California from 1969 through 1973. He obtained a Masters in Public Health in 1975 from Loma Linda University. Dr. Simpson did his residency training, from 1970 to 1975, at the University of Alabama Hospital for general surgery training. Thereafter, he went to UCLA, in the Department of Head and Neck Surgery, for residency training in otolaryngology. He then took a fellowship at Children's Hospital in Boston, Massachusetts in pediatric otolaryngology. He is board certified in otolaryngology (1978) and in laser medicine and surgery (1985). He joined Boston University as the director or chief of the otolaryngology service at Boston City Hospital where he remained until 1990. In January, 1991 Dr. Simpson was recruited by the State University of New York to be professor and chairman of the Department of Otolaryngology at the University in Buffalo. Dr. Simpson has had numerous staff

appointments, administrative appointments, memberships in medical societies, as well as served on numerous medical committees. He has made presentations and lectures and has been involved in numerous educational contributions, research activities, presentations at professional meetings and publications of professional articles. Dr. Simpson is currently chair of the Otolaryngology Department of the SUNY Buffalo Medical College in Buffalo, New York (Respondent's Exhibit # C); [T-219-228]. Dr. Simpson testified on his own behalf as to the surgeries on Patients A [T-219-364, 612-656].

PATIENT A

11. Patient A, an eight year old male, born 2/27/87, was a patient of Respondent since at least April, 1992 (Petitioner's Exhibit # 4); [T-232].

12. On December 4, 1995, Respondent provided medical and surgical care to Patient A, for surgical removal of a massive facial hemangioma (excision of vascular malformation), at Sisters Hospital in Buffalo, New York (Respondent's Exhibit # 5); [T-14, 66]; (Admitted).

13. A hemangioma is a vascular tumor which consists of blood vessels, mainly veins and arteries, that grows as a large mass [T-67, 229-230].

14. Patient A's hemangioma was on his right cheek, existing from the temporalis muscle, crossing midline, affecting the uvula and the soft palate, and intruding the oral pharynx. This hemangioma encompassed almost his entire cheek, went towards his lip and mouth. The hemangioma deviated the patient's tongue to the left on the inside of the mouth. The hemangioma was considered a low (blood) flow type of vascular neoplasm. The hemangioma was massive and quite extensive, of rare size and depth, and this surgery was a major and extensive surgical case [T-14-15, 66-67, 168, 339, 447-448, 495, 514].

15. Blood loss, during surgery, of two to four units was anticipated by Respondent [T-99, 270-271, 326, 653].

16. Respondent considered the possibility that Patient A would not be going home right after surgery. He contemplated the possibility that intensive care unit ("**ICU**") admission would be necessary [T-261-263, 314, 340, 654]. In fact, this extensive surgery is considered more appropriate as an overnight surgery as opposed to an outpatient surgery [T-514].

17. Respondent had no documentation of discussing risks, benefits and the types of procedures that he was planing on doing or which could be done on Patient A [T-341].

18. The surgery was originally scheduled at Sisters Hospital. Respondent requested his office staff schedule the procedure for four hours; however the surgery was only scheduled for one hour and forty-five minutes. Respondent was aware of this scheduling error prior to December 4, 1995, the day of surgery (Petitioner's Exhibits # 4 & # 5); [T-17, 314-315, 388].

19. Respondent was aware of this scheduling error prior to December 4, 1995. The schedule for surgery was posted at least five days prior to surgery (Respondent's Exhibit # 4); [T- 314-316, 388].

20. A short surgery was anticipated by circulating nurse Campanella. After conversation with C.R.N.A. Kakavand, the plastic surgical kit set up for small procedures was changed to a more standard ENT surgical pack to accommodate this surgery [T-186-187, 280].

21. An MRI/MRA[7] was performed on Patient A in September of 1995 at Children's Hospital of Buffalo ("**Children's Hospital**") (Respondent's Exhibit # 4); [T-72, 254, 258].

[7] MRI is an abbreviation for magnetic resonance imaging; MRA is an abbreviation for magnetic resonance angiography and is a further technique to look at the blood supply of the tumor or any blood supply. An MRA also identifies feeding vessels [T-73, 254, 327]; Stedman's Medical Dictionary, 25th Edition, 1990.

22. An MRI/MRA was an appropriate diagnostic test for this patient [T-73, 450-451].

23. In December, 1995, Sisters Hospital did not offer services exclusively to children. Sisters Hospital routinely handled small ambulatory surgeries on children over the age of six months. Sisters Hospital was a well-equipped hospital for head and neck surgery, but not for pediatric ICU patients [T-54-55, 259-260]; (Petitioner's Exhibit # 10).

24. In December, 1995, only a very small percentage of the patients coming through the morning admission unit were children [T-213]. There was no longer a pediatric in-patient unit at Sisters Hospital (ceased to be in existence February 1, 1993) and Respondent, having been on the task force committee, should have been aware of the demise of the pediatric in-patient unit (Respondent's Exhibit # 10); [T-264, 354-357].

25. At Sisters Hospital, all in-patient medical pediatric admissions were to be discontinued as of January 28, 1993. Emergency pediatric cases were to be handled by the emergency department of Sisters Hospital and, once patients were treated and stabilized, transferred to Children's Hospital. There was no separate ICU for pediatric patients. Sisters Hospital was not a hospital staffed to take care of tertiary problems like Patient A's case (Petitioner's Exhibit # 10); [T-106, 362].

26. Respondent had not had a pediatric patient in a ICU at Sisters Hospital for more than a year [T-353].

27. Respondent was a member of the active staff at both Children's Hospital and Sisters Hospital. Respondent had privileges to perform head and neck surgery on adult and pediatric patients at each of those institutions [T-225, 338].

28. Patient A was brought from the admission unit of Sisters Hospital to the pre-operative holding area without having any blood t ped or cross matched. Although a written order for a type and screen was made at 8:15 A.M. by one of the residents, it was not carried out [T-15-18, 186, 201-202, 378, 402].

29. Ann Kakavand was the C.R.N.A. on duty on December 4, 1995, at Sisters Hospital. Her first contact with Patient A was at 8:45 A.M., in the pre-operative area. C.R.N.A. Kakavand discussed the procedure with Dr. Chung, the anesthesiologist in charge that day, and they discussed that it was highly likely the patient would need blood. The decision to actually type blood and order blood products (type and cross) was made at 8:45 A.M., in the pre-operative holding area. Blood was not actually drawn for a type and crossmatch until after the patient was under anesthesia, between 9:30 A.M. to 9:45 A.M., shortly before surgery began. Thereafter, two units of blood were ordered (Petitioner's Exhibit # 5); [T-12-18, 49].

30. Type and screen means to see what kind of blood (i.e: Type A, B, etc) the patient has, but, not necessarily setting it up or actually ordering it. The purpose of a type and screen is to put the laboratory on notice that blood might be needed. Type and screen takes approximately 45 minutes at Sisters Hospital [T-18, 203, 211, 344, 379, 568].

31. Type and cross (or crossmatch) means setting up blood to be there and available for a particular patient (the blood is set aside for that patient, checked for multiple antibodies). Type and cross takes approximately 15 to 20 minutes (in addition to the type and screen time of 45 minutes) at Sisters Hospital [T-15-16, 137, 157-158, 203, 344, 379, 568].

32. Respondent did not order any blood products to be typed and screened or typed and cross matched [T-272-273, 402].

33. The morning, admission unit nurse, Nancy Donahue, R.N., was not aware of the type or extent of surgery to be carried out on Patient A that day [T-200].

34. Neither Dr. Chung nor C.R.N.A. Kakavand knew what to expect about the length or extent of the surgery scheduled for Patient A [T-16-17, 381].

35. Dr. Myers, the resident on the surgery, was not aware of the type or process for surgery that morning [T-376-377, 395-398, 413-414].

36. Dr. Myers received his information concerning the method for surgery from the parents of the patient that morning [T-376-377, 395-398, 403, 413-414].

37. The parents of Patient A first went to Children's hospital [T-320].

38. Respondent was unsure on the day of surgery whether he would begin with an intraoral excision or an external excision [T-351-352, 377, 395, 403, 462-463].

39. Patient A was intubated a second time with a laser safe tube because the first tube used to intubate did not withstand manipulation of the hemangioma by the residents during the examination under anesthesia. The surgical team was unsure what tube should be used [T-23, 381].

40. The surgery on Patient A started at 10:00 A.M. [T-23]. By 10:30 A.M. the patient had lost 350 milliliters of blood [T-23-24]. By 11:00 A.M. the patient had a total blood loss of 738 milliliters [T-24]. By 11:45 A.M. the patient had a total blood loss of 1,200 milliliters [T-28]. By 1:00 P.M. the patient had a total blood loss of 1,700 milliliters [T-30]. By 3:00 P.M. the patient had a total blood loss of 2,352 milliliters [T-34]. By the end of surgery, 4:30 P.M., the patient had a total blood loss of at least 3,199 milliliters [T-40, 43]; (Petitioner's Exhibit # 5).

41. Patient A's total blood volume was calculated to be 2,160 milliliters [T-40].

42. Dr. Chung was not told of the amount of time needed for surgery until the patient was already under anesthesia and the operating room team was scrubbing [T-381].

43. Between 10:00 A.M. and 11:00 A.M., Patient A suffered drops in blood pressure and increases in heart rate (episodes of hypotension and tachycardia) (Respondent's Exhibit # 5); [T-24, 385, 406].

44. Patient A needed his first transfusion (1 unit of packed cells) less than one hour after surgery began. Patient A subsequently required four more units of blood or blood products. Patient A lost approximately one unit (500 milliliters) of blood per hour of surgery, a total which is excessive over a long (6 ½ hours) period of time (Petitioner's Exhibit # 5); [T-25, 29, 40, 325-326, 575, 578].

45. The first transfusion was given to address the need to replace Patient A's loss of fluids and his episodes of hypotension and tachycardia (Petitioner's Exhibit # 5); [T-385, 406, 576].

46. Patient A required the use of an arterial line. An arterial line is used to monitor changes in blood pressures and also to sample the actual amount of oxygen within the arterial blood. The arterial line, inserted at approximately 12:30 P.M., was used because there was major blood loss and to better monitor what was happening with the patient [T-95-96, 477-478].

47. At 1:00 P.M. the first discussion of post-operative care for the patient was being discussed by Respondent and the operating room team. It was clear by that time that there would be a need for post-operative ventilation and admission to an ICU [T-37].

48. Since only two units of blood had been ordered, more units had to be set up. There was a delay while waiting on the next units of blood. The third transfusion was given at 1:15 P.M. [T-29-31].

49. Dr. Chung had been in and out of the room several times during the entire surgery and was aware of the blood loss and discussed it with Respondent. Dr. Chung was concerned and asked, repeatedly (at least three times), how much longer the surgery would take. (Respondent's Exhibit # 5); [T-30, 33, 38, 51, 188, 385-386]. Dr. Chung also told Respondent the team was having a difficult time keeping up with the patient hemodynamically [T-385, 401].

50. At 1:30 P.M., Patient A suffered drops in blood pressure which was addressed with blood being given to the patient (Respondent's Exhibit # 5); [T-576].

51. At 2:00 P. M. the lab tests results for "the FDP, fibrinogen, PT, and PTT"[8] levels (blood had been submitted at 12:30 P.M.) came back and were dangerously abnormal (Respondent's Exhibit # 5); [T-31, 45-46].

52. The results of the 2:00 P.M. lab tests showed, and Respondent was informed, of the possibility that Patient A was developing disseminated intravascular coagulation ("**DIC**")[9]. DIC is an acquired initiation of a coagulation cascade that sets up microvascular thrombi that will cause multi-system failure. DIC is a disequilibrium between bleeding and clotting within all the systems and multi-system failure can occur [T-32-33, 94].

53. At 2:00 P.M. Children's Hospital was called at the direction of Respondent to reserve a bed in their ICU (Respondent's Exhibit # 5); [T-37-38].

54. Fresh-frozen plasma and super packed platelets were ordered at 2:00 P.M. to deal with the DIC condition the patient was nearing [T-33-36, 39, 289, 291, 385].

55. The fresh-frozen plasma was given when it arrived at the operating room at approximately 3:00 P.M. The super packed platelets were given at approximately 4:00 P.M., as they had to be ordered from the Red Cross. (Respondent's Exhibit # 5); [T-34-36, 290].

56. At 3:30 P.M., Patient A suffered more drops in blood pressure which was addressed with fresh frozen plasma being given to the patient (Respondent's Exhibit # 5); [T-576].

57. At 3:30 P.M., Respondent was told, by C.R.N.A. Kakavand, that she thought the patient was in DIC [T-38-39].

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[8] FDP is an abbreviation for fibrin/fibrinogen degradation products; fibrinogen is a blood clotting factor; PT is an abbreviation for prothrombin (another blood clotting factor); and PTT is an abbreviation for partial prothrombin time [T-32, 208, 266] and Stedman's Medical Dictionary, 25th Edition, 1990.

[9] DIC is defined as a hemorrhagic syndrome which occurs following the uncontrolled activation of clotting factors and fibrinolytic enzymes throughout small blood vessels; fibrin is deposited, platelets and clotting factors are consumed, and fibrin degradation products inhibit fibrin polymerization, resulting in tissue necrosis and bleeding Stedman's Medical Dictionary, 25th Edition, 1990, p. 320.

58. At 4:00 P.M., Dr. Chung came into the operating room and told Respondent that the patient was nearing DIC and that it was unsafe to continue [T-39].

59. Dr. Chung spoke with Respondent on at least three different occasions regarding the continuation of surgery [T-51-52, 291, 385].

60. Surgery on Patient A ended at 4:30 P.M. The removal of the hemangioma had not been completed (Petitioner's Exhibit # 5); [T-39-40, 289].

61. Patient A was transferred to Children's Hospital at approximately 5:00 P.M. [T-40].

62. Prior to transfer, Patient A was given his fifth transfusion [T-40, 325-326].

63. Respondent transferred Patient A to Children's Hospital for observation in the ICU, based on Respondent's concerns that such monitoring was necessary for observation of the patient's hematological status and the fact that there was no pediatric ICU at Sisters Hospital (Respondent's Exhibit # 5); [T-38, 295, 298-300; 331].

64. Patient A was subjected to six and a half hours of surgery (without any large complications except for the blood loss and the episodes of hypotension and tachycardia) versus schedule of one hour and forty five minutes or even four hours (Petitioner's Exhibit # 5).

65. Respondent was only able to complete dissecting of the facial nerve during the six and a half hours of surgery on Patient A on December 4, 1995 (Petitioner's Exhibit # 5); [T-498].

66. Patient A was subjected to significant increases in morbidity and mortality each time he required another blood transfusion and these risks increased over the course of the surgery [T-94].

67. Prior to December 4, 1995, Respondent did not have an arteriogram performed on Patient A (Petitioner's Exhibit # 4); [T-74-76, 125].

68. No ligation was performed in the December 4, 1995 surgery on Patient A (Respondent's Exhibits # 5 & # 6); [T-494, 528].

69. Patient A's PT levels were not within normal limits on transfer to Children's Hospital. His fibrinogen level was very low and did not return to a safe level for approximately 36 hours (Respondent's Exhibits # 5 & # 6).

70. Prior to or on December 4, 1995, Respondent did not embolize any vessels feeding into the hemangioma of Patient A (Petitioner's Exhibits # 4 & # 5); [T-75-76, 127-128].

71. Dr. Panje only reviewed Exhibits 1, 4 and 5 (the medical charts of Dr. Simpson, Sisters Hospital and the Statement of Charges). Dr. Panje also reviewed the professional medical conduct depositions of Dr. Simpson , Nurse Kakavand and Dr. Ruben. Finally, Dr Panje reviewed some of the articles that Dr. Ruben had obtained or had researched from Med. Index [T-443-445, 490-491].

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 May 16, 1996, Statement of Charges, are **SUSTAINED:**[10]

Paragraphs A. & A.1.	:	(11-18, 21, 23-27, 47, 53, 61, 63)
Paragraphs A.2 & A.2.a	:	(11-15, 28-36, 40-46, 48)
Paragraph A.2.b but not A. or A.2	:	(11-14, 21-22, 68)
Paragraphs A.2 & A.2.c	:	(11-14, 16-20, 23-66)

[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.

Paragraph A.2.d but not A. or A.2 : (11-14, 21-22, 71)

Paragraphs A. & A.3 : (11-15, 40-46, 48-62, 64-66, 68-69)

Based on the above and the complete Findings of Fact, the Hearing Committee, by a VOTE of 2 to 1, concludes that the Specification of practicing with gross negligence contained in the May 16, 1996, Statement of Charges is **SUSTAINED:**[11]

SPECIFICATION: (Paragraphs: A., A.1., A.2., A.2.a., A.2.c. & A.3.).

DISCUSSION

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

The Administrative Law Judge ("**ALJ**") issued copies, to 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 with gross negligence.

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

[12] A copy of this memorandum, was made available to Respondent on the first day of the Hearing, June 10, 1996 [T-6].

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

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

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). 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 is to make a determination as to which evidence is 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. Robert Ruben, as the State's expert, had no professional association with Respondent. Dr. Ruben was considered to be knowledgeable in the area of pediatric surgery. No reason was advanced to show Dr. Ruben to have any prejudice against Respondent. By his own testimony, Dr. Ruben admitted that he has not had a great deal of experience with the type of major head and neck surgery presented in this case. His expertise lies in somewhat less complex pediatric head and neck surgery. Overall, the Hearing Committee found Dr. Ruben to be credible, honest and forthright and accepted a number of his opinions, which were supported by Patient A's medical record. Dr. Ruben gave detailed impartial testimony 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. William Panje as the Respondent's expert presented credible and thorough review of the information which he was provided. Dr. Panje was impressive, erudite, and practical. Dr. Panje gave the Hearing Committee a good lecture/presentation on proper ENT surgery. The Hearing Committee believes that Dr. Panje called it "the way he saw it." The Hearing Committee believes that Dr. Panje's testimony was truthful in light of the fact that Dr. Panje was not given all of the medical records, all the available evidence and his view of the surgery was limited because of his acceptance of the testimony of Respondent. He 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. His testimony was practical, pragmatic and forthright.

Dr. Knight's testimony was found to be somewhat evasive, and on occasion arrogant.

Dr. Myers was believed to be generally credible and straight forward. The Hearing Committee agreed with the State's counsel that Dr. Myers was in a tough spot but his position did not affect the veracity of his testimony.

Nurse Rickard's hearsay testimony was corroborated by other evidence. Nurse Kakavand and Nurse Donahue were credible and forthright fact witnesses with no apparent bias toward Respondent.

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. His testimony showed a general laisser-faire attitude uncommon of a prudent surgeon. Taking into consideration the above, respondent's bias, and lackadaisical attitude, the Hearing Committee found Respondent's testimony not as credible as the other witnesses.

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

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a vote of 2 to 1 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 charge of misconduct contained in the May 16, 1996 Statement of Charges. The Hearing Committee was of the opinion that the factual allegations could have been set out or documented more from a medical point of view.

The Hearing Committee votes 2 to 1 to sustain the charge of misconduct against Respondent. Respondent's care, treatment and management of Patients A was a significant and egregious deviation of acceptable standards of medical care required of an ENT. Respondent was grossly negligent in the medical care he provided to Patient A.

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

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

I. Schedule of the procedure at Sisters Hospital

The Hearing Committee finds that Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that he scheduled and performed the surgery on Patient A's hemangioma at Sisters Hospital rather than a facility with a pediatric intensive care

unit. This error, which may have started as poor judgment, was almost catastrophic for Patient A. Respondent knew, or should have known, that Sisters Hospital did not have a pediatric ICU. The surgery on Patient A, on December 4, 1995, should not have been performed at Sisters Hospital. The procedure was an elective, extensive, major surgery and proper planning for this surgery would include ascertaining the availability of pre, peri and post-operative services (such as airway problems, massive bleeding and ICU care) necessary for this type of procedure. Respondent admitted performing a similar, smaller and less complex, procedure at Children's Hospital previously. There was no medically reasonable explanation why this procedure was not done at Children's Hospital as well. Patient A's intubation and transfer to Children's Hospital after 6 1/2 hours of surgery substantially increased Patient A's morbidity. Children's Hospital is equipped with a pediatric ICU and a prudent ENT would have anticipated and prepared for a large loss of blood on this 8 year old patient. Therefore, a prudent ENT would have inquired, before the surgery, if an ICU bed could be available , if needed, for Patient A.

Having a choice between two institutions, one of which specialized in children and had the resources available, a prudent physician, dealing with this major type of hemangioma would chose the institution that had the specialized care. The Hearing Committee unanimously determines that Respondent's use of Sisters Hospital for Patient A's surgery was negligence.

II. Providing for blood and blood products

The Hearing Committee finds that Respondent failed to perform a proper pre-operative evaluation on Patient A in that he failed to take adequate steps to provide for blood and blood products during surgery. By everyone's testimony, the surgical removal of Patient A's hemangioma was a major case. Respondent created a significant potential problem and risk to Patient A's health by failing to have blood, at least, typed and screened, if not typed and crossed matched, prior to bringing Patient A to the operating room. This type of major elective surgery

called for type and screen to be done the day before the date of the scheduled surgery. This is true even though the patient lived more than an hour away from the hospital.

As indicated by Dr. Ruben, the extent of the pre-operative blood work done for Patient A was not within acceptable standards of medical care. A reasonably prudent physician would have had the blood work done sometime before the day of this elective surgery under the circumstances presented by Patient A's condition.

Respondent was fortunate that Patient A did not have a rare blood type which may not have been available in the hospital's blood reserves. Respondent was also fortunate that sufficient quantities of blood and blood products were available, or made available, in the hospital blood reserves. Although the Hearing Committee recognizes that some steps were done to provide for blood prior to the actual incision, the Hearing Committee is of the opinion that these steps were late and not adequate. Respondent placed Patient A at additional risks for no reason by not providing for blood ahead of time, but waiting until the patient was anesthetized before drawing blood for typing and screening. As testified, a surgery of this type would normally require two to four units of blood (Dr. Panje indicated four to six units). If Respondent had communicated to the anesthesia team that two to four units of blood were anticipated, the anesthesia team could have been better prepared.

The Hearing Committee believes that it was fortunate circumstances that the blood was available when needed shortly after 10:30 A.M. The Hearing Committee believes that the episodes of hypotension and tachycardia could have been avoided if there had been adequate supplies of blood available in the operating room. The combination of lack of planning, lack of communication with the staff, having to send for additional units of blood several times, and the absence of blood being drawn earlier for testing shows the failure of Respondent to take adequate steps for this surgery. This was an elective case in which acceptable standards of

medical care were not met where blood is drawn for testing, with the patient under anesthesia, five minutes before the first incision was made. The Hearing Committee unanimously determines that Respondent was negligent in not providing for blood and blood products for Patient A.

III. Arteriogram

Respondent did not perform or order an arteriogram. The Hearing Committee agrees with Respondent and Dr. Panje that in this case an arteriogram was not essential. The MRA is a special test for arterial system evaluation, especially in the head area. As Respondent testified:

> ... necrosis is a risk of both embolization and arteriography. The state of the art now with magnetic resonance angiography is such that except in dealing with a diagnosis involving conditions within the lumen of specific vessels, the quality of the information is essentially as good in identifying blood vessels and vessel flow. It is superior in offering the potential of delineating the volume of the tumor mass and its relation to surrounding tissues ... . In a child it is an ideal test. It gives you maximum information at very low risks.

As Dr. Panje testified:

> Typically you try to stay away from doing angiograms or arteriograms and embolization on low flow vascular tumors because they have a much higher complication rate. Vascular lesions that occur on the facial or the outside parts of the face or the head and neck, are less likely to be embolized because doing so have caused major infarcts of tissue, necrosis of facial tissues, facial muscle, the facial nerve, paralyzation of the facial nerve ... we have also found that embolizing these types of tumors that the low-flow ones, you can go in and embolize it and it makes the tumor bigger and it actually makes the blood come in from the periphery more after you do it and a lot of times you go in and, say, I embolize this patient and yet they are bleeding even more than I anticipated ...

The Hearing Committee also agrees with Dr. Panje that the MRI and MRA done before the December 4, 1995 surgery was an appropriate procedure to evaluate Patient A's vascular mass. It was consistent with medically accepted standards of care for Respondent to have used the MRI/MRA diagnostic test in his pre-operative evaluation of this patient.

> ... Arteriography is great for selectively identifying blood vessels to the area. And if you are going to embolize and that's the only time we will do that now is if we are going to embolize. If we feel we are going to embolize, we will do the arteriography. If we feel that there is a high chance that we are not going to need embolization and we figure it's a low-flow condition, it's a hemangioma, we just do the MRA and MRI.

The dangers of an arteriogram for this patient, with this hemangioma, may have outweighed its benefits. The Hearing Committee unanimously determines that Respondent was not negligent in not performing or ordering an arteriogram.

IV. Surgical plan and post-operative plan

Respondent failed to adequately prepare or document a surgical plan or a post-operative plan for Patient A prior to surgery. The Hearing Committee did not expect Respondent to have a "10 step" plan. Respondent did not have a clear plan for surgery. There is no indication, in the medical records and in the testimony presented, that the surgery had been previously planned or thought out. There is no believable evidence of a written plan or oral communications to the operating room team concerning a clear pre or post-operative plan. Respondent did not know, five minutes before surgery, whether Respondent was going to do the incision intra orally or by an external incision; the operating room instruments were not set up correctly, the type of intubation tube was a guess by the staff; scheduled hours of surgery went from 1 3/4 to 4 to 6 1/2 hours; no blood testing or blood matching was done on Patient A until the patient was actually in the operating room; Patient A had to be transferred to another hospital; Respondent indicated that he was expecting to be discharging Patient A that evening but Respondent was also expecting to have Patient A admitted to an ICU at Sisters Hospital. The only post-operative plan which could be deduced by the Hearing Committee was that if anything went wrong, the patient would be transferred to Children's Hospital. Even that plan was not

thought out until 1:00 P.M., when Patient A's condition was deteriorating. The Hearing Committee finds that all of these factors, as well as others included in the findings of fact, are indicative of Respondent's lack of communication and planning. Although the Hearing Committee agrees with Dr. Panje that there is a need for some flexibility, Respondent's failure to provide necessary information to the surgical team placed the patient, unnecessarily, at increased risk. This is especially true considering that this surgery was an unusual, major and rare case in which a number of residents wanted to "scrub in" to observe. The other members of the surgical team had inadequate information to prepare for this major surgery. As Dr. Panje indicated:

> "I come into my room and we talk, 'What are we doing today? What do you expect here?' And they -- a lot of them say, 'Are you going to be here longer than two-and-a-half hours?' He says, 'We are going to put a Foley in.'. And if he thinks it's an unstable person, if there is some problems with instability, he puts in all the monitors he wants and I don't tell the anesthesiologist what to do. They are trained, ... they have board certification, ... they are the ones that have to monitor the patient, so I let them do that."

This type of communication did not occur on December 4, 1995 between Respondent and the surgical team.

Although the Hearing Committee did not necessarily expect a written surgical plan (and one was not done by Respondent), Respondent's failure to communicate orally placed the patient at additional, unnecessary, risk. The Hearing Committee believes that in essence Respondent was "winging it" and doing the surgery by the "seat of his pants" A reasonably prudent physician would have had communicated to the operating room team, pre-operatively, at least, what to expect, what was going to be done, and, generally, how it was going to be accomplished. The Hearing Committee unanimously determines that Respondent's failure to adequately prepare a pre and post-operative plan for Patient A was negligence.

V. **Embolization of the major feeding vessels**

Respondent did not embolectomise the major feeding vessels. The Hearing Committee agrees with Dr. Panje and Respondent that low (blood) flow hemangiomas do not necessarily do well when embolized. The dangers of embolization for this patient, with this hemangioma, may have outweighed its benefits. Arteriograms and embolization are more fully discussed in Part III above.

The increased risks associated with embolization were not warranted in this case. Even some of the documents reviewed by Dr. Ruben show similar conclusions. Therefore, the Hearing Committee unanimously determines that Respondent was not negligent in failing to embolize the major feeding vessels.

VI. **Continuation of surgery despite extensive blood loss**

Respondent failed to provide acceptable standards of medical care in that he continued surgery despite repeated and extensive blood loss. By 2:00 P.M. when the FDP, fibrinogen, PT, and PTT results came in from the lab, there were indications that thoughts should be given to stopping the surgery. Although Respondent could reasonably assume that the anesthesia team would try to control and regulate the coagulopathy, that was the time for a reasonably prudent surgeon to choose a good point to begin to "close up" and terminate this elective surgery. Respondent continued surgery for an additional two hours before understanding and acting on the communications from the anesthesia team that the patient was in danger of DIC. DIC, coagulopathy and the episodes of hypotension and tachycardia were indicative of repeated and extensive blood loss by Patient A. Respondent knew, or should have known, of Patient A's coagulopathy. Respondent did not know for sure whether the anesthesia team would be able to control the coagulopathy. Respondent was not near the end of the surgery.

Under the above circumstances, a reasonably prudent surgeon would have terminated this elective surgery before the third request. Failure to do so was negligence. The response of Respondent to the continuing blood loss in Patient A, during the surgery of December 4, 1995, was not within acceptable standards of medical care. The Hearing Committee determines that Respondent's continuation of the surgery despite repeated and extensive blood loss was negligence.

Gross Negligence

The Hearing Committee finds, determines, and concludes, by a vote of 2 to 1, that when taken in the aggregate, the four separate acts of negligence discussed above, add up to gross negligence. The Hearing Committee, unanimously agreed that each of the four separate acts of negligence, individually, were not sufficient to arrive at a finding of gross negligence. However, when taken together, two members of the Hearing Committee agreed that, the four acts of negligence committed by Respondent during the surgery on Patient A results in egregious conduct. The Hearing Committee was concerned by the lack of attentiveness and response by Respondent by continuing surgery despite the extensive blood loss and Respondent's failure to take adequate steps to provide for blood prior to commencement of the surgery.

The actual amount of bleeding experienced by Patient A was not as critical an issue to the Hearing Committee as the Respondent's failure to act appropriately. In addition, it appeared to the Hearing Committee that Respondent made no serious consideration for intensive care after the surgery and had no thought out plan prior to the surgery. The "success" of the December 4, 1995 surgery was the result of luck, not the result of Respondent's attentiveness to details or communication. Two members of the Hearing Committee determined that there were a sufficient amount of major flaws in the care and treatment of Patient A on December 4, 1995 by Respondent, in the aggregate, to arrive at a result of gross negligence.

Respondent was chief of the otolaryngology department at Sisters Hospital. He should have known that Sisters did not have a pediatric ICU. The anesthesia team did know and they also knew that, under existing policies, this surgery should not be performed at Sisters. One would have expected the anesthesia team to notify Respondent of that fact. Unfortunately, Respondent did not communicate to the anesthesia team what he was "planning" for Patient A, and, therefore, they were unable to tell him that this type of surgery was against the policy and procedures of Sisters Hospital.

Respondent was only able to complete dissecting of the facial nerve during the six and a half hours of surgery on Patient A on December 4, 1995. The Hearing Committee took that fact as an indication of Respondent's lack of planning. It is an example of a "slow puttering surgeon" unclear of his next steps. It was Respondent's responsibility to know what each step, or alternatives, were and how to get there. It was Respondent's responsibility to be prepared for an ICU option, for blood products, for knowing when to stop, and for having a concrete plan.

The Hearing Committee believes that this surgery was done at Sisters for the convenience of the Respondent. Respondent acted like a technician, with a "what have I got today" attitude. If in fact Respondent had a plan in mind, he certainly did not share that plan with anyone. In sum, the Hearing Committee is of the unanimous opinion that Respondent did not approach this major surgery with the deference it required.

The dissent (one member of the Hearing Committee) did believe that Respondent was negligent, on the four separate factual allegations, but could not agree that the negligence was sufficient to be of egregious consequences. He did indicate that he was of the opinion that Respondent showed very poor judgment and failed to provide acceptable standards of medical care and treatment to Patient A during the surgery. The only issue in which the dissent disagreed with the other members of the Hearing Committee, was on a finding of gross negligence. All other findings, conclusions and determinations were unanimous.

DETERMINATION AS TO PENALTY

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

Respondent's license to practice medicine in New York State should be SUSPENDED for two (2) years; one and one half (1 ½) year of said suspension should be STAYED. Respondent should be placed on probation in New York State for a period of two (2) years from the effective date of this Determination and Order; and Respondent must comply with the standard terms and conditions of probation contained in Appendix II.

Respondent's probation should be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct.

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

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

Once the Hearing Committee arrived at a finding of gross negligence, the three members voted unanimously for the penalty indicated above. The Hearing Committee agreed that: Respondent is capable of providing good and adequate medical care; Respondent is not incompetent; Respondent has provided a service to the community in his research studies and production of young physicians through his teachings at SUNY, Buffalo.

Respondent has made significant contributions, as shown by his Curriculum Vitae, to many organizations, his medical field, and to medicine in general. The Hearing Committee believes Respondent is capable of continuing to contribute to medicine. Therefore, the Hearing Committee determines that license revocation would be disproportionate, inappropriate and excessive.

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. Respondent's teaching provides sufficient public service.

The Hearing Committee does not believe that re-training or attendance at CME seminars is appropriate because there was no evidence that Respondent lacked competence. The Hearing Committee does not believe that monitoring would be beneficial because surgeries performed by Respondent need to be viewed before they occur. Monitoring is more of an after the fact remedy.

The Hearing Committee was disappointed that no penalty recommendations were provided by the State. The Hearing Committee found it difficult to arrive at an appropriate penalty under the law, but unanimously believes that the penalty imposed above is an appropriate balance between adequately safeguarding and protecting the public and sufficiently punishing Respondent for his conduct.

The Hearing Committee does strongly believe that overall Respondent, is capable of providing medically acceptable care and treatment. However, Respondent has a mildly arrogant attitude and a "I'm the best, don't question me" view of himself, which needs to be addressed.

It is for that reason that the Hearing Committee believes a 2 year period of Probation will help Respondent, as well as adequately safeguard and protect the public. In addition, the Hearing Committee believes that an actual 6 month suspension with 1 1/2 years of stayed suspension will send a sufficiently sobering message to Respondent and will better benefit society than revocation or other penalty.

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

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

ORDER

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

1. The Specification of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) is **SUSTAINED**, by a vote of 2 to 1; and

2. Respondent's license to practice medicine in New York State is **SUSPENDED for two (2) years** from the effective date of this Determination and Order; and

3. **One and one half (1 ½) year of the SUSPENSION is STAYED** as long as Respondent complies with the terms of probation; and

4. Respondent shall be on **PROBATION** in New York State for a period of **two (2) years** from the effective date of this Determination and Order; and

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

6. Respondent's probation shall be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct; and

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

DATED: Albany, New York
September, 25 1996

PETER B. KANE, M.D. (Chair),

ERNST A. KOPP, M.D., and

IRVING S. CAPLAN

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
GEORGE TRUE SIMPSON, M.D.	:	CHARGES

----------X

George True Simpson, M.D., the Respondent, was authorized to practice medicine in New York State on November 15, 1990 by the issuance of license number 184484 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995, through March 31, 1997, with a registration address of 130 Lebrun Road, Buffalo, New York, 14215.

FACTUAL ALLEGATIONS

A. Respondent, on or about December 4, 1995, provided surgical care to Patient A [patient is identified in Appendix], an eight year old boy, for removal of a massive, cavernous facial hemangioma, which caused the patient facial disfigurement, drooling and oral bleeding. The surgery took place at Sisters Hospital in Buffalo, New York. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that:

1. Respondent scheduled the procedure at Sisters Hospital rather than a facility with a pediatric intensive care unit.

2. Respondent failed to perform a proper pre-operative evaluation of Patient A in that:

   a. Respondent failed to take adequate steps to provide for blood and/or blood products during surgery.

   b. Respondent failed to perform and/or order an arteriogram.

   c. Respondent failed to adequately prepare and/or document a surgical plan and/or post operative plan for Patient A prior to surgery.

   d. Respondent failed to embolectomise the major feeding vessels.

3. Respondent continued surgery despite repeated and extensive blood loss.

SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a single occasion under N.Y. Educ. Law §6530(4) (McKinney Supp. 1996) in that Petitioner charges:

1. The facts in paragraphs A and A.1, and/or A.2, and/or A.2.a, and/or A.2.b, and/or A.2.c, and/or A.2.d, and/or A.3.

DATED: May 16, 1996
Albany, New York

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

APPENDIX II

APPENDIX I I

TERMS OF PROBATION

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

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board addressed to the Director, Office of Professional Medical Conduct, (hereinafter "**OPMC**") Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. The probation periods shall be tolled until the Respondent returns to practice in New York State.

6. Respondent shall have quarterly meetings with an employee or designee of OPMC during the periods of probation. In these quarterly meetings, Respondent's professional performance may be reviewed by inspecting selections of office records, patient records and hospital charts.

7. Respondent shall submit semi-annual declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

8. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

9. Respondent shall maintain legible medical records which accurately reflect evaluation and treatment of patients. These records will contain, at least, a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment.

10. All expenses, including but not limited to those, of complying with these terms of probation and the Determination and Order, including retraining and monitoring, shall be the sole responsibility of the Respondent.

11. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.