STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

June 29, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

E. Marta Sachey, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Kevin D. Porter, Esq.
Bower and Gardner
110 East 59th Street
New York, New York 10022

Gerald Einaugler, M.D.
33 New Port Drive
Hewlett, New York 11557

Effective Date: 7/6/94

RE: In the Matter of Gerald Einaugler, M.D.

Dear Ms. Sachey, Mr. Porter and Dr. Einaugler:

Enclosed please find the Determination and Order (No. BPMC-94-101) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
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:crc

Enclosure

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

IN THE MATTER

OF

GERALD EINAUGLER, M.D.

DETERMINATION

AND ORDER

OF THE

HEARING COMMITTEE

ORDER NO.BPMC-94-101

The undersigned Hearing Committee consisting of **MS. OLIVE M. JACOB, Chairperson, ROGER M. OSKVIG, M.D.,** and **DANIEL A. SHERBER, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Esq.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) of the New York State Public Health Law and sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **GERALD EINAUGLER, M.D.** (hereinafter referred to as "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 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 PROCEEDING

Original Notice of Hearing and Statement of Charges:	May 19, 1993
Notice of Hearing returnable:	June 23, 1993
Place of Hearing:	New York, New York
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	Diane Abeloff, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York
Respondent appeared in person and was represented by:	Kevin D. Porter, Esq. Bower and Gardner 110 East 59 th St. New York, New York 10022
Respondent's present address	33 New Port Drive, Hewlett, N.Y. 11557
Hearings held on:	March 1, and 24, 1994 April 7 and 11,1994
Conferences held on:	March 1, 1994
Closing briefs received: State Respondent	 May 17, 1994 May 23, 1994
Record closed:	June 1, 1994
Deliberations held:	June 1, 1994

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has committed Gross Negligence, negligence on more than one occasion and Gross incompetence. Respondent is also charged with misconduct under Education Law Section 6530 (9) (a) (i) on the basis of his conviction of a crime. The allegations arise from the treatment of two patients. one in 1989 and the other in 1990. The charges also arise from a criminal conviction of June 4, 1993 which arose out of the care of one of

the patients. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges except that Respondent admitted that a jury verdict was rendered. Respondent interposed affirmative defenses, all of which are more particularly set forth in Respondent's Verified Answer, which is attached hereto as Appendix II.

The State called these witnesses:

Micheline Sanon, L.P.N.	Fact Witness
Ira Yearwood, L.P.N.	Fact Witness
Charlene L. Lowe, RN	Fact Witness
Irving Dunn, M.D.	Fact Witness
Stephen Moshman, M.D.	Expert Witness

Respondent testified in his own behalf and called these witnesses:

Elister Dennie, RN	Expert Witness
Eleanor Kay, R.N.	Expert Witness
William Lois, M.D.	Expert Witness
Morton Kurtz, M.D.	Expert Witness

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Committee that negligence is the failure to use that level of care and diligence expected of a prudent physician under the circumstances. The standard to be applied is consistency with accepted standards of medical practice in this state. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Incompetence was defined as a failure to exhibit that level of knowledge and expertise

expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. Gross incompetence was defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any. Under any circumstances, the Committee was instructed that patient harm need never be shown to establish negligence in a proceeding before the Board For Professional Medical Conduct.

The following findings of fact were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The State was required to meet the burden of proof 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. Unless otherwise stated, all findings and conclusions herein were unanimous.

GENERAL FINDINGS OF FACT

Respondent was authorized to practice medicine in New York state on February 25, 1977, by the issuance of license number 129970 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 33 New Port Drive, Hewlett, N.Y. 11557

FINDINGS OF FACT WITH REGARD TO PATIENT A

A.1. Patient "A" was a 78 year old woman who was admitted to the Jewish Hospital and Medical Center of Brooklyn (JHMCB) on May 18, 1990. (Ex. 3, p. 1). Patient A, at the time of admission was not communicative, bedridden and blind. She had a history of diabetes mellitus, End Stage Renal Disease (ESRD), and was receiving Intermittent Peritoneal Dialysis ("IPD") (Ex. 3 p. 14; T. 295-296)

A.2. Patient A had been transferred to JHMCB from Interfaith Medical Center (IMC) at about 3 p.m. on Friday, May 18, 1990. (Ex. 3, p. 19)

A.3. Upon admission to the nursing home, patient A was accompanied by a transfer summary. It was noted in the transfer summary that the patient was receiving Sustacal. Sustacal is a fluid nutritional supplement. (T. 413). Various other medications were also listed, but the route of administration of these medications was not noted. (Ex. 3, p. 11)

A.4. Patients who are being transferred from a hospital to a nursing home, are required to be sent to the new facility with a Patient Review Instrument (PRI). (10 N.Y.C.R.R. 400.13). At the time of her admission to the nursing home, the PRI was not with patient A. (T. 84)

A.5. Shortly after admission to the nursing home, patient A was examined by Respondent. A physical examination report was documented. (Ex. 3, pp. 14 and 16; T. 162) Upon evaluation of patient A, Respondent observed a tube or catheter in the patient's abdomen, situated a little to the right midline of the umbilical area. This is not the usual location for a Tenckhoff Catheter. It is also not the usual location for a gastrostomy tube(T. 139, 185, 213,289, 296, 396,402,407; Ex. E)

A.6. Based upon the information available in the transfer summary, and his physical examination of the patient, and the location of the tube that he observed, Respondent concluded that the tube that he saw protruding from patient's abdomen was a gastrostomy tube used for feeding. He wrote admission orders which included Isocal feedings via g. t. tube (Ex. 3 p. 5; T. 402).

A.7. This order was carried out by the nursing staff and the patient was fed through the tube from May 18 through the early morning of May 20th.

A.8. Early on the morning of May 20th, the nursing staff found the patient's abdomen to be distended. The Patient was in discomfort. The nursing supervisor was called. The Nursing supervisor recognized that the tube was not a gastrostomy tube, but rather a Tenckhoff Catheter, which was not meant or intended for feedings. (T.73-6

A.9. Respondent was notified by telephone at his home by the nursing staff about the discovery of this error. He was informed that the nursing staff had removed approximately 2000 cc. of feeding solution from the peritoneal cavity of the patient. The nursing staff reported that the patient's vital signs were stable

A.10. Respondent immediately telephoned Dr. Dunn at his home that morning to discuss the mistake that had occurred and to seek his guidance. In this conversation with Dr. Dunn, the respondent provided information about the patient's vital signs and general health status as told to

Allegation A.1, Respondent is charged with inappropriately leaving orders for this patient to be fed through the existing tube. The Committee sustains this charge. First, Respondent does not deny he wrote the orders which treated the tube as a gastrostomy tube, which it was not, instead of a Tenckhoff Catheter, which it was. However, in sustaining the charge, the Committee finds that Respondent's order was more than a mere error, it was a violation of appropriate standards of medicine. The conclusion regarding culpability will be addressed at length in the conclusions regarding specifications which appears below.

Therefore:

Factual Allegation A.1 is **SUSTAINED.**

In Allegation A.2 Respondent is charged with a failure to perform an adequate examination. In Allegation A.3, Respondent is charged with a failure to review the papers which were sent with the patient, including the patient summary, transfer note and Patient Review Instrument. In Allegation A.4, Respondent is cited for failing to adequately educate himself about the type of tube in this patient. As all three of these charges address what resources and information Respondent had before him at the time the patient came into his care, they will be dealt with together. With regard to the physical examination, the evidence shows Respondent did a sufficient examination to see and identify the tube and its position on the anatomy of the patient. In the context of this case, the extent of the physical examination is irrelevant beyond the fact that Respondent knew of the existence of a tube and its location. The significance of this knowledge will be addressed later. However, for the purposes of this charge, the Committee finds that the examination performed was sufficient for the purposes of addressing the charges herein. The Committee specifically avoids any finding with regard to the over all adequacy of the examination as such a finding would be beyond the scope of the inquiry herein.

With respect to the documentation which came with the patient, there is no dispute that Respondent did indeed review the patient summary and transfer note which accompanied the patient. There was much discussion of the Patient Review Instrument. Clearly, that document was unavailable to Respondent at the time he wrote his admitting orders. However, the Committee finds

that the availability of the document was of no great moment to the essence of the charge: Respondent confused a Tenckhoff Catheter for a Gastrostomy tube. Ultimately, it is the finding of the Committee that Respondent had sufficient information, at the time of admission, to make an appropriate identification of the tube in question. This also will be discussed more fully under the specifications.

Finally, in Allegation A.4, Respondent is charged with a failure to adequately educate himself about the type of tube in this patient. It is the finding of this Committee, that Respondent took the basic steps available to him in drawing his conclusion. The Committee finds that Respondent drew the wrong conclusion, not that he was careless. The Committee also notes that with the exception of a physical examination and a review of the documents, there was little in the way of data for Respondent to rely upon. The patient was blind and could not communicate at the time of admission. The location of the tube was atypical for both a gastrostomy tube as well as for a Tenckhoff. Again, the Committee finds Respondent reviewed the data available to him but did not allow the data to reveal the appropriate findings.

Therefore:

Allegation A.2 is **NOT SUSTAINED.**

Allegation A.3 is **NOT SUSTAINED.**

Allegation A.4 is **NOT SUSTAINED.**

In Allegation A.5, Respondent is charged with a failure to transfer the patient to the hospital in a timely manner. Here, the Committee was split. The majority found that Respondent should have immediately transferred this patient to the emergency room. It was the opinion of the majority that given the fragile state of this patient's health as well as her age and the enormity of the anatomical insult to her, there was nothing to be lost by an immediate transfer and waiting was an unacceptable alternative. Had the patient been transferred, antibiotics could have been started, the patient's renal functions could have been measured, and she could have been observed under

controlled surroundings. Much was made of the fact that the patient was generally stable and once the fluid was drained, appeared to be in no discomfort. However, this ignores the fact that a foreign body which was capable of fermentation had been introduced to the body cavity. This was a situation which included peritonitis to one degree or another. Immediate action, to avoid the patient becoming unstable, was warranted. The patient's condition, at the time the error was discovered could have been seen as a serendipitous delay of what would undoubtedly be a very serious course for this particular patient. Finally, Respondent submitted significant evidence to the effect that Dr. Dunn, the doctor under whose care dialysis would be performed, thought the patient could wait until the following day; that little would be done for her if she were admitted on a Sunday. It is the finding of the majority that Respondent should have had this patient admitted through the Emergency Room if necessary, but that the patient needed to be in a hospital rather than a nursing home. While the Committee recognizes that lavage and other activities that the patient needed might not be performed on a Sunday, that misses the point. This fragile patient had been significantly compromised. There was little the nursing home was capable of doing for her. While there was little the hospital was likely to do on a Sunday, the fact is that the hospital had capabilities available to it that the nursing home did not. As far as the majority was concerned, the immediate transfer of this patient was not a close judgement call but rather a clear and obvious one.

It was the opinion of the minority that Respondent took appropriate action by contacting the patient's treating physician and deferring to his judgement. The minority view was that the State had not established that this patient was in serious danger at the time of discovery. Hence, based upon the record before the minority, it could not be said that Respondent failed to act in a timely manner.

Therefore:

Allegation A.5 (by a 2-1 vote) is **SUSTAINED**

FINDINGS OF FACT WITH REGARD TO CONVICTIONS (ALLEGATIONS B)

On or about June 4, 1993, after a jury trial, Respondent was convicted of two misdemeanors. The first misdemeanor was reckless endangerment in the second degree, which constitutes a violationof section 120.20 of the Penal Law. The conviction states that on May 20, 1990, Respondent recklessly engaged in conduct which created a substantial risk of serious physical injury toPatient A when he failed to immediately hospitalize Patient A after learning that she hadbeen given Isocal through a peritcneal catheter.

The second misdemeanor conviction was for the willful violation of Section 12(b) of the Public Health Law. That conviction states that: Respondent neglected Patient A by ordering a feeding solution be administered through a peritoneal dialysis tube and, having become aware of that error and of the necessity for immediate hospitalization in order to rectify it, knowingly failed to do so. (Pet. Ex.. 6,7)

CONCLUSIONS WITH REGARD TO CRIMINAL CONVICTIONS

Respondent is collaterally estopped from denying the facts contained in Allegation B.

FINDINGS OF FACT WITH REGARD TO PATIENT B (ALLEGATIONS C)

C.1. Patient B was a 67 year old woman who was admitted to the Jewish Hospital and

Medical Center of Brooklyn (JHMCB) on May 26, 1989 (Ex. 5, p. 1). Patient B at the time of admission had a chronic tracheostomy. She was routinely capable of breathing room air. (Ex. 5, p. 18; T. 264, 230).

C.2. On June 21, 1989, the patient's metal tracheostomy tube came out as she was being suctioned by a licensed practical nurse. (Ex. 5, p. 57; T. 23, 41).

C.3. Respondent had just completed his annual assessment of the patient and was located close by, at the nursing station performing paper work. (T. 43-44, 218, 262)

C.4. Upon notification of the displacement of the tracheostomy tube, Respondent was at the patient's side in a very short period of time. (T. 24, 44-45)

C.5. Prior to calling Respondent, the nurses attempted to replace the tube. The attempts were unsuccessful and were abandoned. (T. 38, 25, 46, 36, 61-62,)

C.6. After assuring himself that the patient was in no distress, he ordered that the patient be transferred to the Emergency Room, immediately (stat).

C.7. Respondent ordered that in the interim, the patient be suctioned to keep her airway clear of any secretions. He remained in the room and observed the nurse suctioning the patient to ensure that it was being performed properly and to observe the type and quantity of secretions being removed from the trachea. (T. 24, 27, 46, 264 268)

C.8. Respondent then returned to the nurse's station, documented in the patient's medical record that the tracheostomy tube had fallen out and that she was to be sent to the Interfaith Medical Center Emergency Room stat. (Ex. D; T. 277, 278).

C.9. Respondent attempted to notify the Emergency Room resident to let that doctor know that patient B was coming to the Emergency Room and that her tracheostomy tube needed to be reinserted. The hospital operator was not able to obtain that resident. Respondent went across the street to the Emergency Room to advise the doctor of the events that had occurred. (T. 265, 277).

C.10. Insertion of a tracheostomy tube is not an easy procedure. Faulty attempts at insertion can result in such problems as local trauma, bleeding and re-occlusion. (T. 226, 371). There was no tracheostomy set or crash cart available to Respondent in the nursing home. (T. 377).

C.11. Patient B had a chronic tracheostomy. As such, a wider stoma was created. It can be anticipated that such a wide stoma generally will not close quickly. (T. 232, 233, 237). Patient B was not ventilator dependent, but was breathing room air prior to the tracheostomy tube falling out. (T. 230)

C.13. The nursing staff, made multiple attempts to reinsert this tube. The attempts at reinsertion were unknown to Respondent (T. 23, 25, 28, 38, 61, 62).

CONCLUSIONS WITH REGARD TO PATIENT B (ALLEGATIONS C)

The allegations which address Patient B are denominated Allegations C.1 and C.2. In Allegation C.1, Respondent is charged with failing to replace or attempt to replace the tracheostomy (trach) tube which had fallen from the patient. While it is certainly true Respondent neither replaced the tube nor attempted to do so, the Committee does not sustain this allegation. The essence of the allegation is that the failure to replace the tube or attempt to replace the tube

was inappropriate. The Committee finds to the contrary: That under the circumstances, ordering the patient transferred to the emergency room stat and making sure she was stable was entirely appropriate; moreover, for a physician in Respondent's situation to have attempted to reinsert the tube would have constituted sub-standard medicine. As an internist, Respondent would not be expected to be familiar with the subtleties of trach reinsertion. The evidence clearly shows that since the patient had a chronic trach site, there was little chance of spontaneous closure. The evidence further shows that insertion of a tracheostomy tube is not an easy procedure. Faulty attempts at insertion can result in such problems as local trauma, bleeding and re-occlusion. Respondent noted that there was neither a crash cart nor a trach set at the nursing home. Respondent was wise enough to recognize his limitations and the limitations of his situation. His course of conduct: to ensure that the patient was stable, order a stat transfer to the hospital and endeavor to contact the emergency room doctor, were entirely consistent with accepted medical standards.

Therefore:

Allegation C.1 is **NOT SUSTAINED**

In Allegation C.2, Respondent is charged with failing to remain with a patient whose airway was obstructed. This allegation is also not sustained. The evidence clearly shows that at the time of his examination of Patient B, after the trach tube came out, the airway of this patient was patent and clear. Respondent gave appropriate orders to maintain those conditions, including the requirement that the nursing staff suction the patient. He then remained long enough to ensure that the nurses were acting appropriately. Respondent had done his duty to this patient and he had a right to rely on the nurses to carry out his orders. More specifically, Respondent had a right to rely upon the nurses to effect the transfer on an immediate basis, as ordered, and leave the trach site alone. It is the conclusion of the Committee, based upon the testimony and evidence that Respondent had no way to know that in his absence, the nursing staff would further disrupt the trach site from additional attempts to reinsert the trach tube. It is this manipulation of the patient's anatomy which led to the calamity which befell this patient, not Respondent's absence. Respondent certainly had no duty to remain with this patient, especially given his next act, which

was to go to the emergency room and seek out the physician in charge.

Therefore:
Allegation C.2 is **NOT SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE FIRST AND SECOND SPECIFICATIONS

In the First and Second Specifications, Respondent is charged with gross negligence based upon the factual allegations with regard to Patient A and Patient B. As the Committee has not sustained Allegations A.2, A.3, A.4 and C.1 and C.2, these allegations cannot form the basis of a finding of misconduct.

With regard to Allegation A.1, which was sustained, the Committee believes that the confusion over the nature of the tube constitutes culpable misconduct. However, the Committee also believes that there was sufficient mitigation such that the conduct does not rise to the level of egregious acts. The location of the tube, was unusual. It is unlikely that at the time and given the nature of his practice, Respondent would have seen many patients with Tenckhoff catheters. Given these factors, the Committee finds an act of simple negligence, not gross negligence.

Likewise with reference to Allegation A.5, that Respondent failed to transfer the patient in a timely manner, while the Committee finds Respondent culpable, the majority cannot find that the omission constitutes a flagrant or dramatic departure from standards. Respondent consulted with an appropriate colleague and relied upon his understanding of the advice given. While the Committee believes there was sufficient basis for Respondent to admit the patient immediately, notwithstanding the opinions of others, it is understandable that Respondent would give significant weight to the opinion of Dr. Dunn. Furthermore, Respondent came to the nursing home and examined the patient twice, during the day. Such conduct, while not dispositive, is certainly

appropriate, and mitigates against a finding of gross departures from standards.

Therefore:
The First Specification is NOT SUSTAINED
The Second Specification is NOT SUSTAINED

CONCLUSIONS WITH REGARD TO THE THIRD SPECIFICATION

In the Third Specification, Respondent is charged with negligence on more than one occasion. As the Committee has not sustained Allegations A.2, A.3, A.4 C.1 and C.2, these allegations cannot form the basis of a finding of misconduct. With regard to Allegations A.1 and A.5, the Committee finds a single occasion of negligence consisting of two intertwined and dependant events. The first event was the misidentification of the tube. In his failure to accurately identify the tube which protruded from this patient, the Committee finds the first element of this occasion of negligence. The Committee concludes that appropriate attention to the details of this patient's presentation would have led Respondent to question the nature of the tube such that an accurate identification would have been ascertained. The Committee can find no excuse for Respondent's unequivocal conclusion that the tube was a g.i tube. The evidence shows clearly that this particular tube was located in a position that was inconsistent with both a feeding tube and a Tenckhoff. It follows therefore that a prudent physician would have been alerted to the existence of a tube in an unusual location and taken no irrevocable or potentially harmful action until the character of the tube could be confirmed. While the Committee is mindful that it may have been difficult to obtain appropriate information late on a Friday afternoon (the time of the transfer of this patient), given the consequences from an unconfirmed assumption and misidentification, a prudent physician would have made the effort to confirm the identification of the tube in question.

With regard to the failure to transfer this patient in a timely manner, the Committee finds this to be part and parcel of a single event of care. Had not the tube been misidentified, the peculiar

reasons that warranted this transfer would not have arisen. Therefore, the failure to transfer is combined with the failure to recognize the nature of the tube and forms a single occasion of negligence. More specifically, the Committee finds that a prudent physician would have made arrangements to have this patient admitted to a hospital immediately upon learning of the particular situation in this case. As stated previously, it is not overlooked that Respondent consulted with an expert and visited the patient twice. Moreover, the Committee recognizes that this patient would ultimately be under Dr. Dunn's service. The committee is mindful that Respondent did not have nephrology privileges at JHMC. However, he did have general admitting privileges at that facility. Ultimately, the patient was the responsibility of Respondent and the majority of the Committee finds that a prudent physician would have taken whatever steps were necessary to admit the patient on that Sunday morning including having her admitted through the Emergency Room if necessary.

The Committee has not sustained the allegations associated with Patient B (Allegation C.1 and C.2). Under the circumstances, only one occasion of negligence can be found.

Therefore:

The Third Specification is **NOT SUSTAINED**

CONCLUSIONS WITH REGARD TO THE FOURTH AND FIFTH SPECIFICATIONS

In the Fourth and Fifth Specifications Respondent is charged with gross incompetence based upon the allegations with regard to Patient A and Patient B. Since the Committee did not sustain the allegations with regard to Patient B (Allegations C.1 and C.2) the Fifth specification cannot be sustained.

With regard to Factual Allegations A.1 and A.5, which were sustained, the Committee finds neither gross nor simple incompetence. The Committee finds that Respondent knew that feeding solution would not be appropriate for entry through a Tenckhoff catheter. The Committee also finds

that the orders given with regard to the tube would have been appropriate if the tube had been a g.i tube. Therefore, Respondent knew the appropriate practices and procedures,. There was no lapse in his knowledge. The failure was in his diligent attention to detail. Therefore, with regard to the misidentification of the tube, the Committee finds no incompetence.

Likewise, with regard to the failure to transfer the patient in a timely manner, the Committee finds no fault with Respondent's skill and expertise. He knew that a very serious situation existed. He also knew the array of options open to him. His failure then, was not one of knowledge or expertise, rather, he made the wrong decision in selecting from the constellation of options open to him.

Therefore:
The Fourth Specification is **NOT SUSTAINED**
The Fifth Specification is **NOT SUSTAINED**

CONCLUSIONS WITH REGARD TO THE SIXTH SPECIFICATON

Finally, with regard to the Sixth Specification, here Respondent is charged with misconduct by virtue of his conviction of acts constituting a crime under New York state law. The Committee recognizes that under the theory of collateral estoppel, the fact that Respondent was convicted of the crimes set forth above cannot be denied. Hence, the Committee must, as a matter of law, sustain the Sixth Specification. However, the Committee makes reference to its previous discussion of the underlying facts of the conviction with regard to the conclusions of this body in reference to his care of Patient A. While the Committee has found Respondent to have acted negligently, they specifically found no egregious conduct.

Therefore:
The Sixth Specification is **SUSTAINED**

CONCLUSIONS
WITH REGARD TO PENALTY
AND
ORDER

This Committee has sustained only one specification of misconduct. That specification, the Sixth, was sustained by operation of law rather than as a judgement of the Committee. The Committee has set forth in detail its conclusions with regard to the patient care under review herein. The Committee has found one occasion of negligence in the care of Patient A. The Committee has found no evidence of incompetence on the part of Respondent. The Committee has found no egregious conduct. Moreover, the Committee has sustained none of the charges arising from the care of Patient B. The Committee has found the care provided by Respondent to Patient B to be consistent with accepted standards of medicine.

Consequently, the Committee can find no basis for action against this Respondent's license to practice medicine. While the conviction is, in and of itself, professional misconduct, it does not necessarily follow that a penalty must be attached to a Respondent's license to practice. Again, the Committee makes reference to their findings regarding the care which gave rise to the conviction.

Therefore, upon review of all the evidence and the entire record herein, the Committee concludes that no penalty should inure to Respondent arising from the events reviewed herein.

ORDER

THEREFORE, it is hereby ordered that;

The Specifications of Misconduct are **NOT SUSTAINED;**

And it is further **ORDERED THAT;**

No penalty shall be assesed against Respondent.

Dated: Albany, New York

June 29th, 1994

Olive M. Jacob
OLIVE M. JACOB
Chairperson

ROGER M. OSKVIG, M.D.
DANIEL A. SHERBER, M.D.

APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
GERALD EINAUGLER, M.D.	:	CHARGES

----------X

GERALD EINAUGLER, M.D., the Respondent, was authorized to practice medicine in New York State on February 25, 1977 by the issuance of license number 129970 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, 1993 through December 31, 1994 from 33 Newport Drive, Hewlett, N.Y. 11557.

FACTUAL ALLEGATIONS

A. On or about May 18, 1990, Patient A, (the patients' identities are contained in the appendix), a 77 year old woman with diabetes, hypertension, blindness, anemia, and end-stage renal disease on chronic hemodialysis, was transferred from Interfaith Medical Center, Brooklyn, N.Y., to the Jewish Hospital and Medical Center of Brooklyn (JHMCB), Brooklyn, N.Y. The inter-institutional transfer form stated that the patient was sent with a "Tenckhoff catheter placed for CAPD" (chronic ambulatory peritoneal

dialysis). Respondent left orders at JHMCB for Patient A to receive "Isocal 480 cc with 100cc H2O before and after each feeding at 200cc/hr. q. shift via GT" (gastrostomy tube), along with "DSD (dry sterile dressing) to GT site." This patient did not have a GT tube. The nurses followed Respondent's written orders. After 48 hours of administration of Isocal and water through the Tenchoff peritoneal catheter Patient A's abdomen became distended. Patient A developed chemical peritonitis. She died on or about May 24, 1990.

AMENDED 3/24/94

1. Respondent inappropriately left orders at JHMCB for Patient A to be fed through a GT tube; however, the patient had a Tenchoff catheter not a GT tube.

2. Respondent failed to perform an adequate physical examination of Patient A prior to issuing the orders for feeding her through the non-existent GT.

3. Respondent failed to review the summary and transfer note and/or the Patient Review Instrument from Interfaith Hospital for Patient A prior to issuing his feeding order.

4. Respondent failed to adequately educate himself about the type of tube in Patient A prior to leaving an order in Patient A's chart that she be fed through that tube.

5. Respondent failed to transfer Patient A from the nursing home to a hospital in a timely fashion.

B. On or about June 4, 1993, Respondent after a jury trial was found guilty and convicted of violating: section 120.20 of the Penal Law, reckless endangerment in the second degree and section 12-b(2) of the Public Health Law, willful violation of the health laws, by willfully committing an act of patient neglect. On or about July 23, 1993, Respondent was sentenced to spend one year of weekends at Rikers Island Prison.

C. Patient B, a 67 year old woman with a tracheostomy, was institutionalized at JHMCB. At or about 11:35 a.m. on or about June 21, 1989, Patient B coughed out her tracheostomy tube during a routine suctioning by the nursing staff. Respondent was asked by the nursing staff to help the patient. Respondent went to the patient's room and told the nurse to transfer Patient B to the hospital. While waiting for the ambulance to arrive, the nursing staff tried to maintain Patient B's airway. The nursing staff had

difficulty maintaining the airway and paged Respondent for further assistance. Respondent failed to answer his page. Respondent left the nursing home without attending to Patient B. Patient B was pronounced dead by another physician at or about 12:50 p.m. on June 21, 1989.

1. On or about June 21, 1989, Respondent failed to replace or attempt to replace Patient B's tracheostomy tube.

2. Respondent failed to remain with a patient whose airway was obstructed.

SPECIFICATIONS OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law section 6530 (4)(McKinney Supp. 1993), Petitioner charges:

1. The facts in paragraph A, A 1 through A 5.

2. The facts in paragraph C, C 1 and C 2.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASSION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law section 6530 (3)(McKinney Supp. 1993), in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in paragraph A, A 1 through A 5 and/ or C, C 1 and C 2.

FOURTH THROUGH FIFITH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law section 6530(6) (McKinney Supp.1993), in that Petitioner charges:

4. The facts in paragraph A, A 1 through A 5.

5. The facts in paragraph C, C 1 and C 2.

SIXTH SPECIFICATION

CONVICTION OF A CRIME

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law sec. 6530 (9)(a)(i) (McKinney Supp. 1993), in that Respondent was convicted of committing an act constituting a crime under New York state law, specifically:

6. The facts in paragraph B.

DATED: New York, New York
January 25, 1994

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct

APPENDIX II

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

IN THE MATTER

OF

GERALD EINAUGLER, M.D.

RESPONDENT'S
VERIFIED ANSWER

----------X

Respondent, Gerald Einaugler, M.D., by his attorneys, Bower & Gardner, as and for his Answer to Petitioner's Statement of Charges respectfully shows to this Panel and alleges upon information and belief:

FACTUAL ALLEGATIONS

1. Denies the facts as alleged in paragraph A.

2. Denies each and every allegation contained in paragraphs A1, A2, A3, A4 and A5.

3. Denies in the form alleged, except admits that a jury verdict was rendered against the Respondent on or about June 4, 1993, further admits that said conviction is currently on appeal before the Appellate Division Second Department with briefs in support of the Respondent, Dr. Einaugler, having been submitted by various medical societies, including the Medical Society of the State of New York, and refers all questions of fact to the Hearing Panel and questions of law to the Administrative Law Judge.

4. Denies each and every allegation contained in paragraphs C, C1, and C2.

FIRST THROUGH SECOND SPECIFICATIONS

5. Respondent denies each and every allegation contained in the first through second specifications.

THIRD SPECIFICATION

6. Respondent denies each and every allegation contained in the third specification.

FOURTH THROUGH FIFTH SPECIFICATIONS

7. Respondent denies allegation contained in the fourth through fifth specifications.

SIXTH SPECIFICATION

8. Denies in the form alleged, except admits that a jury verdict was rendered against the Respondent on or about June 4, 1993, further admits that said conviction is currently on appeal before the Appellate Division Second Department with briefs in support of the Respondent, Dr. Einaugler, having been submitted by various medical societies, including the Medical Society of the State of New York, and refers all questions of fact to the Hearing Panel and questions of law to the Administrative Law Judge.

FIRST AFFIRMATIVE DEFENSE

9. Respondent alleges that the medical care rendered by Respondent to patients A and B comported in all respects with

accepted standards of medical practice and that there was no departure from said standards.

SECOND AFFIRMATIVE DEFENSE

10. The factual allegations set forth in specifications one through five do not meet the statutory threshold of professional misconduct.

THIRD AFFIRMATIVE DEFENSE

11. The decision to transfer the patient to Interfaith Medical Center from the Jewish Hospital and Medical Center of Brooklyn (JHMCB) was based on accepted standards of medical practice and consistent with the recommendation of a board certified nephrologist.

FOURTH AFFIRMATIVE DEFENSE

12. The untimely notification of the Respondent by the nursing staff at JHMCB, the failure of the nurses at JHMCB to recognize and appreciate that the patient was being fed through a Tenckhoff catheter, and the inaccurate patient medical record created by these nurses were intervening, independent and competent producing causes of any alleged negligence, gross negligence, and/or incompetence in this case.

FIFTH AFFIRMATIVE DEFENSE

13. The inaccurate medical record keeping by the nurses at JHMCB has created an incompetent medical record that cannot be relied upon in this proceeeding.

SIXTH AFFIRMATIVE DEFENSE

14. The evidence from the records and testimony of the prior criminal proceeding established that the actions and treatment rendered by the Respondent conformed with accepted standards of medical practice.

WHEREFORE, Respondent, GERALD EINAUGLER, M.D. requests that the Statement of Charges be dismissed in its entirety.

BOWER & GARDNER
Attorneys for Respondent
Gerald Einaugler, M.D.

Office & P.O. Address
110 East 59th Street
New York, New York 10022
(212) 751-2900

ATTORNEY'S VERIFICATION

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

KEVIN D. PORTER, being duly sworn, deposes and says:

That he is a Partner in the law firm of Bower & Gardner, attorneys representing the Respondent, GERALD EINAUGLER.

That he has read the attached ANSWER and the same is true to his own belief, except as to matters alleged on information and belief, and as to those matters, he believes them to be true to the best of his knowledge.

That deponent's sources of information are the legal files containing statements, reports and records of investigation, investigators, parties and witnesses, with which deponent is fully familiar.

That this verification is made by deponent because the Respondent resides in a County outside the deponent's place of business.

Kevin D. Porter
KEVIN D. PORTER

Sworn to before me this
24th day of February, 1994.

Notary

96