STATE OF NEW YORK DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

August 9, 1996

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OFFICE OF PROFESSIONAL MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Walter R. Marcus, Esq.
80 John Street-20th Floor
New York, New York 10038

David Handwerker, M.D.
3409 Bertha Drive
Baldwin, New York 11510

RE: In the Matter of David C. Handwerker, M.D.

Dear Mr. Guenzburger, Mr. Marcus and Dr. Handwerker:

Enclosed please find the Determination and Order (No. 96-184) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

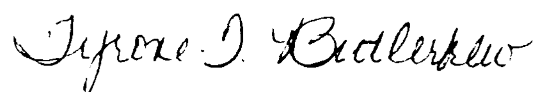
The notice of review served on the Administrative Review Board should be forwarded to:

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

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

IN THE MATTER OF DAVID C. HANDWERKER, M.D.	DETERMINATION AND ORDER BPMC-96-184

COPY

The Hearing Committee, composed of **MILTON O.C. HAYNES, M.D.,** Chairperson, **WILLIAM P. DILLON, M.D.,** and **VICTOR B. MARROW**, was duly designated and appointed by the Commissioner of Health of the State of New York pursuant to New York Public Health Law § 230, subd. 10(e). **EUGENE A. GAER, ESQ.,** Administrative Law Judge, served as Hearing Officer for the Committee.

The Committee, each member of which has considered the entire record in this matter, hereby renders its decision on the charges of professional misconduct filed against David C. Handwerker, M.D (the "Respondent"). All findings, conclusions and dispositions herein are unanimous.

STATEMENT OF CHARGES

Respondent is charged by Petitioner Department of Health (the "Petitioner" or the "Department") with the following five types of professional misconduct under the definitions contained in New York Education Law § 6530:

- Practicing the profession with negligence on more than one occasion (§ 6530, subd. 3)(first specification);

- Practicing the profession with incompetence on more than one occasion (§ 6530, subd. 5)(second specification);

- Practicing the profession with gross negligence (§ 6530, subd. 4)(third and fourth specifications);

- Practicing the profession with gross incompetence (§ 6530, subd. 6)(fifth and sixth specifications), and

- Failing to maintain a record which adequately reflects the evaluation and treatment of a patient (§ 6530, subd. 32) (seventh and eighth specifications).

- These allegations relate to Respondent's treatment of two patients: one in 1988 and one in 1993. The charges are more particularly set forth in the Amended Statement of Charges (the "Amended Statement") .[1]

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	August 18, 1995
Amended Statement of Charges dated:	November 1, 1995
Pre-hearing Conference:	September 8, 1995
Hearing dates:	September 15, 1995 November 1, 1995
Closing briefs submitted on:	December 15, 1995
Deliberation date:	February 13, 1996

[1] A copy of the Amended Statement (P. Ex. 7) is attached hereto as Appendix I.

Place of Hearing:		NYS Department of Health 5 Penn Plaza New York, New York 10001
Petitioner represented by:	BY:	Henry M. Greenberg, General Counsel NYS Department of Health Daniel Guenzburger, Esq. Assistant Counsel 5 Penn Plaza New York, New York 10001
Respondent represented by:		Walter R. Marcus, Esq. 80 John Street, 20th Floor New York, New York 10038

WITNESSES

Petitioner called one witness:

Joseph Rovinsky, M.D. — Expert Witness

Respondent testified in his own behalf but did not call any other witness.

FINDINGS OF FACT

The following findings of fact were made after review of the entire record by the Committee. Citations indicate evidence found persuasive by the Committee in arriving at the finding. "Tr." citations are to the transcript of the hearing. "P.Ex." and "R.Ex." citations are to the exhibits introduced by Petitioner and Respondent. Evidence which conflicted with any finding of the Committee was considered and rejected.

General Findings

1. Respondent was authorized to practice medicine in the State of New York in 1977 by the issuance of License No. 130395 by the Department of Education. See P. Ex. 2, pp. 2-3; R. Ex. A; Tr. 194-95. As of the date of the hearings Respondent was current in his registration with the Department of Education for the purpose of practicing medicine in the State. See P. Ex. 2, p. 12. Respondent's current address is 3409 Bertha Drive, Baldwin, New York 11510. R. Ex. A; Tr. 194.

2. Respondent has completed residency training in obstetrics and gynecology. He became a Diplomate of the American Board of Obstetrics and Gynecology in 1980. R. Ex. A; Tr. 200.

3. Patient A and Patient B were treated by Respondent while they were patients at South Nassau Communities Hospital, Oceanside, New York (the "Hospital"). Respondent was a member of the Hospital's Department of Obstetrics and Gynecology at the time. See P. Ex. 4, pp. 11-12; P Ex. 5, p. 8; R. Ex. A; Tr. 196-97.

Findings as to Patient A

4. Patient A was 24 years old in January 1988 when she was first seen by Respondent for a gynecological examination at his office at 165 North Village Avenue, Rockville Center, New York 11570. Tr. 200; P. Ex. 3, pp. 5, 8. In 1984 Patient A had given birth to a baby at a different hospital; Respondent had no role in that delivery. Patient A reported no problems with her prior pregnancy or delivery. See P. Ex. 3, pp. 8, 12; Tr. 201-02.

5. On June 14, 1988, Respondent examined Patient A at his office and determined that Patient A was pregnant and that the expected date of confinement was February 5, 1989. P Ex. 3, p. 2; Tr. 201-02.

6. Patient A returned to Respondent's office four times during July-September 1988. On July 14 she was examined by Respondent, who found her weight, blood pressure and other indicators to be normal. P. Ex. 3, p. 3; Tr. 39-41, 58, 203. On August 15, Patient A was examined by Respondent's associate, who noted the patient's weight as 111 pounds, her blood pressure as 120/80 and her urinalysis as negative. P. Ex. 3, p. 3; Tr. 204; cf. Tr. 41-43, 59-60.[2] The patient underwent certain tests in the office on August 25 without being seen by a physician. P. Ex. 3, p. 3; Tr. 43, 204-05.

7. On September 19, 1988, Patient A was examined by Respondent at his office. At that time her weight was 115 pounds and there was a finding of albumin in the urine, four plus protein. This may have been an indicator of a renal problem or of toxemia (also termed preeclampsia). P. Ex. 3, p. 3; Tr. 43-47, 205-08. Respondent directed that Patient A's urine be tested for a possible bladder infection. Tr. 207-09; see also P. Ex. 3, p. 17.

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[2] Patient A's office chart (P. Ex. 3, p. 3) does not record which physician examined her on a particular day. Respondent testified that many of the entries were in the same nurse's handwriting, irrespective of whether the patient was seen by Respondent or his associate. Tr. 238.

8. On September 29, 1988, Patient A called Respondent complaining of a headache Respondent told her to take Tylenol and made a note that a neurological consultation may be ordered if the headache did not improve. P. Ex. 3, p. 3; Tr. 49-50, 210-13.

9. On October 2, 1988, at about 9:03 a.m., Patient A was admitted to the Hospital via the emergency room after passing out at home. See P. Ex. 3, p. 11; P. Ex. 4, pp. 3, 17, 20, 25. She was now 22 weeks pregnant. P. Ex. 4, pp. 17, 31, 33.

10. Respondent met Patient A in the emergency room, performed a physical examination and took her history. He recorded, among other things, complaints of headaches for the past month, blurred vision, dots before her eyes, weakness on her right side, nausea and vomiting. P. Ex. 4, pp. 17-19, 31, 177; Tr. 50-53, 70-73, 214-16. Respondent recorded Patient A's blood pressure as 160/100. He noted his impression as "migraine" and called for a consultation with Dr. Kefalos, a neurologist. P. Ex. 4, pp. 19, 177. The main concern of Respondent and Dr. Kefalos at that time was to rule out a cerebrovascular accident. Tr. 219.[3]

11. Dr. Kefalos confirmed the physical findings, but was unable to make a diagnosis and ordered a CAT scan. Patient A suffered a grand mal seizure on her way to the CAT scan in the presence of Respondent, Dr. Kefalos and the emergency room nursing staff. The patient was treated immediately with Valium and the CAT scan was conducted as planned.

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[3] On the neurological consultation sheet toxemia of pregnancy was listed by Dr. Kefalos as the fourth possibility to be ruled out. P. Ex. 4, p. 178; cf. Tr. 73-74, 219.

P. Ex. 4, pp. 11, 20-21, 178; Tr. 54-55. It showed diffuse encephalopathy with no localizing signs and no evidence of hemorrhage. P. Ex. 4, p. 178; Tr. 55.

12. At 11:30 a.m. Patient A returned to the emergency room where her blood pressure was recorded as 170/130 and magnesium sulfate **was** administered. P. Ex. 4, pp. 21, 31. Following this, a lumbar puncture was performed. It was negative for blood. P. Ex. 4, pp. 21, 32, 178, 241; Tr. 55.[4] The patient was conscious during this period. P. Ex. 4, pp. 21, 35.

13. The combination of symptoms led Respondent to conclude that Patient A was preeclamptic and that it would be necessary to evacuate her uterus once her blood pressure was stabilized. Tr. 56, 222-23; cf. Tr. 47. A hysterotomy was performed by Respondent at 5:00 p.m. resulting in the delivery of a non-viable 13 ounce infant of 22 weeks gestation. P. Ex. 4, pp. 188, 193-94, 197; Tr. 56.

14. On October 3 Patient A showed slight improvement. She responded to her name and was able to follow simple commands and shake her head yes and no to questions. P. Ex. 4, pp. 43, 45. Her condition thereafter deteriorated; on October 5 two neurological entries stated "No evident cerebral function" and "no response prognosis hopeless." P. Ex. 4, pp. 56-57; see also P. Ex. 3, pp. 9-10. Patient A was maintained on a respirator until November 12,

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[4] At some time Patient A's urinalysis again was reported as measuring 4+ protein. P. Ex. 4, pp. 20, 33-34. cf. Tr. 217.

1988, when she expired. P. Ex. 4, pp. 12, 14.[5]

Findings as to Patient B

15. Patient B was a 28 year old pregnant woman whose estimated date of confinement was September 30, 1993. Respondent first examined her in his office on January 30, 1993. P. Ex. 5, pp. 13, 16. This was the patient's fourth pregnancy. She had given birth twice (once by caesarian section) and had experienced one miscarriage. P. Ex. 5, p. 14; Tr. 252.

16. Patient B's pregnancy was uneventful until her 26th week. See P. Ex. 5, pp. 1, 8, 11; Tr. 252-53. At about 12:24 a.m. on June 29, 1993, the patient's husband called to report that he had found her lying on the floor in severe abdominal pain and complaining of nausea. P. Ex. 5, pp. 8, 10, 12.

17. An ambulance was ordered to bring Patient B to the Hospital, where she arrived at 12:51 a.m. See P. Ex. 5, p. 10. The ambulance attendants recorded Patient B's blood pressure as 122/88 at 12:37 a.m. They recorded her pulse as 48 and noted that her skin was cyanotic. Later in the ambulance ride (before 12:51 a.m.) her blood pressure was recorded as 110/70. P. Ex. 5, p.10; Tr. 106.

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[5] By stipulation of the parties the Committee reviewed the report of the November 12, 1988, autopsy of Patient A, which her family commissioned and which was not part of the Hospital record. See Tr. 234-37. It concluded that the "Cause of Death" was "Hypotension during hysterotomy and termination of pregnancy for [eclampsial], with anoxic cerebal necrosis and [persistent] coma for 41 days; bronchopneumonia."

18. Patient B was transferred to the Hospital's labor and delivery suite at 1:06 a.m. P. Ex. 5, pp. 11, 17 In the hour-and-a-half after her arrival her blood pressure and pulse were recorded as 70/40 and 88 (1:06 a.m.), 72/50 and 90 (1:30 a.m.), 80/60 and 90 (1:40 a.m.), 74/54 and 92 (1:42 a.m.), 90/60 and 88 (2:00 a.m.) and 70/50 and 92 (2:20 a.m.). P Ex. 5, pp. 17-20, 137; Tr. 119, 121-22, 263.

19 Respondent, who was already at the Hospital attending another patient, examined Patient B at 1:10 a.m. P. Ex. 5, p. 17; Tr. 253-54. He noted her complaint as severe lower abdominal pain with nausea and retching for two days. Her blood pressure was 80/40, her pulse was 88 and the abdominovaginal examination was normal. The fundus was palpated about one finger above the umbilicus. On pelvic examination the cervix was not palpable, and there seemed to be a pelvic mass posterior, which was also felt on rectal examination. Respondent entered his Impression as "incarcerated uterus" and drew a diagram illustrating his finding that the cervix had rotated superiorly. P. Ex. 5, pp. 63-65, 81-82; Tr. 108-09, 254-56.

20. At 1:20 a.m. Respondent commenced performing an ultrasonogram on Patient B. He was able to visualize the fetus and pick up its heartbeat, but the sonogram did not enable him to clarify his diagnosis of Patient B's problem. P. Ex. 5, pp. 17-18; Tr. 256, 261-62, 264.

21. When Patient B was admitted to the labor and delivery suite Respondent ordered several lab tests including CBC (i.e., "complete blood count") to determine the patient's

hemoglobin and hematocrit, platelets to determine if coagulation was functioning properly, blood typing and cross-matching and biochemistry SMA. P. Ex. 5, p. 96; Tr. 112-14, 258, 271, 280. These were all ordered on a "STAT" (i.e., urgent) basis. P. Ex. 5, p. 96; Tr. 113-14; cf. Tr. 271.

22. Patient B continued to be in severe pain, which Respondent believed to stem from the incarcerated uterus he had diagnosed. Beginning at 1:42 a.m. the patient was placed in a knee-chest position and attempts were unsuccessfully made to reposition the uterus. P. Ex. 5, pp. 18-20, 97; Tr. 260, 263, 265.

23. Respondent was afraid the Hospital might be incapable of dealing with a delivery respecting a 26 week pregnant patient with incarcerated uterus. He called Dr. S. Klein, a perinatologist at Winthrop Hospital, because he thought the patient might have to be transferred to a facility with a neonatal intensive care unit.[6] P. Ex. 5, p. 26; Tr. 256, 259-60, 275. Dr. Klein suggested relaxing the patient with analgesia to facilitate repositioning the uterus. Tr. 259, 265, 296-97. At 1:40 a.m. Patient B received 50 milligrams of Demerol and 25 milligrams of Phenergan at Respondent's direction. P. Ex. 5, pp. 18, 96; Tr. 120.

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[6] Respondent directed that an ambulance be called in case it was decided to go through with the transfer. P. Ex. 5, pp. 20-21. He later decided that surgery should be performed at the Hospital and the transfer to Winthrop was cancelled. P. Ex. 5, pp. 26, 96; Tr. 281.

24. Respondent had also ordered insertion of an intravenous line and a Foley catheter at the time Patient B was admitted. When the nurse had difficulty inserting the catheter. Respondent completed the insertion himself P. Ex. 5, pp. 17, 96; Tr. 256. At 1:16 a.m. this note was entered in the Labor Progress Record: "25 cc clear, scant light yellow urine return." P. Ex. 5, p.17. At 3:50 a.m. this note was entered in the Labor Progress Record: "Foley draining scant, clear urine." P. Ex. 5, p. 23. There are no other entries concerning the patient's urine output prior to her surgery. See Tr. 127-28; cf. P. Ex. 5, p. 138.

25. During most of the time from about 2:00 a.m. to about 3:20 a.m. Respondent was away from Patient B's bedside, first assisting another physician who was performing a caesarian section, and then attending a patient of his own whose baby was delivered at 3:03 a.m. Respondent did see Patient B briefly around 2:40 a.m. He was notified of developments respecting Patient B while he was attending the other patients. Tr. 123, 267-71, 274, 278-79; P. Ex. 5, pp. 19-22.

26. Around 2:45 a.m. Patient B's husband approached a nurse and asked if his wife could receive more pain medication. Respondent was informed of this request and prescribed two 25-milligram doses of Demerol for Patient B, one to be administered intravenously and one intramuscularly. The nurse then observed that the patient's blood pressure measured 50/0 at 3:00 a.m. and refused to administer the Demerol. P. Ex. 5, p. 21, 137; see also P. Ex. 5, pp. 97, 104-05.

27. Around 3:00 a.m. the Pathology Department reported the results of the lab tests which Respondent had ordered when Patient B was first admitted (see Finding of Fact 21, supra).[7] See Tr 279-80. The test results included hemoglobin 7.9, hematocrit 23.6 and white blood count 18,400/cubic millimeter. P. Ex. 5, p. 84. Respondent concluded that the patient was bleeding internally. P Ex. 5, pp. 8, 26, 42; Tr. 280.

28. Respondent ordered that the patient receive a blood transfusion and be prepared for an exploratory laparotomy. P. Ex. 5, pp. 23, 89-90, 96. He noted at 3:40 a.m. that he suspected a possible ruptured uterus. P. Ex. 5, p. 26.

29. Surgery began at 4:15 a.m. The abdomen was found to be filled with blood from a uterine rupture. Placenta was oozing through a 5 centimeter opening at the scar site of the patient's prior caesarian section. The uterus was severely retroflexed with the fundus in the cul-de-sac and fixed. Respondent repaired the uterus but Patient B's infant was stillborn. Blood loss was estimated at 3,500 cc's. P. Ex. 5, pp. 8, 42-43.

30. Patient B was discharged from the Hospital in good condition on July 4, 1993. P. Ex. 5, p. 9.

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[7] The Hospital record is unclear when Respondent received the lab results. The Pathology Department report gave 2:26 a.m. as the "pickup time" (P. Ex. 5, pp. 84-86), but there was no evidence whether that meant the time the test samples were obtained on the patient's floor, the time the samples arrived in the lab or on the technician's desk, or the time the results were available for delivery to the requesting physician. cf. Tr. 272-74. 277-8. 298-99. 303.

CONCLUSIONS AS TO FACTUAL ALLEGATIONS

Patient A

Patient A was a young woman who died as a result of toxemia during her second pregnancy. The charges against Respondent arise from his failure to diagnose and treat this condition in a timely and appropriate manner. Subject to the qualifications noted below,[8] **Paragraph A** is **SUSTAINED** as a general statement of Patient A's history and treatment by Respondent.

Paragraph A.1 alleges five ways in which Respondent dealt inadequately with the 4+ albumin found in Patient A's September 19, 1988, urinalysis. Subparagraph A.l.a states that Respondent "failed to take an adequate history" in connection with this report. Respondent regarded the finding of 4+ protein only as a possible indicator of infection and did not follow up further when no infection was found.

Despite the negative lab report, the 4+ finding may still have indicated some other (and in reality more serious) problem. Since no consideration was given to the possibility of preeclampsia, the patient was not asked whether she experienced any of its symptoms such as headaches, dizziness, spots before her eyes, abdominal pain or bloating. Nor did Respondent order a retest. **Subparagraph A.l.a** is **SUSTAINED.**

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[8]Patient A was 24, not 25, during most of the time she was treated by Respondent. She was not personally examined by Respondent during visits to his office on August 15 and 25 after the morning of October 3, 1988. See Findings of Fact 12 and 14; See also P. Ex. 4, pp. 43, 45, 47-49. The date Patient A expired was November 12, 1988. P. Ex. 4, p. 14.

Subparagraph A.1.b states that Respondent failed to "perform an adequate physical examination" on September 19, 1988. This charge finds support in the record of the patient's visit that day P Ex. 3, p. 3. The only readable entries are weight of 115 pounds, fundus of 19 centimeters, and fetal heart OK. The blood pressure is indecipherable, as is the entry under "remarks". The general impression is that of a less than thorough examination. **Subparagraph A.1.b** is **SUSTAINED.**

Subparagraph A.1.c charges that Respondent should have ordered "a blood test to evaluate serum uric acid and electrolytes" after the urinalysis showed 4+ albuminuria. Petitioner's expert witness testified convincingly that further testing of Patient A's blood chemistries, including uric acid and creatinine, was indicated by the possibility of undiagnosed kidney or liver disease or "the early appearance of toxemia of pregnancy." Tr. 44-48. Respondent does not contest that further testing should have been done. See Tr. 240. **Subparagraph A.1.c** is **SUSTAINED.**

Subparagraph A.1.d charges that it was improper for Respondent not to have ordered a catheterized urine test for albumin and infection on September 19, 1988. However, Respondent did order a test for urine culture and sensitivity (See P. Ex. 3, p. 17), which were appropriate in the circumstances. Catheterization was not mandatory. cf. Tr. 78-79. **Subparagraph A.1.d** is **NOT SUSTAINED.**

Subparagraph A.1.e charges that Respondent improperly "failed to order a return office visit for appropriate follow up on the abnormal laboratory finding." Respondent's office records give no indication that a speedy return visit was suggested to Patient A. See P. Ex. 3, p. 3. In view of the possibly grave consequences of failing to identify the source of the elevated protein, another examination should have been scheduled within a few days. Tr. 79-81. **Subparagraph**

A.I.e is **SUSTAINED.**

Paragraph A.2 charges that it was improper for Respondent to have

> failed to order an immediate office visit in response to Patient A's complaint of headaches, which she reported to him in a telephone conversation on or about September 29, 1988.

Ten days after Patient A's urinalysis was recorded as 4+ albumin, she called Respondent to complain about a headache. When a pregnant woman experiences a headache in conjunction with elevated albuminuria, there is a serious possibility of toxemia, which needs to be investigated immediately. Tr. 49-50. Yet all Respondent did was advise her to take Tylenol and enter in the office record: "to neurology if no better." P. Ex. 3, p.3; cf. Tr. 210-11.

The record is not clear whether Respondent was aware of the 4+ albuminuria at the time Patient A called him on September 29, 1988, whether he became aware of it later in the day or whether he did not notice the connection between the two symptoms until after Patient A entered the Hospital three days later.

Respondent testified before the Committee that he had no specific recollection of the call from Patient A, but that his ordinary practice would be to take the patient's call, ask her to describe the pain and review her chart afterward. Tr. 213-14; see also Tr. 244-45. Respondent testified elsewhere that he noticed the 4+ albuminuria later in the day when he wrote the entry concerning the headache. P. Ex. 8.

Under any scenario the physician was remiss. It would have been inexcusable not to look over the patient's chart at once. If Respondent did record the headache shortly after speaking to Patient A, he should have connected that symptom with the 4+ protein and brought her in immediately for blood pressure and blood chemistry testing. Tr. 50. Respondent cannot explain

why he failed to do so. See Tr. 246-48. **Paragraph A.2** is **SUSTAINED.**

Respondent is further charged with failing "to appropriately diagnose that Patient A had toxemia of pregnancy" (¶. A.3) and "to appropriately treat Patient A for toxemia of pregnancy" (¶. A.4). These charges are closely related.

As discussed above, Respondent did not recognize the significance of Patient A's 4+ albuminuria on September 19, 1988, and did not diagnose and treat toxemia when he received the telephone call on September 29, 1988. While the 4+ protein may not in itself have been a sufficient indicator for the diagnosis, it should have been a danger sign for preeclampsia once the patient reported her headache.

This diagnostic lapse continued after Patient A presented to the Hospital's emergency room around 9:03 a.m. on October 2, 1988. Respondent noted his initial Impression as "migraine R/O CVA" (i.e., "rule out cerebrovascular accident") and his Plan as "neuro consult." P. Ex. 4, p. 19. The neurologist's consultation sheet, completed no earlier than 10:30 a.m., still listed "toxemia of pregnancy" as only the fourth possible diagnosis. See P. Ex. 4, pp. 177-78.

Respondent testified that he did not recall the 4+ protein when Patient A presented in the emergency room. Although concerned about the 160/100 blood pressure, he did not immediately consider it a sign of preeclampsia. He did not recall the prior headache, but, in any event, he regarded the persistence of headaches for a month as contraindicating preeclampsia. This was because preeclampsia rarely occurs as early as the eighteenth week of pregnancy. Tr. 216-18.

Between 11:30 a.m. and 2:00 p.m. Respondent finally diagnosed preeclampsia. Despite the patient's 160/100 blood pressure upon admission, the correct diagnosis was only made after that reading had risen to 170/130, after the neurological tests had proven negative for cerebral

hemorrhage and after 4+ albuminuria had again been reported. See Findings of Fact 10-13, supra.

At that point, Respondent chose the correct procedure, a hysterotomy. The surgery appears to have been carried out properly (and as soon as the patient's dangerous condition allowed), but it was performed too late to save the patient.

The conclusion is inescapable that Respondent's failure to diagnose toxemia earlier than midday on October 2nd was professionally inappropriate, as charged in Paragraph A.3. From this it follows that Respondent failed to treat Patient A's toxemia appropriately, as charged in Paragraph A.4. See Tr. 101-02.

On the afternoon of October 2nd a hysterotomy was the only possible treatment, but because of the delay in recognizing the patient's condition, she still did not survive. In this case, the failure to diagnose in time meant the failure to treat in time. **Paragraphs A.3** and **A.4** are **SUSTAINED**.

Paragraph A.5 charges that Respondent failed "to maintain a record which accurately reflected the evaluation and treatment of Patient A." This charge is not well phrased. There is no way to determine whether Respondent evaluated or treated Patient A otherwise than as he recorded.

Nonetheless, Respondent's recordkeeping was defective with respect to Patient A. So many of the problems relating to this patient stem from Respondent's practice of using a single card (P. Ex. 3, p. 3) to record everything that transpired during all her office visits.

For example, there is no indication what questions he may have asked when he saw her or how she may have replied.[9] The "remarks" on September 19 (the day the 4+ albumin was recorded) are illegible. Significant too is Respondent's own inability to read the blood pressure recorded on July 14, 1988. Tr 203

It is entirely reasonable to conclude that Respondent's inadequate recordkeeping contributed to this patient's tragic outcome. As so understood, **Paragraph A.5** is **SUSTAINED.**

Patient B

Patient B, a 28 year old woman, was in the 26th-week of her fourth pregnancy when she presented to the Hospital around 12:51 a.m. on June 29, 1993, complaining of severe abdominal pain and nausea. Petitioner's charges all arise from Respondent's diagnosis and treatment of this patient between her admission and the surgery Respondent performed at 4:15 a.m.

The surgery itself has not been criticized and Patient B was ultimately discharged in good condition (although the baby was stillborn), but Respondent's handling of this case was flawed in several respects. Subject to the qualifications noted below,[10] **Paragraph B** is **SUSTAINED** as a general statement of Patient B's history and treatment by Respondent.

Subparagraph B.l.a states that at "the time of Respondent's initial evaluation, he...

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[9] See the Conclusions respecting Subparagraphs A.1.a and A.1.b, supra.

[10] Patient B was 28 years old, not 26, on June 29, 1993, and she was generally listed as 26 weeks pregnant, not 27. The lab results read as set forth in Finding of Fact 27, supra. It was not established that Respondent received the results at 2:40 a.m. They may have been received around 3:00 a.m. See Footnote 7.

[i]nappropriately diagnosed incarcerated uterus." Surgery confirmed that, however unusual it was for a woman to experience an incarcerated uterus at this late a stage in her pregnancy, the condition was indeed one of the sources of Patient B's pain. Tr. 130, 256-58, 287; P. Ex. 5, p. 42. This was conceded by Petitioner's expert witness. Tr. 176-77; cf. Tr. 109.

Taking account of Patient B's severe abdominal pain upon admission and of Respondent's physical examination, it cannot be said that incarcerated uterus was an inappropriate initial diagnosis. **Subparagraph B.1.a** is **NOT SUSTAINED.**

Subparagraph B.1.b and Paragraph B.6 both relate to Respondent's prescription of Demerol for Patient B in the early morning of June 29, 1993 -- "at the time of his initial evaluation" (¶. B.1.b) and at 2:45 a.m. (¶. B.6).[11]

As an opiate Demerol has the effect of lowering blood pressure; its use can be dangerous in a hypotensive patient. See Tr. 120, 174-75. Respondent prescribed it in two different situations.

The first prescription was at 1:40 a.m. in order to relax Patient B and ease her pain while Respondent was trying to reposition the uterus manually. Tr. 265. At that time her blood pressure was 80/60; a half-hour earlier it had been as low as 70/40. P. Ex. 5, pp. 17-18.

Respondent testified that he was "concerned" about the blood pressure and "hesitant to give her anything," but that he reached the decision to administer the Demerol after consulting with a perinatologist. Tr. 265, 296-97. He stated that he could not "ascertain" any negative effect on the patient's vital signs, but that the medication did not help him reposition the uterus.

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[11] In Paragraph B.6 the medication is called "meperidine." This is the same as Demerol. See Tr. 174.

Tr 265 He still believes Demerol was appropriate in view of Patient B's presenting symptoms. Tr 290

The second prescription was to alleviate the patient's continuing pain. Respondent testified that he was not informed that her blood pressure had fallen to 50/0 and that he would "obviously" have done "something else" if he had been told of that "shocking number". Tr. 285. Respondent asserted that the nurses' notes were not available at any time prior to the surgery. Tr. 285; see also Tr. 307.[12]

Despite the rationales offered by Respondent for the two prescriptions of Demerol, the fact remains that the patient was, at the least, hypotensive and, as soon became evident, "on the borderline of going into deeper shock." Tr. 124-25. The source of her other symptoms had not been determined. Prescription of a narcotic was inappropriate under those conditions. **Subparagraph B.I.b** and **Paragraph B.6** are **SUSTAINED.**

Paragraphs B.2 and B.3 relate to the diligence with which Respondent had the patient tested and monitored. Paragraph B.2 charges that Respondent "failed to adequately follow-up the performance of laboratory blood studies that he ordered." Paragraph B.3 charges that he "failed to order adequate monitoring of urinary output."

The results of the blood tests ordered by Respondent at 1:06 a.m. upon the patient's admission did not come back until some time around 2:45-3:00 a.m. These tests were of great significance -- Respondent testified that he would have made no decision on surgery without these results. Tr. 298.

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[12] At some point Respondent circled the nurse's entry of blood pressure of 50/0 at 3:00 a.m. on the Labor Progress Record. Respondent wrote on the chart: "Never informed of this BP." P. Ex. 5, p. 21.

Nevertheless he demonstrated no sense of urgency about receiving them, beyond writing "STAT" on the order sheet. See P. Ex. 5, p. 96; Tr. 305, 309, 318. He explained that he tried not to "rant and rave" when test results were slow in arriving because it "always gets me in trouble" with the nursing staff. Tr. 329; see also Tr. 309.

The Committee cannot accept a physician's reluctance to be forceful when a patient's life or health may be at stake. It is the responsibility of the attending physician to insure that support staff carry out necessary assignments. See Tr. 114-15. In this case, prompt receipt of test results would have led to an earlier realization that the patient was bleeding internally and that surgery was necessary immediately

An accurate understanding of the patient's condition was also impeded by the failure to monitor the patient's urinary output. When Respondent inserted the Foley catheter he expected "massive amounts of urine" because that was "standard" in cases of incarcerated uterus. Tr. 266-67, 307-08, 310. For Patient B, however, the urine output was noted as scanty at 1:16 a.m. and 3:50 a.m. P. Ex. 5, pp. 17, 23.

Even though the patient's low urine output cast doubt on Respondent's initial diagnosis, there is no indication that he saw a need to monitor it closely. In this case low urine output was an indicator of low blood pressure and internal bleeding. Tr. 127-28. Better monitoring would have led to swifter intervention.

Respondent cannot escape his responsibility as attending physician to insure that he receives the information necessary to make the appropriate treatment decisions. **Paragraphs B.2** and **B.3** are **SUSTAINED.**

Paragraph B.4 alleges that "Respondent failed to appropriately diagnose that Patient B was in clinical shock." Paragraph B.7 alleges that he failed to treat her for clinical shock, including "inappropriately delaying surgical intervention for a hemoperitoneum."

These charges follow directly on those previously discussed. It is not clear whether the patient was in shock, as distinguished from being hypotensive, when she first presented. Although her blood pressure dropped between the ambulance and her admission to the labor suite, it arguably hovered in a narrow range for a period of time thereafter. See Findings of Fact 17 and 18, supra.

But the patient's condition was not stable. The fact that she was sinking into shock should have been addressed before the bottom fell out on her blood pressure. A more careful consideration of her condition should have alerted Respondent to the possibility of a ruptured uterus or some other area of internal bleeding. See Tr. 125-26, 133-34, 137, 153-54. As noted above, the anomalous aftermath of the insertion of the Foley catheter was one danger sign. The lab results would have been another, if they had arrived sooner.

Shock should have been diagnosed and treated at an earlier point. **Paragraphs B.4** and **B.7** are **SUSTAINED.**

Paragraph B.5 alleges that "Respondent failed to remain appropriately available to treat Patient B" between about 1:10 a.m. and 3:45 a.m. But the Hospital record shows that Respondent was with Patient B at 1:42 a.m. and 2:40 a.m. (P. Ex. 5, pp. 17-18, 20) and from 3:20 a.m. onward (P. Ex. 5, p. 22). He was kept notified about her condition while he was attending other patients. P. Ex. 5, pp. 20-21. The failings noted in Respondent's performance cannot be characterized as unavailability. **Paragraph B.5** is **NOT SUSTAINED.**

Paragraph B.8 alleges that "Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient B." There is no basis for this charge. All the relevant records were compiled by Hospital personnel under Respondent's supervision. They were maintained adequately. **Paragraph B.8** is **NOT SUSTAINED.**

DISPOSITION OF SPECIFICATIONS

The dominant problem in both these cases was Respondent's unwillingness to consider alternatives once he had made an initial diagnosis. Both of these were atypical presentations. Yet until there was overwhelming evidence that the patient was suffering from different, or additional, problems, the physician clung stubbornly to the course he had first chosen. It is not lack of skill but tunnel vision that must be confronted here.

The First Specification charges that Respondent practiced the profession with negligence on more than one occasion within the meaning of Education Law § 6530, subd. 3. In the context of professional discipline, "negligence" is the "deviation from accepted standards" or "from good and accepted medical practice." Matter of Morfesis v. Sobol, 172 A.D. 2d 897, 898, 567 N.Y.S. 2d 954, 955-56 (Third Dept.), app. den., 78 N.Y. 2d 856, 574 N.Y.S. 2d 937 (1991).

The Committee determines that the First Specification is adequately supported by the acts underlying Paragraphs A.1.a, A.1.b, A.1.c, A.1.e, A.2, A.3, A.4, A.5, B.1.b, B.2, B.3, B.4, B.6 and B.7.

The Second Specification charges that Respondent practiced the profession with incompetence on more than one occasion within the meaning of Education Law § 6530, subd.

5 The Fifth and Sixth Specifications charge that Respondent practiced the profession with gross incompetence within the meaning of Education Law § 6530, subd. 6. In the context of professional misconduct, incompetence may be considered a lack of requisite skill and knowledge appropriate to the specialty, treatment and procedure under consideration.

Having reviewed the record and heard Respondent's testimony, the Committee has determined that Respondent did not lack requisite skill and knowledge with respect to the matters under consideration. It therefore determines that he was neither "incompetent" nor "grossly incompetent."

The Third and Fourth Specifications charge that Respondent practiced the profession with gross negligence within the meaning of Education Law §6530, subd. 4. "Gross negligence" is "a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct." Rho v. Ambach, 74 N.Y. 2d 318, 322, 546 N.Y.S. 2d 1005, 1007 (1989). The Committee determines that Respondent's acts, evaluated either individually or as a whole, did not constitute egregious conduct.

The Seventh and Eighth Specifications charge that Respondent failed to maintain a record for each patient which adequately reflects the evaluation and treatment of each patient in violation of Education Law § 6530, subd. 6. As noted above the Committee has determined that Respondent's recordkeeping with respect to Patient A was inadequate, but it did not find inadequacies in the record for Patient B.

The Committee has therefore entered the following Dispositions of the Specifications of Charges:

FIRST SPECIFICATION (negligence on more than one occasion):

SUSTAINED

SECOND SPECIFICATION (incompetence on more than one occasion):

NOT SUSTAINED

THIRD AND FOURTH SPECIFICATIONS (gross negligence):

NOT SUSTAINED

FIFTH AND SIXTH SPECIFICATIONS (gross incompetence):

NOT SUSTAINED

SEVENTH SPECIFICATION (inadequate recordkeeping with respect to Patient A):

SUSTAINED

EIGHTH SPECIFICATION (inadequate recordkeeping with respect to Patient B):

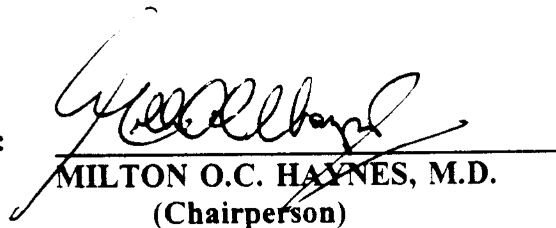
NOT SUSTAINED

ORDER

The Committee, by unanimous vote, has determined that the following penalty should be, and it hereby is,

ORDERED that the license to practice medicine of Respondent **DAVID C. HANDWERKER, M.D.**, shall be **SUSPENDED** for a period of **TWO YEARS,** but that said suspension shall be **STAYED INDEFINITELY, on the conditions** that (1) the practice of Respondent **DAVID C. HANDWERKER, M.D.,** shall be **monitored** for a period of **two years** by a physician nominated by Dr. Handwerker and approved by the Office of Professional Medical Conduct; and (2) that the monitor shall **review all cases** handled by Dr. Handwerker-during the monitoring period and shall **report regularly** to the office of Professional Medical Conduct as to Dr. Handwerker's mode of practice and of recordkeeping.

Dated: **New York, New York**
August 7, 1996



By: **MILTON O.C. HAYNES, M.D.**
(Chairperson)

WILLIAM P. DILLON, M.D.
VICTOR B. MARROW

APPENDIX 1

Ex T 7
Replaces Ex T 1

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

IN THE MATTER OF DAVID C. HANDWERKER, M.D.	AMENDED STATEMENT OF CHARGES

DAVID C. HANDWERKER, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 24, 1977, by the issuance of license number 130395 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between June 14, 1988 and October 2, 1988, the Respondent rendered obstetric care to Patient A, a 25 year old gravida 2, para 1, with an estimated date of confinement of February 5, 1989. Respondent examined Patient A on June 14, August 15, August 25, and September 19, 1988, at his office located at 165 North Village Avenue, Rockville Centre, New York. (Patient A and the other patient in the Statement of Charges are identified in the attached Appendix)

On or about October 2, 1988, Patient A presented to the emergency room of South Nassau Community Hospital, Oceanside, New York, with complaints of increasingly severe headaches for approximately one month, blurred vision , and vomiting. Her blood pressure was 160/100. Patient A experienced a grand mal seizure within an hour of presenting to the emergency room. She never regained consciousness and expired on November 2, 1988. During the period of treatment regarding Patient A, Respondent:

1. Inadequately responded to the 4+ albuminuria finding on or about September 19, 1988, in that he:

   a. Failed to take an adequate history.

   b. Failed to perform an adequate physical examination.

   c. Failed to order a blood test to evaluate serum uric acid and electrolytes.

   d. Failed to order a catheterized urine to test for albumin and infection.

   e. Failed to order a return office visit for appropriate follow up on the abnormal laboratory finding.

2. Respondent failed to order an immediate office visit in response to Patient A's complaint of headaches, which she reported to him in a telephone conversation on or about September 29, 1988.

3. Failed to appropriately diagnose that Patient A had toxemia of pregnancy.

4. Failed to appropriately treat Patient A for toxemia of pregnancy.

5. Failed to maintain a record which accurately reflected the evaluation and treatment of Patient A.

B. On or about June 29, 1993, 12:51 A.M., Patient B, a 26 year old gravida 4 para 2-0-1-2 in her 27th week of gestation, presented by ambulance to the South Nassau Community Hospital with a complaint of severe abdominal pain. Respondent evaluated Patient B upon her arrival at the hospital, diagnosed incarcerated uterus and ordered her admission.

Patient B's blood pressure taken en route to the hospital on or about 12:37 A.M. was 122/88 and 110/70. By 1:06 A.M. her blood pressure had dropped to 70/40 and by 3:00 A.M. her blood pressure was 50/0. At 2:40 A.M., the Respondent received laboratory results indicating that Patient B had a hemoglobin of 7.9, a hematocrit of 23 and a white blood count of 18,400 ml. Respondent's treatment of Patient B at the South Nassau Community Hospital deviated from medically accepted standards, in that:

1. At the time of Respondent's initial evaluation, he:

   a. Inappropriately diagnosed incarcerated uterus.
   b. Inappropriately prescribed Demerol.

2. Respondent failed to adequately follow-up on the performance of laboratory blood studies that he had ordered.

3. Respondent failed to order adequate monitoring of urinary output.

4. Respondent failed to appropriately diagnose that Patient B was in clinical shock.

5. Respondent failed to remain appropriately available to treat Patient B on or about and between June 29, 1993, 1:10 A.M. and June 29, 1993, 3:45 A.M.

6. Respondent inappropriately prescribed 25 milligrams of meperidine intravenously and 25 milligrams of meperidine intramuscularly on or about June 29, 1993, 2:45 A.M.

7. Respondent failed to adequately treat Patient B for clinical shock, including but not limited to inappropriately delaying surgical intervention for a hemoperitoneum.

8. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient B.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession with negligence on more than occasion within the meaning of N.Y. Educ. Law §6530(3) (McKinney Supp. 1995), in that Petitioner charges that respondent committed two or more of the following:

1. The facts in Paragraphs A and A1, A1(a), A1(b), A1(c), A1(d), A1(e), A2, A3.

A4, A5, B and B1, B1(a), B1(b), B2, B3, B4, B5, B6, B7, and/or B8.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law §6530(5) (McKinney Supp. 1995), in that Petitioner charges Respondent committed two or more of the following:

2. The facts in Paragraphs A and A1, A1(a), A1(b), A1(c), A1(d), A1(e), A2, A3, A4, A5, B and B1, B1(a), B1(b), B2, B3, B4, B5, B6, B7, and/or B8.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

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

3. The facts in Paragraphs A and A1, A1(a), A1(b), A1(c), A1(d), A1(e), A2, A3, A4.

4. The facts in Paragraphs B and B1, B1(a), B1(b), B2, B3, B4, B5, B6, and B7

FIFTH AND SIXTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence on a particular occasion within the meaning of N.Y. Educ. Law §6530(6) (McKinney Supp. 1995), in that Petitioner charges:

5. The facts in Paragraphs A and A1, A1(a), A1(b), A1(c), A1(d), A1(e), A2, A3 and A4.

6. The facts in Paragraphs B and B1, B1(a), B1(b), B2, B3, B4, B5, B6, and B7.

SEVENTH THROUGH EIGHTH SPECIFICATIONS

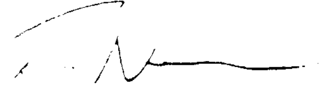
FAILING TO MAINTAIN AN ADEQUATE RECORD

Respondent is charged with professional misconduct pursuant to N.Y. Educ. Law §6539(32) (McKinney Supp. 1995), by reason of failing to maintain a record for each patient which adequately reflects the evaluation and treatment of the patient, in that Petitioner charges:

7. The facts in Paragraphs A and A5.

8. The facts in Paragraphs B and B8.

DATED: November 1, 1995
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct