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

PUBLIC

April 10, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001

Stanley R. Goodman, Esq.
Goodman, Saperstein & Cuneo
600 Old Country Road, Suite 530
Garden City, New York 11530

Warren Janus, M.D.
325 West Park Avenue
Long Beach, New York 11561

RE: In the Matter of Warren Janus, M.D.

Dear Ms. Abeloff, Mr. Goodman and Dr. Janus:

Enclosed please find the Determination and Order (No. 96-81) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

WARREN JANUS, M.D.

DETERMINATION

AND

ORDER

BPMC-96-81

The Hearing Committee, composed of **STANLEY L. GROSSMAN, M.D.**, Chairperson, **JOSEPH B. CLEARY, M.D.**, and **THEA GRAVES PELLMAN**, 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 Warren Janus, M.D. (the "Respondent"). Unless otherwise noted, 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 four (4) types of professional misconduct under the definitions contained in New York Education Law §6530:

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

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

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

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

These allegations relate to Respondent's treatment of two (2) patients in 1989 and one (1) patient in 1992. The charges are more particularly set forth in the Notice of Hearing and Statement of Charges (the "Notice" and "Statement"), a copy of which is attached hereto as Appendix 1.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	September 15, 1995
Answer dated:	October 19, 1995
Pre-Hearing Conference:	October 24, 1995
Hearing dates:	November 2, 1995 November 14, 1995 December 12, 1995
Closing briefs submitted on:	January 16, 1996
Deliberation date:	January 30, 1996

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 Dianne Abeloff, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent represented by:		Stanley R. Goodman, Esq. Goodman, Saperstein & Cuneo 600 Old Country Road, Suite 530 Garden City, New York 11530

WITNESSES

Petitioner called one witness:

Alfred M. Markowitz, M.D.	Expert Witness

Respondent testified in his own behalf and also called one other witness:

M. Michael Eisenberg, M.D.	Expert 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 on July 9, 1962, by the issuance of License No. 087860 by the Department of Education. (P.Ex. 2, p. 3) He remains licensed to practice medicine in the State. (See Tr. 328-29; P.Ex. 2, p. 2) His address is 325 West Park Avenue, Long Beach, New York 11561. (R.Ex. C; P.Ex. 2, p. 2)

2. Respondent has completed residency training in surgery and is a general surgeon. He became a Diplomate of the American Board of Surgery in 1967 and a Fellow of the American College of Surgeons in 1973. (R.Ex. C; Tr. 329-30)

3. Patient A, Patient B and Patient C were treated by Respondent in the course of Respondent's service as a member of the Department of Surgery of Long Beach Memorial Hospital, Long Beach, New York (the "Hospital"). (See P.Ex. 3, p. 2; P.Ex. 4, p. 2; P.Ex. 5, p. 3)

FINDINGS AS TO PATIENT A

4. Patient A, a 68 year old woman, was admitted to the Hospital by her internist, Dr. L. Taubman, on March 12, 1989. Dr. Taubman had seen her in his office three weeks earlier because of weight loss, decreased appetite, hypertension, anxiety and a history of diarrhea reported variously as two weeks to more than two months. (P.Ex. 3, pp. 13, 30, 138; cf. Tr. 337; P.Ex. 3, pp. 23, 111)

5. Examination of Patient A at the time of admission revealed occult blood in the stool and possible abdominal mass. The patient was admitted to rule out (a) a gastrointestinal malignancy and (b) sepsis of gastrointestinal origin. She was referred to Dr. J. Aaron, a gastroenterologist, and a colonoscopy was scheduled. (P.Ex. 3, pp. 23-24, 30-31, 103, 112; cf. Tr. 333)

6. On March 15, Dr. Aaron performed a colonoscopy on Patient A. The colonoscope could not be passed beyond 35 centimeters because the lumen narrowed to the size of a pinhole. Multiple biopsies of edematous tissue were taken. (P.Ex. 3, p. 116) The pathologist's report, dated March 16 (P.Ex. 3, p. 117), stated:

> *"MICRO*
> *Sections reveal numerous fragments of colonic mucosa with severe, chronic inflammation and marked dysplasia of the glands. No crypt abscesses are noted. The glands are [basophilic] and the cells in the glands are somewhat crowded. No changes that would be considered characteristic of carcinoma are recognized.*
>
> *Diagnosis*
>
> *Colonic mucosa with chronic inflammation and marked glandular dysplasia."*

7. Respondent saw Patient A in consultation on March 15. This was after the patient had undergone the colonoscopy but before Respondent received the pathology report. Respondent diagnosed Patient A as suffering from obstructing carcinoma of the sigmoid colon. (P.Ex. 3, p. 106; Tr. 332-35)[1]

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[1]Respondent's Consultation Record, reporting on his visit with Patient A at 3:30 p.m. on March 15, states: "IMPRESSION OBSTRUCTING CARCINOMA OF THE SIGMOID COLON PROVEN ON COLONOSCOPY." (P.Ex. 3, p. 106) This entry was based on a conversation with Dr. Aaron, not on the written pathology report, which was not yet typed. (Tr. 334-35) Respondent has conceded that the term "proven on colonoscopy" was "improper" and that he should have said "probable or suggested." (Tr. 336-37)

8. On March 17 Respondent performed a sigmoid colectomy with primary anastomosis on Patient A. (P.Ex. 3, pp. 123-24) There is no indication that Respondent considered performing a colostomy in conjunction with the resection, a procedure which may have been appropriate. (Tr. 154-55, 162; cf. Tr. 96-97, 567-68; P.Ex. 3, pp. 123-24)

9. The "Micros" pathology report on the March 17th surgery, which was dated March 20 (P.Ex. 3, p. 125), revealed:

> *"The mucosa, in the area of diverticulitis and diverticulosis and also at the margins, show severe chronic and acute inflammation with numerous [crypt] abscesses.*[2] *[Occasionally] small focal ulcerations are also recognized. Although the glands in the areas of severe inflammation show dysplastic changes no glands can be classified as carcinoma."*

10. The March 20th pathology report indicated only inflammatory bowel disease. It contained this diagnosis:

> *"Diverticulosis and diverticulitis, severe with pericolic abscesses and stenosis of the lumen.*
> *Acute and chronic colitis, severe.*
> *Eleven pericolic lymph nodes with reactive hyperplasia.*
> *Margins with severe chronic inflammatory colitis." (P.Ex. 3, p. 125)*

This report does not indicate that there was any carcinoma in the colon specimen submitted. (Tr. 169-70)

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[2]A crypt abscess "is a microscopic abscess formed in the lining of the colon. When present, it indicates the presence of ulcerative colitis." (Tr. 83)

11. Patient A's record contains no indication that Respondent disputed the pathologist's diagnosis. (See Tr. 39, 570-73) If Respondent disputed the pathologist's findings he had an obligation to discuss this with the pathologist or to request further review by the pathologist. (Tr. 38-39, 167-68, 625-27)

12. None of the Respondent's entries following the March 17th surgery indicates that he was aware of the pathologist's report. (See P.Ex. 3, pp. 123-24, 160-62, 167, 169-71, 174, 183-85)

13. Patient A required further treatment for ulcerative colitis and diverticulitis, about which there should have been consultation with the gastroenterologist and the internist. (See Tr. 33-37, 46-47, 109-11, 162-63; cf. Tr. 573)

14. Beginning March 21 Patient A was having liquid green stools and was anemic. By March 25, she was too weak to get out of bed to go to the bathroom and was having loose bowel movements in bed. Anti-diarrhea medication, including kaopectate and lomotil, were prescribed for her, despite which she was free of diarrhea for only about one day during the period March 21-31. During this period the patient also experienced psychiatric problems. (P.Ex. 3, pp. 24-27, 104, 165-87; Tr. 40-42; cf. Tr. 346-49, 576-77, 609-11)

15. The patient's stool was tested for the presence of Clostridium difficile, which could have explained the persistent diarrhea. None was found, thereby supporting a diagnosis of ulcerative colitis. Pus had also been found in the stool, which would further have supported a diagnosis of severe inflammation as a result of ulcerative colitis. (P.Ex. 3, pp. 63, 68; Tr. 44-46)

16. There is no entry by Respondent in Patient A's record which indicates that he considered inflammatory bowel disease as a contributing factor to the diarrhea. (See Tr. 39, 601-03; see also Tr. 620-24)

17. On or about March 31, Patient A suffered from peritonitis, as evidenced by the elevated white blood count of 22,000, pain in her left shoulder and the fact that her abdomen was tender and distended. (P.Ex. 3, pp. 182-84; Tr. 117-18, 616-17)

18. Respondent appropriately ordered a gastrografin study in timely fashion to ascertain the cause of Patient A's peritonitis. (P.Ex. 3, pp. 184-85; Tr. 47-49) The radiologist's report (P.Ex. 3, p. 93) indicated an anastomotic leak. It stated:

> *"There is noted to be ~~extralumination~~ extravasation of contrast from the colon [along] the ventral lateral surface of the surgical anastomosis. There are inflammatory changes in the colonic mucosa and the descending colon and residual sigmoid colon. The remainder of the colon is incompletely filled but appears grossly normal."*

19. Respondent performed a transverse colostomy on Patient A on March 31. (P.Ex. 3, pp. 131-32) This could be considered an appropriate procedure given Respondent's determination that the cause of the peritonitis was an anastomotic leak. (Tr. 48-49, 584-85)

20. Respondent's March 31st operative note (P.Ex. 3, p. 131) failed to include a specific description of the colon, but he did state:

> *"The area of the previous resection showed the bowel to be somewhat boggy and edematous. A clear cut perforation was not noted, however, the flammatory reaction suggested that the anastomotic leak occurred on the lateral wall of the sigmoid colon. The remainder of the abdominal exploration was unremarkable. There was no pus, feces or fibrin in the abdominal cavity."*

21. Patient A expired early in the morning of April 4, 1989. (P.Ex. 3, pp. 2, 4, 28-29) The Discharge Summary listed the "Principal Cause of Death" as "Shock, Sepsis Cardiopulmonary Arrest." (P.Ex. 3, p. 2) The Certificate of Death listed the "Immediate Cause" as "cardiopulmonary arrest. . . due to or as a consequence of : shock; " it also entered "inflammatory bowel disease" under "other significant conditions contributing to death but not related to [the immediate] cause." (P.Ex. 3, p. 4)

22. At autopsy two (2) small areas of perforation were seen in the anterior wall of the cecum. (P.Ex. 3, p. 7) As indicated in Finding of Fact 20, at the time of the March 31 operative report, a "clear cut perforation was not noted" and other observations were "unremarkable." The Autopsy Report makes no reference to extensive adhesions which would have precluded visualization of any perforations. (See P.Ex. 3, pp. 7, 9; see also Tr. 359-61) Thus the perforations likely developed after the March 31st surgery. (Tr. 362, 587, 593-94, 617-19; cf. Tr. 137-39)

FINDINGS AS TO PATIENT B

23. Patient B, an 87 year old man, was admitted to the Hospital on July 11, 1989, with complaints of pain in his left heel and calf and of gangrene of his left great toe. He was under the care of Dr. M. Reddy, an internist, and of Dr. R. Ryzoff, a vascular surgeon. (P.Ex. 4, pp. 2, 10-12, 17-20; Tr. 383-84)

24. Patient B subsequently underwent two (2) surgical procedures, an amputation of the left great toe on July 13, and a left femoral-anterior tibial bypass on July 20, both of which were performed by Dr. Ryzoff. (P.Ex. 4, pp. 78, 89-92; Tr. 174)

25. Dr. Ryzoff requested Respondent to cover him with respect to Patient B during the early part of August and Respondent agreed to do so.[3] (See Tr. 380-81; R.Ex. B, p. 4)

26. Respondent was a general surgeon and was not permitted to perform vascular surgery at the Hospital. However, Dr. M. Goldberg, Chief of Surgery at the Hospital, permitted Respondent to cover for Dr. Ryzoff with respect to Patient B, subject to the conditions that Patient B had to be stable and that Dr. Ryzoff had to remain within telephone contact and 90-120 minutes driving distance from the Hospital. The conditions established by Dr. Goldberg set the limits of Respondent's medical obligations and responsibilities with respect to Patient B. (Tr. 214-16, 380-81, 399-400, 540, 550; R.Ex. B, p. 4)

27. Respondent examined Patient B on August 2. (P.Ex. 4, p. 154) There is no evidence that Respondent examined the patient again or received any further information about him until August 8. (See P.Ex. 4, pp. 155-61; Tr. 199, 202, 383, 396)

28. During this time the patient was seen every day but one (August 4) by Dr. Reddy, his internist. (P.Ex. 4, pp. 155, 157, 159, 161; cf. Tr. 383-84, 396) Beginning on August 4 the hospital record shows edema, infection, pain, discoloration and drainage from the leg wound. (P.Ex. 4, pp. 155-59)

29. On August 7 pus was reported coming from the toe wound and the staples at the incision at the left tibial area. Approximately one-third of the foot had black discoloration, as did an area of the heel the "size of a quarter." There is no record that Respondent was informed of any of this. (P.Ex. 4, p. 159; Tr. 202, 383)

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[3]There is no specific record that Respondent assumed responsibility for Patient B. The last entry signed by Dr. Ryzoff in Patient B's Progress Record is dated "7/31/89"; the first entry signed by Respondent is dated "8/2". (P.Ex. 4, pp. 152, 154. See also Tr. 175, 381-83)

30. There are two notes in Patient B's August 8th record, one timed at 7:30 p.m. by M. Johnson, L.P.N., and one at 8:00 p.m. by C. Kelly, D.O. The patient was reported to be pale and exhibiting malaise. His blood pressure was 100/60; his pulse was 76.[4] There was a palpable mass above the incision and a large ecchymotic area around the groin suture line radiating into the scrotum, which was draining foul-smelling material. (P.Ex. 4, p. 161; Tr. 175-76)

31. Between 7:00 and 8:00 p.m. on August 8, Respondent was called at home by the nursing staff and informed of Patient B's condition. (Tr. 384) Respondent then ordered that warm compresses be applied to the left inguinal area. He also ordered "CBC and lytes", i.e., a complete blood count and electrolytes, on the assumption that Dr. Ryzoff would need them to evaluate the patient's condition and the possibility of further surgery.[5] (P.Ex. 4, pp. 161, 191; Tr. 388, 390, 393-94. See also Tr. 177-78)

32. Respondent telephoned Dr. Ryzoff, who was about one-and-a-half hours away, and advised him of Patient B's condition. Dr. Ryzoff said he would take care of the patient. (Tr. 389-91)

33. Respondent did not go to the Hospital on the night of August 8 to see Patient B. (Tr. 394-95)

34. Patient B expired on August 9, 1989, at approximately 12:30 a.m. (P.Ex. 4, pp. 6, 19-20, 161)

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[4]Patient B's hemoglobin and hematocrit had fallen from 10.2 and 31.5 on August 7 to 7.8 and 24 on August 8, indicating that he was losing blood. (P.Ex. 4, pp. 28-29; Tr. 176, 178; see also Tr. 388) The 7:30 nurse's note (P.Ex. 4, p. 161) indicates that the "CBC" (i.e., complete blood count) results were given to Respondent, although Respondent testified that he did not recall having received them at the time he called Dr. Ryzoff. (Tr. 390, 392)

[5]The Hospital's Log of Doctor's Orders records that at 8:00 p.m. Respondent ordered a CBC to be done in the morning. (P.Ex. 4, p. 191) Respondent could not recall whether he actually had two telephone calls to the Hospital concerning Patient B on the evening of August 8. (See Tr. 395, 397-99)

FINDINGS AS TO PATIENT C

35. Patient C was an 82 year old woman who was admitted to the Hospital on May 11, 1992, with abnormal renal function tests indicating "severe uremia." She exhibited weakness, nausea, diminished appetite and dehydration, but no symptoms of an acute abdominal condition. (P.Ex. 5, pp. 2, 9, 27-29; Tr. 226-27, 249) There was no evidence of jaundice during her hospitalization. (Tr. 326, 499-500)

36. On May 12 Patient C's white blood count was slightly elevated at 11.7 (P.Ex. 5, p. 32. See Tr. 227)

37. Several entries in Patient C's record suggest that there may have been a urinary tract infection. These include a physical examination on May 11 by Dr. A. Mackenzie, who noted "pyuria" (P.Ex. 5, p. 31); a gastroenterology consultation on May 13 by Dr. J. Loewenstein, who noted "both pus and blood in her urine" (P.Ex. 5, p. 136); a nephrology consultation on May 13 by Dr. P. Friedman, who noted "a history of . . . urinary tract infections or vaginal infections" (P.Ex. 5, p. 138); and a renal sonogram report on May 15 by Dr. J. McCleavey, who stated: . . . "THE KIDNEYS SHOW EVIDENCE OF MEDICAL RENAL DISEASE AS MANIFESTED BY INCREASED GENERALIZED ECHOGENICITY." . . . (P.Ex. 5, p. 130; See also Tr. 520-21)

38. The radiopharmaceutical dye test known as a "DISIDA scan" was performed on Patient C on May 19. Dr. McCleavey's report following the scan (P.Ex. 5, p. 132), which noted . . ."no visualization of the gallbladder," concluded:

"IMPRESSION: FINDINGS INDICATE EVIDENCE OF CYSTIC DUCT OBSTRUCTION. THERE IS PROMINENCE OF THE INTRAHEPATIC BILIARY RADICALS BUT SMALL BOWEL ACTIVITY OCCURS PROMPTLY INDICATING THAT THERE IS NO COMPLETE OBSTRUCTION OF THE COMMON BILE DUCT."

39. On May 21 Patient C's nausea and vomiting were described as improving as her uremia was appearing to resolve. (See P.Ex. 5, p. 173; Tr. 272, 318-19) It was also noted that the patient will . . . "require cholecystectomy, as per Dr. Loewenstein, probably next week." (P.Ex. 5, p. 173)

40. Respondent saw Patient C on May 23. The report of his physical examination, which noted . . . "no masses or tenderness" in the abdomen, does not indicate signs of acute gallbladder inflammation. (P.Ex. 5, p. 5; Tr. 231)

41. As of late May Patient C was still suffering from uremia to a degree. Although the patient had demonstrated gallstones and a small shrunken gallbladder, there was no clinical evidence of acute inflammation of the gallbladder which had to be addressed at that time. (P.Ex. 5, p. 130; Tr. 231, 244-45, 249, 285-86, 302-03, 322-24; cf. Tr. 472-78)

42. On June 8, Respondent commenced an exploratory laparotomy and cholecystectomy on Patient C. Respondent's operative report (P.Ex. 5, p. 7) states:

"The patient had a small contracted gallbladder which was foreshortened and adherent to the superolateral wall of the duodenum. In addition, there was marked areas of concretions running the entire length of the common duct, posterior to it from the duodenum to the liver."

Dissection had to be initiated in a retrograde manner. (See Tr. 234, 297-98, 306, 414-17, 485-87)

43. Respondent's operative report on the June 8 procedure states that a cholecystoduodenal fistula was noted and subsequently closed. (P.Ex. 5, p. 7) The existence of such a fistula would not have precluded performance of a cholecystostomy. (Tr. 235-36; see also Tr. 307-08, 526-29)

44. Massive hemorrhaging occurred during the surgery on Patient C, who lost ten (10) liters of blood. Respondent was unable to stop the bleeding. (P.Ex. 5, pp. 7-8) Patient C expired at 4:40 p.m. on June 8, 1992, about two-and-one-half hours after her transfer from the operating room. (P.Ex. 5, pp. 192-93, 195-96, 200)

CONCLUSIONS AS TO FACTUAL ALLEGATIONS

Patient A

Patient A was admitted to the Hospital by her internist to deal with persistent diarrhea and related symptoms. During her hospitalization, Patient A was treated by several members of the Hospital's staff, including Respondent, who twice (2) operated on her colon. Although Respondent suspected sigmoid carcinoma, no carcinoma was ever found. The patient expired about three weeks after her admission.

Paragraph A of the Statement is **SUSTAINED** as a general summary of Patient A's hospitalization and treatment by Respondent, subject to these qualifications: Patient A was 68 years old, not 69. The cause of death stated in Paragraph A ("peritonitis secondary to a perforation of the cecum") must be read in the light of the Discharge Summary, Certificate of Death and Autopsy report. (See Findings of Fact 21 and 22, supra.[6])

[6]Citations to the record in the Findings of Fact which are applicable to the corresponding Conclusions are not repeated.

Paragraphs A.1 and A.2 state:

> *"Respondent failed to appropriately diagnose the source of Patient A's life-threatening post-operative diarrhea."* ¶ A.1.
>
> *"Respondent failed to appreciate the significance of the pathologist's findings that the tissue showed severe chronic and acute inflammation, and the clinical significance of the pus cells in the stool, without evidence of carcinoma, and act accordingly."* ¶ A. 2.

These two (2) charges relate to the period between Patient A's first and second surgeries, when her diarrhea and other symptoms failed to resolve. Petitioner contends that the persistence of the patient's symptoms, combined with the negative pathology report respecting carcinoma, should have alerted Respondent to alternative explanations for Patient A's condition, such as ulcerative colitis, diverticulitis and Crohn's disease. Treatment should have included steroids and antibiotics, the latter of which Respondent actually ordered terminated. (Tr. 31-37, 44-46, 105-09, 163, 165)

The opposing position is that the postoperative diarrhea was intermittent and non-life-threatening and that it could have arisen from a number of causes. The pathology report, while ruling out carcinoma, was ambiguous as to alternative diagnoses. The measures taken by Respondent were, therefore, appropriate. For example, antibiotics could have had harmful side-effects and their continued administration was unnecessary if, as Respondent believed, the entire area of inflammation had been removed. (Tr. 365, 570-76, 597-602)

Although Patient A in many ways presented a puzzling case (see, e.g., Tr. 157-59, 170, 372-73, 590, 595-96), the Committee finds Petitioner's contentions persuasive. The patient's diarrhea during the period between surgeries was not life-threatening (see Tr. 346-49, 576-77; cf. Tr. 67-68, 112-13), but it was persistent, yielding only briefly to kaopectate and similar medications. Once the patient failed to improve and carcinoma was ruled out, Respondent should have considered other possible diagnoses, such as ulcerative colitis, but he did not.

Accordingly, **Paragraphs A.1** and **A.2** are **SUSTAINED,** except insofar as Paragraph A.1 characterizes the diarrhea as "life-threatening."

Petitioner goes a step further and alleges that "Respondent failed to provide appropriate post-operative medical therapy for the ulcerative colitis, which had been demonstrated on the pathology report." ¶ A.3.

Respondent was not Patient A's sole, or even primary, physician. The patient's case was also being followed by her admitting internist and by the gastroenterologist, both of whom saw her frequently and bore more responsibility for her medical therapy than did Respondent. (See Tr. 173, 361-62, 573-74, 590, 614, 621, 624-25) **Paragraph A.3** is **NOT SUSTAINED.**

The final allegations concerning Patient A are:

> *"Respondent performed the wrong operation on March 31, 1989. He performed an exploratory laparotomy and right transverse colostomy when he should have performed either an ileostomy or a subtotal colectomy, because the source of the peritonitis was the cecum."* ¶ A.4.

> *"Respondent failed to correctly ascertain the source of the patient's peritonitis on or about March 31, 1989, the time of the second operation."* ¶ A.5.

At issue here is not the choice of procedure, which was within the range of reasonable medical options. (Tr. 584-85, 588-89; cf. Tr. 50-51, 139-41) The key element in both charges is that "the source of the peritonitis was the cecum." If this was, or could have been, known at the time Respondent performed the second operation on Patient A, the surgery would have been mistaken because it would have failed to remove the source of the patient's infection.

Respondent testified that at the time of the March 31st surgery all indicators pointed to a leaking anastomosis as the source of the infection and that he acted properly in attempting to correct it. (Tr. 353-54, 356, 359-60) His report on that surgery provides no basis for asserting that the cecum was already perforated. As his expert testified, it there had been such a perforation, "that would have been very hard to miss. [It] almost certainly was not there at the time of the March 31st operation." (Tr. 593)

As there is no evidence that a perforated cecum was the source of Patient A's peritonitis when Respondent performed the second surgery, **Paragraphs A.4** and **A.5** are **NOT SUSTAINED.**

Patient B

Patient B was an 87 year old man who, in July 1989, underwent surgery by Dr. Ryzoff, a vascular surgeon, to relieve gangrene in his left foot. Dr. Ryzoff went on vacation in early August and Respondent, although not a vascular surgeon, was authorized to cover for him under limited conditions established by the Chief of Surgery. Among other things, Dr. Ryzoff was required to stay within a 90-120 minutes drive from the Hospital.

Shortly before 8:00 p.m. on August 8 Respondent was contacted at home by Hospital staff and informed that Patient B's condition was worsening: a large ecchymotic area had been observed around the incision at the groin, foul-smelling material was draining from the suture line and the patient's hemoglobin and hematocrit were dropping.

In consequence, Respondent ordered a complete blood count and electrolytes on a stat basis. He testified that he immediately informed Dr. Ryzoff by telephone of Patient B's condition and that Dr. Ryzoff replied that he would take care of the patient. Five hours later, around 12:30 a.m. on August 9, 1989, Patient B died of undetermined causes (see P.Ex. 4, pp. 19-20, 162; cf. Tr. 223-24, 551, 557-59), never having been seen by Respondent or Dr. Ryzoff.

The Statement charges that this was professional misconduct:

> *"Respondent, upon learning of the drop in Patient B's hemoglobin and the hematocrit, and of the large ecchymotic area, as well as pus exuding from the groin wound, failed to immediately attend to Patient B."*

Respondent contends that his responsibility for Patient B ceased when Dr. Ryzoff stated that he would take care of the patient; this might reasonably be taken to mean Dr. Ryzoff was returning to the Hospital. (See Tr. 222) In Respondent's opinion, there was nothing more he could have done which would have been within the scope of his authorization to cover for the vascular surgeon. (Tr. 391, 394, 396-97; see also Tr. 549-51, 554-57)

Petitioner introduced no evidence to contradict Respondent's testimony about his telephone discussion with Dr. Ryzoff or about the underlying coverage arrangement.

But that does not decide the issue. Respondent was less than 15 minutes from the Hospital; Dr. Ryzoff was 90 minutes away. It cannot be assumed that the attendance of an experienced general surgeon would have been futile. (See Tr. 180, 182-84, 219-20; cf. Tr. 208-11, 545-46, 549-51)

Considering the patient's age and condition and the obscurity of his problem, Respondent should have seen him at the Hospital that night while waiting for Dr. Ryzoff. A firm sense of professional responsibility requires no less. **Paragraph B** is **SUSTAINED**.[7]

Patient C

Patient C was an 82 year old woman who was admitted to the Hospital by her internist on May 11, 1992, because of renal problems. While she was hospitalized there were some limited indications of gallbladder disease. (See Findings of Fact 38, 39, 40 and 41, supra) Respondent examined this patient and recommended a cholecystectomy when feasible.

[7]This conclusion is subject to the following qualifications: Paragraph B alleges that Respondent was notified of Patient B's condition both by Dr. Kelly (identified in the Statement as "an intern") and by "nurses". However, there is not evidence in the record of Dr. Kelly's status. Nor is the record clear as to who spoke to Respondent on August 8 and who received his telephone orders. (See P.Ex. 4, pp. 161, 191; Tr. 205, 386-89, 397-98)

On June 8, 1992, Respondent commenced an exploratory laparotomy, cholecystectomy and closure of a cholecystoduodenal fistula which was revealed during surgery. Patient C began to hemorrhage during the operation. The hemorrhage could not be completely controlled and the patient expired a few hours after the end of the surgery.

Paragraph C of the Statement is **SUSTAINED** as a general summary of Patient C's hospitalization and of her treatment by Respondent, subject to the qualification that the evidence was inconclusive concerning the patient's liver function test (see Tr. 258-61, 460-62, 476) and the source of her hemorrhage, i.e., whether, as charged, it was caused by Respondent's having damaged either the hepatic artery or the portal vein. (See Tr. 237-40, 244, 423-26, 444-45, 487-90, 514-16)

Paragraph C.1 states:

> *"Patient C's clinical condition did not justify removal of her gallbladder at that time."*

This elderly patient primarily suffered from renal problems such as uremia. Examination while she was hospitalized indicated some involvement of the gallbladder, which might have been suspected as a source of sepsis. (Tr. 406, 408, 430-31, 437-41, 462-65) However, the patient's renal infection was subsiding, possibly as a response to treatment with antibiotics. (See Tr. 257, 285, 472-73, 475-76) Moreover, there was an absence of other significant indicators of acute gallbladder disease, such as abdominal pain or tenderness.

When the weak indicators pointing toward surgical intervention are measured against the patient's age and fragile physical condition, it must be concluded that a cholecystectomy should not have been attempted at that time. **Paragraph C.1** is **SUSTAINED.**

Paragraph C.2 is based on the fact that Respondent continued with his intention of performing a cholecystectomy although he began to encounter serious difficulties once the surgery commenced. It states:

"Given the degree of inflammatory reaction, Respondent failed to perform a cholecystostomy and drain the remainder of the gallbladder."[8]

The expert witnesses disagreed about the course Respondent should have followed when the commencement of surgery presented a difficult situation: adhesions, a cholecystoduodenal fistula, extensive calcification, pericholecystic inflammation, areas of severe scarring and contracture and generally poor visualization of anatomical planes. (P.Ex. 5, pp. 7-8; Tr. 232-37, 415-17, 419-20, 481-82)

Petitioner's expert testified that Respondent should have realized that a cholecystectomy could not be successful and instead have performed a cholecystostomy, inserting a tube in the gallbladder and draining out the stones. (Tr. 233-36, 307-09) In contrast, Respondent's expert testified that removing the gallbladder remained the proper course. Merely to have drained it by a cholecystostomy entailed a substantial possibility of leaving behind infection or possible cancer. (Tr. 508)

Upon reviewing this conflicting testimony, the Committee is convinced by Petitioner. In this case, the remote consequences of a cholecystostomy were not as dangerous as going ahead with an attempt to remove all or part of the gallbladder. Drainage of the organ and evacuation of the gallstones may have provided the patient some relief without running the immediate risks incident on continuing the procedure originally planned. A cholecystostomy should have been attempted. **Paragraph C.2 is SUSTAINED.**

Paragraph C.3 states:

"Respondent failed to call for additional surgical assistance to assist him in controlling the hemorrhage which occurred during the June 8th operation."

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[8]Petitioner was granted permission to amend ¶ C.2 of the Statement to strike the word "partial" from before the word "cholecystostomy." (Tr. 319-21)

Respondent concedes that he did not call for additional help after the hemorrhaging began. (Tr. 429) However, Respondent was already being assisted at this operation by Dr. Elliott, the Hospital's former Chief of Surgery. (Tr. 418-19, 425-29) There is no basis for disputing Respondent's judgment that nothing would have been gained by having more surgeons present.

Accordingly, **Paragraph C.3** is **SUSTAINED** because it is literally accurate that Respondent did not call in assistance but **NOT SUSTAINED** insofar as it implies that Respondent had a duty to do so in this situation.

Paragraph C.4 states that Respondent failed to respond appropriately to Patient C's hemorrhage during the June 8 surgery. However, among other things, Respondent attempted to control the bleeding with suture ligatures, staples, manual compression, application of hemostatic material and packing. (P.Ex. 5, pp. 7-8; Tr. 424-29) This was the proper course for dealing with the hemorrhage. (See Tr. 486-94) **Paragraph C.4** is **NOT SUSTAINED.**

DISPOSITION OF SPECIFICATIONS

The First, Second and Third 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 Fourth 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 (3d Dept), app. den., 78 N.Y.2d 856, 574 N.Y.S.2d 937 (1991).

The Committee is unanimous in determining that the Fourth Specification is adequately supported by the acts underlying Paragraphs B, C.1 and C.2.[9] As to the charges in Paragraphs A.1 and A.2, the Committee is divided. A majority of the Committee has determined that those allegations, although factually accurate, do not constitute negligence within the above definition. One member of the Committee, however, dissents and votes that the acts set forth in Paragraphs A.1 and A.2 should also be found to constitute negligence.

The Fifth, Sixth and Seventh Specifications charge that Respondent practiced the profession with gross incompetence within the meaning of Education Law §6530, subd. 6. Gross incompetence may be defined as an unmitigated lack of requisite skill and knowledge. The Committee determines that Respondent's professional failings have not been shown to be grossly incompetence when considered under the above standard.

The Eighth Specification charges that Respondent practiced the profession with incompetence on more than one occasion within the meaning of Education Law §6530, subd. 5. 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.

The Committee is divided on the Eighth Specification. A majority of the Committee has determined that none of Respondent's acts indicate that he is incompetent. One member of the Committee, however, dissents and votes that the acts set forth in Paragraphs A.1, A.2, C.1 and C.2 should be found to constitute incompetence within the above definition.

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[9]¶ C.2, as amended. See Footnote 8.

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

FIRST, SECOND AND THIRD SPECIFICATIONS (gross negligence):

NOT SUSTAINED

FOURTH SPECIFICATION (negligence on more than one occasion):

SUSTAINED

FIFTH, SIXTH AND SEVENTH SPECIFICATIONS (gross incompetence):

NOT SUSTAINED

EIGHTH SPECIFICATION (incompetence on more than one occasion):

NOT SUSTAINED

ORDER

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

ORDERED that Respondent **WARREN JANUS, M.D.,** shall be **CENSURED** and **REPRIMANDED** for committing professional negligence on more than one occasion; and it is further

ORDERED that the practice of Respondent **WARREN JANUS, M.D.,** shall be **MONITORED** for a period of **ONE YEAR** by a physician nominated by Dr. Janus and approved by the Office of Professional Medical Conduct.

DATED: New York, New York
April 8 1996

STANLEY L. GROSSMAN, M.D.
(Chairperson)

JOSEPH B. CLEARY, M.D.
THEA GRAVES PELLMAN

APPENDIX 1

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

IN THE MATTER

OF

WARREN JANUS, M.D.

NOTICE

OF

HEARING

TO: Warren Janus, M.D.
325 West Park Avenue
Long Beach, N.Y. 11561

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 2, 1995, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examin witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note th requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date

Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
[illegible] 1995

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER OF WARREN T. JANUS, M.D.	STATEMENT OF CHARGES

WARREN T. JANUS, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 9, 1962, by the issuance of license number 087860 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about March 12, 1989, Patient A (Patient A and all other patients are identifie in the attached appendix), a 69 year-old woman, with a history of diarrhea for two t three weeks and an obstructed colon, was admitted by her internist to Long Beach Memorial Hospital, Long Beach, N.Y. Respondent saw Patient A on or about March 15, 1989. Respondent incorrectly diagnosed Patient A as suffering from carcinoma of the sigmoid colon. On or about March 17, 1989, Respondent performed a sigmoid colectomy. Subsequent to the March 17, 1989 operation the patient continued to have diarrhea, fluid loss and changes in her mental status. Or or about March 20, 1989, the pathology report revealed that Patient A was sufferin from severe diverticulitis of the colon with abscess and inflammation: and acute an chronic colitis, severe; however, there was no evidence of carcinoma. On or about March 31, 1989, Respondent performed an exploratory laparotomy and right transverse colostomy. Patient A died on April 4, 1989 of peritonitis secondary to a perforation of the cecum.

1. Respondent failed to appropriately diagnose the source of Patient A's life-threatening post-operative diarrhea.

2. Respondent failed to appreciate the significance of the pathologist's

findings that the tissue showed severe chronic and acute inflammation, and the clinical significance of the pus cells in the stool, without evidence of carcinoma, and act accordingly.

3 Respondent failed to provide appropriate post-operative medical therapy for the ulcerative colitis, which had been demonstrated on the pathology report.

4. Respondent performed the wrong operation on March 31, 1989. He performed an exploratory laparotomy and right transverse colostomy when he should have performed either an ileostomy or a subtotal colectomy, because the source of the peritonitis was the cecum.

5. Respondent failed to correctly ascertain the source of the patient's peritonitis on or about March 31, 1989, the time of the second operation.

B. On or about July 11, 1989, Patient B was admitted to Long Beach Memorial Hospital, with complaints of pain in the left heel and calf and gangrene of the left great toe. A vascular surgeon, Dr. Ryzoff, performed a femoral - anterior tibial bypass on or about July 20, 1989. On or about August 7, 1989, the nurses noted that there was gangrene of the forefoot as well as heel, and pus was noted to be coming from the incisions between the staples. Respondent was covering for the vascular surgeon on or about August 8, 1989. On or about August 8, 1989, Dr. Kelly, an intern, described a large ecchymotic area surrounding the incision with radiation into the scrotum with a mass above the incision. Dr. Kelly notified Respondent on or about August 8th of his findings. The nurses also noted the skin suture line was draining foul smelling material. Patient B's hemoglobin dropped to 7.8 on August 8th, from 10.2 the day before, his hematocrit fell to 24 from 31.5 on the day prior. On or about August 8th, the nurses also informed Respondent of the

patient's condition. Respondent did not go to the hospital to see and/or treat Patient B. At or about 1 00 a.m., approximately, five hours later, Patient B was found dead in his bed.

Respondent, upon learning of the drop in Patient B's hemoglobin and the hematocrit, and of the large ecchymotic area, as well as, pus exuding from the groin wound, failed to immediately attend to Patient B.

C. On or about May 11, 1992, Patient C was admitted to the Long Beach Memorial Hospital by her internist due to findings of uremia. The patient's liver function test was basically within normal limits, the patient was not jaundiced, nor did she have abdominal pain or tenderness. A DISIDA scan performed on or about May 19, 1992 showed cystic duct obstruction, but there was dye in the intestine indicating that the common duct was open. Respondent recommended a cholecystectomy for Patient C when medically feasible. On or about June 8, 1992, Respondent began an exploratory laparotomy, cholecystectomy, and closure of the cholecystoduodenal fistula. During the course of the procedure Respondent damaged either the hepatic artery or the portal vein. Patient C began to hemorrhage. Respondent was never able to control Patient C's hemorrhage. She died on June 8, 1992.

1. Patient C's clinical condition did not justify removal of her gallbladder at that time.
2. Given the degree of inflammatory reaction, Respondent failed to perform a partial cholecystostomy and drain the remainder of the gallbladder.
3. Respondent failed to call for additional surgical assistance to assist

him in controlling the hemorrhage which occurred during the June 8th operation.

4. Respondent failed to appropriately treat Patient C's hemorrhage which occurred during the June 8th operation.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS
PRACTICING THE PROFESSION 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 §6530 (4) (McKinney Supp. 1995), in that Petitioner charges:

1. The facts in paragraphs A, A1. through A5 .
2. The facts in paragraphs B.
3. The facts in paragraphs C, C1. through C4.

FOURTH SPECIFICATION
PRACTICING THE PROFESSION NEGLIGENTLY

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 §6530 (3) (McKinney Supp. 1995), in that Petitioner charges that Respondent committed two or more of the following:

4. The facts in paragraphs A, A1 through A5.

B; and/or C, C1 through C4.

FIFTH THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH 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 §6530 (6) (McKinney Supp. 1995), in that Petitioner charges:

5. The facts in paragraphs A, A1. through A5.

6. The facts in paragraphs B.

7. The facts in paragraphs C, C1. through C4.

EIGHTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of 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 that Respondent committed two or more of the following:

8. The facts in paragraphs A, A1 through A5;

B; and/or C, C1 through C4.

DATED September 5, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct