THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

April 12, 1990

Arthur Lewis, Physician
758 East 221st Street
Bronx, New York 10467

Re: License No. 119921

Dear Dr. Lewis:

Enclosed please find Commissioner's Order No. 10301/8583. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: Warren J. Bennia, Esq.
507 E. 80th Street
New York, N.Y. 10021

REPORT OF THE
REGENTS REVIEW COMMITTEE

ARTHUR LEWIS

CALENDAR NO. 10301/8583

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ARTHUR LEWIS, M.D. **No. 10301/8583**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

ARTHUR LEWIS, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

This disciplinary proceeding was properly commenced and on four separate dates between September 16, 1987 and November 20, 1987 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A". Respondent's answer to the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A1".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachments, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was not guilty of the charges and recommended that the charges be dismissed.

The Commissioner of Health, by his designee, recommended to the Board of Regents that the findings of the hearing committee be accepted as to Patients A, B, and C, but that the conclusions of the hearing committee with regard to these 3 patients be rejected; that respondent be found guilty of the first through fifth and seventh specifications of the charges and of the ninth specification to the extent of the first through fifth and seventh specifications; and that respondent's license to practice as a physician be suspended for 3 years and that suspension be stayed provided he comply with certain conditions. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On February 25, 1989, the Regents Review Committee issued a report recommending to the Board of Regents that the matter be remanded to the Commissioner of Health for a de novo recommendation consistent with the Regents Review Committee's report. That prior report deciphered and charted the specifications of the charges, indicated that each specification was not separately stated and numbered in the charges, and indicated that the Commissioner of Health's recommendation did not separately address each definition of professional misconduct. Our prior report recommended that, on remand, the conclusions of the Commissioner of Health should

specifically address the question of guilt as to each charged definition of professional misconduct as it relates to each patient and each specification, and the recommendation should specify that portion of the record relied upon to demonstrate any guilt. A copy of the February 25, 1989 report of the Regents Review Committee, without attachments, is annexed hereto, made a part hereof, and marked as Exhibit "D".

On March 17, 1989, the Board of Regents voted to accept the recommendations of the Regents Review Committee to remand the matter to the Commissioner of Health for a de novo recommendation consistent with the report of the Regents Review Committee, to direct the Commissioner of Health to comply with specified instructions, and to assure that the charges be as specified by the Regents Review Committee. A copy of the March 17, 1989 vote of the Board of Regents is annexed hereto, made a part hereof, and marked as Exhibit "E".

On April 3, 1989, the Commissioner of Education executed an order carrying out the terms of the decision by the Board of Regents. A copy of the April 3, 1989 order of the Commissioner of Education is annexed hereto, made a part hereof, and marked as Exhibit "F".

On August 11, 1989, the Commissioner of Health, by his designee, recommended de novo that the Board of Regents accept the hearing committee's findings of fact; accept his own additional

findings of fact as to Patients A, B, and C; accept the hearing committee's not guilty conclusions regarding the second, sixth, and eighth specifications, and the ninth specification to the extent of the second, sixth, and eighth specifications, and find respondent not guilty thereof; reject the hearing committee's not guilty conclusions regarding the first, third, fourth, fifth, and seventh specifications, and the ninth specification to the extent of the first, third, fourth, fifth, and seventh specifications, and find respondent guilty thereof; and suspend respondent's license to practice medicine for three years and "that that suspension be stayed provided" he comply with certain conditions. A copy of the August 11, 1989 de novo recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "G".

On January 18, 1990, respondent appeared before us in person and was represented by his attorney, Warren Bennia, Esq., who presented oral argument on behalf of respondent. Jean J. Bressler, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was the same as the August 11, 1989 de novo recommendation of the designee.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was no penalty.

We have considered the record as transferred by the Commissioner of Health after each recommendation by his designee in this matter and respondent's October 19, 1989 submission.

This case was previously remanded because the recommendation by the designee of the Commissioner of Health originally failed to make any findings or conclusions as to Patient D, differentiate his conclusions as to each separate definition of professional misconduct, make conclusions as to some of the specifications, support his recommendations with reference to the record, and adequately explain the basis for his differences with the hearing committee. This confusion should have been avoided and a complete recommendation should have been rendered originally without delaying this matter.

ACCEPT DESIGNEE'S CONCLUSIONS

The de novo recommendation by the designee of the Commissioner of Health adds findings of fact not previously found by him. Based on our review of the record and of all the recommendations, we accept the de novo recommendation of guilty by the designee as to the first, fourth, and fifth specifications and the ninth specification to the extent of the first, fourth, and fifth specifications involving Patients A, B, and C respectively.

The additional findings by the designee of the Commissioner of Health as to the first specification include respondent "did not

consider, and should have considered, a diagnosis of pulmonary embolism." Finding e-patient A. The hearing committee had found that respondent did not perform or order an arterial blood gas or lung scan. Hearing committee finding 11-Patient A. We agree with the conclusions of the designee that respondent failed to consider the possibility of pulmonary embolism and to assess that possibility through an arterial blood gas or lung scan, and that such failure constitutes, under the circumstances presented by Patient A, gross negligence, negligence, gross incompetence, and incompetence.

Respondent knew the nursing assessment of Patient A was that she was on birth control pills, there was pain over the sternum, and periods of fainting, Transcript (hereafter Tr.) pages 425-426, and knew the patient's age, weight, pulse rates, and other information. Although respondent acknowledged that blood gas tests could be ordered in the emergency room, Tr. 426-427, he testified that he could not elicit any pathology from this patient to indicate that she was suffering from a pulmonary embolism. Tr. 431. He did not perform or order an arterial blood gas test because he claimed there was no indication from all the information he "could collect from the full protocol", Tr. 430, indicative that such test should be performed. Tr. 446-447.

On the other hand, Dr. Quash testified for petitioner that a high risk for a pulmonary embolism was presented by Patient A.

According to Dr. Quash, such risk should have been "upper most in any physician's mind who saw this patient". Tr. 24. In Dr. Quash's expert opinion, "certainty an arterial blood gas should have come to mind to any physician who would have been experienced or would have thought of the diagnosis." Tr. 24.

On the day that Patient A was discharged by respondent under the diagnosis of "nervous anxiety attack-rule out hypoglycemia", hearing committee finding 6, Patient A died from thromboembolism of pulmonary arteries, thrombosis of lower leg veins, hearing committee finding 9. The emergency room records do not indicate that respondent attempted to rule out the diagnosis for Patient A of pulmonary embolus. Hearing committee finding 10.

A preponderance of the evidence in the record supports the conclusions of the designee as to Patient A. Respondent discharged Patient A without performing adequate tests to rule out pulmonary embolism or admitting her so that such tests could be performed. The hearing committee's conclusions, including the conclusions that respondent's diagnosis seemed to be an appropriate diagnosis, under the circumstances at the time, and that the clinical picture for Patient A did not indicate, at the time, the necessity for such further tests, are not sufficiently supported by the record. For example, the designee found that Patient A's blood sugar level did not support respondent's diagnosis at the time. Findings a and b-Patient A and Tr. 23-24.

The substance of the fifth specification as to Patient C is the same as the first specification as to Patient A. Additional findings now recommended by the designee of the Commissioner of Health include a diagnosis of pulmonary embolism was suggested and respondent should have ordered arterial blood gases and a lung scan to determine whether there was a pulmonary embolism. Findings a and b-Patient C. We agree with the conclusions of the designee that respondent should have done more to address and rule out pulmonary embolism and that such failure constitutes, under the circumstances presented by Patient C, gross negligence, negligence, gross incompetence, and incompetence.

Implicit in the designee's recommendation is the fact, not contested by respondent, that respondent did not order either arterial blood gases or a lung scan in this case. In any event, the record demonstrates that these tests were both not ordered by respondent for Patient C and that respondent released this patient from the emergency room without performing adequate diagnostic tests to rule out pulmonary embolism or admitting her so that such diagnostic testing could be performed. Patient C died the next day of a massive thromboembolism and infarction, due to deep vein thrombosis of lower extremities. Hearing committee finding 5-Patient C.

The testimony of two expert witnesses supports the designee's conclusions regarding the fifth specification. Dr. Quash testified

that Patient C's history of a recently delivered baby and complaint of pain in the rib area were very significant and identified other risk factors presented by Patient C. Tr. 35-37. In view of the life threatening circumstances, Dr. Quash stated that the possibility of a pulmonary embolism or some form of embolic disease was indicated, Tr. 36-37, a pulmonary embolism must be taken into account under applicable standards, Tr. 96-97, and respondent must order further tests to rule in or out pulmonary embolism. Tr. 106, 108 and 111. Dr. Quash specified that these circumstances required, before the patient is sent home, a blood gas test to be done first and then a pulmonary VQ scan. Tr. 107-108.

Dr. Kwiatkowski, respondent's supervisor, testified that there were tests that were not done but should have been done to fully ascertain the reasons for the patient's complaints. Tr. 165. He explained his concern that respondent never entertained a diagnosis of a pulmonary embolism and never ordered a blood gas, Tr. 166-167, that such a diagnosis should have been entertained, Tr. 227, and appropriate studies such as arterial blood gas and lung scan should have been ordered. Tr. 229-230.

A preponderance of the evidence supports the conclusions of the designee as to the fifth specification and the ninth specification to the extent of the fifth specification. The hearing committee's conclusions, including Patient C did not present any post-partum complaints, are not supported by the

record. For example, Dr. Kwiatkowski testified regarding Patient C's post-partum complaints of pain in the right rib area and her clinical post-partum presentation with significant fever and tachycardia. Tr. 236-237 and 166.

The fourth specification relates to respondent's evaluation being inappropriate. Regarding Patient B, the hearing committee did not make any finding as to whether the respondent's diagnosis of a urinary tract infection was appropriate or not; and it neither referred, in the conclusions, to the appropriateness or not of the diagnosis nor specifically addressed this issue. Instead, its report only discusses the appropriateness of the tests which were ordered.

The additional findings of fact by the designee include respondent's diagnosis of a urinary tract infection was not supported by laboratory findings, hyponatremia was indicated and should have been addressed, and further study was indicated by the prior laboratory studies. Findings e, b, and c-Patient B. We agree with the conclusions of the designee that respondent's diagnosis for Patient B constitutes, under the circumstances, gross negligence, negligence, gross incompetence, and incompetence.

Dr. Quash testified that, based upon his review of the entire medical record concerning Patient B, there was most definitely a diagnosis other than urinary tract infection. Tr. 46. According to Dr. Quash, the facts that Patient B's urine was relatively

normal, the rest of the urinalysis was normal, and the white blood cells would be within the expected range of a non-urinary tract infection, "certainly" do not lead to a diagnosis of a urinary tract infection. Tr. 46 and 147. Due to the "whole picture" presented by this patient, Dr. Quash believed it was necessary to perform further study, rule out hyponatremia, and consider other diagnoses. Tr. 47, 125, and 150. He further opined that even if a clean catch of the urine specimen was obtained and there "could" be a minor low-grade urinary tract infection, a physician in the emergency room cannot associate the various other findings as being caused by a urinary tract infection. Tr. 147. We note that there was no mention on the transfer note from the other institution of any symptoms relating to any urinary tract infection. Tr. 154.

Dr. Kwiatkowski testified that based on the constellation of abnormal "findings, especially with regard to laboratory", he felt "strongly" that something more serious was involved in the case of Patient B than a urinary tract infection. Tr 173-175. Dr. Kwiatkowski believed that the diagnosis of a urinary tract infection could not be explained by the results on the chart and that the patient should have been admitted and worked up. Tr. 175.

In our unanimous opinion, respondent is guilty, by a preponderance of the evidence of the fourth specification and of the ninth specification to the extent of the fourth specification.

ACCEPT HEARING COMMITTEE CONCLUSIONS

Next, we turn to the conclusions of not guilty by the hearing committee which we accept, regarding the third and seventh specifications as well as the ninth specification to the extent of the third and seventh specifications, and the conclusions of guilty by the designee of the Commissioner of Health regarding those specifications which we do not accept.

We agree with the hearing committee that respondent is not guilty of the third specification and the ninth specification to the extent of the third specification. The designee of the Commissioner of Health finds respondent guilty of the third specification without making findings regarding treating significant hyponatremia, and without mentioning any specific treatment for this condition or necessity for an emergency room physician to treat Patient B for this condition.

In any event, a preponderance of the evidence does not establish respondent's guilt regarding the third specification. Patient B was transferred to the emergency room from another institution for purposes of an evaluation. Tr. 62. After the evaluation was performed, he was transferred back to the other institution where he was under active treatment, follow-up, and care by physicians. Tr. 454. Moreover, the hyponatremia could have been addressed by informing the other institution about appropriately supervising Patient B. Tr. 176.

With respect to the seventh specification, we agree with the conclusion of the hearing committee that respondent was not guilty of that specification and of the ninth specification to the extent of the seventh specification. The only finding added by the designee regarding this specification was the white blood cells in Patient C's urine could be reasonably explained by Patient C being recently post-partum. In our unanimous opinion, the findings recommended to us were not sufficient to support the conclusion that respondent's diagnosis of urinary tract infection is not supported by the clinical history respondent obtained. We note that this charge was not whether any other explanation for the white blood cell count was or could be reasonable or whether, as charged in the fourth specification, the diagnosis was inappropriate.

Here, without regard to the appropriateness of respondent's diagnosis or to the testing performed, a preponderance of the evidence does not establish that there was no support for respondent's diagnosis of Patient C. After referring to Patient C's history and to the indication and necessity for respondent to consider embolic disease, Dr. Quash testified that the elevation of the white blood cells might indicate a urinary tract infection. Tr. 37-40. The fact that Dr. Quash believed that the number of white blood cells was probably due to post-partum vaginal discharge does not show that the charge, as drafted, should be sustained.

Accordingly, we unanimously recommend that respondent be found not guilty of the seventh specification and of the ninth specification to the extent of the seventh specification.

ACCEPT BOTH DESIGNEE AND HEARING COMMITTEE CONCLUSIONS

Finally, we accept the conclusions of both the hearing committee and designee of the Commissioner of Health with respect to the second, sixth, and eighth specifications and the ninth specification to the extent of the second, sixth and eighth specifications. We note that the designee originally sustained the second specification without making any findings regarding the charged perforated viscus. Now, he accepts the hearing committee's conclusion that respondent is not guilty of this specification and of the ninth specification to this extent. We further note that the designee originally did not make any recommendation as to the eighth specification. Now, the designee accepts the hearing committee's conclusions that respondent is not guilty of the eighth specification and the ninth specification to the extent of the eighth specification.

The measure of discipline recommended by the designee of the Commissioner of Health involved a stayed three year suspension provided three enumerated conditions are met. This recommendation was based on his sustaining specifications concerning 5 instances constituting, among other things, gross negligence and gross incompetence. We do not accept this recommendation, which does not

provide for a definite period in which an actual suspension would be imposed under the circumstances herein, especially without identifying or addressing the existence of any mitigating factors.

In our unanimous opinion, respondent's professional misconduct involving three separate patients and three seperate instances committed over an eight month period in 1984 warrants a six month actual suspension as part of a three year suspension with 30 months of the suspension stayed and with three years of probation to include training in emergency room medicine.

We take a more serious view of respondent's misconduct, including gross negligence and gross incompetence. Respondent's repeated failures to perform adequate diagnostic tests or to make an appropriate diagnosis placed these three emergency room patients' lives in jeopardy. Respondent's inability to make appropriate medical decisions in conformance with acceptable medical standards presents a substantial risk to the health of his patients and warrants an actual suspension and probation including training.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee, the de novo recommendation of the designee of the Commissioner of Health as to these findings, and the additional findings in that de novo recommendation be accepted;

2. The conclusions of the hearing committee be accepted, except the conclusions as to the first, fourth, fifth, and ninth specifications to the extent of the first, fourth, and fifth specifications not be accepted;

3. The de novo conclusions of the designee of the Commissioner of Health be accepted, except the conclusions as to the third, seventh, and ninth specifications to the extent of the third and seventh specifications not be accepted;

4. Respondent be found, by a preponderance of the evidence, guilty of the first, fourth, and fifth specifications based upon gross negligence and gross incompetence; guilty of the ninth specification to the extent of the first, fourth, and fifth specifications based upon negligence on more than one occasion and incompetence on more than one occasion; and not guilty of the remaining charges;

5. The recommendations of the hearing committee and the Commissioner of Health as to the measure of discipline not be accepted and;

6. Based upon a more serious view of respondent's professional misconduct, as previously discussed, respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, that execution of the last

30 months of said suspensions be stayed, and that respondent be placed on probation for said three years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "H".

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 3/12/90

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

IN THE MATTER	:	STATEMENT
OF	:	OF
ARTHUR LEWIS, M.D.	:	CHARGES

The State Board for Professional Medical Conduct, alleges as follows:

1. Arthur Lewis, M.D., hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York, on May 6, 1974, by issuance of license number 119921 by the State Education Department.

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 at 758 East 221st Street, Bronx, New York 10467.

3. The Respondent is charged with professional misconduct within the purview of N.Y. Educ. Law §6509 (McKinney 1986) as set forth in the Specifications.

EXHIBIT "A"

FIRST THROUGH EIGHTH SPECIFICATION

4. The Respondent is charged with professional misconduct by reason of practicing the profession with gross negligence and/or gross incompetence within the meaning of N.Y. Educ. Law §6509(2) (McKinney 1986) in that:

A. On or about October 23, 1984, the Respondent examined and/or rendered care or treatment to Patient A age 19 (whose name appears in the annexed appendix), at the Emergency Department at Queens General Hospital. Patient A presented with tachycardia and had an abnormal EKG. The history recorded by the triage nurse reveals patient takes birth control pills, has pain over sternum, experienced palpitations, and had fainted the previous day. Patient A died on the same date from pulmonary embolus. Respondent's care of Patient A deviated from accepted medical standards in that:

i. Respondent released Patient A from the Emergency Room without, performing adequate diagnostic tests to rule out pulmonary embolism or admitting her so that such tests could be performed.

B. On or about April 17, 1984, the Respondent examined and rendered care or treatment to Patient B, age 44, (whose name appears in the annexed appendix), at the Emergency Department of Queens General Hospital.

Patient B (a schizophrenic transferred from Creedmore Psychiatric Hospital), had been hospitalized on prior occasions for injuries resulting from his swallowing foreign bodies such as glass and for hyponatremia. The transfer notes from Creedmore stated on April 17, 1984 the patient had a temperature of 102, had an elevated diaphram on the right side, was status post media sternal hematoma and status post hemogastrectamy for swallowed glass. He presented with temperature of 101, blood pressure of 90/70, pulse 100, sodium level of 124, white blood count of 14.6 and urinary amylase of 187. Respondent's own notes indicate he observed the patient's abdominal and chest incisions from prior surgeries. Patient B died on April 21, 1984, according to the autopsy report from diffuse peritonitis due to perforated ileum from ingested foreign matter. Respondent's care or treatment of Patient B deviated from accepted medical standards in that:

i. Respondent failed to admit Patient B to Queens General Hospital for purposes of ascertaining whether there was perforated viscus.

ii. Respondent failed to treat significant hyponatremia.

iii. Respondent diagnosis of urinary tract infection is an inappropriate diagnosis given the totality of Patient B's history, presenting symptoms and the results of laboratory tests performed.

C. On or about February 8, 1984 Respondent examined and rendered care or treatment to Patient C, age 34, (whose name appears in the annexed appendix), in the Emergency Department of Queens General Hospital. Patient C presented with the following history: Patient C had delivered her seventh child on January 30, 1984 at Queens General Hospital, and was discharged from the hospital on February 4th.

She presented to the Emergency Department on February 8th, complaining of pain right rib region and reported no trauma, she had a pulse of 120 and temperature of 101.8. Respondent's notes, indicate no pain on or freguency of urinations, she had fever, flank pain and that she delivered a baby 10 days ago. Respondent released Patient C from the Emergency Department on oral antibiotics and made a diagnosis of urinary tract infection. Patient C died the following day of pulmonary embolus. Respondent's care or treatment of Patient C deviated from acceptable medical standards in that:

i. He released Patient C from the Emergency Room without performing adequate diagnostic tests to rule out pulmonary embolism or admitting her so that such diagnostic testing could be performed.

ii. He failed to obtain an Ob-Gyn consultation, despite Patient C's being 9 days post-portum.

iii. Respondents diagnosis of urinary tract infection is not supported by the clinical history obtained by the Respondent himself.

D. On or about March 27, 1984 Respondent examined Patient D (whose name appears in the annexed appendix) in the Emergency Department of Queens General Hospital. At the time Respondent examined Patient D she was having difficulty breathing. Respondent's conduct deviated from accepted medical standard in that:

i. He failed to treat Patient D's pulmonary edema in an appropriate and timely manner.

NINTH SPECIFICATION

5. Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence or incompetence on more than one occasion within the meaning of N.Y. Educ. Law 6509(2) (McKinney 1986) in that:

Petitioner repeats all factual allegations set forth in Specifications One through Eight.

Kathleen M. Tanner JCB
KATHLEEN M. TANNER
Director
Office of Professional
Medical Conduct

Dated: Albany, New York
aug 3, 1987

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

IN THE MATTER OF ARTHUR LEWIS, M.D.	ANSWER TO STATEMENT OF CHARGES

In response to the Statement of Charges filed in the above captioned matter, Arthur Lewis, M.D. states as follows:

1. I graduated from New York Medical College, Flower and Fifth Avenue Hospitals during 1973. On May 6, 1974, I was authorized to engage in the practice of medicine in New York State. From 1973 through 1977, I completed a year of internship and my residency, both of which were at Jewish Hospital Medical Center, Brooklyn, New York. From approximately 1977 through 1978, I completed a one year fellowship at Coloumbia Presbyterian in combination with the teaching of residents.

2. I am currently registered with the New York State Education Department to practice medicine until December 31, 1988. My license number is 119921.

3. I have not engaged in the professional misconduct with which I have been charged in the Specifications of the Statement of Charges.

ANSWER TO FIRST THROUGH EIGHTH SPECIFICATION

4. I have not practiced the profession with gross negligence and/or gross incompetence, and consequently, have not engaged in professional misconduct.

A. Patient A presented to the Emergency Room on or about October 23, 1984. At 8:40 a.m. patient complained to the

triage nurse of pain over sternum. The triage nurse noted episode of fainting day before. I considered the notes of the triage nurse and the nursing assessment. At 11:00 a.m. when seen by me, the patient was not complaining of chest pain. I probed the patient concerning whether she experienced chest pain, pain with movement, any nausea, vomiting or sweating. After questioning the patient, I noted that she was alert; awake, ambulatory, and had no syncope, nor orthostasis. I also noted that the patient indicated she suffered no loss of consciousness.

i. I obtained a medical history which included allergies, medicines, operations, hospitalizations, clinics, cardiovascular, respiratory, GU, GYN and endocrine. I also examined the patient's head, eyes, ear, nose and throat, chest, heart, abdomen, extremities and calf. I specifically indicated that the extremities and calves were within normal limits. By indicating within normal limits, I was noting complete observation, ausculation, palpation, examination of the skin, bones, muscular system, vascular system, and the nervous system of the thigh, knee, calf and foot. I also checked for Homen's sign and the results were negative. Laboratory tests included CBC, differential, urinalysis, SMA-6, chest xray and EKG. The EKG within the chart was not abnormal, but showed a tachycardia. I also reviewed a second EKG which was within normal limits, but apparently is not with the chart. In addition, I observed the patient until 1:30 p.m., rechecked her vital signs and repeated whatever tests were appropriate.

The patient was discharged with a pulse of 88 (down from the nurse's reading of 126), a normal blood pressure and a recommendation for follow-up at the medical clinic on the next day. My diagnosis was nervous anxiety, rule out hypoglycemia. I indicated that hypoglycemia should be ruled out since the young female patient had experienced some symptoms the day before, was no longer complaining about chest pain, had not had breakfast, and was looking for work under tension and stress. I considered the diagnosis of pulmonary embolus, and based on my examination of the patient, including her legs, lab tests, EKG and chest xray, ruled out pulmonary embolus. There was no evidence to indicate that an acute process of pulmonary embolus existed when I saw the patient, and the diagnosis of pulmonary embolus was reached after the patient died.

B. The patient was sent to the Emergency Room from Creedmoor for the evaluation of fever. I kept the patient under observation in the Emergency Room for approximately five hours. I reviewed the patient's prior chart and ordered a CBC, urinalysis, SMA-6, arterial blood gas, chest xray, EKG and blood cultures. I examined the patient's head, eyes, ears, nose, throat, chest, heart, abdomen, inguinal area and rectum. I also made a drawing on the chart of the patient's old surgical scars. The patient was released with a normal pulse, normal respiration, normal blood pressure and a temperature of 99, after five hours of observation.

i. Apparently the patient died of abdominal perforation caused by some foreign body swallowed after the patient was seen by me. The abdominal xray I ordered did not reveal any foreign

bodies. Consequently, due to this fact, my examination of the patient, the patient's past history, and the lab tests results, it was my professional judgment that admission of the patient to ascertain whether there was perforated viscus was not warranted in the circumstances.

ii. I recognized the hyponatremia because I ordered the SMA-6, reviewed the patient's old chart and personally recorded the sodium level of 124. The patient had been hospitalized for approximately one month for a work up for hyponatremia and had been discharged from the hospital only three days prior to being seen by me. My treatment of the patient after five hours of observation, with a discharge with normal vital signs, was correct in the circumstances.

iii. Based on the results of all the lab tests, including the findings of a urinalysis with clean-catch midstream, my physical examination of the patient and the patient's complaint of pain upon urination, I made the diagnosis of urinary tract infection. My diagnosis was appropriate.

C. I conducted a physical examination of the patient's head, eyes, ears, nose and throat, chest, heart, abdomen and extremities. The only positive finding was pain on the right costophrenic area with palpation, right more than left costophrenic. No edema was found with respect to the extremities.

i. According to the patient's autopsy report, the cause of death was a massive pulmonary thrombo-embolism and infarction due to deep vein thrombosis of the lower extremities. The

patient's death occurred the day after I examined her. The day I examined the patient, I examined the lower extremities and found no edema. The radiologist's xray report indicated there was no evidence of acute cardiac pleural or pulmonary pathology. I also checked the pulse and ausculation of the heart, and rechecked the patient's blood pressure, which was normal. I checked the results of lab tests. The condition of the patient when examined by me and her good condition on discharge did not mandate any further diagnostic testing to rule out pulmonary embolism, or admission so that further diagnostic testing could be performed.

ii. I requested an Ob-Gyn consult.

iii. A clean catch urinalysis showed bacteria. The diagnosis of urinary tract infection was supported by my physical examination, the laboratory tests, including CBC, SMA 6, and chest xray.

D. I did not examine the patient. There is nothing in the patient's medical records to indicate that the patient was seen by me. For some unexplained reason there are no triage notes in the chart.

ANSWER TO NINTH SPECIFICATION

5. I deny that I engaged in professional misconduct, or practiced the profession of medicine with negligence or incompetence, for the reasons stated in answer to the first through eighth specification.

Dated: New York, New York
September 15, 1987

Arthur Lewis M.D.
ARTHUR LEWIS, M.D.

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

IN THE MATTER	:	REPORT OF THE
OF	:	HEARING
ARTHUR LEWIS, M.D.	:	COMMITTEE

TO: HONORABLE DAVID AXELROD, M.D.,
Commissioner of Health, State of New York

The undersigned, Hearing Committee (the Committee) consisting of Mrs. Priscilla R. Leslie, Chairperson, George W. Melcher, Jr., M.D. and W. Graham Knox, M.D. was duly designated, constituted and appointed by the State Board for Professional Medical Conduct (the Board). Michael P. McDermott, Esq., served as the Administrative Officer.

The hearings were conducted pursuant to the provisions of the New York Public Health Law §230 and New York State Administrative Procedure Act §§301-307 to receive evidence concerning the charges that the Respondent has violated provisions of New York Education Law Section 6509. Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the record in the above captioned matter and and makes this Report of its Findings, Conclusions and Recommendations.

RECORD OF PROCEEDINGS

Notice of hearing and Statement of Charges Dated:	August 3, 1987
Notice of Hearing Returnable:	September 3, 1877
Place of hearing:	New York, N.Y.
The Board for Professional Medical Conduct, the Petitioner, Appeared by:	Peter J. Millock, General Counsel New York State Department of Health By: Jean Bresslar, Esq. Associate Counsel By: Diane Abeloff, Esq. Associate Counsel
Respondent Appeared by:	Warren Bennia, Esq. 220 East 54th Street New York, New York 10022
Respondent's Present Address:	758 East 221 Street Bronx, New York 10467
Hearings Held on:	September 16, 1987 October 7, 1987 November 19, 1987 November 20, 1987

SUMMARY OF THE PROCEEDINGS

STATEMENT OF CHARGES

The Statement of Charges essentially alleges that the Respondent practiced the profession with gross negligence and/or

gross incompetence and with negligence or incompetence in his treatment of four patients.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

WITNESSES

For the Petitioner:

1) Eugene T. Quash, M.d.
2) Thomas Kwaitkowski, M.D.
3) Gail Wilder, M.D
4) [redacted]

For the Respondent:

1) Arthur Lewis, M.D.

FINDINGS OF FACT

Arthur Lewis (Respondent) was authorized to engage in the practice of medicine in the State of New York in the year 1974 by the issuance of license number 119921 by the State Education Department. (Pet. Ex. 5).

FINDINGS OF FACT AS TO PATIENT A

1. Patient A, a 19 year-old black female who was 5'6" tall and approximately 170 pounds, went to Queens Hospital Center (QHC) emergency room on October 23, 1984 (Pet. Ex. 2a).

2. Patient A told the nurse in the QHC emergency room she had an episode of fainting the day before, October 22, when she passed out for a few seconds, had palpations, and shortness of breath. She has no history of drugs besides birth control pills. Her pulse was 126 beats per minute. (Pet. Ex. 2a, Pg. 6).

3. Respondent reviewed everything the nurses wrote in their assessments. (T. 406).

4. Respondent examined Patient A. From his examination and conversation with Patient A, he found that she had no chest pain, nausea or vomiting and that during the fainting episode she never lost consciousness, but she was nervous and anxious. Respondent also learned that Patient A had not eaten breakfast that morning. (Pet. Ex. 2).

5. Respondent ordered a chest X-ray and EKG (Pet. Ex. 2, Pg. 6).

6. Respondent diagnosed Patient A's condition as a "nervous anxiety attack - rule out hypoglycemia." He discharged her from

QHC emergency room at approximately 1:30 p.m. of October 23, 1984 (Pet. Ex. 2a, Pg. 6).

7. Patient A arrived at Jamaica Hospital emergency room on October 23, 1984, approximately 4:00 p.m. (Pet. Ex. 2c, Pg. 2).

8. When she arrived in the hospital she was in full cardiac arrest. (Pet. Ex. 2c, Pg. 2).

9. Patient A died on October 23, 1984 from thromboembolism of pulmonary arteries, thrombosis of lower leg veins. (Pet. Ex. 2b, Pg. 2).

10. Respondent's emergency room records for Patient A do not indicate that he attempted to rule out the diagnosis of pulmonary embolus. (T. 24).

11. Respondent did not perform or order an arterial blood gas, or lung scan. (T. 26, Pet. Ex. 2a).

CONCLUSION AS TO PATIENT A

The Hearing Committee concludes that the Respondent ordered appropriate tests (blood count, CBC with differential, SMA 6, urine, chest X-ray, EKG) in response to the symptoms and

findings present at the time of Patient A's visit to the QHC emergency room. His discharge diagnosis was "nervous anxiety, rule out hypoglycemia", which seemed to be an appropriate diagnosis under the circumstances at the time.

The Hearing Committee also concludes that the clinical picture at the time did not indicate the necessity for a lung scan or blood gas test.

FINDINGS OF FACT AS TO PATIENT B.

1. Patient B was transferred from Creedmoor Psychiatric Hospital to QHC emergency room on April 17, 1984. (Pet. Ex. 4a).

2. The transfer note from Creedmoor stated that Patient B had a temperature of 102, an elevated diaphragm on the right side, was status post mediastinal hematoma and status post hemigastrectomy for swallowed glass. (Pet, Ex. 4a, pg. 20).

3. Respondent examined Patient B on April 17. At 3:30 p.m., the time of the initial examination, Patient B's vital signs were: blood pressure 90/70, a pulse of 100, a temperature of 101 and respiration was 20 and a urinary amylase of 187, normal is less than 34. (Pet. 4a, pps. 16, 36; T. 46).

4. Patient B had been hospitalized at QHC on several occasions for swallowing foreign bodies and for hyponatremia. (Pet. Ex. 4a).

5. Respondent knew that Patient B had been hospitalized for these conditions, and, in fact, treated him on a prior occasion. (Pet. Ex. 4a).

6. Respondent diagnosed the patient as having a urinary tract infection and discharged Patient B on Bactrim (Pet. Ex. 4a).

7. The Respondent advised a follow up visit to the urology clinic within one week.

CONCLUSIONS AS TO PATIENT B

The Hearing Committee concludes that the Respondent ordered appropriate tests i.e., abdominal X-ray, chest, abdominal and rectal examinations, blood count, urine analysis, SMA 6 and chest X-ray, including lateral decubitus, in response to the symptoms and findings present at the time of Patient B's visit to the QHC emergency room. The patient presented no signs of a perforated viscus at the time.

The Respondent also advised a follow-up visit to the urology clinic within one week.

FINDINGS OF FACT AS TO PATIENT C.

1. Patient C, a 34 year old woman who was 5'7" tall and approximately 170 pounds, was treated by Respondent in the QHC emergency room on February 8, 1984. (Pet. Ex. 3a, 3b).

2. Patient C complained to the nurse at QHC emergency room of right rib pain, but no history of trauma. She had delivered a baby ten days prior. Her temperature was 101.8 (oral) her pulse was 120 and her respiratory rate was 20. Pet. Ex. 3a, Pg. 3).

3. Respondent examined Patient C. His examination revealed that Patient C experienced no pain, burning or excessive frequency with urination, but that she did have pain on her right side, pain in the right costophrenic angle with palpation (Pet. Ex. 3a, Pg. 3).

4. Respondent discharged Patient C with a diagnosis of urinary tract infection and a prescription for Bactrim and Tylenol. (Pet. Ex. 3a).

5. Patient C died on February 9, 1984. The cause of death was massive pulmonary thromboembolism and infarction due to deep vein thrombosis of lower extremities. (Pet. Ex. 3b).

CONCLUSIONS AS TO PATIENT C

The Hearing Committee concludes that Patient C did not present any post-partum complaints and while a OB/GYN consult would not be inappropriate under the circumstances, such a consult was not clearly indicated.

The Respondent ordered chest X-rays, blood count and urine analysis.

With the finding of right costovertebral angle tenderness associated with the presence of fever, a diagnosis of urinary tract infection is not inappropriate.

FINDINGS OF FACT AS TO PATIENT D

1. Patient D was admitted to QHC emergency room at approximately 11:30 p.m. on March 27, 1984. (Pet. Ex. 7, Pg. 9).

2. 2. There are no written clinical or administrative records of any kind which record that Patient D was treated by the Respondent.

CONCLUSIONS AS TO PATIENT D

The Hearing Committee concludes that the Petitioner failed to meet its burden of proof with regard to the charges against the Respondent relative to Patient D.

The Respondent denies ever having treated Patient D and there are no written clinical or administrative records of any kind to contradict him.

The Petitioner produced three witnesses, Dr. Kwiatkowski, Dr. Wilder and Patient D's daughter, who testified that the Respondent did treat Patient D. However, there were inconsistencies in their testimony and they contradicted themselves and each other to an extent which tended to negate their credibility.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously (3-0) that the charges specified in Paragraphs 4(a)(i), 4(B)(i)(ii)(iii), 4(C)(i)(ii)(iii),4(D)(i) and 5 of the Statement of Charges are NOT SUSTAINED.

RECOMMENDATION

The Hearing Committee votes unanimously (3-0) that the charges against the Respondent be DISMISSED.

DATED: Syracuse, New York
1988

Respectfully submitted,

Priscilla R. Leslie, R.N.C.

George W. Melcher, M.D.
W. Graham Knox, M.D.

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

IN THE MATTER :
OF :
ARTHUR LEWIS, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on September 16, October 7, November 19 and November 20, 1987. The Respondent, Arthur Lewis, M.D., appeared by Warren Bennia, Esq. The evidence in support of the charges against the Respondent was presented by Jean Bressler, Esq. and Diane Abeloff, Esq., both of Counsel. David Axelrod, M.D., Commissioner of Health, has designated me to recommend a disposition of this case in his place and stead. I have reviewed the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee and hereby make the following recommendations to the Board of Regents.

EXHIBIT "C"

Patient A

I agree with the Committee's Findings of Fact but not its Conclusions regarding Respondent's care of Patient A. Respondent's diagnosis of hypogylcemia is not supported by blood sugar of 113 mgm percent a day after syncopal attack. In view of the massive bilateral pulmonary occlusions by blood clot, it is surprising that there were no physical findings in the chest examination or the examination of the lower extremities. Dr. Lewis did not consider a diagnosis of pulmonary embolism despite the frequency of onset of this phenomenon with syncope and chest pains, the age of patient, and her use of birth control pills. Therefore, I would sustain the First Specification and so much of the Ninth Specification as refers to Patient A.

Patient B

I agree with the Committee's Findings of Fact but not its Conclusions regarding Patient B. Respondent's diagnosis of urinary tract infection is not supported by laboratory findings. The serum sodium of 124 meq/L was not addressed and certainly merited attention as hyponatremia had in the past. The leucocytosis and the high amylase excretion in the urine also suggested more study rather than discharge back to Creedmore. Therefore, I would sustain the Second, Third, and Fourth Specifications and so much of the Ninth Specification as refers to Patient B.

Patient C

I agree with the Committee's Findings of Fact but not its Conclusions regarding Respondent's care of Patient C. Respondent's diagnosis is not supported by laboratory findings even if the possibility of upper urinary tract involvement was suspected. It is remarkable in view of the post-mortem findings that there were not findings on physical examination of the chest or extremities. The persistent tachycardia, chest pain and fever, the young age of the woman, and the fact that she was post-partum should have suggested pulmonary embolism in the differential diagnosis. Therefore, I would sustain the Fifth and Seventh Specifications and so much of the Ninth Specification that refers to the Fifth and Seventh Specifications.

I recommend that Dr. Lewis's license to practice medicine be suspended for three years and that that suspension be stayed provided that (a) he comply with the standard terms of probation; (b) he enroll in and successfully complete a remedial course in either surgery or emergency medicine approved in advance by the Office of Professional Medical Conduct (OPMC), and (c) during such three year period, his practice be monitored by a physician approved in advance by OPMC. The monitoring

physician shall supervise Dr. Lewis's patient care and make quarterly reports to OPMC concerning the appropriateness of his practice.

Dated: Albany, New York

, 1988

ALFRED GELLHORN, M.D.
Director of Medical Affairs
New York State Department of Health

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ARTHUR LEWIS, M.D.

No. 8583

who is currently licensed to practice as a physician in the State of New York.

Report of the Regents Review Committee

ARTHUR LEWIS, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

This disciplinary proceeding was properly commenced and on four separate dates between September 16, 1987 and November 20, 1987 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, excluding the attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was not guilty of the charges and recommended that the charges be dismissed.

EXHIBIT "D"

ARTHUR LEWIS, M.D. (8583)

The Commissioner of Health recommended to the Board of Regents that the findings of the hearing committee be accepted, but that the conclusions of the hearing committee with regard to Patients A, B, and C be rejected and that respondent be found guilty of the first through fifth specifications of the charges, the seventh specification of the charges, and the ninth specification to the extent indicated in his report and that respondent's license to practice as a physician be suspended for three years, execution stayed provided he comply with terms of probation. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On August 24, 1988 Warren J. Bennia, Esq., presented oral argument on behalf of respondent. Jean Bresler, Esq., presented oral argument on behalf of the Department of Health.

We have considered the record as transferred by the Commissioner of Health in this matter as well as the submissions from the respondent and petitioner.

It is our unanimous opinion that this matter should be remanded.

The Commissioner of Health dramatically changed the conclusions of the hearing committee while accepting their findings of fact, but did not cite to the record to support those changes.

In addition, respondent is charged herein with gross

negligence "and/or" gross incompetence as well as with negligence "or" incompetence on more than one occasion. The Commissioner of Health should have indicated whether respondent was guilty, specifically, by addressing each one separately, of gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion and avoiding guilt in the alternative. The Commissioner of Health did not do so in this case. This could have been avoided had each of the charges herein - gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, as well as any other charge of professional misconduct, been separately stated and numbered. Doing so would have avoided confusion as well as our having to interpret whether each specification was based upon a paragraph, subparagraph, or combination of subparagraphs, the date thereof, and the patient involved.

We unanimously recommend to the Board of Regents that this matter be remanded to the Commissioner of Health for a de novo recommendation consistent with this report. On remand, the Commissioner of Health should recommend conclusions specifically addressing the question of guilt as to gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion as each relates to each patient, as well as to each specification

hereafter listed. In doing so, the Commissioner of Health should specify that portion of the record relied upon to demonstrate any guilt. After deciphering the charges herein, it should be assumed that the specifications are as follows:

SPECIFICATION	PARAGRAPH
1	4. A and A(i)
2	4. B and B(i)
3	4. B and B(ii)
4	4. B and B(iii)
5	4. C and C(i)
6	4. C and C(ii)
7	4. C and C(iii)
8	4. D and D(i)
9	5.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 2/25/89

Approved March 17, 1989

No. 8583

Upon the report of the Regents Review Committee, under Calendar No. 8583, the record herein, and in accordance with the provisions of Title VIII of the Education Law, it was

Voted:* That, in the matter of ARTHUR LEWIS, respondent, the recommendation of the Regents Review Committee be accepted; that this matter be remanded to the Commissioner of Health for a de novo recommendation consistent with the report of the Regents Review Committee; that on remand, the Commissioner of Health should recommend conclusions specifically addressing the question of guilt as to gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion as each relates to each patient, as well as to each specification as listed by the Regents Review Committee and that, in doing so, the Commissioner of Health should specify that portion of the record relied upon to demonstrate any guilt; that the charges herein should be assumed to be as specified by the Regents Review Committee; and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote.

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*Regent Lustig abstained

EXHIBIT "E"

The University of the State of New York

IN THE MATTER

OF

ARTHUR LEWIS
(Physician)

DUPLICATE
ORIGINAL ORDER
NO. 8583

Upon the report of the Regents Review Committee, under Calendar No. 8583, the record herein, the vote of the Board of Regents on March 17, 1989, and in accordance with the provisions of Title VIII of the Education Law, which report and vote are incorporated herein and made a part hereof, it is

ORDERED that, in the matter of ARTHUR LEWIS, respondent, the recommendation of the Regents Review Committee be accepted; that this matter be remanded to the Commissioner of Health for a de novo recommendation consistent with the report of the Regents Review Committee; that on remand, the Commissioner of Health should recommend conclusions specifically addressing the question of guilt as to gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion as each relates to each patient, as well as to each specification as listed by the Regents Review Committee and that, in doing so, the Commissioner of Health should specify that portion of the record relied upon to demonstrate any guilt; and that the charges

EXHIBIT "F"

ARTHUR LEWIS (8583)

herein should be assumed to be as specified by the Regents Review Committee.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 3rd day of April, 1989.

Thomas Sobol

Commissioner of Education

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

IN THE MATTER	:	COMMISSIONER'S
OF	:	DE NOVO
ARTHUR LEWIS, M.D.	:	RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on September 16, October 7, November 19 and November 20, 1987. The Respondent, Arthur Lewis, M.D., appeared by Warren Bennia, Esq. The evidence in support of the charges against the Respondent was presented by Jean Bresler, Esq. and Diane Abeloff, Esq. The Hearing Committee recommended that all of the charges against the Respondent be dismissed.

David Axelrod, M.D., Commissioner of Health, designated me to recommend a disposition of this case in his place. I reviewed the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Hearing Committee and submitted my Recommendation to the Board of Regents. I recommended that some of charges against the Respondent be sustained and that, among other things, Respondent's license to practice medicine be suspended.

EXHIBIT "G"

The Regents Review Committee heard oral argument on this case on August 24, 1988. On April 3, 1989, the Commissioner of Education remanded this case to the Commissioner of Health for a "de novo recommendation."

I have reviewed the Order of the Commissioner of Education, the actions of the Board of Regents, the Report of the Hearing Committee and the record of this case. I hereby make the following "de novo recommendation" to the Board of Regents.

A. The Findings of Fact and Conclusions of the Hearing Committee should be adopted fully with respect to Patient D but not with respect to Patients A, B, and C. I adopt the Hearing Committee's first Finding of Fact relating to Respondent's license.

Patient A

I accept the Hearing Committee's Findings of Fact ##1-11 relating to Patient A. I also make the following additional Findings of Fact relating to Patient A:

a. On October 23, 1984, a day after a syncopal attack, Patient A had blood sugar of 113 mgm percent. (Tr. 23; Pet. Ex. 2A, pp. 2 and 6).

b. This blood sugar level does not support Respondent's diagnosis of hypoglycemia on October 23, 1984. (Tr. 23-24).

c. The massive pulmonary occlusions by blood clot later on October 23, 1984 is inconsistent with the fact that Respondent made no physical findings in the chest examination or the examination of the lower extremities earlier that day.

d. Pulmonary embolism frequently accompanies syncope and chest pains in persons of Patient A's age who use birth control pills. (Tr. 23, 83, 84; Pet. Exs. 2A, 2B, 2C)

e. Respondent did not consider, and should have considered, a diagnosis of pulmonary embolism. (Tr. 24)

In light of the foregoing, I reject the Hearing Committee's Conclusions with regard to Patient A and, in lieu thereof, I conclude that the First Specification alleging gross negligence and gross incompetence and so much of the Ninth Specification alleging negligence and incompetence as relates to Patient A should be sustained. Respondent's failure to consider the possibility of pulmonary embolism and to assess that possibility through an arterial blood gas or lung scan constituted a significant deviation from accepted standards of medical practice.

Patient B

I accept the Hearing Committee's Findings of Fact ##1-7 relating to Patient B. I make the following additional Findings of Fact relating to Patient B:

a. Patient B had a serum sodium level of 124 milliliter per liter. The normal level is 135 to 153. (Tr. 49; Pet. Ex. 4A, p. 36).

b. Patient B's serum sodium level was significantly below normal. That and Patient B's history of hyponatremia, indicate that Patient B was suffering from hyponatremia on April 17, 1984. (Tr. 49). This condition should have been addressed by Respondent but was not. (Tr. 49).

c. Patient B's laboratory studies revealed a leucocytosis of 14,600. (Pet. Ex. 4A, p. 16) and high urine amylase. This should have strongly indicated a need for further study.

d. Patient B's urine was relatively normal. It had only 4 to 5 white blood cells high powered field. The rest of the urinalysis was normal. (Tr. 46).

e. Respondent's diagnosis of urinary tract infection was not supported by laboratory findings (Tr. 46).

In light of the foregoing, I reject the Hearing Committee's Conclusions with regard to the Third and Fourth Specifications and accept the Hearing Committee's Conclusions with regard to the Second Specification. I conclude that the Third and Fourth Specifications alleging gross negligence and gross incompetence and so much of the Ninth Specification alleging negligence and incompetence as relates to Patient B (except as it relates to the failure to admit to Queens General Hospital) should be sustained.

Patient C

I accept the Hearing Committee's Findings of Fact ##1-5 relating to Patient C and make the following additional Findings of Fact:

a. Patient C's recent delivery of a baby, chest pain, fever, young age, and persistent tachycardia suggests a diagnosis of pulmonary embolism. (Tr. 35-37).

b. Respondent should have ordered arterial blood gases and a lung scan to determine whether there was a pulmonary embolism. (Tr. 38, 167).

c. The white blood cells in Patient C's urine could be reasonably explained by Patient C being recently post partum (Tr. 39).

In light of the foregoing, I reject the Hearing Committee's Conclusions with regard to the Fifth and Seventh Specifications and accept the Hearing Committee's Conclusions with regard to the Sixth Specification. I conclude that the Fifth and Seventh Specifications alleging gross negligence and gross incompetence and so much of the Ninth Specification alleging negligence and incompetence as relates to Patient C (except as it relates to the failure to secure an OB-GYN consult) should be sustained. Respondent should have done more to address and rule out pulmonary embolism. His diagnosis of urinary tract infection was not supported by Patient C's condition and history.

B. I recommend that Respondent's license to practice medicine be suspended for three years and that that suspension be stayed provided that (a) he

comply with the standard terms of probation; (b) he enroll in and successfully complete within one year of such suspension a remedial course in either surgery or emergency medicine of no less than six months' duration and approved in advance by the Office of Professional Medical Conduct (OPMC), and (c) during such three-year period, his practice be monitored by a physician approved in advance by OPMC. The monitoring physician shall supervise Respondent's patient care and make quarterly reports to OPMC concerning the appropriateness of his patient care.

The entire record of the within proceeding is transmitted with this Recommendation.

Dated: Albany, New York
August 11, 1989

ALFRED GELLHORN, M.D.
Director of Medical Affairs
New York State Department of Health

EXHIBIT "H"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

ARTHUR LEWIS

CALENDAR NO. 10301/8583

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of

Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That respondent shall, at respondent's expense, no later than the first three months of the period of probation, enroll in and diligently commence a course of training in emergency room medicine, said course of training to be for a minimum of six months and to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said course to be successfully completed within the first one year of the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct, unless respondent demonstrates, to the satisfaction of said Director, that respondent cannot comply with said course requirement, or said course is for a shorter period of time, or more time is needed to complete the course, and said Director either excuses respondent from compliance with said course requirement or adjusts the above specified periods within the probationary period.

3. That, at any time during the period of probation in which respondent practices the profession of medicine in the State of New York, until the Director of the Office of Professional Medical Conduct is satisfied with the completion of the training course as specified in term number 2 or until respondent has been excused from compliance with term number 2, respondent shall have respondent's emergency room practice monitored, at respondent's expense, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records, office records, hospital charts in regard to

respondent's emergency room practice, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

c. That said monitor shall submit a report, once every three months, regarding the above-mentioned monitoring of respondent's emergency room practice to the Director of the Office of Professional Medical Conduct;

4. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

ARTHUR LEWIS

CALENDAR NOS. 10301/8583

The University of the State of New York

IN THE MATTER

OF

ARTHUR LEWIS
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NOS. 10301/8583

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar Nos. 10301/8583, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED* **(March 23, 1990):** That, in the matter of ARTHUR LEWIS, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee, the de novo recommendation of the designee of the Commissioner of Health as to these findings, and the additional findings in that de novo recommendation be accepted;
2. The conclusions of the hearing committee be accepted, except the conclusions as to the first, fourth, fifth, and ninth specifications to the extent of the first, fourth, and fifth specifications not be accepted;
3. The de novo conclusions of the designee of the Commissioner of Health be accepted, except the conclusions as to the third, seventh, and ninth specifications to the extent of the third and seventh specifications not be accepted;
4. Respondent is, by a preponderance of the evidence, guilty of the first, fourth, and fifth specifications based upon gross

*Regent Gerald J. Lustig, M.D. abstained

negligence and gross incompetence; guilty of the ninth specification to the extent of the first, fourth, and fifth specifications based upon negligence on more than one occasion and incompetence on more than one occasion; and not guilty of the remaining charges;

5. The recommendations of the hearing committee and the Commissioner of Health as to the measure of discipline not be accepted; and

6. Based upon a more serious view of respondent's professional misconduct, as discussed in the Regents Review Committee report, respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which respondent is guilty, said suspensions to run concurrently, that execution of the last 30 months of said suspensions be stayed, and that respondent be placed on probation for said three years under the terms prescribed by the Regents Review Committee;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 30th day of March, 1990.

Thomas Sobol

Commissioner of Education