STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

October 31, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ronald A. Bailey, M.D.
PO Box 312
Oneonta, New York 13820

Michael Hiser, Esq.
Rm 2429 Corning Tower
Empire State Plaza
Albany, New York 12237

Robert J. Poulson, Jr. Esq.
PO Box 310
Cooperstown, New York 13326

RE: In the Matter of ~~Robert~~ Ronald A. Bailey, M.D.

EFFECTIVE DATE
11/07/94

Dear Dr. Bailey, Mr. Hiser and Mr. Poulson :

Enclosed please find the Determination and Order (No. 94-98) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler (M)

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

RONALD A. BAILEY, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-98

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on September 30, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) June 29, 1994 Determination finding Dr. Ronald A. Bailey (Respondent) guilty of professional misconduct. The Office of Professional Medical Conduct (Petitioner) requested the Review through a Notice which the Board received on July 14 ,1994. James F. Horan served as Administrative Officer to the Review Board. Michael A. Hiser , Esq. filed a brief for the Petitioner, which the Review Board received on August 23 , 1994. Robert J. Poulson, Esq. filed a brief for the Respondent, which the Review Board received on September 13 , 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law, and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the

[1] Sumner Shapiro recused himself from participating in this case.

Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, failure to maintain adequate records and with being a habitual user of alcohol. The charges involving negligence, incompetence and failure to maintain adequate records arose from the treatment of eight patients, whom the record refers to as A through G and I to J. The alcohol charges stem from two separate incidents.

The Hearing Committee determined that the Respondent was not guilty of gross negligence or gross incompetence. The Committee sustained the charges that the Respondent was guilty of negligence on more than one occasion, incompetence on more than one occasion, failure to maintain adequate records and being a habitual user of alcohol.

The Committee found the Respondent negligent in the treatment of Patients A, B, E, F and G. The Committee found that the Respondent had prescribed an excessive dose of Fentanyl to Patient A, due to an error by the Respondent in calculating the concentration of the Fentanyl. The Committee found that such a calculation is at the very heart of anesthesia practice and that the error resulted from an unacceptable failure of attention by the Respondent to basic elements of his profession. In the treatment of Patient B, the Committee found that the Respondent set a ventilator dial incorrectly , on excessively high pressure, and that a dangerous condition resulted from the Respondent's lapse of care and diligence. In the treatment of Patient E, the Committee found that the Respondent administered an excessive amount of electrolyte solution to the Patient. The Committee found that the Respondent had failed to close the roller valve on the IV tube and failed to notice the error three different times when a new unit of the solution was hung. The Committee found the Respondent negligent in the treatment of Patient F for giving the Patient a high initial dose of duramorph and for failing to give the Patient an intense level of outpatient attention that was called for due to the mode of administering the drug. The Committee found the Respondent negligent in the

treatment of Patient G for giving the Patient an excessive dose of Fentanyl .

The Committee found that the Respondent practiced with incompetence in his treatment of Patient A by failing to produce appropriate treatment notes. The Committee found that the Respondent's treatment of Patients B, F and G, as described in the prior paragraph, constituted incompetence as well as negligence.

The Committee found that the Respondent had abused alcohol based upon incidents in November 1991 and October 1993. At both those times, the Respondent's blood alcohol content (BAC) was determined to have been as high as .38-.40. The Respondent's BAC was checked in November 1991 following his arrest for driving while intoxicated and his BAC was checked in October 1993 after Police determined that the Respondent had demonstrated aggressive behavior towards his wife and had made suicide threats. Based upon the Respondent's testimony about his use of alcohol, his very high BAC levels and expert testimony that stated that the Respondent could have survived the extremely high BAC levels only through a tolerance that would develop by increasing alcohol intake over a considerable period of time, the Committee found that the Respondent was a habitual abuser of alcohol.

The Committee concluded that the Respondent had demonstrated a pattern of negligence and incompetence that could not be tolerated in a physician practicing in New York. The Committee stated that they could not discern whether the Respondent's negligence and incompetence were related to his alcohol problems or were based upon arrogance and a failure of attentive intensity. The Committee stated that, in addition to the Respondent's pattern of negligence and incompetence, they discerned a threatening level of denial on the Respondent's part concerning the Respondent's problem with alcohol and his serious lapses in patient care. The Committee found the Respondent's pattern of substandard practice, substance abuse and denial was an extremely dangerous combination. The Committee felt, however, that remediation short of revocation was possible. The Committee voted to suspend the Respondent's license to practice medicine until the Respondent completes successfully, both a program of substance abuse treatment and medical retraining, in the discipline of the Respondent's choice, followed by five years probation, and with the probation three years of monitoring.

REQUESTS FOR REVIEW

The Petitioner has asked the Review Board to overturn the Hearing Committee's Penalty and revoke the Respondent's license to practice medicine. The Petitioner argues that the Hearing Committee's Penalty is not consistent with the Committee's Findings and Conclusions, that the Respondent's ordered grossly disproportionate medications; caused serious life threatening events for two patients; treated a patient in an irresponsible, almost cavalier manner and failed to discharge fundamental aspects of his practice of anesthesiology. The Petitioner argues that the Penalty is not appropriate because there is no retraining program which would be available for the Respondent.

The Respondent opposes the Petitioner's request. The Respondent asserts that the Petitioner is estopped from asking for the revocation of the Respondent's license because the Petitioner had asked the Hearing Committee for suspension and retraining of the Respondent as an alternative penalty. The Respondent argues further that there is nothing in the record which justifies the rejection of the Hearing Committee's Penalty, that none of the Patients in this case suffered permanent harm and that the Respondent has already initiated steps to begin retraining and has become a participant in a Medical Society approved substance abuse program.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding Dr. Bailey guilty of negligence on more than one occasion, incompetence on more than one occasion, failing to maintain adequate records and being a habitual abuser of alcohol. The Determination is consistent with the Committee's Findings and Conclusions, and the Determination on the charges was not contested by either party.

The Review Board votes to modify the Hearing Committee's Penalty because we do not believe that the Penalty is appropriate to protect the public and because the Penalty is not consistent with the Committee's Findings and Conclusions concerning the Respondent's pattern of

negligence and incompetence and the Respondent's abuse of alcohol. In the case of Patient A, the Committee found the Respondent guilty of unacceptable failure of attention to basic elements of the practice of anesthesiology. In the case of Patient B, the Respondent was guilty of a lapse of care and diligence. In the case of Patient E, the Committee found that the Respondent guilty of a clear lapse of attention in requisite elements of care. In the case of Patient F, the Committee found the Respondent guilty of failing to provide a proper level of outpatient attention to the Patient. Anesthesiology is a specialty in which lapses of care and a lack of attentiveness can place patients in grave danger and produce disastrous results. The Respondent's lapses of care and neglect of attention in these cases demonstrate that the Respondent is not fit to practice anesthesiology. Further, the Review Board does not believe that remediation can correct such deficiencies in the Respondent's practice and make him fit to return to the practice of anesthesiology. Anesthesiology is also an extremely stressful specialty. The Respondent's abuse of alcohol may or may not have resulted from the stress of the specialty. The Review Board does not believe, however, that the Respondent's recovery from alcohol abuse will be assisted by returning him to such a stressful environment. The Review Board votes to limit the Respondent's license to prohibit him from practicing anesthesiology.

The Review Board finds further that the limitation of the Respondent's license alone, will not be sufficient to protect the public in this case. The Respondent's pattern of substandard care and his abuse of alcohol demonstrate that the Respondent will not be able to return to the practice of general medicine, without the successful completion of a substance abuse program and a program of retraining in an area of medicine other than anesthesiology. The Review Board agrees with the Hearing Committee that the Respondent should be suspended totally from the practice of medicine during the period of treatment and retraining. We also agree with the Hearing Committee that the Respondent should be on Probation for five years following the retraining and that the Respondent should be monitored during probation. The Review Board believes, however, that the Respondent should be monitored for the full five years of probation rather than for three years, as the Hearing Committee provided. The Review Board leaves the specific terms of the monitoring to the Office of Professional Medical Conduct, except that we direct that the Respondent should be monitored both for substance abuse and in his practice of medicine.

The Respondent shall successfully complete the substance abuse program prior to commencing the retraining program. The Review Board directs that the Respondent undergo his retraining, in an area other than anesthesiology, through the two phase Physician Prescribed Education Program at Syracuse[2](PPEP).

[2] Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center Syracuse, 479 Irving Avenue, No. 200, Syracuse, New York 13210.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **sustains** the Hearing Committee's June 29, 1994 Determination finding Dr. Ronald A. Bailey guilty of professional misconduct.

2. The Review Board **modifies** the Hearing Committee's Penalty, for the reasons stated in this Determination.

3. The Review Board **limits** Dr. Bailey's license to prohibit him from practicing anesthesiology.

4. The Review Board **suspends** the Respondent's license, to practice medicine other than anesthesiology, until the Respondent:

a. successfully completes a program of treatment for substance abuse; and

b. successfully completes the Phase I Evaluation and the Phase II Retraining, in an area other than anesthesiology, at the Physician Prescribed Education Program at Syracuse.

5. The Review Board **places the Respondent on probation,** if he successfully completes alcohol treatment and retraining. The Respondent shall be on probation for **five years,** following the completion of treatment and retraining, and the terms of probation shall provide that the Respondent will be **monitored** for substance abuse and in his practice of medicine.

ROBERT M. BRIBER

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF RONALD A. BAILEY, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Bailey.

DATED: Albany, New York

10/28, **1994**

ROBERT M. BRIBER

IN THE MATTER OF RONALD A. BAILEY, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr.

DATED: Brooklyn, New York

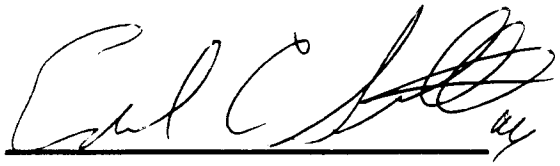
_____, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF RONALD A. BAILEY, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Bailey.

DATED: Roslyn, New York
October 21, **1994**



EDWARD C. SINNOTT, M.D.

IN THE MATTER OF RONALD A. BAILEY, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Bailey.

DATED: Syracuse, New York
21 Oct. , **1994**

William A Stewart

WILLIAM A. STEWART, M.D.

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

IN THE MATTER

OF

RONALD A. BAILEY, M.D.

RESPONDENT

DECISION

AND ORDER

OF THE

HEARING COMMITTEE

BPMC 94-98

The undersigned Hearing Committee consisting of **SUMNER SHAPIRO, Chairperson, JAMES FOLLETTE, M.D., and THERESE G. LYNCH, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) of the New York State Public Health Law and sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **RONALD A. BAILEY, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges dated:	October 29, 1993
First Amended Statement of Charges dated:	December 1, 1993
Notice of Hearing returnable:	December 7, 1993
Place of Hearing:	Syracuse, New York Albany, New York
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	Michael A. Hiser, Esq. Associate Counsel Bureau of Professional Medical Conduct Room 2429 Corning Tower Empire State Plaza Albany, New York
Respondent appeared in person and was represented by:	Robert J. Poulson, Jr. Esq. P.O. Box 310 Cooperstown N. Y. 13326
Respondent's present address:	P.O. Box 312 Oneonta, New York 13820
Hearings held on:	December 7, 14, 15, 1993 February 7, 8, 17, 18, 1994
Conferences held on:	December 3, 1993 February 7, 17, 1994
Closing briefs dated:	March 24, 1994
Record closed:	March 29, 1994
Deliberations held:	March 29, 1994

SUMMARY OF PROCEEDINGS

The Statement of Charges in this matter alleges Respondent has practiced his profession with gross negligence, negligence on more than one occasion gross incompetence and incompetence on more than one occasion. Respondent is also charged with a failure to maintain

appropriate patient records. In addition, Respondent is charged with being a habitual user of alcohol. The allegations arise from the treatment of eight patients and two incidents. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Ronald Dougherty, M.D.	Expert Witness
Alexander Hastie, M.D.	Expert Witness

Respondent testified in his own behalf and called:

William Nugent, M.D.	Expert Witness

SIGNIFICANT LEGAL RULINGS

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

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

With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of

each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart and be able to understand a practitioner's course of treatment and the basis for same.

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

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

The Committee was further instructed that the definitions offered by the State's expert would be adopted by the Administrative Law Judge. Hence, habitual abuse of alcohol constitutes the abuse of alcohol on a regular basis. It is something less than addiction in that alcohol abuse can be episodic and does not require a showing of addiction or addictive behavior. The Committee was further instructed that alcohol abuse is the use of alcohol in spite of negative social, recreational, or occupational consequences, and a considerable amount of time is spent in acquisition of the substance.

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

the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

GENERAL FINDINGS OF FACT

1. Ronald A. Bailey, M.D., the Respondent, was authorized to practice medicine in New York State on January 23, 1984, by the issuance of license number 157205 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from P.O. Box 312, Oneonta, New York 13820. (Pet. Ex. 1 and 2)

FINDINGS OF FACT WITH REGARD TO PATIENT A

A.1. Respondent provided medical care to Patient A, a 78 year old female, at the A. O. Fox Memorial Hospital, One Norton Avenue, Oneonta, New York, 13820 on or about August 30, 1991. Respondent provided post-operative pain management with epidural Fentanyl to Patient A approximately 12 hours after she underwent a surgical operation. (Pet. Ex. 3, pp. 5-7, 18, 67, 169)

A.2 An epidural catheter was inserted for post-operative pain management. Patient A received an initial epidural infusion of Fentanyl with an 11 cc bolus of Fentanyl/saline solution. The bolus contained 11 cc of Fentanyl/saline solution with 10 micrograms of Fentanyl per cc of solution, for a total of 110 micrograms of Fentanyl. The solution was thereafter infused via the catheter at 4 cc per hour, i.e., at 40 micrograms of Fentanyl per hour. This catheter was placed and the infusion was ordered by another anesthesiologist at A. O. Fox Hospital. (Pet. Ex. 3, pp. 22, 167)

A.3. The pharmacy at A. O. Fox Hospital mixes the drug based on orders given by the

anesthesiologist. (Varghese, T. 34)

A.4. Fentanyl is a short acting narcotic designed primarily for use in the operating room. It adds analgesia to the system. The dosage of 40 micrograms per hour of Fentanyl was an appropriate dose. (Hastie, T. 153-154)

A.5. At about 4:30 a.m. on August 30, 1991, the epidural for the patient became occluded and the pump stopped functioning . The occlusion of an epidural catheter is not uncommon. (Varghese, pp. 22-23; Hastie, T. 153)

A.6. Dr. Bailey was on call for anesthesiologist services the morning of August 30, 1991, and was contacted at home by the ICU nurse at approximately 4:30 am. She informed him that the epidural pump was blocked and that no Fentanyl was infusing. The pump was turned off at approximately 4:35 a.m. (Pet. Ex. 3, p. 18)

A.7. At approximately 5:45 am, Dr. Bailey came in and checked the epidural. Dr. Bailey then wrote an order for a loading dose of Fentanyl. Dr. Bailey's order was for 1.5 micrograms of Fentanyl per kilogram of body weight. The patient was approximately 55 kilograms, for a total dose of approximately 80 micrograms. (Pet. Ex. 3, p. 18)

A.8. Dr. Bailey further ordered the infusion of Fentanyl to be at the rate of 450 cc per hour for ten minutes, or 75 cc in ten minutes. (Pet. Ex. 3, p. 169,)

A.9. When the ICU nurse saw Respondent's order, she inquired of him if that was the right dose. She specifically questioned whether the patient was to get 450 cc and not 45 cc. Respondent made a recalculation and told her it was the correct dose. (Varghese, T. 25-26, 38-39; T. 1023)

A.10. Respondent was filling-in for the original treating anesthesiologist who placed the catheter in patient A. Notwithstanding that Respondent was not the original treating anesthesiologist, Respondent had the same responsibility as the original treating physician, including the same responsibility for knowing the dose and mixture of any medication he gave to the patient. Accepted standards of practice of anesthesiology, require that an anesthesiologist must be certain as to the precise contents of any infusion given to a patient. Where an anesthesiologist is uncertain regarding any factor, his duty is to take whatever steps are necessary to obtain absolute clarity (Nugent, T. 692, 709; Hastie, T. 191-192)

A.11. The original treating anesthesiologist had left orders for an infusion of an 11 cc bolus of saline/Fentanyl. The infusion was then to run at 4 cc per hour. (Nugent, T. 686, 699-700; Pet. Ex. 3, p. 167)

A.12. The bolus amount Respondent ordered was nearly seven times the original bolus ordered by the original treating anesthesiologist. (Pet. Ex. 3, pp. 167, 169)

A.14. At a concentration of 10 micrograms per cc of solution, Respondent ordered 750 micrograms of Fentanyl to be infused in Patient A in ten minutes. Respondent's order of 750 micrograms of Fentanyl to be infused epidurally in Patient A in ten minutes was a gross overdose. Providing that amount of Fentanyl to a patient epidurally would stop the patient's breathing. It was not in accordance with accepted standards of practice. (Hastie, T. 157-158; Nugent, T. 695)

A.15. At approximately 6:30 a.m., shortly after Patient A began receiving Respondent's ordered amount of Fentanyl, Patient A became unresponsive and her respiratory rate fell to three per minute. Patient A received only 26 cc of the Fentanyl saline solution, or approximately 260 micrograms of Fentanyl. (Pet. Ex. 3, p. 18, 263)

A.16. The patient was successfully treated with a narcotic reversal agent and survived this adverse event.

A.17. It was a serious and life threatening event when Patient A's respiratory rate dropped to 3 per minute. Accepted standards of anesthesiology would require the practitioner to record such an event. Respondent's did not record that this patient's respiratory rate dropped to three per minute. (Nugent, T. 706-707)

CONCLUSIONS WITH REGARD TO PATIENT A

In factual allegation A.1, Respondent is charged with writing orders to give this patient Fentanyl saline solution at a rate of 450 cc. per hour for ten minutes. It is further alleged that this constituted approximately ten times the "accepted, safe dosage." While it can be disputed as to whether or not the dose was actually ten times the "accepted, safe dosage," there can be no doubt that Respondent issued orders which called for an amount far in excess of what was appropriate under the circumstances and that the patient suffered a life threatening event as a result. The theory of this allegation is not how far in excess the dosage ordered was, rather, the allegation addresses the fact that Respondent wrote an order for a dangerous amount of Fentanyl. On this theory, there can be no doubt that the allegation must be sustained as Respondent's calculation of the amount to be given was grossly disproportional to the appropriate amount.

Therefore:

Factual allegation A.1 IS SUSTAINED.

In factual allegation A.2, Respondent is charged with a failure to order and or record the discontinuance of Fentanyl. It is undisputed that Respondent neither wrote an order for the discontinuation of the Fentanyl nor did he record that the Fentanyl was discontinued. In this case

however, the original treating anesthesiologist had left standing orders such that if the patient fell into distress, the staff was to discontinue Fentanyl. In the presence of such a standing order, Respondent had no obligation to write a new order to end administration of the medication. Likewise, when the medication was discontinued, pursuant to the orders of the original treating physician, Respondent had no duty to record same.

Therefore:

Factual Allegation A.2 IS NOT SUSTAINED.

In factual allegation A.3, Respondent is alleged to have failed to record the patient's adverse response to the Fentanyl. Respondent is further charged with a failure to adequately record how the patient was treated. There can be no doubt that Respondent had a duty to set down in writing his participation in a very significant event in this patient's course. Yet there is virtually no record of Respondent's clinical assessment, what Respondent did and why he took the action he took. Such information is basic to medical practice both in the sense that basic tenets of medical practice require that such records be kept and also because it is necessary for such records to be kept, especially where, as in this case, a physician is substituting for another practitioner. Upon the return of the original treating physician, absent clear notes, there is no way for the patient record to communicate to the other practitioner what took place and the basis for the action taken. The purpose of medical records is to preserve the important events of care and treatment so that future reviewers can understand what took place and why. Clearly, Respondent failed to fulfill this basic standard.

Therefore:

Factual Allegation A.3 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT B

B.1. Respondent provided general anesthesia to Patient B, a 67 year old male, at the A.

O. Fox Hospital on or about April 2, 1992. Patient B weighed 230 pounds (100 kilograms) (Pet. Ex. 4, pp. 7-9)

B.2. During the post-operative period, Patient B experienced severe bradycardia and hypotension. (Pet. Ex. 4, pp. 12-13, 20)

B.3. Patient B was under general anesthesia from approximately 9:20 a.m. through 2:15 p.m. on April 2, 1992, or approximately five hours. Respondent found that this patient had delivered a small amount of urine during the surgery. (Pet. Ex. 4, pp. 7, 12)

B.4. When Patient B went from the operating room to the Intensive Care Unit (I.C.U.), his breathing was being done by Respondent through the use of an AMBU bag. (Pet. Ex. 4, p. 12; Respondent, T. 644)

B.5. Shortly after arrival in the I.C.U. unit, Patient B was put on a mechanical ventilator. The ventilator was the Puritan Bennett 7200 series. The ventilator was in the SIMV (Synchronized Intermittent Mechanical Ventilation) Mode as ordered by Respondent. (Pet. Ex. 4, pp. 11, 109; Simmerly, T. 54; Doxtader. T. 86; Respondent, T. 644-645)

B.6. The ventilator settings were for 40% oxygen with a Tidal volume of 850 milliliters and a respiratory rate of 10. The PEEP (Positive End Expiratory Pressure) setting was at 5 centimeters. The patient responded well to these settings, and became progressively more responsive. (Pet. Ex. 4, pp. 11-12, 109; Simmerly, T. 55)

B.7. Had PEEP pressure been set at 46 centimeters with the ventilator in the SIMV mode, this would have been immediately apparent, as the patient would have experienced bradycardia, loss of consciousness, and appearance of apnea when the ventilator mode was changed.

(Respondent, T. 645)

B.8.. Respondent changed the ventilator settings to put the patient on Continuous Positive Airway Pressure (CPAP). CPAP is a ventilator mode that requires the patient to be able to breath on his own. The responsibility for changing ventilator settings is adopted by the anesthesiologist if the anesthesiologist makes the changes. (Respondent, T. 647; Doxtader, T. 90; Hastie, T. 247-248)

B.9. Respondent changed the CPAP -- PEEP knob to alter the positive end expiratory pressures. (Respondent, T. 671)

B.10. There are two ways to measure the positive end expiratory pressure on a Puritan Bennett 7200 series ventilator. The first is a needle gauge in the upper left hand corner of the control panel; however, the needle gauge does not reflect PEEP pressure unless the button marked "airway pressure" below it is pressed. The second way to measure PEEP is the digital readout in the upper center portion of the control panel. However, the digital readout does not reflect PEEP pressure unless the button marked "PEEP/CPAP" is pressed. (Pet. Ex. 5, p. 3-9; Doxtader, T. 95-96).

B.11. Either measurement device -- needle gauge or digital readout -- will portray information that can be misread as the PEEP pressure if the observer is not careful that the proper button is pressed. (Doxtader, T. 109-110)

B.12. Thirty seconds after Respondent put the patient on the CPAP mode on the ventilator and adjusted the PEEP/CPAP control knob, the patient became unresponsive to verbal stimuli. The patient's pupils were at approximately five millimeters and not reacting. The patient's blood pressure dropped, followed by bradycardia. The patient was disconnected from the ventilator. A code blue

was called at 14:46 and CPR was begun. The patient was resuscitated successfully, approximately 10 minutes later. (Pet. Ex. 4, pp 20)

B.13. The patient was reconnected to the ventilator with no change of settings. Within thirty seconds, the respiratory therapist, Mr. Doxtader noticed a noise which indicated "back pressure" from the ventilator. The patient began experiencing the same problems as before. (Doxtader, T. 93)

B.14. Once the patient was disconnected from the ventilator, Respondent then found that PEEP had been set at 46 centimeters. Mr. Doxtader brought this to the attention of Respondent and confirmed that the desired setting should be 5, not 46. The patient was then reconnected to the ventilator with the correct setting. Thereafter, the patient experienced no further respiratory difficulties. (Doxtader, T. 94-95)

CONCLUSIONS WITH REGARD TO PATIENT B

In factual allegation B.1, Respondent is charged with a failure to adequately monitor or treat this patient's urinary output. The exact amount of urine put out by this patient is ambiguous. The record shows one conclusion of 100 cc. and another of 125 cc The record is sufficiently compete to show there was no evidence at the time that this patient suffered renal failure, nor hypotension, tachycardia or other indication of hemodynamic instability. Furthermore, Respondent was treating this patient's fluid balance and blood pressure with crystalloid and Hespan plus blood replacement. Given all these factors, the Committee concludes Respondent's monitoring and treatment regarding this patient's urinary output did not fall outside accepted standards.

Therefore:

Factual Allegation B.1 IS NOT SUSTAINED.

In factual allegation B.2, Respondent is charged with the failure to adequately monitor this patient's intravascular pressure by use of a CVP or Swan Ganz catheter. While it was admitted that Respondent used neither a CVP nor Swan Ganz, he had no duty to use either. Prior to the surgery, Respondent had consulted with this patient's cardiologist. The cardiologist recommended that routine intraoperative and post-operative monitoring be utilized. Furthermore, given the prone position of the patient in this procedure, there was some danger in the placement of a catheter. Respondent's reliance on the opinion of the cardiologist, and his decision to forgo the use of the CVP and Swan Ganz based upon that opinion was appropriate and completely consistent with accepted standards of medicine.

Therefore:

Factual Allegation B.2 IS NOT SUSTAINED.

In factual allegation B.3, Respondent is charged with twice placing the patient on continuous positive airway pressure (CPAP) set at excessive levels. The Committee sustains this charge in consideration of the following factors: There can be no doubt that this patient was placed on CPAP at excessive levels. Respondent does not deny that there came a point, after the patient had been resuscitated for the second time, that he was informed that the ventilation machine was set to 46 centimeters of pressure, instead of the 5 cm. which was the desired level. Respondent admits adjusting the machine, but denies having created the problem. At page 653 of the transcript, Respondent, at first, suspected that the CPAP mode was responsible for the patient's difficulties. However, he eventually realized that it was the pressure setting, not the mode which placed this patient in jeopardy. The excessive pressure had the effect of interrupting normal blood flow and cardiac performance leading to insufficient oxygen perfusion. Thus the patient became apneic, bradycardic, and unresponsive. A code blue was called. The Committee acknowledges that when the patient was found by Respondent to be in a compromised state, he took the correct immediate action. He removed the mechanical ventilation source and used an AMBU-bag to hand ventilate

the patient. However, Respondent's corrective action does not insulate him from the essence of the charge: Respondent's testimony makes it clear, that he adjusted the machine, and in adjusting the machine, misread the gauges thereby placing the patient on excessive pressure. Respondent's erroneous setting might be mitigated had he recognized the mistake. However, his failure to recognize the signs and symptoms of this very serious error in a timely fashion is not excusable and is entirely supportive of the charge.

Therefore:

Factual Allegation B.3 IS SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT C

C.1. Respondent provided general anesthesia to Patient C, an 84 year old female, at the House of the Good Samaritan Hospital, 830 Washington Street, Watertown, New York, 13601 (hereafter "Good Samaritan Hospital") on or about March 3, 1990. (Pet. Ex. 6, p. 20)

C.2. An anesthesia record is meant to record events as they transpire and to act as a document which allows the recreation of the circumstances under which the anesthesia is given. (Hastie, T. 249-250)

C.3. At the minimum, the anesthesia record should include all drugs and agents given, the routes of administration, as well as the timing of administration and the amounts given. Vital signs should also be recorded. The record should reference the type or system of monitors used to measure the patient's temperature, oxygen, and carbon dioxide during the surgery. There should also be a record of the fluids that were given. Estimates should be made of the blood loss and urine output. End tidal carbon dioxide should be recorded. (Hastie, T. 252)

C.4. End Tidal Carbon Dioxide Measurement reflects the adequacy of the patient's ventilation. It is thus indicative of whether the patient is over-ventilated or under-ventilated. (Hastie, T. 250-251)

C.5. Respondent's anesthesia record does not indicate the time that he gave fluids nor the types and amounts of fluids given. It is standard practice to indicate the type and amount of fluids given in relationship to time. (Hastie, T. 254-255)

C.6. Respondent's anesthesia record does not document the patient's temperature. Respondent's anesthesia record does not record end tidal carbon dioxide. The anesthesia in this case ended at 11:20 a.m. Respondent's anesthesia record does not record oxygen saturations after 9:00 a.m., (Pet. Ex. 6, p. 28; Hastie, T.15 255-257)

C.7. Patient C regurgitated at the time of intubation. Regurgitation is a serious event, since it can lead to aspiration. Aspiration occurs when fluid in the stomach runs into the pharynx and down into the lungs. Aspiration is a danger for a patient because,
depending on the fluid's acidity, a more or less severe reaction in the lung can be created. (Pet. Ex. 6, p. 28; Hastie, T. 267)

C.8. Respondent viewed this as a "very critical event", as it could lead to aspiration, with its serious pulmonary effects. He had never had this problem occur before. (Respondent, T. 1042, 1050).

C.9. Patient C was moved from the operating room at approximately 11:20 a.m. and admitted to the Post-Anesthesia Care Unit (PACU). At the time of the move, the patient was unresponsive, and had the endotracheal tube in place. Patient C had shallow respirations of 14-16 per minute on arrival in the PACU. The patient was AMBU-sighed and tolerated this well. There

were expiratory wheezes found in the left apical lobe and arterial blood gases were drawn. (Pet. Ex. 6, pp. 27, 29, 43)

C.10. Expiratory wheezes heard in the apical region of the lung is a finding associated with aspiration. (Hastie, T. 265)

C.11. At the time the patient was admitted to the PACU, Patient C's surgeon entered a note that described the patient's regurgitation on induction of anesthesia. In this note, the surgeon questions whether aspiration had occurred. (Pet. Ex. 6, p. 20)

C.12. A chest x-ray taken at 6:00 p.m. on the day of surgery contains findings consistent with the patient having aspirated. Respondent's anesthesia post-operative note made reference to "persistent disease" as shown by the chest x-ray. Respondent's impression was "infiltrates - aspiration". (Pet. Ex. 6, pp. 18, 85)

C.13. On arrival in the PACU, Patient C was placed on a Briggs adaptor. A Briggs adaptor is also known as a T-piece. A Briggs adaptor is a method by which room air is combined with mechanical ventilation where a patient is breathing spontaneously with an endotracheal tube in place. Its purpose is to allow the patient to do some of the work entailed in spontaneous breathing while an evaluation is made if the patient is able to begin breathing entirely without assistance. (Pet. Ex. 6, p. 43; Hastie, T. 258-260)

C.14. Respondent wrote a progress note at 14:00 on March 4, 1990, indicating that the patient would continue on CPAP "times 2 hours and then extubate". Respondent wrote a second progress note also on March 4, 1990 at "2:00" that the patient was doing well. (Pet. Ex. 6, p. 19)

C.15. Respondent concurred in the extubation of the patient as ordered by Dr. Roche at

14:45 on March 4, 1990. (Pet. Ex. 6, p. 35)

C.16. The patient record discloses three separate notes written by Respondent on three separate occasions on March 4. (Pet. Ex. 6, p. 18-19)

CONCLUSIONS WITH REGARD TO PATIENT C

In factual allegation C.1, Respondent is charged with a failure to monitor and record significant aspects of the anesthesia procedure. Clearly, the record of the administration of anesthesia and immediate after-care of this patient is seriously lacking. However, the Committee attributes this, less to a failure to monitor, than a failure to record. First, the Committee recognizes that patient had regurgitated. Therefore, it is understandable that Respondent would not be able to record all the information available to him at the time, as his attention had to be directed entirely to stabilizing the patient. Upon review of Respondent's testimony, the Committee is convinced that Respondent was very involved in treating this patient. Hence, it cannot be said Respondent was not monitoring the patient's condition.

At 9:45, there is a change in personnel as evidenced by the initials "JGB" on the record. Upon review of Respondent's testimony, it is apparent that Respondent had transferred the care of this patient to a CRNA. From the point that the care was transferred, the information recorded is even less than that recorded by Respondent. Oxygen saturation and fluid management were no longer recorded. End tidal volume, Carbon dioxide and temperatures were never recorded by the CRNA.

The Committee accepts the opinion of Dr. Hastie with regard to this charge: Ultimately, it is the responsibility of the anesthesiologist to see that the patient record for the administration of anesthesia is complete. Notwithstanding the change of personnel and the immediate condition of

the patient, the anesthesiologist is responsible to develop a contiguous if not contemporaneous record of occurrences. The anesthesia record for this patient, as a whole, shows an unacceptable level of inattention to detail. If, as well may have been the case, Respondent could not record all data contemporaneously, Respondent nevertheless had a duty to record the events in question at a later time. Furthermore, his duty was to record with sufficient detail, such that future reviewers could understand what took place, what Respondent did and why. Absent the testimony by Respondent, one is left to speculate about important aspects of the care of this patient. This need to speculate is a clear violation of accepted standards of medical record keeping. Consequently although the Committee finds Respondent did monitor this patient, his records were unacceptably substandard and thus entirely supportive of the charge.

Therefore:

Factual Allegation C.1 IS SUSTAINED.

In allegation C.2, Respondent is charged with "inappropriately" leaving this patient on a Briggs adaptor for an excessive period of time. The Committee does not sustain this allegation on the grounds that the Committee finds the amount of time was not inappropriate. How long a given patient is left on a Briggs adaptor is a clinical judgement, best left to the practitioner caring for the patient. There was no danger or harm likely to the patient by the use of the Briggs adaptor, and if Respondent was unsure as to whether the patient should be extubated, the Briggs adaptor was a better choice than premature extubation. Under all the facts and circumstances, the Committee can find no violation of accepted standards of medicine with regard to the use of the Briggs adaptor in this case.

Therefore:

Factual Allegation C.2 IS NOT SUSTAINED.

In Allegation C.3, the State alleges that Respondent failed to place Patient C on a ventilator despite a prior aspiration. To sustain this charge, the State must show that Respondent failed to place the patient on a ventilator, and that the patient had aspirated. The first part of the allegation, that the patient was not placed on a ventilator, is self-evident. However, as to the second part of

the allegation, that the patient aspirated, this was not proven by a preponderance of the evidence. while the State proved that the patient had regurgitated, the State did not prove, by a preponderance of the evidence, that the patient had aspirated. The fact that the patient had regurgitated, absent aspiration, would not require the use of a ventilator. Without this key element, the allegation cannot be sustained.

Therefore:

Factual Allegation C.3 IS NOT SUSTAINED.

In Allegation C.4, the State alleges Respondent failed to adequately monitor this patient prior to extubation. The Committee does not sustain this allegation. The patient was in the PACU where there are specially trained staff and there is constant mechanical and electronic monitoring. It was not a violation of accepted standards of practice for Respondent to rely on the staff and sophisticated equipment to which the patient was connected. Nevertheless, Respondent visited the patient on two occasions and reviewed lab reports and conferred with the primary care physician. By any fair measurement, Respondent monitored this patient adequately. Respondent's activities with regard to his monitoring of this patient were entirely within accepted standards of medicine.

Therefore:

Factual Allegation C.4 IS NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT D

D.1. Respondent provided general anesthesia to Patient D, an 80 year old male, at the Good Samaritan Hospital on or about October 2, 1989. Shortly after Patient D's extubation, Patient D experienced respiratory distress, and had to be re-intubated. (Pet. Ex. 7, pp. 89-94)

D.2. Patient D underwent surgical procedures on October 2, 1989 that included an

exploratory laparotomy, pancreatic biopsy, cholecystojejunostomy, and gastrojejunostomy. (Pet. Ex. 7, p. 6)

D.3. Patient D had upper abdominal surgery. Patients who have such surgery have reductions in their vital capacity. They cannot take as deep a breath and have pain which limits their breathing. They thus have a tendency to breath in a very shallow manner, which sets the stage for atelectasis and collapse of the lung. Mechanical ventilation provides a means of keeping the patient's lungs functioning well during the immediate post-operative period. (Hastie, T. 303-304)

D.4. Prior to surgery, the possibility of prolonged mechanical ventilation was discussed with the patient and his family. Prolonged mechanical ventilation was likely possibility given the type of surgery planned, the patient's age, and the patient's history of chronic obstructive pulmonary disease (COPD). Respondent agreed it was not an unreasonable possibility. (Pet. Ex. 7, pp. 2, 68; Hastie, T. 302; Respondent, T. 1082)

D.5. Patient D was breathing with the assistance of a ventilator when brought to the (PACU) at 16:10 on October 2, 1989. Between 16:45 and 17:00, Respondent ordered morphine to be given to the patient in the amount of 10 milligrams. (Pet. Ex. 7, p. 18)

D.6. Morphine will alleviate pain and produce respiratory depression in a patient. Morphine tends to slow the rate of breathing and increase tidal volume. If patients are unable to take a deep breath, their blood gases may become abnormal. That effect, however, would not be revealed if the patient was on a ventilator. (Hastie, T. 306-307)

D.7. Patient D was restless at 17:15. Restlessness can be a sign of hypoxia. (Pet. Ex. 7, p. 94; Hastie, T. 313-314)

D.8. At 17:35, the nursing staff advised Respondent that the patient was able to sustain a head lift for five seconds, his hand grips were strong, that he nodded his head when asked if he minded the tube, and that tidal volume was approximately 700 cc. Respondent was notified in the OR of the patient's status and that the patient remained restless. Respondent made the decision to extubate the patient if the patient met criteria and to sedate the patient if he did not meet the criteria. (Pet. Ex. 7, p. 94; Hastie, T. 313-314)

D.9. Respondent did not personally evaluate Patient D immediately prior to extubation. (Pet. Ex. 7, p. 96, Respondent, T. 1075)

D.10. At 17:50, the patient was found to be restless and not able to answer questions. Restlessness can be a sign of hypoxia. The patient's restlessness following so soon after extubation is highly indicative that the patient was not ready for unassisted breathing. (Pet. Ex. 7, p. 94; Hastie, T. 313-314)

D.11. At 18:07 the patient was restless, unresponsive, and his pupils were described as pinpoint. The patient very quickly showed signs of respiratory failure. The patient was re-intubated at 18:10. No relaxant or sedation was given for the re-intubation at 18:10. (Pet. Ex. 7, pp. 18, 90, 92-94)

CONCLUSIONS WITH REGARD TO PATIENT D

There was only one factual allegation with regard to Patient D. This factual allegation had two components: That Respondent improperly authorized the nursing staff to extubate this patient and that at the time of the extubation, the patient was in an obtunded state. The Committee was split in their conclusion. The majority opinion held that since the nursing staff reported that the

patient was showing signs and symptoms consistent with safe extubation, it was acceptable for Respondent to rely on the report of the nursing staff, authorize extubation and that the nursing staff to extubate the patient. Hence, Respondent was acting within accepted standards of medical care in this case. The entire Committee agreed that the patient was reported to have a strong hand grip, appropriate tidal volume, good head lift and appropriate responses. Consequently, at the time of the extubation, the patient could not have been characterized as obtunded. Furthermore, all agreed that appropriately trained nurses were entirely adequate to perform the extubation. Finally, the Committee recognized that from time to time, patients who appear ready for extubation, may need to be re-intubated and such a situation, in and of itself does not constitute medical misconduct. The point upon which the Committee was split had to do with Respondent's duty to actually examine the patient directly prior to extubation. The majority was of the opinion that the report from the nurses, under these circumstances, was sufficient. The minority was of the opinion that the age and seriousness of this patient's condition warranted a direct examination by Respondent at a time shortly prior to extubation.

Therefore, by a 2-1 vote:

Allegation D.1 IS NOT SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT E

E.1. Respondent provided general anesthesia to Patient E, a 64 year old male, at the Good Samaritan Hospital on or about March 19, 1990. Following Patient E's extubation in the operating room, Patient E experienced respiratory distress, and had to be re-intubated. (Pet. Ex. 8, pp. 3-4, 8)

E.2. Patient E underwent a hydrocele repair on March 19, 1990. The operation started

at 8:07 a.m. and finished at 8:24 a.m. The patient left the operating room at 9:20 a.m. (Pet. Ex. 8, pp. 2, 26)

E.3. A hydrocele repair is a relatively simple operation. It is not associated with significant blood or fluid loss. The estimated blood loss in this procedure less than 10 cc (Pet. Ex. 8, p. 3; Hastie, T. 339)

E.4. During the period of anesthesia, the patient received approximately 3100 cc of Ringer's lactate. Ringer's lactate is a salt containing solution used as a substitute for the fluid portion of the blood or for tissue fluid. (Pet. Ex. 8, p. 3)

E.5. Respondent admitted the fluids administered to the patient were excessive but not a planned event. Respondent explained that the excessive administration of fluids occurred because he was distracted and did not occlude the roller control when the fluid bags were replaced. (Pet. Ex. 9; Nugent, T. 812)

E.6. There are risks to giving excessive amounts of fluid to a patient. When the volume in the vascular system is increased, the body can compensate to some degree by dilating the veins and increasing the capacity of the system. Once that is exceeded, the intravascular pressures are elevated. This may precipitate cardiac problems such as pulmonary edema. (Hastie, T. 342)

E.7. The chest x-ray of Patient E taken in the recovery room is suggestive of pulmonary edema; the patient was also diagnosed as having pulmonary edema. (Pet. Ex. 8, pp. 20, 37)

E.8. From approximately 8:30 a.m. through 9:15 a.m., the patient's blood pressure was in the range of 200/100. (Hastie, T. 343-344)

E.9. Respondent administered labetalol to the patient as treatment for the hypertension at approximately 8:40 a.m. (Pet. Ex. 8, p. 3)

CONCLUSIONS WITH REGARD TO PATIENT E

In allegation E.1, Respondent is charged with administering 3000 cc of Lactated Ringer's Solution to this patient. Respondent admits that the patient received approximately 3100 cc of solution during this surgery and that this amount was far in excess of what was called for under the circumstances. Respondent states that he undoubtedly failed to close the roller which controls the flow of solution. While the Committee recognizes that mistakes such as the failure to close a roller can occur, under the facts of this case, Respondent failed to notice the situation, not once, but three times. Each time a new unit of solution was hung, Respondent had the opportunity to notice that the infusion was running much too quickly. He failed in this basic obligation.

Therefore:

Factual Allegation E.1 IS SUSTAINED.

The remaining allegations are that Respondent failed to treat this patient's hypertension in the operating room (E.2), Respondent prematurely extubated the patient (E.3), and Respondent improperly delegated the responsibility for deciding whether to extubate the patient (E.4). The Committee sustains none of these charges. With regard to the issue of hypertension, under all the facts and circumstances, the use of labetalol was acceptable treatment for this patient. As far as the extubation was concerned, at the time, Respondent had administered the reversal agents and had a good "train of four." Hence, all the indications supported extubation. That Respondent consulted with another physician, prior to extubation is certainly not a deviation from accepted standards and is, in fact, required where the practitioner is unsure how to proceed. Upon review of all the evidence, the Committee can find no violations of accepted medical practice with regard to the three remaining charges.

Therefore:

Factual Allegation E.2 IS NOT SUSTAINED.
Factual Allegation E.3 IS NOT SUSTAINED.
Factual Allegation E.4 IS NOT SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT F

F.1. Patient F received epidural lumbar blocks with morphine (Duramorph) on May 28, 1991, June 7, 1991, and August 20, 1991. The patient received an intrathecal block on August 27, 1991. All blocks were scheduled and performed on an outpatient basis. (Pet. Ex. 10)

F.2. An epidural block is performed by using a needle and placing that needle in the epidural space, i.e., between the sac holding the spinal fluid and the ligaments in the vertebral canal. (Hastie, T. 393)

F.3. An intrathecal block is performed by advancing the needle through the dura, and injecting the drug into the spinal fluid. (Hastie, T. 394)

F.4. An intrathecal block is not commonly used on outpatients. (Hastie, T. 394)

F.5. Duramorph is morphine without preservative. There are no generally accepted standard for intrathecal use of morphine. (Hastie, T. 395-396; Nugent, T. 896 Pet. Ex. 16, p. 938-939)

F.6. Side effects from using morphine intrathecally or epidurally include pruritus (general itching), nausea and vomiting, urine retention, and delayed respiratory depression. (Hastie, T. 397-398)

F.7. On May 28, Patient F received 2.5 milligrams of morphine *epidurally*. (Pet. Ex. 10, p. 23; Hastie, T. 396)

F.8. On June 7, 1991, Patient F received 1 milligram of morphine *epidurally*.(Pet. Ex. 10, p. 15; Hastie, T. 396)

F.9. On August 20, 1991, Patient F received 1 milligram of Morphine *epidurally*. (Pet. Ex. 10, p. 6; Hastie, T. 396)

F.10. On August 27, 1991, Respondent gave 1.5 milligrams of Duramorph to Patient F *intrathecally,* on an outpatient basis. (Hastie, T. 397)

F.11. Patient F came into the operating room at 11:15 a.m. She returned from the operating room at 11:30 a.m. Respondent discharged the patient by note written between 11:30 a.m. and 11:45 a.m. She remained at the hospital to have lunch for the next hour. (Pet. Ex. 10, pp. 50-51, 78)

F.12. Approximately one hour after administration of the intrathecal morphine, Patient F became pale, was diaphoretic, was vomiting, had atrial fibrillation. The patient was hypothermic, and had decreased urine output. The patient's symptoms were consistent with the known and recognized side effects which are possible from intrathecal administration of morphine. (Pet. Ex. 10, pp. 55-56, 81; Hastie, T. 400)

F.13. The patient's arterial blood gas studies also showed changes. The changes in arterial blood gases are consistent with respiratory depression. (Pet. Ex. 10, pp. 70; Hastie, T. 400)

CONCLUSIONS WITH REGARD TO PATIENT F

Allegations F.1 and F.2 will be combined for discussion. Respondent is charged with the use of an excessive dose of Duramorph on Patient F (F.1) and a failure to adequately monitor the patient after the administration (F.2). The Committee sustains these charges. While the Committee finds there are no generally accepted standards for the use of intrathecal morphine, generally accepted standards of medicine require that a practitioner move cautiously when administering such potent substances in an area of the anatomy where an untoward result could be catastrophic. In finding that there are no generally accepted standards for the administration of intrathecal morphine, the Committee has given greater weight to the testimony of Dr. Nugent. This is because Dr. Nugent has had more experience in the treatment of chronic pain than the State's expert. Nevertheless, the ultimate conclusion of the Committee is consistent with Dr. Hastie's opinion.

Under the specific facts of this case, Respondent had no experience with intrathecal administration of morphine to this particular patient. Since all patients respond differently to the administration of potent analgesics, and since the potential for very serious results existed in this administration, prudence would have dictated a smaller dose than that given by Respondent. As prescribed and administered by Respondent, there was no titration of the morphine for this individual. Respondent merely gave a significant dose, without any kind of trial. This is particularly imprudent given the higher incidence of quicker side-effects, some extremely dangerous, from this kind of administration. Upon questioning by the Committee, Respondent was unable to justify the dose given.

With regard to the failure to monitor, this patient was allowed to leave the outpatient treatment area in less than thirty minutes. Such a period is hardly long enough to establish that the administration had been successfully accomplished without undue side-effects. While the administration of intrathecal morphine on an outpatient basis, is not without controversy, certain clear rules of generally accepted medicine apply: This patient should not have been released for a significant time, particularly since this was the first administration, so that untoward post-administration side-effects could be ruled out. It was merely fortuitous that the patient remained

in the hospital for approximately an hour after the administration. Respondent's acts in this administration were irresponsible and almost cavalier. Hence it is found that Respondent violated accepted standards of medicine.

Therefore:

Allegation F.1 IS SUSTAINED.
Allegation F.2 IS SUSTAINED.

FINDINGS OF FACT WITH REGARD TO PATIENT G

G.1. Respondent provided spinal anesthesia to Patient G, a 69 year old male, at A. O. Fox Hospital on or about January 22, 1991, during Patient G's surgical procedure for replacement of left hip. Respondent gave Patient G 150 micrograms of Fentanyl intrathecally as part of the anesthesia administered. (Pet. Ex. 11, p. 17)

G.2. Fentanyl is a narcotic that works on narcotic receptors in the spinal cord similar to morphine. It is used to supplement the spinal anesthesia by working in conjunction with local anesthetics to give a more intense and better block. The risks of giving too high a dose of Fentanyl intrathecally are similar to the risks of giving morphine except that there would be a lower probability of serious complication. (Hastie, T. 410-411, 414-415)

G.3. One of the side effects of Fentanyl is bradycardia. Bradycardia caused by Fentanyl, if untreated, can lead to cardiac arrest. (Nugent, T. 888-889, 901)

G.4. Patient G suffered a cardiac arrest at approximately the time that the acetabulum was being affixed in the hip replacement operation. The acetabulum was affixed with screws, not cement. There was no causal relationship between cement being applied to the acetabulum and the cardiac arrest occurring, since the operative note did not mention that cement was used as a means of fixing the acetabulum. (Pet. Ex. 11, p. 21)

G.5. The accepted dose range of Fentanyl when used epidurally runs anywhere from 50 to 150 micrograms. (Hastie, T. 413)

CONCLUSIONS WITH REGARD TO PATIENT G

In the sole allegation associated with this patient, Respondent is charged with providing an excessive dose of Fentanyl to this patient. In his testimony, Dr. Hastie put forth the proposition that an intrathecal administration of anesthesia would be about 10 times as potent as an epidural administration. While the Committee does not accept the 10:1 ratio put forth by Dr. Hastie, the Committee does agree that the dose, in this case was clearly excessive. Respondent offered no rationale for his dosage. Accordingly, the Committee finds that he violated accepted standards of medicine in regard to this patient.

Therefore:

Allegation G.1 IS SUSTAINED.

PATIENT H

The factual allegations regarding Patient H were withdrawn by the Petitioner.

FACTUAL ALLEGATIONS WITH REGARD TO PATIENT I

I.1. Respondent provided epidural anesthesia to Patient I, a thirty year old female, at the A. O. Fox Hospital on or about September 26, 1991. Patient I was nine months pregnant, and was admitted for a term delivery. (Pet. Ex. 13, pp. 4-5, 19, 28)

I.2. At approximately 2:40 p.m. on September 26, 1991, the patient requested an epidural. At approximately 3:35 p.m., the patient was prepared for an epidural by Respondent. The patient received an epidural bolus beginning at 3:45 p.m. At 4:00 p.m., Respondent left the patient's side to attend to other matters in the operating room. (Pet. Ex. 13, pp. 26-28)

I.3. Between 4:00 p.m. and 8:00 p.m., Respondent did respond to phone calls regarding the patient's care. Respondent ordered Ephedrine to be given to the patient at 4:30. (Pet. Ex. 13, pp. 22, 27)

I.4. An anesthesia record is meant to record events as they transpire and to act as a document which allows the recreation of the circumstances under which the anesthesia is given. (Hastie, T. 249-250)

I.5. Basic patient information is to be recorded on the anesthesia record. The information that should be recorded includes all drugs given, the agents used, the timing and the dose. Vital signs should also be recorded, and there should be reference to the monitors used. There should also be a record of the fluids that were given. (Hastie, T. 250-251)

I.6. Recording a test dose given by the anesthesiologist is a significant item in an epidural anesthesia procedure. (Hastie, T. 439-440)

I.7. Respondent recorded fluids to be given to the patient as "per OB". (Pet. Ex. 13, p. 28)

CONCLUSIONS WITH REGARD TO PATIENT I

In allegation I.1, Respondent is charged with failing to make appropriate arrangements for

monitoring of the patient. There is no dispute that after administering the epidural anesthesia, Respondent left the patient and went to the OR Respondent did not leave the hospital. Moreover, the patient was under the care of her obstetrician. Respondent was available by telephone and was only a short distance from the patient. Under all the facts and circumstances, the Committee can find no violation of accepted standards of medicine in that Respondent made adequate arrangements for the care and treatment of this patient.

Therefore:

Allegation I.1 is NOT SUSTAINED.

In Allegation I.2, Respondent is charged with a failure to record significant aspects of his care and treatment of this patient. The Committee sustains this charge citing Respondent for an unacceptable lack of information regarding his activity with this patient.

Therefore:

Allegation I.2 IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO ALLEGATIONS OF ALCOHOL ABUSE (ALLEGATIONS J AND K)

Allegation J

J.1. Habitual abuse of alcohol occurs when an individual abuses alcohol on a regular basis. Alcohol abuse is the use of alcohol in spite of negative social, recreational or occupational consequences, and a considerable amount of time is spent in acquisition of that substance.

The American Society of Addiction Medicine definition of alcoholism is use of alcohol despite a specific problem with family, friends, job, health, law or finances. (Dougherty, T. 475-476)

J.2. Respondent was arrested on a charge of driving while intoxicated on November 20, 1991, by the Oneonta City Police.

J.3. At approximately 2:30 p.m. on November 20, 1991, a breathalyzer test was administered to him by a breath analyzer operator certified by the New York State Department of Health. The breathalyzer test result showed that Respondent's blood alcohol content (BAC) was .22%. The charge that Respondent was driving while intoxicated was later dismissed and Respondent pled guilty to driving while ability impaired.
(Stipulated fact, T. 467-468)

J.4. A BAC of .20% to .22% generally requires eight or nine cans of beer or its equivalent in glasses of wine or shots of whiskey within the last three hours.

J.5. A person's BAC drops at approximately .02% per hour after the peak alcohol level is reached. (Dougherty, T. 477-478, 486)

J.6. Respondent drank heavily, beginning on the evening of November 19. He continued through the morning of November 20, 1991, until approximately 4:00 or 5:00 a.m. Respondent then slept. When he awoke, later on November 20, he had nothing further to drink. It was at this point, after he awoke on November 20, that the driving incident occurred. (Respondent, T. 536-537)

J.7. Applying the general formula that a person's BAC will drop at approximately .02% per hour, and given that Respondent's BAC at approximately 2:00 p.m. on November 20, 1991 was .22%, Respondent's BAC at approximately 5:00 a.m. on November 20, 1991, was approximately .38 to 40%.

J.8. A BAC level of .38% leaves most people confused and in a stupor. At .40%, they are disoriented and in a coma. At .50, they would experience respiratory collapse and death.

J.9. .383% is close to a lethal BAC. 75% of all people who have a BAC of .383 will be deceased. (Dougherty, T. 482-483)

Allegation K

K.1. On October 13, 1993, Respondent had been drinking alcoholic beverages. He was brought to the emergency room of A. O. Fox Hospital in Oneonta, N.Y. by Oneonta Police at approximately 6:00 p.m. after demonstrating aggressive behavior toward his wife and making suicide threats. (Ex. 15)

K.2. On arrival at the Emergency Room at A. O. Fox Hospital, Respondent was ambulatory with slurred speech, and alert but uncooperative. He was placed in four point restraint. (Ex. 15, p. 5)

K.3. At about 8:00 p.m. on October 13, 1993, blood test results showed Respondent's BAC to be 383 milligrams per deciliter, i.e. .383% BAC. (Ex. 15, p. 9). A BAC of .383% represents approximately 15 glasses of beer, glasses of wine, or shots of whiskey within approximately three hours. (Dougherty, T. 481)

K.4. Since Respondent came into the Emergency Room at approximately 6:00 p.m., and did not have his blood level measured until approximately 8:00 p.m., (at which time it measured .383%), it can be estimated that Respondent's BAC when he was brought into the Emergency Room was approximately 40%. (Dougherty, T. 483)

K.5. The fact that Respondent was ambulatory, with slurred speech, and that he was alert and uncooperative when brought into the Emergency Room with a .383% BAC indicates that

Respondent had a fairly substantial tolerance to alcohol. (Dougherty, T. 484)

K.6. Tolerance at the level referred to herein is created when a person consumes alcohol over an extended period of time. The period of time would have to be greater than one month. The consumption of alcohol during the time that such a tolerance is built would have to be on a daily basis. There is no other way that the tolerance described herein could be created in a non-research fashion. (Dougherty, T. 484-485)

K.7. At 9:00 a.m. on October 14, 1993, Respondent's blood alcohol level was tested again. It was found to be 128 milligrams per deciliter. This is equivalent to .128% BAC. (Pet. Ex. 15, p. 8; Dougherty, T. 486)

K.8. By applying the formula which states that a BAC drops by .02% per hour, and multiplying by 12 hours, a BAC of .128% at 9:00 a.m. on October 14 is consistent with a BAC of .383% at 8:00 p.m. on October 13. (Dougherty, T. 486)

K.9. Respondent admitted to daily intake of alcohol. Daily consumption of alcohol is one factor in the definition of a habitual user of alcohol. (Pet. Ex. 15, p. 19; Dougherty, T. 486-487)

K.10. Respondent admitted that alcohol is a problem for him. (Pet. Ex. 15, p. 15; Dougherty, T. 487)

K.11. Respondent was diagnosed as being depressed had multiple episodes of suicidal ideation on October 13, 1993. Depression Suicidal ideation and alcohol abuse are consistent with the condition of alcoholism (Pet. Ex. 15, pp. 2, 5, 15, 17, 26, 29; Dougherty, T. 487-488)

K.12. Respondent's father was alcoholic. Statistics show that if a person's father is

alcoholic and that person is male, there is four times the likelihood that the person is going to develop the disease of alcoholism. (Pet. Ex. 15, p. 15; Dougherty, T. 488-489)

K.13. Respondent experienced stress in his career. Stress in one's job function is commonly associated with chronic alcohol abuse. (Pet. Ex. 15, p. 17; Dougherty, T. 489)

K.14. Respondent's alcohol abuse had gone on for greater than two years, and was seen to be a serious problem by his spouse. Generally persons who are habitual abusers have consumed alcohol in larger amounts than they would like for over a two year period of time. (Pet. Ex. 15, p. 17, 26; Dougherty, T. 490)

CONCLUSIONS WITH REGARD TO ALLEGATIONS OF ALCOHOL ABUSE (ALLEGATIONS J AND K)

The factual allegations under charges J and K 1 and 2 are simply that Respondent had a BAC of .383 mg/dl on October 13, 1994 and a BAC of .128 on October 14. Respondent did not deny these allegations.

DISPOSITION OF FACTUAL ALLEGATIONS

Allegation A.1 was sustained
Allegation A.2 was Not sustained
Allegation A.3 Was sustained

Allegation B.1 was Not sustained
Allegation B.2 was Not Sustained
Allegation B.3 was Sustained

Allegation C.1 was Sustained
Allegation C.2 was Not Sustained
Allegation C.3 was Not Sustained
Allegation C.4 was Not Sustained

Allegation D.1 was Not Sustained

Allegation E.1 was Sustained
Allegation E.2 was Not Sustained
Allegation E.3 was Not Sustained
Allegation E.4 was Not Sustained

Allegation F.1 was Sustained
Allegation F.2 was Sustained

Allegation G.1 was Sustained

Allegations with regard too Patient H were withdrawn

Allegation I.1 was Not sustained
Allegation I.2 was Sustained

Allegation J was Sustained
Allegation K .1 and K.2 were Sustained

CONCLUSIONS WITH REGARD TO THE FIRST THROUGH FIFTH SPECIFICATIONS (GROSS NEGLIGENCE)

Having sustained a number of factual allegations, the Committee now turns its attention to

whether any of the allegations which were sustained, constitute medical misconduct, as defined earlier in this decision. With regard to the First Specification, the State alleges that Respondent committed gross negligence in the treatment of Patient A. The Committee did not sustain allegation A.2,. The Committee does not find that the acts proven under allegation A.1 constitute an egregious deviation from standards. The Committee has found that the dose was excessive. However, Respondent seemed to know the correct dose and attempted to set forth appropriate orders. While the error made (as will be more fully discussed below) was a serious one, under all the facts and circumstances, the Committee cannot find a sufficient deviation from standards to characterize the conduct as gross negligence.

Therefore:

THE FIRST SPECIFICATION IS NOT SUSTAINED.

Likewise, with regard to the Second specification, although the Committee finds Respondent to have acted negligently and incompetently, there was sufficient mitigation not to find a gross departure from accepted standards. While Respondent did place the wrong settings on the ventilator and failed to recognize his mistake, his overall management of the situation was not so severe a deviation from accepted practice to warrant a finding of gross negligence.

Therefore:

THE SECOND SPECIFICATION IS NOT SUSTAINED.

The Third, Fourth and Fifth Specifications are based upon allegations C.2, C.3, D.1, and E.3, respectively. None of these allegations were sustained, therefore they cannot be the basis for a finding of medical misconduct.

Therefore:

THE THIRD SPECIFICATION IS NOT SUSTAINED.
THE FOURTH SPECIFICATION IS NOT SUSTAINED.
THE FIFTH SPECIFICATION IS NOT SUSTAINED.

CONCLUSIONS
WITH REGARD TO
THE SIXTH THROUGH TENTH SPECIFICATIONS
(GROSS INCOMPETENCE)

In the Sixth and Seventh Specifications, Respondent is charged with gross incompetence. In the Sixth Specification, the charge is based upon the excessive dose of Fentanyl given to Patient A (the Sixth Specification also makes reference to allegation A.2 which was not sustained). The Seventh Specification is based upon the setting of excessive pressure levels with regard to Patient B. As stated above, although the Committee finds Respondent's conduct to be in violation of accepted standards of medicine, in both instances the Committee cannot find the conduct to rise to the level of characterization as egregious.

Therefore:

THE SIXTH SPECIFICATION IS NOT SUSTAINED.
THE SEVENTH SPECIFICATION IS NOT SUSTAINED.

The Eighth, Ninth and Tenth Specifications are based upon allegations C.2, C.3, D.1, and E.3, respectively. None of these allegations were sustained, therefore they cannot be the basis for a finding of medical misconduct.

Therefore:

THE EIGHTH SPECIFICATION IS NOT SUSTAINED.
THE NINTH SPECIFICATION IS NOT SUSTAINED.
THE TENTH SPECIFICATION IS NOT SUSTAINED.

CONCLUSIONS
WITH REGARD TO
THE ELEVENTH SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

In the Eleventh Specification, Respondent is charged with negligence on More than one occasion. With regard to patient A and allegation A.1, The Committee finds clear evidence of a failure by Respondent to use that level of care and diligence expected of a prudent physician in this

State. While at first glance, the inappropriate administration may seem to be the result of a simple arithmetic error, upon review of Respondent's testimony, it would appear that the problem is much deeper. The excessive dose of Fentanyl prescribed by Respondent is due to an unacceptable failure of attention, by Respondent, to basic elements of his profession as an anesthesiologist. Respondent noted the bolus given to this patient contained 11 cc of 10 microgram Fentanyl. According to his own testimony, he then assumed 10 micrograms (mics) to be the total weight of Fentanyl in the bolus. Thus, he divided the 11 cc volume by 10 mics in an effort to determine the concentration of Fentanyl per cc. His result was 1.1 mics per cc. This was an error in that he mistakenly inverted the fraction. The appropriate division would have placed the 10 mics in the numerator which, when divided by 11 cc, would have yielded 0.91 mics per cc. Respondent characterized the calculation here as a "straightforward process." The Committee agrees that this type of calculation is at the very heart of basic anesthesia procedures. This makes the inversion of the fraction all the more serious given the fundamental nature of the error.

While Respondent's arithmetic skills were found to be seriously deficient, his fundamental misinterpretation of the composition of the bolus must also be addressed. Respondent erroneously assumed the 11 cc bolus contained a total of 10 mics of Fentanyl. In fact, the bolus contained 10 mics per cc. This stark error, independently produced a gross life threatening condition.

To summarize, Respondent committed a very serious error based both upon a mistake in setting up a routine equation as well as by misunderstanding a simple weight to volume concept. Neither of these lapses involve esoteric or unusual issues for an anesthesiologist. Indeed, these two mental operations are fundamental to anesthesiology. Moreover, the nature of the failure is aggravated in that Respondent had two opportunities to correct his analysis. Respondent was questioned twice by members of the nursing staff. A thoughtful response to such questioning would have alerted a prudent physician that the 75 cc loading dose Respondent he ordered exceeded both another physician's originally prescribed dose and any realistic level of administration. In addition to the excessive nature of the loading dose, to reach the situation in this case, Respondent had to overlook the fact that if the concentration were in fact only 1.1 mics per cc, his prescribed

maintenance dose of 4 cc per hour would have infused only 4.4 mics of Fentanyl per hour, whereas, 40 mics per hour constituted an appropriate dose for pain relief. His failure to recognize this stark inconsistency and re-examine his assumptions and procedures in light of opportunities to do so constitutes a deviation from accepted standards of medical care.

In reaching the conclusions herein, the Committee took notice of the time of day and circumstances under which the order was written. The Committee finds that practice within appropriate standards would have dictated an even higher than normal effort to make careful calculations, knowing that one might well be prone to error. Furthermore, at the time and under the circumstances of this event, Respondent had all the more reason to consider the comments of other care givers to avoid just this sort of mistake. Respondent did not rise to the appropriate standard of attention. He therefore failed in his duty of care and diligence to this patient and hence committed negligence.

In reference to allegation A.3, here, the Committee is asked whether the poor quality of Respondent's records reflects acts of negligence. The Committee is convinced that Respondent did not overlook his obligation to write appropriate notes, rather, this case and the others presented evidence an indifference on the part of Respondent to meet his responsibilities with regard to adequate record keeping. The Committee believes Respondent did not forget to record appropriate events, but chose not to put forth the effort required to maintain appropriate records. In so finding, the Committee finds a failure to meet that level of care and diligence expected of a prudent physician and hence, negligence.

In reference to allegation B.3, the Committee finds Respondent exhibited negligence in his attempt to regulate the ventilation machine. It is the conclusion of the Committee that Respondent had a duty to be sufficiently familiar with the gauges and dials to properly set the machine, or he should have relied upon others more adept than he. As set forth in the factual conclusions, the Committee believes that Respondent misread the gauges on the machine and thus allowed a setting much higher than that appropriate under the circumstances. The Committee also found that Respondent did not recognize the signs and symptoms which were demonstrative of pressure

which was intolerably high. The Committee finds that the dangerous condition which resulted sprang from a lapse of care and diligence on the part of Respondent. Respondent was negligent, both in the fact that he placed the machine at the wrong setting and equally negligent in that he did not realize his own limitations and seek guidance and help. Hence, the Committee finds that allegation B.3 supports a charge of negligence.

The Committee does not find acts of negligence with reference to allegation C.1. Here, as stated in the discussion of the factual allegations, the Committee found no lapse in care or diligence as addressed to the patient. The Committee found Respondent's records to be seriously substandard but not due to oversight. It is the conclusion of the Committee that Respondent's failure to record reflects a lack of effort by Respondent to meet the full requirements of appropriate record keeping.

In reference to patient E, the Committee finds a clear lapse in attention to requisite elements of care. Respondent admitted that the rate of infusion was inappropriately high and that this was undoubtedly attributable to a failure to close the roller valve on the IV tube. The failure to close a roller valve, is not in and of itself an act of negligence that rises to the level of misconduct. Here, however, Respondent had no less than three opportunities to notice and address his error. Each time he had to hang a new bag of fluid, he had to overlook the condition of the valve and the fact that replacements were called for more quickly than would be anticipated. He failed to do so and in so doing is guilty of negligence.

Addressing patient F, the Committee finds Respondent to have been seriously remiss in his administration of Duramorph to this patient. Respondent made no effort to titrate the dosage for this patient. His initial dose was a high one. Appropriate attention to patient care would have dictated a small dose, followed by larger ones based upon the individual patient's tolerance and results. Respondent exacerbated his failure to titrate the patient dosage by not requiring the patient to remain in the area until any untoward side-effects could be ruled out. The administration of Duramorph, intrathecally is not without very serious potential risks. Respondent was duty bound to give this patient an unusual level of outpatient attention based upon the serious nature of the

risks and the fact that they are known to have very rapid onset. However instead of addressing a higher than usual level of attention to this patient, Respondent opted for a rather routine approach. In so doing, he violated accepted standards of medical conduct and was negligent.

For many of the reasons cited above regarding patient F, the Committee finds Respondent's dose of Fentanyl to Patient G demonstrated negligence. Respondent admitted the dose was a high one but could give no justification for it. Fentanyl is not a benign substance which can be dosed casually. A practitioner is expected to dose according to accepted parameters unless some unusual basis presents itself. Absent a clear and medically warranted reason, the dose given was excessive. By giving a clearly excessive dose, Respondent committed negligence.

The Committee did not sustain the factual allegations with regard to Patient I. Therefore the allegations cannot form the basis for a finding of medical misconduct.

Therefore, based upon allegations A.1, A.3, B.3, E.1, F.1, F.2 and G.1:
The Eleventh Specification IS SUSTAINED.

CONCLUSIONS WITH REGARD TO THE TWELFTH SPECIFICATION (INCOMPETENCE ON MORE THAN ONE OCCASION)

In the Twelfth Specification, the Committee is asked to consider whether the acts established support a conclusion of negligence on the part of Respondent. With regard to allegation A.1, the Committee does not believe the lapse was due to a gap in Respondent's knowledge. Therefore, allegation A.1 will not support a charge of incompetence. However, the Committee concludes that Respondent demonstrated a significant lack of knowledge in his failure to produce appropriate treatment notes as established under allegation A.3. The utter paucity of information indicates a lack of understanding of the necessary elements of appropriate documentation. This patient underwent a serious event. However, absent testimony by Respondent, one cannot know with certainty what Respondent did for the patient and why. Respondent's failure to provide basic information in his patient notes combined with his testimony

indicates to the Committee an unacceptable level of knowledge with regard to the purpose and importance of patient records. Hence, in the acts established under allegation A.3, the Committee finds incompetence.

In the assessment, by the Committee, of Respondent's acts under allegation B.3, the Committee again finds incompetence. While an anesthesiologist is not required to know the operation of all models of all ventilation machines, one is required to know the operation of the one in use on the particular patient or rely upon someone who does. Respondent demonstrated a failure to know and understand this basic rule. Furthermore, by his inability to recognize the signs and symptoms of excessive pressure in this patient Respondent demonstrated another unacceptable gap in his knowledge. Therefore, on these two bases, the Committee concludes Respondent demonstrated incompetence.

The Committee finds that the lapses in record keeping established under allegation C.1 do not reflect incompetence but rather poor quality in the keeping of otherwise acceptable records. Therefore, allegation C.1 will not support the Twelfth Specification. Likewise, with regard to Allegation E.1, the Committee finds Respondent knew the appropriate rate of infusion but negligently allowed a much faster rate to flow. Therefore, Allegation E.1 will not support the Twelfth Specification.

Turning to Patient F, the Committee finds both the dose administered (allegation F.1) and Respondent's failure to monitor this patient (allegation F.2) constitute incompetence. As stated earlier, Respondent neither worked up to an appropriate dose for this patient nor did he require her to remain where she could be observed until untoward side effects could be ruled out. These acts constitute a significant lapse in knowledge about the appropriate management of outpatient anesthesia. A physician demonstrating an appropriate level of knowledge would understand the importance of gradually reaching an appropriate treatment dose of a potent drug such as morphine. Moreover, such a physician would demonstrate knowledge of the importance of careful post administration observation of the patient. Respondent failed in both these regards and therefore demonstrated incompetence.

Finally with regard to Patient G, Respondent again showed serious lapses in knowledge by administering such a high dose of Fentanyl to this patient without medical justification. A physician demonstrating an appropriate level of knowledge and expertise would not have given the dose establish here absent a clear and convincing medical justification. Respondent had no such justification and hence demonstrated incompetence.

Therefore, based upon allegations A.3, B.3, F.1, F.2 and G.1:
The Twelfth Specification IS SUSTAINED.

CONCLUSIONS WITH REGARD TO THE THIRTEENTH SPECIFICATION (FAILURE TO MAINTAIN ACCURATE RECORDS)

In the Thirteenth Specification, Respondent is charged with inadequate record keeping citing allegations A.3, C.1, I.2, (allegation A.2 was also cited but not sustained). The Committee has consistently found Respondent's records to be substandard in that absent his testimony, important questions with regard to his care and treatment could not be known. The standard by which physician records are assessed is whether a future reviewer could ascertain from a patient record, the care and treatment rendered, as well as the thought process upon which the care and treatment were based. As pointed out earlier, Respondent consistently failed to meet this criteria.

Therefore, based upon allegations A.3, C.1, and I.2,
The Twelfth Specification IS SUSTAINED.

CONCLUSIONS WITH REGARD TO THE FOURTEENTH SPECIFICATION (BEING A HABITUAL ABUSER OF ALCOHOL)

Respondent admitted allegations J and K. Thus it is left to the Committee to decide if the events admitted demonstrate Respondent is a habitual abuser of alcohol. The Committee answers this question in the affirmative. Clearly, on the dates in question, November 20, 1991 and October

13, 1993 Respondent had ingested very large amount of alcohol. This is evidenced both by the BAC levels measured on both dates and the inappropriate conduct in the emergency room on October 13. The question then is whether these were two isolated events or were indicative of an ongoing and long term problem. The testimony by the State's witness to the effect that only by gradually increasing one's intake of alcohol over a considerable period of time, could one survive the BAC's reported, was entirely convincing and fundamentally unrefuted. The fact that on two occasions in 23 months Respondent had public problems with alcohol is indicative of a long term pattern of alcohol abuse. Based upon the facts admitted and upon consideration of Respondent's testimony, the Committee finds Respondent is a habitual abuser of alcohol.

Therefore:

The Thirteenth Specification IS SUSTAINED.

CONCLUSIONS WITH REGARD TO PENALTY

In the charges that were sustained, Respondent demonstrated a pattern of negligence and incompetence which cannot be tolerated in a physician practicing in this state.. Whether these instances were related to Respondent's alcohol problems or were merely based upon arrogance and a failure of attentive intensity is difficult to discern. For instance, with regard to Patient F, Respondent gave a dangerously high dose of morphine and failed to keep the patient under observation. In these acts, it cannot be discerned whether Respondent was egotistically convinced that he knew the correct dose, without the need for titration or whether he was too inattentive to the patient situation and inherent risks to seek other authoritative sources for dosage advice. In either event, his actions were unacceptable and extremely dangerous to the patient. Although Respondent is not charged with practicing while impaired, his problems with alcohol could not be expected to assist either his level of concentration or memory. The arithmetic error established through Patient A and the failure to recognize the open roller valve established in Patient E are

examples of this point.

In addition to the pattern of incompetence and negligence, the Committee discerned a threatening level of denial on the part of Respondent. Respondent refuses to admit he has a problem with alcohol. Although he did undergo short period of treatment, he stated that he is now capable of remaining sober without any assistance of any kind. He has made no effort to join any local support groups, although he has followed up with professional care. Though Respondent testified he enrolled in the Medical Society's Committee for Physician Health, there was no testimony about compliance with their program. Likewise, with regard to his professional development, after the near tragedies in the cases of Patients A, B, and F, a prudent practitioner would be expected to make some effort to analyze his practice methods and seek remediation as warranted. The Committee saw no evidence that Respondent realizes he has demonstrated serious lapses in care, much less an effort to seek solutions to his practice difficulties. The pattern of substandard practice, substance abuse and denial as described herein are an extremely dangerous combination in any professional.

While the Committee has found very serious problems with this practitioner, there is a way to balance public protection with remediation short of revocation. Therefore, it is the conclusion of this Committee that the license of Respondent be suspended until such time as he successfully completes both a program of substance abuse treatment and medical retraining in the discipline of his choice, followed by probation for a period of five years and within the probation monitoring for a period of three years.

ORDER

Wherefore it is hereby ORDERED;

That the license to practice medicine in the State of New York of **RONALD A. BAILEY** be and is hereby **SUSPENDED;** and it is further **ORDERED;**

That said suspension be in effect until such time as Respondent fulfills the following requirements;

1. Respondent shall successfully complete a program of retraining in the discipline of his choice. The said program shall be at the level of a residency program. The content and duration of the said program shall be approved by the Director of the Office of Professional Medical Conduct or his or her designee (hereinafter referred to collectively as "the Director");

2. Respondent shall successfully complete a program of substance abuse treatment. The said program shall be approved by the Director;

And it is further **ORDERED;**

That the said suspension shall not be construed as an impediment to the full participation by Respondent in the approved training program referred to above;

And it is further **ORDERED;**

That upon the successful completion of requirements one and two above, the said suspension shall be stayed in lieu of **PROBATION** for a period of **FIVE YEARS**

The Said **PROBATION** shall include **MONITORING** for a period of not less than **THREE YEARS**. The Said **MONITORING** shall include the following elements:

1. Respondent shall submit to a period of **MONITORING** as set forth in Section 230 (18) (a). The said monitoring shall include, but not be limited to:

   a. Review of randomly selected records;

   b. periodic visits to a member of the State Board or designee;

   c. a practice monitor;

d. random substance tests;

e. such other requirements as the Director may deem appropriate.

DATED:
ALBANY, NEW YORK

June 27 **1994**

SUMNER SHAPIRO, Chairperson

JAMES FOLLETTE, M.D.,
THERESE G. LYNCH, M.D.,

APPENDIX I

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

----------X

	:	FIRST
	:	AMENDED
IN THE MATTER	:	STATEMENT
OF	:	OF
RONALD A. BAILEY, SR., M.D.	:	CHARGES

----------X

RONALD A. BAILEY, SR., M.D., the Respondent, was authorized to practice medicine in New York State on January 23, 1984, by the issuance of license number 157205 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from P.O. Box 312, Oneonta, New York 13820.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the attached Appendix), a 78 year old female, at the A.O. Fox Memorial Hospital, One Norton Avenue, Oneonta, New York, 13820 (hereafter, "A.O. Fox Hospital") on or about August 30, 1991. Respondent provided post-operative pain management with epidural fentanyl to Patient A approximately 15 hours after she underwent several surgical operations, including

an exploratory laparotomy, hysterectomy, splenectomy, and sigmoid colon resection.

AMENDED 2/7/94 B

1. Respondent, at approximately 6:00 a.m. on August 30, 1991, wrote orders for Patient A to receive fentanyl SALINE SOLUTION at the rate of 450 cc/hr for ten minutes, approximately 10 times the accepted, safe dosage.

2. Respondent, after being informed at approximately 6:30 a.m. on August 30, 1991 that Patient A's respiratory rate had dropped to 3 per minute and the patient had become unresponsive, failed to order and/or record the order for discontinuance of the excessive dose of fentanyl.

3. Respondent failed to record Patient A's adverse response to the fentanyl overdose and/or how Respondent treated the overdose.

B. Respondent provided general anesthesia to Patient B, a 67 year old male, at the A.O. Fox Hospital on or about April 2, 1992. During the post-operative period, Patient B experienced severe bradycardia and hypotension.

1. Respondent failed to adequately monitor or treat Patient B's urine output of 25cc over the 5 hour operation on April 2, 1992.

2. Respondent failed to adequately monitor Patient B's intravascular pressure by use of a CVP or Swan Ganz catheter over the five hour operation on April 2, 1992.

3. Respondent, during the post-operative period on April 2, 1992, twice put the patient on continuous positive airway pressure set at excessive levels, up to 46 cm/ H^2O, during which times the patient became apneic, bradycardic, and unresponsive.

C. Respondent provided general anesthesia to Patient C, an 84 year old female, at the House of the Good Samaritan Hospital, 830 Washington Street, Watertown, New York 13601 (hereafter, "Good Samaritan Hospital") on or about March 3, 1990. ~~During the post-operative period, Patient C had to be re-intubated.~~

DELETED 2/18/94 B

1. Respondent failed to monitor and/or record significant aspects of the anesthesia procedure, including the type and amount of fluids given, patient's temperature, oxygen saturation, and end tidal carbon dioxide level.

2. Respondent inappropriately left Patient C on a Briggs adaptor for approximately 3 hours, which was excessive.

3. Respondent failed to place and/or order Patient C to be placed on a ventilator prior to 2:10 p.m. on March 3, 1990, despite Patient C's prior aspiration and wheezing.

4. Respondent failed to adequately monitor Patient C prior to her extubation on March 4, 1990.

D. Respondent provided general anesthesia to Patient D, an 80 year old male, at the Good Samaritan Hospital, on or about October 2, 1989. Following Patient D's extubation in the Post-Anesthesia Care Unit, Patient D experienced respiratory distress, and had to be reintubated.

1. Respondent improperly authorized the nursing staff to post-operatively extubate Patient D, despite Patient D's continued obtunded state.

E. Respondent provided general anesthesia to Patient E, a 64 year old male, at the Good Samaritan Hospital on or about March 19, 1990. Following Patient E's extubation in the Post-Anesthesia Care Unit, Patient E experienced respiratory distress, and had to be reintubated.

1. Respondent administered or ordered the administration of 3000cc of Lactated Ringers Solution to Patient E during the period of anesthesia, which amount was excessive.
2. Respondent failed to treat Patient E's hypertension in the operating room appropriately.
3. Respondent prematurely extubated Patient E without adequate indication.
4. Respondent improperly delegated the responsibility for deciding whether Patient E should be extubated.

F. Respondent performed an intrathecal morphine block on Patient F, a 50 year old female, at the A.O. Fox Hospital on or about August 27, 1991. Respondent used 1.5 milligrams of duramorph for the intrathecal block, which was performed on an outpatient basis. Respondent discharged Patient F within one hour of his administration of the block. Thirty minutes after discharge, Patient F experienced dizziness, vomiting, and atrial fibrillation. She was admitted to the hospital.

1. Respondent used an excessive dose of duramorph on Patient F to accomplish an intrathecal block.
2. Respondent failed to adequately monitor Patient F's recovery from the intrathecal morphine.

G. Respondent provided spinal anesthesia to Patient G, a 69 year old male, at A.O. Fox Hospital, on or about January 22, 1991. Respondent gave Patient G 150 micrograms of fentanyl intrathecally.

1. Respondent provided an excessive dose of fentanyl to Patient G as a spinal anesthetic supplement.

2. ~~Respondent failed to treat Patient G with atropine in timely fashion after Patient G was bradycardic for an extended period.~~

WITHDRAWN 12/15/93 B

H. Respondent provided general anesthesia to Patient H, a four year old male, at the Good Samaritan Hospital on or about September 6, 1989.

WITHDRAWN 12/15/93 B

1. Respondent provided .625 milligrams of inapsine to Patient H for nausea following the operative procedure, which dose was excessive in combination with other concurrent medications, including 25 micrograms of Fentanyl.

2. Respondent failed to reintubate Patient H after 11:04 a.m., despite Patient H's continuing postoperative tachycardia and respiratory distress.

I. Respondent provided epidural anesthesia to Patient I, a 30 year old female, at the A.O. Fox Hospital on or about September 26, 1991. Patient I was nine months pregnant, and was admitted for a full term delivery.

1. Respondent initiated epidural anesthesia on Patient I without adequate provision for his availability and monitoring of the patient's condition and progress.

LINED MATERIAL WITHDRAWN 2/7/94 JB

2. Respondent failed to record significant aspects of the anesthesia procedure, including test dose given, amount of anesthetic agent given, fluid choice, ~~level of anesthesia~~, removal of epidural catheter, and the patient's post-anesthesia status.

J. Respondent, on or about 1:30 p.m. on November 20, 1991, was arrested by Oneonta City Police on a charge, among others, of driving while intoxicated. By two blood alcohol tests administered between approximately 1:30 p.m. and approximately 2:35 p.m., Respondent's blood alcohol level was determined to be between 0.18% and 0.22%. Respondent denied having ingested any alcohol that day.

K. Respondent, on or about 6:00 p.m. on October 13, 1993, was taken to the A.O. Fox Emergency Room by the Oneonta City Police due to, among other reasons, Respondent's intoxication from the ingestion of alcohol and suicidal ideation. Respondent was alert, but non-cooperative, able to converse, and needed to be restrained on numerous occasions during the first 12 hours he remained at the emergency room. Respondent also admitted that alcohol "is a problem" for him.

1. At approximately 8:00 p.m. on October 13, 1993, Respondent's blood alcohol content was determined to be .383 mg/dl.

2. At approximately 9:00 a.m. on October 14, 1993, Respondent's blood alcohol level was determined to be .128 mg/dl.

SPECIFICATIONS OF MISCONDUCT

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law §6530(4) (McKinney Supp. 1993) in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A and A.2.
2. The facts in Paragraphs B and B.3.
3. The facts in Paragraphs C and C.2 and/or C and C.3.
4. The facts in Paragraphs D and D.1.
5. The facts in Paragraphs E and E.3.

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence on a particular occasion under N.Y. Educ. Law §6530(6) (McKinney Supp. 1993) in that Petitioner charges:

6. The facts in Paragraphs A and A.1 and/or A and A.2.
7. The facts in Paragraphs B and B.3.
8. The facts in Paragraphs C and C.2 and/or C and C.3.
9. The facts in Paragraphs D and D.1.
10. The facts in Paragraphs E and E.3.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1993) in that Petitioner charges that Respondent committed two or more of the following:

11. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, G and G.1, G and G.2, H and H.1, H and H.2, I and I.1 and/or I and I.2.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1993) in that Petitioner charges that Respondent committed two or more of the following:

12. The facts in Paragraphs A and A.1, A and A.2, A and A.3, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, G and G.1, G and G.2, H and H.1, H and H.2, I and I.1 and/or I and I.2.

THIRTEENTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record that accurately reflects the evaluation and treatment of Patients A, C, and I, within the meaning of N.Y. Educ. Law §6530(32) (McKinney Supp. 1993), in that Petitioner charges:

13. The facts in Paragraphs A and A.2, A and A.3, C and C.1, and/or I and I.2.

FOURTEENTH SPECIFICATION

BEING A HABITUAL ABUSER OF ALCOHOL

Respondent is charged with being a habitual abuser of alcohol, within the meaning of N.Y. Educ. Law §6530(8) (McKinney Supp. 1993), in that Petitioner charges:

14. The facts in Paragraphs J, and/or K and K.1 and/or K. and K.2.

DATED: Albany, New York
December 1, 1993

Peter D. Van Buren

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