Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

C. Maynard Guest, M.D.
Executive Secretary

February 9, 1993

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Arthur Loman, M.D.
Indian Health Service
Sisseton, South Dakota 57262

RE: License No. 077035
Effective Date: 2/12/93

Dear Dr. Loman:

Enclosed please find Order #BPMC 93-17 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0614

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

[redacted]

[redacted]

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

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IN THE MATTER :

OF : ORDER

ARTHUR J. LOMAN, JR., M.D. : #93-17

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Upon the Application of Arthur J. Loman, Jr., M.D. (Respondent) to Surrender his or her license as a physician in the State of New York, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of Respondent be stricken from the roster of physicians in the State of New York; it is further

ORDERED, that Respondent shall not apply for the restoration of Respondent's license until at least one year has elapsed from the effective date of this order; and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order via certified mail, whichever is earliest.

SO ORDERED,

DATED: 3 February 1993

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

IN THE MATTER OF ARTHUR J. LOMAN, JR., M.D.	APPLICATION TO SURRENDER LICENSE

STATE OF SOUTH DAKOTA)
ss.:
COUNTY OF ROBERTS)

ARTHUR J. LOMAN, JR., M.D., being duly sworn, deposes and says:

On or about September 12, 1955, I was licensed to practice as a physician in the State of New York having been issued License No. 077035 by the New York State Education Department.

I am not currently registered to practice as a physician in the State of New York.

I understand that I have been charged with twenty specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A".

I am applying to the State Board for Professional Medical Conduct for permission to surrender my license as a physician in the State of New York on the grounds that I admit guilt to the specifications of professional misconduct set forth in the charges.

I hereby make this application to the State Board for Professional Medical Conduct and request that it be granted.

I understand that, in the event that the application is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such application shall not be used against me in any way, and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that in the event the State Board for Professional Medical Conduct grants my application, an order shall be issued

striking my name from the roster of physicians in the State of New York without further notice to me.

I am making this Application of my own free will and accord and not under duress, compulsion, or restraint of any kind or manner.

Arthur J. Loman Jr. M.D.

ARTHUR J. LOMAN, JR., M.D.
Respondent

Sworn to before me this
14th day of January 1993

NOTARY PUBLIC

My Commission Expires
5/10/94

ARTHUR J. LOMAN, JR., M.D.

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

IN THE MATTER	APPLICATION TO
OF	SURRENDER
ARTHUR J. LOMAN, JR., M.D.	LICENSE

The undersigned agree to the attached application of the Respondent to surrender his license.

Date: 1/19, 1993

ARTHUR J. LOMAN, JR., M.D.
Respondent

Date: January 27, 1993

FREDERICK ZIMMER
Assistant Counsel
Bureau of Professional
Medical Conduct

Date: Feb. 5, 199

KATHLEEN M. TANNER
Director, Office of Professional
Medical Conduct

Date: 3 February 199

CHARLES J. VACANTI, M.D.
Chairperson, State Board for
Professional Medical Conduct

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
ARTHUR J. LOMAN, JR., M.D.	:	CHARGES

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ARTHUR J. LOMAN, JR., M.D., the Respondent, was authorized to practice medicine in New York State on September 12, 1955 by the issuance of license number 077035 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, 1991 through December 31, 1992 with a current registration address of 800 Carter Street, Rochester, New York 14621.

FACTUAL ALLEGATIONS

A. Respondent, at various residences and other locations, during various and extensive periods of time, beginning in or about April of 1978 through at least August of 1990, was the primary care physician for a family member Patient A (all patients are identified in the attached Appendix). During this period, Patient A was diagnosed with various medical problems including but not limited to pulmonary aspiration, pulmonary fibrosis, Lyme Disease, mixed connective tissue disease,

cervical disc disease, diabetes, depression, recurrent neutropenia, recurrent hypokalemia, recurrent venous access problems due to multiple placement of central venous catheters and various complications including clotting of the catheters and infection. Respondent's care was deficient in the following respects:

1. Respondent failed throughout this period to maintain adequate records of Patient A's outpatient care including reports of follow-up care, interval histories, reports of physical examinations and diagnostic assessments.

2. Respondent, on numerous occasions, during a period beginning in or prior to March of 1985 and continuing through in or about August of 1990, inappropriately treated Patient A's chronic non-malignant pain syndrome with intravenous narcotic analgesics including Nubaine, Morphine, and substantial amounts of Stadol, and with controlled substances such as Dilaudid, Talwin, Diazepam, Valium, Ativan, Lorazepam, Phenobarbital, Percocet, Chloral Hydate, Tylenol with Codeine § 3 and Noludar.

3. Respondent during a period of October 17, 1989 through October 24, 1989, treated Patient A's hypokalemia with Potassium supplements. Patient A's potassium levels during this period fluctuated between 1.2 and 2.1 millimoles per liter. Nevertheless, Respondent failed to have an EKG performed on Patient A nor did he have her admitted to a hospital.

B. Respondent, on January 24, 1990, was the emergency room physician for Patient B at Erie County Medical Center, 462 Grider Street, Buffalo, New York (hereinafter "Erie County Medical Center"). Patient B presented with increasing shortness of breath over two to three days, and a dry cough. She had been put on steroids three days prior to admission and had a history of multiple medical problems including diabetes and heart

disease. Patient B was an asthmatic on Theophylline and Proventil inhalers. Patient B was discharged with an increase in her Theophylline dose.

1. Respondent failed to take and/or document complete vital signs on Patient B.

2. Respondent failed to utilize a peak flow-meter to measure Patient B's effective ventilation.

3. Respondent failed to obtain and/or document Patient B's Theophylline blood level prior to increasing Patient B's Theophylline dose.

4. Respondent failed to adequately document any history or a treatment plan addressing Patient B's use of steroids for three days prior to her arriving at the emergency room.

C. Respondent, on January 26, 1990, was the emergency room physician for Patient C at Erie County Medical Center. Patient C presented as "upset and delusional" with leg pain and genital pain, a blood pressure of 138/92, a heart rate of 120 and a respiratory rate of 30.

1. Respondent failed to perform an adequate physical examination and/or document the results.

2. Respondent failed to perform necessary laboratory diagnostic tests including a complete urine and serum drug screen for toxic substances.

3. Respondent failed to perform an EKG upon Patient C.

D. Respondent, on January 19, 1990, was the emergency room physician for Patient D at Erie County Medical Center. Patient D presented with a several day history of coughing to the point of nausea, vomiting, chest and back pain and fever. This patient had an injected ear drum, an elevated pulse rate

of 120 and an elevated respiratory rate of 26, a reddened throat with no exudate, a tender trachea and was found to have a small area of pneumonia on her right lung. Patient D was discharged on an antibiotic.

1. Respondent did not determine and/or document whether Patient C had epiglottitis and/or stridor.

2. Respondent failed to obtain any blood work other than a CBC.

3. Respondent failed to document what antibiotic Patient D was discharged on.

E. Respondent, on January 26, 1990, was the emergency room physician, for Patient E, an insulin dependent diabetic, at Erie County Medical Center. Patient E presented to the emergency room following the onset of nausea and emesis with left sided chest pain, a recorded blood glucose of over 400, abdominal tenderness and difficulty retaining solid food. Respondent diagnosed Patient E as having gastritis and discharged him with no change in therapy.

1. Respondent failed to have appropriate lab work performed to check for diabetic ketoacidosis or other related conditions.

F. Respondent, on January 4, 1989, was the emergency room physician for Patient F at Erie County Medical Center. Patient F presented with increasing lower leg swelling, swelling of the abdomen, shortness of breath, a palpable liver, evidence of right sided heart failure with jugular venous distension and edema of the extremities to knee level. Distal pulses were

documented as absent. This patient who was on multiple medications, had a history of hypertension, insulin dependent diabetes melitis and congestive heart failure. A chest x-ray revealed an enlarged heart and a prominent interstitial vascular pattern. Patient F was treated with intravenous Lasix and discharged with a modification of her medication.

1. Respondent failed to perform an electrocardiogram upon Patient F.

2. Respondent failed to perform a rectal exam or abdominal x-ray to thoroughly determine the cause of Patient F's abdominal swelling.

3. Respondent failed to obtain a digitalis level to determine if Patient F's digitalis level had become toxic.

G. Respondent, on March 13, 1989, was the emergency room physician for Patient G, at Erie County Medical Center. Patient G, a 73 year old man, had experienced dizziness while urinating which resulted in a fall. Respondent diagnosed orthostatic hypotension and planned to discharge Patient G. While the patient was preparing to leave, he had another episode of near syncope and was discovered by another physician to have black stool which was heme positive. Patient G was subsequently admitted and treated for a bleeding duodenal ulcer.

1. Respondent did not perform and/or document a complete physical examination including a rectal examination.

2. Respondent did not obtain appropriate laboratory tests.

3. Respondent did not obtain and/or document blood pressure and heart rate while the patient was in both a supine and upright position.

4. Respondent failed to admit Patient G as an inpatient.

H. Respondent, on January 21, 1989, was the emergency room physician for Patient H, at Erie County Medical Center. Patient H presented with an irregular pulse, an elevated respiratory rate, a complaint of chest pain non responsive to nitroglycerine and a history of congestive heart failure and lupus. Patient H had a pacemaker. Patient H was discharged the same day with a diagnosis of emphysema and "doubt cardiac pain". On January 27, 1989, she re-presented with chest pain and was admitted by a second physician with a diagnosis of exacerbation of congestive heart failure with unstable angina. Patient H was hospitalized for a week.

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent rendered and/or documented no treatment for Patient H.
4. Respondent failed to follow up on a chest x-ray which he had ordered.
5. Respondent failed to admit Patient H as an inpatient and/or obtain an appropriate consultation.
6. Respondent failed to provide and/or document discharge instructions.

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Sec. 6530(4) (McKinney Supp. 1992) in that the Petitioner charges:

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

2. The facts in Paragraphs B and B.1, B and B.2, B and B.3 and/or B and B.4.

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

4. The facts in Paragraphs D and D.1, D and D.2 and/or D and D.3.

5. The facts in Paragraph E and E.1.

6. The facts in Paragraphs G and G.1, G and G.2, G and G.3 and/or G and G.4.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Sec. 6530(6) (McKinney's Supp. 1992) in that the Petitioner charges:

7. The facts in Paragraphs A and A.1, A and A.2 and/or A and A.3.

8. The facts in Paragraphs B and B.1, B and B.2, B and B.3 and/or B and B.4.

9. The facts in Paragraphs C and C.1, C and C.2 and/or C and C.3.

10. The facts in Paragraphs D and D.1, D and D.2 and/or D and D.3.

11. The facts in Paragraphs E and E.1.

12. The facts in Paragraphs G and G.1, G and G.2, G and G.3 and/or G and G.4.

THIRTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1992). The Petitioner charges that Respondent committed at least two of the following:

13. 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, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5 and/or H and H.6.

FOURTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992). The Petitioner charges that Respondent committed at least two of the following:

14. 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, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5 and/or H and H.6.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1992) in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient.

Specifically, the Petitioner charges:

15. The facts in Paragraphs A and A.1.

16. The facts in Paragraphs B and B.1, B and B.3 and/or B and B.4.

17. The facts in Paragraphs C and C.1.

18. The facts in Paragraphs D and D.1 and/or D and D.3.

19. The facts in Paragraphs G and G.1 and/or G and G.3.

20. The facts in Paragraphs H and H.1, H and H.2, H and H.3 and/or H and H.6.

DATED: Albany, New York
November 30, 1992

Peter D. Van Buren

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