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.H.P.
*Commissioner*

Paula Wilson
*Executive Deputy Commissioner*

2)

October 6, 1994

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

Paul Stein, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Effective date: 10/13/94

Kenneth Harfenist, Esq.
55 Old Turnpike Road
Suite 105
Nanuet, New York 10954

**RE: In the Matter of Pickward James Bash, M.D.**

Dear Mr. Stein and Mr. Harfenist :

Enclosed please find the Determination and Order (No. 94-212) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

As prescribed by the New York State Public health Law §230, subdivision 10,

paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

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|---|---|
| IN THE MATTER<br>OF<br>PICKWARD JAMES BASH, JR., M.D. | DETERMINATION<br>AND<br>ORDER<br><br>No. BPMC-94-212 |

The Hearing Committee, composed of Fr. Daniel Morrissey, O.P., Chairperson, Joseph B. Cleary, M.D., and Kenneth J. Freese, M.D., was duly designated and appointed by the Commissioner of Health of the State of New York pursuant to New York Public Health Law § 230, subd. 10(e). Eugene A. Gaer, Esq., Administrative Law Judge, served as Hearing Officer for the Committee.

The Committee, each member of which has considered the entire record in this matter, hereby renders its decision with regard to the charges of medical misconduct filed against Pickward James Bash, Jr., M.D. (the "Respondent"). All findings, conclusions and dispositions herein are unanimous.

## STATEMENT OF CHARGES

Respondent has been charged by Petitioner Department of Health (the "Petitioner") with five types of professional misconduct, under the definitions contained in New York Education Law § 6530, as detailed below.

The charges are that he practiced the profession with gross

negligence (§ 6530, subd. 4)(first through fourth specifications), that he practiced the profession with gross incompetence (§ 6530, subd. 6)(sixth through ninth specifications), that he practiced the profession with negligence on more than one occasion (§ 6530, subd. 3)(eleventh specification), that he practiced the profession with incompetence on more than one occasion (§ 6530, subd. 5)(twelfth specification) and that he failed to maintain a record which accurately reflects the evaluation and treatment of a patient (§ 6530, subd. 32)(thirteenth through sixteenth specifications).[1]

These allegations relate to Respondent's treatment of four patients in April 1985, June 1987, and February and March 1988. The charges are more particularly set forth in the Statement of Charges, a copy of which is attached hereto as Appendix 1.

## RECORD OF PROCEEDINGS

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| Notice of Hearing and Statement of Charges dated: | February 24, 1994 |
| Pre-hearing Conferences: | March 21, 1994<br>March 23, 1994 |
| Hearing dates: | April 5, 1994<br>April 12, 1994<br>May 4, 1994<br>May 12, 1994<br>May 25, 1994 |
| Closing briefs submitted on: | June 22, 1994 |

[1]The fifth, tenth and seventeenth specifications were withdrawn by Petitioner. Tr. 292-93. See, also, Petitioner's Proposed Findings of Fact and Conclusions ("Pet. Prop. Fin."), p. 11.

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|---|---|
| Deliberation date: | June 24, 1994 |
| Place of Hearing: | New York State<br>Department of Health<br>5 Penn Plaza<br>New York, New York 10001 |
| Petitioner represented by: | Paul Stein, Esq.<br>Associate Counsel<br>Bureau of Professional<br>Medical Conduct<br>5 Penn Plaza<br>New York, New York 10001 |
| Respondent represented by: | Kenneth Harfenist, Esq.<br>55 Old Turnpike Road<br>Suite 105<br>Nanuet, New York 10954 |

## WITNESSES

Petitioner called one witness:

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| Albert M. Betcher, M.D. | Expert Witness |

Respondent testified in his own behalf and also called these witnesses:

| | |
|---|---|
| Isaac Azar, M.D. | Expert Witness |
| V.S. | Fact Witness |
| I. Cary Andrews, M.D. | Expert Witness |

## FINDINGS OF FACT

The following findings of fact were made after review of the entire record by the Committee. Citations indicate evidence found persuasive by the Committee in arriving at the findings. "Tr." citations are to the transcript of the hearing. "P. Ex."

and "R.Ex." citations are to the exhibits introduced by Petitioner and Respondent. Evidence which conflicted with any finding of the Committee was considered and rejected.

General Findings

1. Respondent was authorized to practice medicine in the State of New York on June 23, 1959, by the issuance of License No. 82072 by the Department of Education. P.Ex. 2, p. 3. He is currently licensed to practice medicine in the State. Id., p. 2.

2. Respondent completed residency training in anesthesiology in 1960. Since then he has practiced anesthesiology at Peekskill Community Hospital, now known as Hudson Valley Hospital Center, 1980 Crompond Road, Peekskill, New York (the "Hospital"). Tr. 296-97; R.Ex. D. He is not board-certified in anesthesiology. Tr. 296, 379.

3. Patients A, B, C and D were treated by Respondent in the course of Respondent's service as a member of the Department of Anesthesiology at the Hospital. See P.Ex. 3, pp. 67-69, 74; P.Ex. 4, pp. 30, 34-37; P.Ex. 5, pp. 25-29; P.Ex. 6, pp. 49-53.

Findings as to Patient A

4. Patient A, an 82 year old woman, was admitted to the Hospital on February 8, 1988, with an admitting diagnosis of iron

deficiency anemia and cancer of the esophagus. P.Ex. 3, p. 5. A subsequent biopsy disclosed cancer of the stomach and surgery was recommended to relieve symptoms of obstruction. P.Ex. 3, pp. 11, 17.

5. Surgery was scheduled for February 22, 1988. During the weeks between her admission and her scheduled surgery, Patient A's appetite deteriorated. She was placed on total parenteral nutrition ("TPN") to help build her strength prior to surgery. Although she had difficulty swallowing, she was not completely unable to swallow. P.Ex. 3, pp. 7, 13, 78, 83-84, 88, 90, 92, 99, 103; Tr. 69-72, 302-06, 331-35, 381-82, 504, 510.

6. Respondent was the anesthesiologist at Patient A's February 22 surgery. The surgeon at that procedure, Jose G. Garcia, M.D., told Respondent that he had previously attempted to insert a nasogastric tube into Patient A, but the patient refused it. However, Dr. Garcia did not request Respondent to insert a nasogastric tube at the time of surgery and Respondent did not do so. Tr. 301, 339; cf. P.Ex. 3, pp. 2, 72-74.

7. While Respondent was beginning to administer anesthetic to Patient A the patient regurgitated 60 cc's of gastric contents. P.Ex. 3, pp. 72, 74; Tr. 310, 340, 354, 518.

8. Respondent did not attempt an awake intubation.

Respondent began a rapid sequence induction with a Sellick maneuver when the patient regurgitated again and aspirated. Respondent then finished administering Pentothal, administered Tracrium, sucked the fluid from the patient's pharynx and mouth, intubated her as rapidly as possible, suctioned out the endotracheal tube and placed the patient on the ventilator and the anesthesia machine. Tr. 307-12, 358-66; see, also, Tr. 46-7.

9. Respondent did not record that he began a rapid sequence induction. See P.Ex. 3, pp. 68-69; Tr. 520, 538-40, 557.

10. Respondent did not order arterial blood gas tests during the surgery on Patient A, but did use a pulse oximeter and an end tidal carbon dioxide analyzer. P.Ex. 3, p. 68; Tr. 314-15, 493. The pulse oximeter readings showed 100% oxygen saturation at all times, and the end tidal carbon dioxide analyzer recorded values of 36, 36 and 37. P.Ex. 3, p.68; Tr. 78-79, 314-15.

11. Respondent did not raise the positive end-expiratory pressure ("PEEP") on Patient A's ventilator during surgery.[2] Tr. 48-49, 315-17.

12. At the end of surgery Patient A was able to breathe

[2]"PEEP is a mechanism [for maintaining] positive pressure in the airway at all times during the breathing cycle." Tr. 495. It works on the principle of forcing "fluids out of the lung field, to prevent the possibility of pulmonary edema." Tr. 81.

spontaneously. Respondent extubated her in the operating room. P.Ex. 3, p. 76; Tr. 88-89, 319-20.

13. Respondent put Patient A on an oxygen mask in the recovery room and allowed her to breathe on her own. Tr. 322; see, also, P.Ex. 3, pp. 76, 105.

14. Respondent did not sedate Patient A in the recovery room. There were no indications for sedating Patient A. Tr. 324; cf. Tr. 99-100, 502-03.

15. Patient A was not intubated while in the recovery room and was not ventilated with PEEP. See P.Ex. 3, pp. 76, 105; Tr. 50-51, 324.

16. Patient A expired at 2:20 p.m. on February 23, 1988. P.Ex. 3, p. 111. Her death certificate, which was signed by Dr. Garcia, listed the causes of death as "Advanced metastatic carcinoma stomach" and "Bronchopneumonia." P.Ex. 3, p. 2.

Findings As To Patient B

17. Patient B was a 55 year old man who was admitted to the Hospital on April 21, 1985, for resection of rectosigmoid cancer. P.Ex. 4, p. 2. The patient had a prior history of hypertensive heart disease. Id., p. 5.

18. Respondent was the anesthesiologist at Patient B's surgery, which was performed on the morning of April 24. Surgery was completed by 10:15 a.m. and Patient B was transferred to the recovery room at 10:20 a.m. in apparently satisfactory condition. P.Ex. 4, pp. 38, 42, 44; Tr. 127-28, 433-34.

19. Beginning at 11:15 a.m., Respondent was administering anesthesia to another patient, Patient RS, who was undergoing surgery in Operating Room 1 at the Hospital. At 11:40 a.m. Patient B developed a "Sudden onset of respiratory distress" while in the recovery room. P.Ex. 4, p. 44. Respondent was notified of this while he was attending at Patient RS's surgery. Tr. 434, 437-39, 447-50; P.Ex. 4, p. 44; R.Exs. A-2, A-5, B.

20. Respondent indicated that he could not leave the surgery on Patient RS and that other physicians should be called to treat Patient B in the recovery room. Tr. 438-39.

21. Patient B was attended in the recovery room by a cardiologist and an anesthesiologist. At 12:00 noon these physicians began to administer CPR to Patient B, but he expired from a cardiac arrest at 12:35 p.m. See P.Ex. 4, p. 44; Tr. 445-46, 452.

22. Respondent remained in Operating Room 1 attending to Patient RS until surgery was completed at 1:15 p.m. R.Exs. A-1

A-5, A-6, B.

23. Respondent did not enter Patient B's estimated blood loss in the Anesthesia Record. See P.Ex. 4, p. 35.

24. Following Patient B's death Respondent made an entry in Patient B's Progress Record describing the events in the recovery room. The note failed to state the names of the cardiologist and anesthesiologist who were in attendance, failed to identify who pronounced Patient B dead and failed to state that Respondent was not present. See P.Ex. 4, p. 49; Tr. 439-40, 451-53. Respondent also countersigned the Recovery Room Record, which contained the same defects. P.Ex. 4, p. 44.

25. Respondent subsequently completed a "Post-Anesthesia Evaluation" for Patient B, dated "4/25/85", checking the box for "No Known Anesthetic Complications" and commenting "BP, pulse stable; Pt states he has no problems w/ anesthesia." P.Ex. 4, p. 36; cf. Tr. 456, 469-70.

Findings As To Patient C

26. Patient C was a 77 year old man who was admitted to the Hospital on March 20, 1988, for a right hemicolectomy for a probable colon tumor. The patient had a history of atherosclerotic heart disease, with an old myocardial infarction,

and diabetes. P.Ex. 5, pp. 2, 4, 7; Tr. 176-77.

27. Respondent was the anesthesiologist at Patient C's surgery, which was performed on March 21. Respondent, who could not visualize Patient C's vocal cords, made two attempts to intubate the patient. On the first attempt the endotracheal tube slipped into the esophagus off the cricoids, which Respondent was able to visualize. Recognizing that the tube was inserted in the esophagus, he removed it and re-inserted it in the trachea by changing the angle of the tip. P.Ex. 5, p. 27; Tr. 180, 201, 386.

28. Respondent extubated Patient C while the patient was still in the operating room. Tr. 181, 388. The patient appeared to be in satisfactory condition when he left the operating room. P.Ex. 5, p. 30.

29. Patient C arrived in the recovery room at 9:50 a.m. and was breathing spontaneously at the time. P.Ex. 5, p. 36.

30. At 9:55 Patient C ceased respiration and became apneic. Respondent, who was present at the patient's bedside, immediately administered oxygen by Ambu bag, called for the resuscitation team, reintubated the patient and attached him to a ventilator. P.Ex. 5, pp. 25, 36, 41; Tr. 390, 395-96.

31. Patient C expired from a cardiac arrest at 10:20 a.m. P.Ex. 5, pp. 36, 41-42.

32. Respondent's notes respecting Patient C did not record the patient's blood loss and urinary output or the use of a nerve stimulator. See P.Ex. 5, pp. 27-28, 36; Tr. 198-200, 401-03, 412-16, 571-72, 576.

Findings As To Patient D

33. Patient D was a 74 year old man who entered the Hospital as an outpatient on June 2, 1987, for cataract surgery on the left eye. P.Ex. 6, pp. 2-3, 6.

34. Respondent was the anesthesiologist at Patient D's surgery. Among other drugs, he used Innovar as an induction agent at the surgery. Innovar is a combination of Droperidol and Fentanyl. P.Ex. 6, p. 50; Tr. 251, 261.

35. During the course of surgery, Patient D developed hypotension, his blood pressure dropping to 80/50. Tr. 421-22. When this occurred, Respondent discontinued the anesthetics, administered 100% oxygen and flushed the Patient's system. Tr. 422-23. Respondent monitored the patient's blood pressure and when it returned to normal Respondent recommenced the anesthetics and the surgery was completed. Id.; cf. P.Ex. 6,

pp. 6, 53-54.

36. Respondent did not enter in the anesthesia record that he had totally turned off the anesthetic agent during the procedure, that he had increased Patient D's oxygen or that he had flushed the system during the procedure. See P.Ex. 6, p. 50; Tr. 259-60, 425, 427-28.

37. Patient D developed chest pain and EKG changes in the recovery room, but his EKG changes soon returned to pre-operative status. P. Ex. 6, pp. 6, 11, 58; Tr. 426, 581. Patient D remained in the Hospital, where his cardiac condition was monitored, until June 6, 1987, when he was discharged. P.Ex. 6, pp. 3, 6-7.

38. Respondent subsequently completed a "Post-Anesthesia Evaluation" for Patient D, dated "7/13/87." He checked the box for "No Known Anesthetic Complications" and wrote "No problems w/ anesthesia." P.Ex. 6, p. 51.

## CONCLUSIONS AS TO FACTUAL ALLEGATIONS

Patient A

There is, in the main, little dispute over the facts

concerning this elderly woman who expired within a day after surgery disclosed that she was suffering from unresectable stomach cancer. Rather, the primary disputes are over the appropriateness of steps taken or not taken by Respondent during and after the administration of anesthesia.

The first allegation (¶ A.1), on which the expert witnesses were sharply divided, concerns the fact that Respondent did not insert a nasogastric tube into Patient A prior to surgery. Petitioner's expert testified that insertion of a tube would have forestalled regurgitation and aspiration upon the administration of anesthetic to a patient who showed strong indications of abdominal obstruction. Tr. 45, 67-68.

Respondent's expert, in contrast, testified that the placement of a nasogastric tube was not required because the patient was continuing to take some food and medication orally; an abdominal obstruction was therefore not a certainty. In this expert's view, a nasogastric tube would have severely disturbed an elderly patient and may actually have increased the danger of vomiting and aspiration. He was also of the opinion that it was primarily the surgeon's responsibility to determine that a nasogastric tube should be placed; if the surgeon did not do so in the weeks before surgery, the anesthesiologist should not be faulted. Tr. 487-88, 517-18, 541-42; cf. Tr. 68.

Balancing the testimony of the two experts in the light of the facts here presented, the Committee finds that Petitioner has not established that a nasogastric tube was required.

A second allegation (¶ A.2) is that Respondent failed to perform a crash intubation or an awake intubation when Patient A aspirated. Neither branch of this allegation can be accepted. An awake intubation would likely have been overly stressful for an elderly patient with a cardiac history, and Respondent cannot be criticized for opting against it. Tr. 307-10; cf. Tr. 490-91, 543.

As to the remainder of Paragraph A.2, the Committee accepts Respondent's description of the relevant events. When the patient regurgitated upon coming into the operating room, Respondent commenced a rapid sequence induction with a Sellick maneuver, but the patient regurgitated a second time and aspirated. The procedure Respondent then followed was appropriate. See Finding of Fact 8, supra; Tr. 490-91.

Respondent did not, however, document this procedure adequately (as alleged in ¶ A.9). His choice of a rapid sequence induction was nowhere recorded in Patient A's anesthesia record. See Finding of Fact 9, supra. This was an important aspect of the patient's operative course, and the failure to note it accurately cannot be dismissed as inconsequential. See Tr. 524.

It is alleged also that Respondent "failed" to order arterial blood gas tests (¶ A.3) and "failed" to raise the PEEP on Patient A's ventilator (¶ A.4; see also ¶ A.8).[3] The Committee does not find these bases for charges against Respondent. There was consensus between the expert witnesses that the use of a pulse oximeter and an end tidal carbon dioxide analyzer (both of which showed normal readings) provided adequate data about Patient A's blood gas levels. Tr. 78-80, 493-95.

The experts did disagree whether Respondent should have raised the PEEP on Patient A's ventilator during surgery and whether she should have been ventilated with PEEP in the recovery room. Petitioner's expert was of the opinion that it should have been raised, despite the 100% oxygen saturation readings, as a precautionary measure following the patient's aspiration. Tr. 49, 81-83. However, the Committee finds the contrary positions of Respondent and his expert more convincing -- that when there was no sign of an oxygenation problem there was no reason to utilize PEEP. Tr. 317, 495-97; see also Tr. 537-38.[4]

Further allegations relate to Respondent's conduct following

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[3]Apparently Petitioner is no longer pressing the allegation about failure to check arterial blood gasses (¶ A.3) as a basis for charging Respondent with negligence or incompetence. See Pet. Prop. Fin., pp. 11-12.

[4]Respondent's expert also testified that PEEP carries risks in elderly patients, such as barotrauma, lung injury, interference with venous return to the heart, and a fall in cardiac output and blood pressure. Tr. 496.

conclusion of the surgical procedure: "Respondent inappropriately extubated Patient A in the operating room, despite the fact it had been a difficult intubation" (¶ A.5); "Respondent inappropriately put Patient A on oxygen by mask in the recovery room and allowed her to breathe on her own" (¶ A.6); "Respondent failed to keep Patient A sedated in the recovery room" (¶ A.7); and "Respondent failed to keep Patient A intubated and ventilated with [PEEP] in the recovery room" (¶ A.8). The Committee rejects each of these as a basis for charges against Respondent.

Respondent testified, and the records confirm, that at the close of surgery Patient A's breath sounds were clear and she was capable of breathing spontaneously. Tr. 322-23; P.Ex. 3, p. 76. Thus, despite Respondent's record entry that the intubation was "difficult" (P.Ex. 3, p. 68), it was appropriate for him to have extubated her in the operating room and permitted her to breathe with an oxygen mask thereafter. Tr. 500-02.

As there was no evidence that Patient A was in pain following surgery, sedation was not indicated. Tr. 324, 502-03. The only reason for alleging that she should have been kept sedated is that it would have been necessary if she had remained intubated in the recovery room. Petitioner's expert conceded that no independent clinical basis existed for sedating the patient at that time. Tr. 51, 99-100.

Summarizing the foregoing, **Paragraph A.9** is **SUSTAINED**. **Paragraphs A, A.1, A.3, A.4, A.5, A.6, A.7** and **A.8** are **SUSTAINED** insofar as they describe the facts concerning Respondent's actions when attending Patient A, but **NOT SUSTAINED** insofar as they allege that those actions were improper or inappropriate. **Paragraph A.2** is **SUSTAINED** only insofar as it states that Respondent did not perform an awake intubation on Patient A, but **NOT SUSTAINED** insofar as it alleges that Respondent did not perform a crash intubation.[5]

Patient B

This 55 year old man developed respiratory distress some 80 minutes after being transferred to the recovery room and, despite efforts by a cardiologist and anesthesiologist to employ CPR, expired less than an hour later. P.Ex. 4, p. 44.[6] Respondent, who had been the anesthesiologist at Patient B's surgery, was already attending at another operation when the crisis occurred. Although informed immediately, he replied that he could not leave a surgery in progress.

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[5]**Paragraph A.2** is also not sustained to the degree that it implies that it was inappropriate for Respondent to have performed a rapid sequence induction in preference to an awake intubation.

[6]As a general statement of the course of Patient B's hospitalization and treatment by Respondent, **Paragraph B** is **SUSTAINED.**

It is impossible to credit Petitioner's implication that Respondent should have left the patient to whom he was then administering anesthesia. See Tr. 126-27, 136-37; cf. Tr. 150-51. The emergency arose at 11:40 a.m. on a weekday and Respondent was justified in believing that other physicians were available to deal with it. See Tr. 612-15. **Paragraph B.1**, which alleges a failure to respond appropriately to the notification about Patient B's respiratory distress, is **NOT SUSTAINED.**[7]

Respondent's subsequent documentation of this incident is troubling.[8] Even though he was not present in the recovery room at any time between the onset of Patient B's respiratory distress and the patient's death, Respondent countersigned the Recovery Room Record, which contains the ambiguous, if not misleading, entries: "Dr. Bash notified [-] Pt unresponsive - CPR started." P.Ex. 4, p. 44. No other physician's name appears in this record.

The Patient's Progress Record (P.Ex. 4, p. 49), written and signed by Respondent, contains a detailed description of the

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[7]**Paragraphs B.2, B.3, B.4** and **B.5**, which allege steps which should have been taken by Respondent had he gone to Patient B's side, have no basis once Respondent's duty to attend Patient B was rejected. They are therefore **NOT SUSTAINED.** Cf. Pet. Prop. Fin., pp. 11-12.

[8]The Committee also finds troubling Respondent's failure to document Patient B's blood loss on the Anesthesia Record. P.Ex. 4, p. 35. In view of Patient B's subsequent course this may have had serious consequences. Cf. Tr. 571.

procedures taken to deal with Patient B's cardiac crisis in the recovery room from the time "Pt became unresponsive" to the time "Pt was pronounced dead @ 12:35 P.M." Inexplicably it does not identify the physicians who performed these procedures or who pronounced Patient B dead. Nor does it indicate that Respondent was absent. Some time later Respondent also completed (and misdated) the totally erroneous Post-Anesthesia Evaluation of Patient B quoted in Finding of Fact 25, supra.

Submission of such inaccurate and misleading records cannot be excused.[9] **Paragraph B.6 is SUSTAINED.**

Patient C

Patient C was a 77 year old man with a history of serious heart disease who underwent surgery for a suspected tumor of the colon. This patient expired of a cardiac arrest 30 minutes after arriving in the recovery room.[10]

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[9]Respondent's explanation for the Post-Anesthesia Evaluation was that he later became confused about Patient B's case while hurriedly trying to clear up a paperwork backlog. Tr. 456, 469-70. His explanation for the omissions in the Patient's Progress Record -- that it was a "silly attempt" to shield fellow physicians from potential malpractice claims -- is baffling. Tr. 451-52, 457-59.

[10]As a general statement of the course of Patient C's hospitalization and treatment by Respondent, **Paragraph C is SUSTAINED.**

Petitioner's first allegation concerning Patient C is that, because there had been a difficult intubation, it was inappropriate for Respondent to have extubated him in the operating room. The Committee finds this allegation groundless.

The intubation was "difficult" (as Respondent noted on the Anesthesia Record) because it had to be attempted a second time after the endotracheal tube slipped into the esophagus on the first attempt. As Respondent's expert testified, this kind of occurrence did not bar extubation before transfer to the recovery room. Tr. 561-62. In addition, Respondent reasonably believed that extubating the patient while he was still "deep" would place less stress on his heart. Tr. 387-88. **Paragraph C.1 is NOT SUSTAINED.**

It is also alleged (¶ C.2) that "Respondent failed to promptly institute resuscitative measures for Patient C when he became apneic." The key word in this Allegation is "promptly." When Petitioner's expert was asked if the response to the apnea was appropriate, he replied:

> With the exception of the possible time interval, the right steps were taken. The question in my mind is when did they take place. Tr. 187-88.

According to this expert's reconstruction of the events in the recovery room, the variations in Patient C's blood pressure

cannot readily be explained unless the patient had a "bout of hypoxia" around the time he was transferred from surgery, which Respondent either failed to observe or to record. Tr. 197; see, also, Tr. 224-25; cf. Tr. 567-68. This witness' reconstruction otherwise rests on the time lapse between the first reference to apnea in the record (9:55 a.m.) and the times entered on the Resuscitation Flow Chart (Ambu bag at 10:00; massage at 10:05; intubation at 10:12). P.Ex. 5, p. 52; Tr. 187-88.[11]

Respondent sharply disputed this reconstruction. After relating that the patient was initially doing well upon his transfer, Respondent's testimony continued:

> The nurses were at this point hooking up. They hooked the Swan first, whatever it was, 42/60. They hooked up the arterial line and got a reading of -- it took them a couple of minutes to do. They got a reading of 40 over something.
>
> I said, you know, that is impossible, we just got 140/80.
>
> I was standing at the foot of the bed watching this man. He was breathing normally, and then I noticed he didn't take a breath, he stopped breathing. He took his last breath, and that was that.
>
> I said, he is not breathing. So I quickly grabbed the Ambu bag, which we have right on the wall, and took off the oxygen mask he had on, started breathing him, called for the team and all the other events then proceeded from there. There was no delay in

[11]The Recovery Room record states that the patient was re-intubated at 10:05. P.Ex. 5, p. 36.

recognizing this event or treating it, none whatsoever. Tr. 389-90.

The Committee finds Respondent's version more convincing than the expert's reconstruction of a cold record. The nurse's notes clearly document Respondent's presence and do not show that he was a passive onlooker. The somewhat conventional breakdown of the entries into five-minute intervals forms no basis for speculating to the contrary. See Tr. 229-31, 566-67. **Paragraph C.2** is **NOT SUSTAINED**.

Respondent's recordkeeping as to Patient C did leave gaps. The failure to indicate blood loss and urinary output on the record could have had adverse consequences and was not mitigated by the fact that a Swan-Ganz catheter was in place. Respondent also should have recorded the use of a nerve stimulator and noted the patient's vital signs more carefully. See Tr. 234-35, 412, 414-16, 571-73, 576-77. **Paragraph C.4** is **SUSTAINED**.[12]

Patient D

Patient D was a 74 year old man who experienced an incident of hypotension during ambulatory cataract surgery. The patient later had chest pains, EKG changes and hypotension in the recovery room.

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[12]No evidence was presented as to Paragraph C.3 of the Allegations and it has apparently been withdrawn by Petitioner. See Pet. Prop. Fin., pp. 11-12. Cf. Tr. 214.

Although three of the Allegations concerning this patient are no longer being pressed by Petitioner (see Pet. Prop. Fin., pp. 11-12), two of them (¶¶ D.2 and D.3) require consideration because they are intertwined with the single Allegation (¶ D.4) which is still being asserted.[13]

These Allegations concern Respondent's handling of the incident of hypotension during surgery. Contrary to Paragraphs D.2 and D.3, Respondent testified at the hearing that when he saw the patient's blood pressure dropping he decreased the flow of anesthetic and increased the oxygen until pressure returned to normal and it was possible to resume anesthesia. Tr. 422-23. His testimony finds corroboration in a note dictated by a consultant the day of the surgery and transcribed three days later. P.Ex. 6, pp. 11-12; see, also, P.Ex 6, pp. 6-7.

While Respondent's conduct was appropriate, his total failure to document it (as alleged in Paragraph D.4) is again problematical. Respondent compounded the difficuly a month later by submitting an erroneous Post-Anesthesia Evaluation stating that there were "No problems with anesthesia." P.Ex. 6, p. 1. Tr. 427, 431.

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[13]Paragraph D.1, which alleged that Respondent should not have used Innovar as an inductive agent, became unviable when Petitioner's expert conceded that it was not a departure to use this drug in 1987. Tr. 261-62, 274.

Accordingly, **Paragraphs D** and **D.4** are **SUSTAINED; Paragraphs D.1, D.2** and **D.3** are **NOT SUSTAINED.**

## DISPOSITION OF SPECIFICATIONS

Having entered the foregoing Findings of Fact and Conclusions as to the Allegations, the Committee has, by unanimous vote, determined that the Specifications of Charges[14] against Respondent should be disposed of as follows:

**FIRST, SECOND, THIRD AND FOURTH SPECIFICATIONS** (gross negligence):

**NOT SUSTAINED**

**SIXTH, SEVENTH, EIGHTH AND NINTH SPECIFICATIONS** (gross incompetence):

**NOT SUSTAINED**

**ELEVENTH SPECIFICATION** (negligence on more than one occasion):

**NOT SUSTAINED**

**TWELFTH SPECIFICATION** (incompetence on more than one occasion):

**NOT SUSTAINED**

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[14]As noted above (Footnote 1), the Fifth, Tenth and Seventeenth Specifications were withdrawn by Petitioner.

**THIRTEENTH, FOURTEENTH, FIFTEENTH AND SIXTEENTH SPECIFICATIONS** (inaccurate recordkeeping):

**SUSTAINED**

ORDER

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

**ORDERED** that Respondent **PICKWARD J. BASH, JR., M.D.,** shall be **CENSURED** and **REPRIMANDED** for failing to maintain records which accurately reflect the evaluation and treatment of four patients.

Dated: New York, New York
October 4, 1994

By: Fr. Daniel Morrissey, O.P.
FR. DANIEL MORRISSEY, O.P.
(Chairperson)

Joseph B. Cleary, M.D.
Kenneth J. Freese, M.D.