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

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

April 12, 1990

Andrew Morfesis, Physician
P.O. Box 356
Grays Knob, Kentucky 40829

Re: License No. 157926

Dear Dr. Morfesis:

Enclosed please find Commissioner's Order No. 10391. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Moira A. Doran

MOIRA A. DORAN
Supervisor

DJK/MAH/er
Enclosures

CERTIFIED MAIL- RRR
cc: David A. Shultz, Esq.
9 Seneca Street
Hornell, N.Y. 14843

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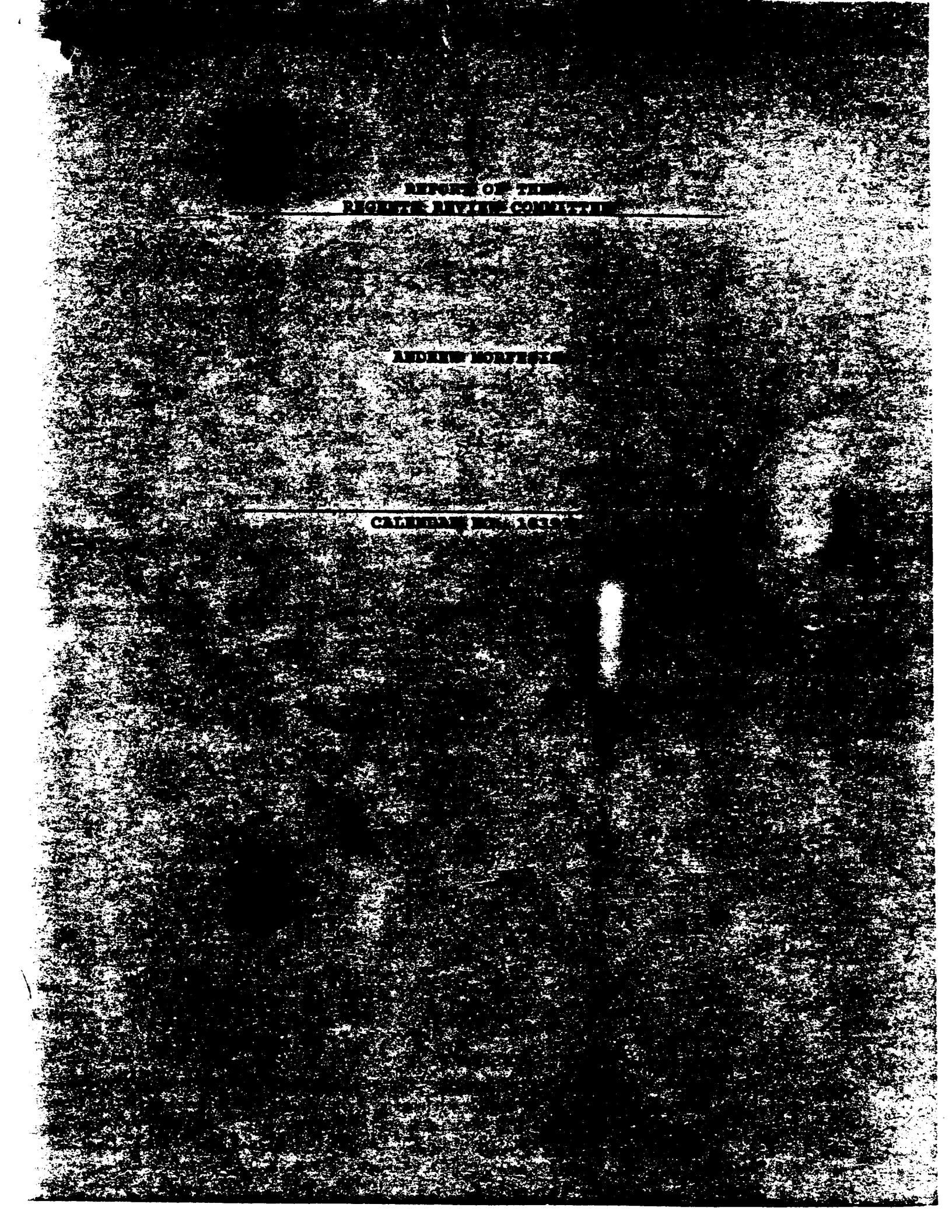
Office of Professional Medical Conduct



The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ANDREW MORFESIS **No. 10391**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

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

The instant disciplinary proceeding was properly commenced. A copy of the amended statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

Between January 25, 1989 and April 3, 1989, a hearing was held on 6 different sessions before a hearing committee of the State Board for Professional Medical Conduct.

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B". The hearing committee found and concluded that respondent was guilty of the first specification to the extent

indicated in its report based upon negligence on more than one occasion and was not guilty of the remaining charges, and recommended that respondent's license to practice as a physician in the State of New York be suspended for six months and that said suspension be stayed.

The Commissioner of Health recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted, the recommendation of the hearing committee be rejected, and respondent's license to practice medicine in New York be suspended for two years and said suspension be stayed provided certain conditions are met. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On December 20, 1989, respondent appeared before us and was represented by his attorney David A Shults, Esq., who presented oral argument on behalf of respondent. Anna Colello, Esq., presented oral argument on behalf of the Department of Health.

We have considered the record in this matter as transferred by the Commissioner of Health, including respondent's memorandum to the Board of Regents.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, which is the same as the Commissioner of Health's recommendation, was that respondent's license to practice as a physician in the State of New

York be suspended for two years and said suspension be stayed provided that respondent causes the chief of surgery at each hospital at which he has admitting privileges and the senior surgeon in Harlan, Kentucky with whom respondent practices to submit letters to OPMC every 6 months attesting to the propriety of respondent's surgical practice.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was no penalty. Respondent recommended that the findings, conclusions, and recommendations of the hearing committee and of the Commissioner of Health be overturned and that the charges be dismissed in their entirety.

Each of the six specifications of the charges brought against respondent combines two different charges involving negligence and incompetence. The amended statement of charges does not, as we have frequently suggested in the past, separately state and number these charges.

The hearing committee concluded that respondent was not guilty of incompetence on more than one occasion, gross negligence, and gross incompetence all with respect to Patients A, B, C, and D. However, no conclusion was made by the hearing committee or the Commissioner of Health as to these charges of incompetence on more than one occasion, gross negligence, and gross incompetence with respect to Patient E.

The first specification of the charges concerns five patients specified in various paragraphs. Four instances of negligence were committed by respondent on three occasions (February 3, 1986, December 16, 1986, and April 9, 1986) with respect to three different patients-Patients B, C, and E. The hearing committee believed that these instances "reflect a pattern of impetuousness."

In our unanimous opinion, based upon the record, including the rulings and review of the standard cited by respondent, such record demonstrates that respondent departed from acceptable standards in the practice of the profession by failing to use that degree of care which a reasonably prudent physician would have used under the circumstances in the cases of Patients B, C, and E. We note that patient harm is not a necessary element to sustain a charge of professional misconduct based upon negligence. In this proceeding where the issue of damages to a private party does not arise, petitioner is not required to plead or prove that any injury to a member of the public was suffered as a result of respondent's conduct. Matter of James Atkinson, Cal. No. 5700; cf. Foltman v. Board of Regents, 97 A.D.2d 661 (3rd Dept. 1983).

We recommend that respondent be found guilty, by a preponderance of the evidence, of negligence on more than one occasion to the extent of paragraphs B1, B2, C, and E2 of the amended charges. We note our rejection of respondent's argument that his performance on Patient C of a right side thoracentesis

instead of the indicated left side thoracentesis did not rise to the level of negligence. As the hearing committee found, respondent reviewed the radiography of Patient C which revealed left side pleural effusion and right lung clear, assessed Patient C as having a fluid collection in the left lung, and decided to perform a left side thoracentesis. Nevertheless, without indication, respondent performed a right side thoracentesis initially.

With respect to Patient B, respondent disputes the hearing committee's findings of fact numbered 25 and 27 regarding an amylase and a lipase test. Respondent's guilt as to the charges concerning a cholecystectomy and operative cholangiogram relates to surgery being contraindicated because the patient did not stabilize pre-operatively. See hearing committee finding of fact number 30. The hearing committee found the indicated treatment would have been to stabilize Patient B's condition with vigorous fluid therapy. Finding of fact 31. The record supports the conclusion that respondent performed surgery prematurely and failed to perform adequate pre-operative preparation in regard to fluid therapy. Findings of fact numbered 25 and 27 provide factual background bearing upon findings of fact numbered 30 and 31, and we accept them (25, 27) to that extent. However, we disregard the first part of the hearing committee's finding numbered 25 solely to the extent it states "Despite Respondent's testimony that

'before we actually started surgery we had the final result'," as not being supported by the record which indicates that respondent had knowledge of the amylase test from an oral report before the surgery.

In our unanimous opinion, the appropriate measure of discipline to be imposed upon respondent should include a two year stayed period of suspension and a two year period of probation. The recommendation of the Commissioner of Health does not expressly and directly place respondent on probation and does not refer to the duration of the probationary period. Instead, probation is mentioned by the Commissioner of Health in the course of his recommendation of a stay of the suspension provided respondent causes certain specified persons to submit letters "every six months during the probationary period". These letters must be sent from each hospital respondent now has admitting privileges in New York or elsewhere, rather than from each hospital where respondent practices during the two year stayed suspension period, and from Harlan, Kentucky where respondent has practiced.

Furthermore, the recommendation of the Commissioner of Health is unclear, indefinite, and unworkable because the condition under which the suspension may or may not be stayed relates to various times in the future after the penalty becomes effective. Therefore, it is uncertain whether the suspension is to be stayed immediately, only after each letter is sent, only after each letter

is received, or after further determinations are made, piecemeal, that the conditions, have been fulfilled. Moreover, there is no mechanism, as there would have been, had there been a complete stay and probation clearly imposed immediately, under which to determine a disputed alleged violation of any condition. In our opinion, the formulation of the penalty recommended by the Commissioner of Health would not sufficiently enable the public, the State, and the parties to know, at the time the Order of the Commissioner of Education first becomes effective, and at all times during the penalty period, whether respondent may practice medicine and is in compliance with that order. This recommendation of the Commissioner of Health should be modified to assure, in compliance with Education Law §§6511 and 6511-a, a definite two year suspension, a definite stay of that suspension, a definite two year probationary period, and a monitoring requirement of respondent's practice during the two year period.

We unanimously recommend the following to the Board of Regents:

1. The 76 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those findings and conclusions be accepted, as indicated herein, and not accepted to the extent of the first part of the first sentence of finding of fact numbered 25 as shown on pages

5-6 of this report;

2. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges based upon negligence on more than one occasion to the extent of paragraphs B1, B2, C, and E2 of the amended statement of charges, and be found not guilty of the remaining charges;

3. The recommendation of the hearing committee not be accepted;

4. The recommendation of the Commissioner of Health be modified; and

5. In agreement with the substance of the recommendation of the Commissioner of Health as to the measure of discipline and in consideration of an appropriate measure of discipline which is in compliance with Education Law §§6511 and 6511-a, respondent's license to practice as a physician in the State of New York be suspended for two years upon the first specification of the charges of which we recommend respondent be found guilty, as aforesaid, and that execution of said suspension be stayed and respondent be placed on probation for two years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D".

ANDREW MORFESIS (10391)

Respectfully submitted,

EMLYN I. GRIFFITH

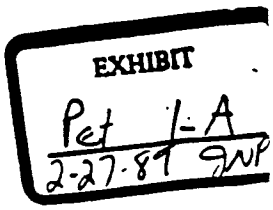
JANE M. BOLIN

PATRICK J. PICARIELLO

Emlyn I. Griffith

Chairperson

Dated: 3/3/90



APPENDIX A

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

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IN THE MATTER : AMENDED
OF : STATEMENT
F. ANDREW MORFESIS, M.D. : OF
: CHARGES

----------X

F. ANDREW MORFESIS, M.D., the Respondent, was authorized to practice medicine in New York Sate on April 9, 1984 by the issuance of license number 157926 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, 1986 through December 31, 1988 from Red Jacket Street, P.O. Box 584, Dansville, New York 14437.

FACTUAL ALLEGATIONS

A. With respect to Patient A (Patient A and all patients mentioned hereafter are more fully identified in Appendix A) admitted to Nicholas H. Noyes Memorial Hospital, Dansville, New York (hereafter Noyes Hospital) on or about February 13, 1985, upon whom the Respondent performed a cholecystectomy, operative

cholangiogram, and common duct exploration on or about February 14, 1985, the Respondent:

1. Performed surgery prematurely;

2. Performed common duct exploration without adequate indication;

3. Allowed prolonged use of a T-tube post-operatively without adequate indication.

B. With respect to Patient B, admitted to Noyes Hospital on or about February 3, 1986, upon whom the Respondent performed a cholecystectomy and operative cholangiogram on said date, the Respondent:

1. Performed surgery prematurely;

2. Failed to perform adequate pre-operative preparation for Patient B including but not limited to fluid therapy, antibiotic therapy, and further diagnostic investigation.

C. With respect to Patient C, admitted to Noyes Hospital on or about December 15, 1986, upon whom the Respondent performed a right and a left side thoracentesis, on or about December 16, 1986, the Respondent mistakenly and without indication performed a right side thoracentesis initially, instead of an indicated left side thoracentesis.

D. With respect to Patient D, admitted to Noyes Hospital from on or about October 7 to October 13, 1984, June 25 to July 6, 1985, and July 9 until expiration on July 13, 1985, upon whom the Respondent performed a left inguinal hernia repair, right inguinal hernia repair, and cholecystectomy, the Respondent:

1. During surgery on or about October 8, 1984, inappropriately injected two anatomic structures of uncertain identity, with absolute alcohol;

2. Performed a cholecystectomy on July 10, 1985, that was not indicated.

E. With respect to Patient E treated by the Respondent at Noyes Hospital on or about April 9, 1986, for an esophogeal obstruction and subsequently for an esophogeal perforation, the Respondent:

1. Used a nasogastric tube to attempt to clear Patient E's esophogeal obstruction;

2. Improperly performed dilitation of the esophogaus after relieving the esophogeal obstruction.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

The Respondent is charged with professional misconduct by reason of practicing the medical profession with negligence and/or incompetence on more than one occasion under N.Y. Educ. Law §6509(2) (McKinney 1985) in that the Petitioner alleges:

1. The facts contained in two or more of the following paragraphs A, A1, A2, A3, B, B1, B2, C, D, D1, D2, E, E1 and/or E2.

SECOND THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE AND/OR GROSS INCOMPETENCE

The Respondent is charged with professional misconduct by reason of practicing the medical profession with gross negligence and/or gross incompetence under N.Y. Educ. Law §6509(2) (McKinney 1985) in that the Petitioner alleges:

2. The facts contained in paragraph A.
3. The facts contained in paragraph B.
4. The facts contained in paragraph C.
5. The facts contained in paragraph D.
6. The facts contained in paragraph E.

DATED: Albany, New York
February 13, 1989

Peter D. Van Buren

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

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
ANDREW MORFESIS, M.D.	:	COMMITTEE

To: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Thea Graves Pellman, Chairman, Michael Golding, M.D., a Glenda Donoghue, M.D. duly designated members of the State Boa of Professional Medical Conduct, appointed by the Commissioner Health of the State of New York pursuant to Section 230(1) of t Public Health Law, served as the Hearing Committee in this matt pursuant to Section 230(10)(e) of the Public Health Law. Marge Gootnick, Esq. served as Administrative Officer for the Heari Committee.

After consideration of the entire record, the Hearin Committee submits this report.

SUMMARY OF PROCEEDINGS

Notice of Hearing & Statement of Charges:	December 9, 1988
Service of Commissioner's Order, Notice of Hearing & Statement of Charges on Respondent:	December 30, 1988
Prehearing conference held:	January 25, 1989

EXHIBIT "B"

Amended Statement of Charges:	February 13, 1989
Answer to Statement of Charges:	None
Hearing Dates:	January 25, 1989 February 3, 1989 February 27, 1989 March 27, 1989 March 28, 1989 April 3, 1989
Place of Hearing:	Holiday Inn, Rochester, NY
Deliberations by Hearing Committee:	June 5, 1989 July 10, 1989 July 19, 1989
Department of Health appeared by:	Peter J. Millock, Esq., General Counsel, Ralph J. Bavaro, Esq., of Counsel (on 6/21/89 Anna Colello replaced Mr. Bavaro)
Respondent appeared by:	David A. Shultz, Esq.
Witnesses for Department of Health:	John B. Rogers, M.D. A. Leonard Bloch, M.D. Richard S. Warren
Witnesses for Respondent:	F. Andrew Morfesis, M.D. Hector R. Nava, M.D. Mario B. LoMonaco, M.D.
Summary of Charges:	Appendix A of Report

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript pages unless otherwise noted. These citations represent evidence found persuasive by the Hearing Committee while arriving at a particular finding. Conflicting evidence, if

any, was considered and rejected in favor of the cited evidence All Findings were reached by unanimous vote. The transcripts fo the hearings on 1/25/89 both begin with page 1. Reference t those transcripts will indicate the date of the transcript cited.

1. Respondent is a graduate of Antioch College, an Pennsylvania State University College of Medicine.

2. Respondent was trained at the University of Marylan Hospital in Baltimore, Maryland, for two years. He had thre years of residency at Lankenaw Hospital in Philadelphia, a accredited Residency Program.

3. At the completion of his residency, Respondent was recruited and began his practice at Noyes Memorial Hospital in Dansville, New York, in 1984. The hospital is a small rural hospital, originally of 84 beds which has been reduced presently to 60 beds. Noyes serves a large, rural community of Livingston and surrounding counties. Respondent was recruited by the hospital CEO. He was the first American Graduate University trained surgeon on the staff of the hospital. He specializes in general surgery and is board eligible. (t. 247-252)

PATIENT A

4. Patient A was a fifty-two year old woman admitted to Noyes Memorial Hospital, Dansville, New York, on February 13, 1985. She came to the Emergency Room at 10:15 p.m. complaining of sudden onset of dull-to-sharp pain in the right upper quadrant one hour after eating, with constant nauseating pain and vomiting. Her temperature was 97.9. Patient A had had similar episodes for the prior two years. Physical findings included: abdomen obese and soft; bowel sounds hypoactive; no guarding or rigidity; right upper quadrant tender. Patient A was obese. Her reported weight was 180 pounds (Exhibit 11 pp. 6, 87).

5. Respondent first saw Patient A at approximately 11:00 p.m. on February 13. He had not known nor treated Patient A previously. Respondent's history of Patient A (dictated 2/13) noted: intermittent right upper quadrant tenderness not relieved by antacids, which is post-prandial brought on by certain fatty foods; urinary tract infection three years ago; pain becoming more severe and more frequent. She had no history of other serious problems or trauma. (t. 402, 528, 627).

6. Respondent ordered a real time abdominal ultrasound. The report on February 14, showed "a small calculus or minimal cholesterolosis (deposit of cholesterol in tissue) of the gall bladder. Respondent also ordered a white blood count at 11:20

p.m. on February 13. The white blood count was 10.1 WBC/10mm (lab normal 4.5-11). (Exhibit 11, pp. 29, 36)(t. 1/25/89: pp 95-96)(t. 475)

7. Respondent ordered a Dynamic Static Hepato Biliary Imaging study (HIDA scan). Intravenous fluids were instituted at approximately midnight on February 13. (Exhibit 11, pp. 36, 84, 89)(t. 1/25/89: p. 98)

8. Antibiotic therapy with ANCEF was ordered and administered. At 1:30 a.m. on February 13, Respondent ordered Demerol 25 milligrams every three hours as needed for pain, and Compazine 5 milligrams every three hours as needed for nausea. (Exhibit 11, p. 56-79)(t. 403 & 404)

9. Respondent consulted with the Hospital Radiologist, Dr. Qureshi and with Dr. Hanson, Patient A's family physician. (t. 479, 480)

10. Patient A continued to have abdominal pain during the evening of February 13. She continued to have nausea and vomiting during the night and into the morning. On the morning of February 14 her white blood count rose to 13,000 plus with a shift to the left. This caused concern in Respondent who felt the patient was developing acute cholecystitis. On the morning of February 14, Respondent made a diagnosis of acute cholecystitis. The diagnosis was based on the persistence of the symptoms throughout the night and on the patient's failure to

respond to I. V. fluids and antibiotics. It was also based on the presence of the stone in the gall bladder and on the history. (Exhibit 11 p. 2)(t. 407)

11. Respondent did not order any additional medication during the evening because there was no physician present in the hospital. In addition, he was concerned that increasing the narcotics would worsen the patient's condition. Respondent did not want to mask any signs of peritonitis or perforation of the gall bladder, or to contribute to respiratory depression. (t. 407, 408, 471, 472)

12. Patient A did have adequate fluids, as per her urine output records. (Exhibit p. 68)(t. 473, 474)

13. After Respondent consulted with the hospital radiologist, Dr. Qureshi, and with Patient A's family physician, Dr. Hanson, he decided to perform the surgery. The decision was based on the consultations and on his judgment that there was a substantial chance that the patient had cholecystitis. Respondent also based his decision on the fact that Patient A was getting worse in spite of conservative treatment. He considered waiting, but performed the surgery because the patient's nausea and vomiting continued. There was no contraindication to surgery. There was a risk in delaying surgery because of the persistent symptoms. Respondent's belief that patients of this type do better statistically with early surgery is substantiated in surgical literature. (t. 479-481, 485-486)

14. Respondent removed the Patient A's gall bladder an performed a cholangiogram. (t. 488).

15. When Respondent put a clamp on the cystic duct he noticed a small cholesterol stone at the point where the clam had been applied. He then opened the duct and picked out the pieces of the stone. (t. 489)

16. Respondent was concerned that he might have pushed a remnant of the stone into the duct by the process of clamping the stone. The cholangiogram showed a small filling defect at the entrance of the cystic duct which suggested the possibility of a stone. Respondent performed a second cholangiogram which confirmed the presence of the defect. (t. 489-492, 558-559)

17. After examining the two cholangiograms and considering the risks of performing a common bile duct exploration, Respondent decided to perform the procedure. The common bile duct exploration revealed no abnormality. (t. 491, 494, 553-559)

18. After the common bile duct exploration, Respondent inserted a T-tube to drain the common bile duct. Patient A was given antibiotics. The condition of Patient A justified leaving the T-tube in for 14 days. (t. 495-496, 540)

PATIENT B

19. Patient B, a sixty-three year old male, presented to the Noyes Hospital Emergency Room at approximately 6:50 p.m. on February 3, 1986, complaining of severe abdominal pain and a questionable fainting episode. Patient B, was a known diabetic with a history of high blood pressure. At the time he was examined his blood pressure was 50/30, pulse 118, respirations 20, temperature 99.5. Patient B's abdomen was tender. He was initially evaluated and treated by emergency room personnel. He was first seen by Respondent on February 3 in the Emergency Room at 8:10 p.m. (Exhibit 12, pp. 1, 3, 8)

20. IV therapy had been ordered in the Emergency Room prior to Respondent's arrival. The order was for 500cc lactated Ringer's "in fast", then 125 cc per hour; Mefoxin, an antibiotic, 2 grams. When Respondent arrived in the Emergency Room a CVP line was placed in Patient B. Respondent made no change in fluid orders. Respondent's initial physical examination findings state "Blood pressure 90/40 after several liters of IV fluids. Respondent's initial physical examination also showed a tender abdomen with rebound in both upper quadrants, no bowel sounds. (Exhibit 12, pp. 8, 13)(t. pp. 644-645 and t. 2/3/89: p. 92)

21. Patient B's laboratory results on admission to the Emergency Room at approximately 4:00 to 4:30 p.m. on February 3, included an elevated bilirubin at 4.1, elevated enzymes, low calcium at 7.9, low albumin at 2.9, hematocrit of 43.7, and a

white blood count of 21,600. A second hematocrit at approximately 7:30 p.m. fell to 37.9 and a second white blood count at the same time increased on 28,300. (Exhibit 12, pp 19A, 26, 27)(t. 640-641)

22. Respondent felt there were a number of possible diagnoses, including ascending cholangitis, acute cholecystitis with gangrene or perforation, perforated ulcer or necrotic bowel. He feared that any one of these could result in death if there was prolonged non-operative therapy.

23. When Respondent evaluated Patient B's condition at approximately 8:10 p.m. on February 3, 1986, he decided to perform an exploratory laparotomy with a pre-operative diagnosis of acute abdomen. (Exhibit 12, pp. 2, 5, 13)(t. 3/28/89: pp. 642-644)

24. Patient B was brought to the operating room where anesthesia was begun at 9:00 p.m. Respondent performed a cholecystectomy and operative cholangiogram on an intra-operative diagnosis of acute colysystitis. (t. 646-649)

25. Despite Respondent's testimony that "before we actually started surgery we had the final result", the medical record indicates that the amylase report was received during the procedure. The amylase lab test ordered pre-operatively was markedly elevated at 3918. (Exhibit 12, pp. 20, 41)(t. 2/3/89: pp. 41-42)(t. 642)

26. Patient B's blood pressure at the commencement of surgery was approximately 90/60. Respondent did not know how much fluid Patient B had received pre-operatively, nor did he know Patient B's normal blood pressure. Intra-operatively at 9:58 p.m., Patient B's blood pressure was recorded at 61/40 and required support with Epinephrine. (Exhibit 12, p. 49)(t. pp. 645, 657)

27. A lipase laboratory test, which is useful in the diagnosis of pancreatitis was not performed. (Exhibit 12)(t. 2/3/89: p. 42).

28. Upon exploration, the pancreas was found to be slightly inflamed. The gall bladder was found to be quite inflamed, turgid and surrounded by many inflammatory adhesions. There was edema in the area of the common duct and at the base of the gall bladder. (Exhibit 12, p. 41)(t. 645-646, 649)

29. The Pathologist' description of the gall bladder included marked congestion with multiple greenish yellow and black stones. (Exhibit 12, p. 43)(t. 649)

30. Patient B did not stabilize pre-operatively. This constituted a contraindication to surgery. (Exhibit 12, pp. 8, 49)

31. The indicated treatment for Patient B would have been to stabilize his condition with vigorous fluid therapy - for

example, an initial order of 500 cc in fast, then 200 cc per hour followed by a period of from 12 to 24 hours of close monitoring, at least until a reasonable blood pressure resumed or a urine output of 30 cc per hour was achieved. Depending on the observations made during the monitoring period, variations in fluid therapy may have been indicated. (t. 2/3/89: pp. 36-38, 86-88)

PATIENT C

32. Patient C was a 65 year old female admitted to Noyes Hospital on December 15, 1986, with complaints of shortness of breath. She was treated by Respondent. (Exhibit 15)

33. One year prior to the December 15, 1986 admission, she had been diagnosed with carcinoma of the left lung. On December 15, 1986, Patient C stated that she desired no further workup for her malignancy other than to make her breathing more comfortable. (Exhibit 15, pp. 2, 5, 16)

34. Radiography of Patient C on December 15 revealed left sided pleural effusion. Radiography showed Patient C's right lung to be clear. Patient C's primary physician, Dr. Hanson, consulted with Respondent regarding the pleural effusion. (Exhibit 15, pp. 2, 23, 24, 34)

35. On December 16, Respondent reviewed the above-mentioned Radiography, assessed Patient C as having a fluid collection in the left lung, and decided to perform a left side thoracentesis. (Exhibit 15, p. 16)(t. pp. 388, 393)

36. After reviewing the x-rays he got side tracked and did not see the patient until approximately one hour later. (t. 388, 393)

37. When Respondent went to Patient C's room, he examined her and found that she had a dullness to percussion on the right side more so than on the left. This is generally a sign that there is fluid present on the right side. (t. 388)

38. On the evening of December 16, Respondent performed a thoracentesis (insertion of needle into the lung to withdraw fluid) on Patient C's right lung, instead of performing the procedure, as indicated, on the left lung. This resulted in pneumothorax of the right lung. (Exhibit 15, pp. 2, 12)(t. pp. 388-390)

39. Patient C complained of a sharp pain and became short of breath. When Respondent realized what the problem was, he immediately withdrew the needle, elevated the chest and inserted a chest tube. He then called Dr. Hanson, the treating physician, spoke to the family and discussed the matter with them. He explained the situation to Patient C. (t. 390)

40. Respondent then proceeded to tap the left side and drain the fluid. This gave the patient substantial relief. The patient died of her carcinoma several days later. (t. 390)

41. Respondent reported the incident to the appropriate hospital authorities, discussed it with the patient, the patient's family, patient's daughter, and with the treating physician. (t. 391)

PATIENT D

42. Patient D, a seventy-one year old male, was admitted to Noyes Hospital and treated by the Respondent on October 7, 1984, June 24, 1985, and July 9, 1985. (Exhibit 16A, 16B, & 16C)

43. Patient D was hospitalized from October 7 to October 13, 1984. His admission history reveals that his chief complaint was pain in the left groin. Patient D's history included: a left inguinal hernia repair five years prior to this admission, following which he had continued pain in the left groin. He had been re-operated on and an indirect hernia was repaired. At that time, his ilioinguinal nerve was freed from adhesions. His pain still did not resolve. He developed bleeding into his left scrotum, and underwent a left orchiectomy. (Exhibit 16A, pp. 2 & 7)

44. Beginning in September 1984, Respondent had attempted to address Patient D's complaint of left groin pain in Respondent's office with two nerve blocks with lidocaine. Neither relieved Patient D's symptoms. (Exhibit 16A, p. 8)(t. 2/3/89, pp. 124)(t. 253)

45. On admission to the hospital on October 7, 1984, physical findings revealed a soft abdomen, a large prostate gland, point tenderness over the left hernia, and a large right inguinal hernia. (Exhibit 16A, p. 8)(t. 2/3/89: p. 124)

46. On October 8, Respondent performed an operation labeled "repair of direct inguinal hernia recurrent, and alcohol injection of ilioinguinal nerve,". The operation was performed under local anesthesia. Respondent decided not to open the floor of the inguinal canal because the previous repair appeared to be strong, and because it would run the risk of injuring Patient D's bowel. (Exhibit 16A, pp. 18 & 19)

47. Respondent considered performing a neurectomy [a resection of the nerve]. However, based on his training, he chose to inject two structures which he felt might be two nerve segments, with two tenths of a cc of alcohol each. Respondent learned this procedure during his residency training in Lankenaw Hospital. (t. 261)

48. The use of alcohol to block a nerve is a standard surgical technique. It leaves less chance of a neuroma

developing on the end stump of the nerve. Injecting the ilioinguinal nerve with alcohol is an appropriate medical practice. The procedure is not potentially dangerous to surrounding areas. (t. 261, 590-595)

49. Respondent's recording of the preoperative diagnosis was inconsistent. It was recorded as recurrent right inguinal hernia in the operative report and as a recurrent left inguinal hernia in the discharge summary. (Exhibit 16A, pp. 2 & 18)

50. Patient D was again hospitalized at Noyes Hospital on July 8, 1985, approximately four days after discharge for an admission during which a right inguinal herniorraphy was performed on July 2, 1985. Upon admission on July 8, 1985 he complained of severe right upper quadrant pain. He was treated by Respondent from July 10 until he expired on July 13, 1985. (Exhibit 16B, pp. 2-5)

51. Patient D's pertinent history on this admission included recurrent, worsening, upper epigastric pain radiating to mid and lower abdomen, no weight loss, appetite good, mild nausea but no vomiting, normal upper GI series on 6/21/85. Gastroscopy on 6/21/85 revealed a large hiatal hernia but no reflux esophagitis.

His duodenum was normal. Patient D was a former alcoholic but reported no alcohol use since 1977. (Exhibit 16B, p. 13; Exhibit 16C, p. 9)

52. A white blood count on July 9, 1985 was normal at 7500 with no left shift, indicating no acute infection. An amylase laboratory test on July 9, 1985 was normal at 164. No laboratory test for lipase was performed. (Exhibit 16B, pp. 24 & 28)

53. Over the previous three months Patient D had been treated for various G.I. disorders, including duodenitis, esophagitis, gastritis and gastric motility disorders. (t. 268)

54. Respondent consulted with Dr. Chaudry, a gastroenteologist, and Dr. Wetterau, Patient D's family physician. During the consultation a plan of treatment was adopted. The plan was that if the pain persisted, Respondent would explore Patient D's abdomen. (t. 269-272)

55. Respondent's evaluation of Patient D on July 9, 1985 as reflected in Respondent's re-admission note states as follows:

> Patient has had right upper quadrant pain and tenderness and nausea for four weeks now. Readmitted twice for this. Ultrasound, barium enema, and upper endoscopy negative. OCG (oral cholecystogram) non-visualized on first dose; faintly visualized on second dose. Discussed with Dr. Chaudry - felt that given history and physical findings and recurrent pain and OCG findings, that next rational step was exploration and cholecystectomy. Patient understands that pain may not be relieved by cholecystectomy and accepts this risk. For operating room tomorrow.

This represents Respondent's efforts to seek consultations in arriving at a course of therapy in an ill patient with a complicated diagnostic problem. (Exhibit 16B, p. 16)(t. 269-271)

56. Respondent performed a cholecystectomy on Patient D for a diagnosis of "abdominal pain - probable cholecystitis". (Exhibit 16B, pp. 16, 54-55)

57. At laparotomy there were extensive adhesions observed around the entire gall bladder suggestive of gall bladder disease. (t. 277)

58. The adhesions were not present along the entire pancreas, indicating that there was no separate pancreas problem. (t. 278)

59. The pancreas was within normal limits. It was soft and not edematous. Patient D's gall bladder was removed. (t. 281 & 282)

60. Pathological examination of the gallbladder revealed chronic cholecystitis. There was a disparity between the gross and microscopic descriptions of the gall bladder. The gross description is normal, the microscopic describes chronic cholecystitis. Review of the slides by Dr. Michael Golding, a member of the panel, confirmed the presence of chronic cholectystitis. (Exhibit 16B, p. 56)(t. 282)

61. On July 12, Patient D developed a pulmonary embolism He deteriorated, and expired on July 13, 1985. (Exhibit 16B, pp 3-5)

PATIENT E

62. Patient E was a 70 year old female admitted to Noye Hospital Emergency Room at 4:20 p.m. on April 9, 1986. She complained of food stuck in her throat and was seen by Respondent. (Exhibits 9 & 10)

63. Respondent had previously treated Patient E on April 2 1986, for complaints of difficulty in swallowing. Respondent ordered a barium study which revealed an esophageal stricture He then performed an endoscopy and examined the stricture. (t p. 347-350)

64. On April 2, 1986, Respondent performed esophageal dilation on Patient E with Hurst Maloney dilators in sizes #38, 40, and 42. (t. 348-349)

65. At the time of the dilation on April 2, Patient E required sedation for anxiety, tachycardia and dyspnea. After dilation, Patient E reported relief. (t. 349-350)

66. Patient E had a history of chronic medical problems, including esophageal reflux, myocardial infarction with

ventricular aneurysm formation, diabetes mellitus and chronic glomerulonephritis. Patient E had been treated with corticosteroids (prednisone) for ten years. (Exhibit 9, pp. 2-4, 11, 13)(t. 346)(t. 1/25/89: p. 32)

67. In the Emergency Room on April 9 at approximately 4:30 p.m., Respondent passed a nasogastric (NG) tube into Patient E's esophagus to clear the foreign body and Patient E reported relief. (t. 358)

68. "Using a nasogastric (NG) tube to clear an obstruction in the esophagus is an option which, over the years, has been used by many physicians." (t. 442)

69. Respondent chose not to use an endoscopy procedure at this time. He testified that it would mean "sedating this woman, putting her in a decubitus position...and this would have interfered with her respiration...(It) would have increased her anxiety and the process of sedating her can cause more respiratory difficulties...I felt the risk of doing this was greater than the risk of simply proceeding". (t. 360)

70. Patient E was then dilated with Maloney dilators Nos. 38, 40 and 42. Respondent made an unsuccessful attempt to pass a No. 44 Maloney dilator. The procedures were performed without repeating endoscopic visualization. (Exhibit 9, pp. 2, 13)(t. 359)

71. Patient E was discharged from the Emergency Room a 4:40 p.m. on April 9, 1986. (Exhibit 10)

72. The act of clearing a foreign body from the esophagu requires great caution due to the significant risk of perforatin the esophagus, a delicate organ. (t. 1/25/89: p. 37)

73. The risk of perforation is even more pronounced in patient on corticosteroids since that medication weakens th connective tissues of the body, including the esophagus. (t. 1/ 25/89: pp. 46-47)

74. Esophageal endoscopy is a procedure which gives ar examiner direct vision of a foreign body and stricture in a patient's esophagus. However, "any tube, instrument that you put inside of the esophagus...always has the potential of causing a perforation". (t. 462)

75. Immediate dilation with Maloney dilators without contemporaneous inspection of the esophagus poses some risks. If, upon endoscopic examination, no inflammation or trauma is present, esophageal dilation can proceed. However, if the esophagus is abnormal, it is more appropriate to delay the dilation until any inflammation or ulceration has resolved. Following the clearance of an esophageal obstruction, there is no urgency for immediate dilations of the esophagus. (t. 1/25/89: pp. 44, 76)

76. Patient E returned to the Noyes Hospital Emergency Roo complaining of chest pain and was admitted at 7:32 p.m. on Apri 9, 1986. A diagnosis of a perforated esophagus was made Patient E underwent surgical repair of the esophagus on April 10, 1986. (Exhibit 9, pp. 2-4, 9, 15, 170, 171)

CONCLUSIONS

Patient A

With respect to Patient A, the Hearing Committee unanimously concludes that Petitioner failed to satisfy its burden of establishing, by a preponderance of the evidence that, Respondent: 1. Performed surgery prematurely; 2. Performed common duct exploration without adequate indication; and 3. Allowed prolonged use of a T-tube post-operatively without adequate indication.

The Hearing Committee unanimously concludes that with respect to Patient A, Petitioner failed to satisfy its burden of establishing that Respondent was negligent or incompetent on more than one occasion or that he was guilty of gross negligence or gross incompetence.

Patient B

With respect to Patient B, the Hearing Committee unanimously concludes that Petitioner did satisfy its burden of establishing that Respondent: 1. Performed surgery prematurely; and 2.

Failed to perform adequate pre-operative preparation for Patien B in that insufficient intravenous fluid therapy wa. administered.

With respect to Patient B, Petitioner satisfied its burde of establishing that Respondent was negligent on more than on occasion.

With respect to Patient B, Petitioner failed to satisfy it burden of establishing that Respondent was incompetent on mor than one occasion or that he was guilty of gross negligence o gross incompetence.

Patient C

With respect to Patient C, the Hearing Committee unanimously concludes that Petitioner did satisfy its burden of establishing that on December 16, 1986, Respondent mistakenly and without indication performed a right side thoracentesis initially, instead of as indicated, a left side thoracentesis.

With respect to Patient C, Petitioner satisfied its burden of establishing that Respondent's action was negligent.

With respect to Patient C, Petitioner failed to satisfy its burden of establishing that Respondent was incompetent on more than one occasion or that he was guilty of gross negligence or gross incompetence.

Patient D

With respect to Patient D, the Hearing Committee unanimously concludes that Petitioner failed to satisfy its burden of establishing that: 1) Respondent acted inappropriately when he injected two anatomic structures with absolute alcohol on October 8, 1982; and 2) Respondent performed a cholecystectomy on July 10, 1985 that was not indicated.

The panel concludes that the preoperative evaluation of Patient D prior to the August 10, 1985 cholecystectomy was adequate and that Respondent acted prudently in seeking multi-disciplinary consultations prior to surgery. The panel unanimously concludes that although the interpretation of the clinical findings and the timing of the surgical procedure were arguably questionable, Respondent's actions did not rise to the level of incompetence or negligence.

With respect to patient D, Petitioner failed to satisfy its burden of establishing that Respondent was negligent or incompetent on more than one occasion or that he was guilty of gross negligence or gross incompetence.

Patient E

With respect to Patient E, the Hearing Committee unanimously concludes that Petitioner failed to satisfy its burden of establishing that Respondent used a nasogastric (NG) tube inappropriately to clear Patient E's esophageal obstruction.

With respect to Patient E, the Hearing Committee unanimousl concludes that Petitioner satisfied its burden of establishin that Respondent improperly performed dilation of the esophagu after relieving the esophageal obstruction. This deviation b Respondent constitutes negligence.

RECOMMENDATIONS

The four instances of negligence reflect a pattern o impetuousness which concerns the panel. In making it recommendations the panel has, however, considered Respondent' present professional situation in which he is in practice with a senior surgeon in Harlan, Kentucky. This is a mento relationship and is advantageous for a junior physician whos errors are primarily judgment errors.

Accordingly, the Committee unanimously recommends that the license of Respondent, Andrew Morfesis, be suspended for six months. The Committee also recommends that the suspension be stayed.

Respectfully submitted,

Thea Graves Pellman,
Chairperson

Glenda Donoghue, M.D.
Michael Golding, M.D.

Dated: August 29, 1989

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

IN THE MATTER :

OF : COMMISSIONER'S

ANDREW MORFESIS, M.D. : RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on January 25, 1989, February 3, 1989, February 27, 1989, March 27, 1989, March 28, 1989 and April 3, 1989. Respondent, Andrew Morfesis, M.D., appeared by David A. Shults, Esq. The evidence in support of the charges against the Respondent was presented by Anna Colello, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full.

B. The Recommendation of the Committee should be rejected and, in lieu thereof, Respondent's license to practice medicine in New York should be suspended for two years and such suspension stayed provided that Respondent cause the chief of surgery at each hospital at which Respondent now has admitting

EXHIBIT "C"

privileges in New York or elsewhere, and the senior surgeon in Harlan, Kentucky, with whom Respondent is in practice, to submit letters to the Office of Professional Medical Conduct, every six months during the probationary period attesting to the propriety of Respondent's surgical practice.

I agree with the Committee's determination that Respondent has demonstrated a pattern of impetuousness. Some scrutiny of Respondent's surgical practice during the next two years should provide greater confidence in his performance as a surgeon. This scrutiny of his practice in Kentucky or elsewhere will provide more protection to New Yorkers if Respondent decides to return to this state.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

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

DATED: Albany, New York
October 19, 1989

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

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

ANDREW MORFESIS

CALENDER NO. 10391

1. That, during the period of probation, respondent shall have respondent's practice monitored, at respondent's expense, in regard to the propriety of respondent's surgical practice as follows:

   a. That said monitoring shall be by the chief of surgery or senior surgeon wherever respondent practices as selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's office records, patient records, and hospital charts, as aforesaid, and respondent shall also be required to make such records and charts available to said monitor at any time requested by said monitor;

   c. That respondent's surgical practices must be proper for respondent to be in compliance with these terms of probation; and

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

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

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

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

ANDREW MORFESIS

CALENDAR NO. 10391

The University of the State of New York

IN THE MATTER

OF

ANDREW MORFESIS
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 10391

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10391, and in accordance with the provisions of Title VIII of the Education Law, it was

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

1. The 76 findings of fact and the conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those findings and conclusions be accepted, as indicated herein, and not accepted to the extent of the first part of the first sentence of finding of fact numbered 25 as shown on pages 5-6 of the Regents Review Committee report;
2. Respondent is guilty, by a preponderance of the evidence, of the first specification of the charges based upon negligence on more than one occasion to the extent of paragraphs B1, B2, C, and E2 of the amended statement of charges, and is not guilty of the remaining charges;
3. The recommendation of the hearing committee not be accepted;
4. The recommendation of the Commissioner of Health be modified; and

5. In agreement with the substance of the recommendation of the Commissioner of Health as to the measure of discipline and in consideration of an appropriate measure of discipline which is in compliance with Education Law §§6511 and 6511-a, respondent's license to practice as a physician in the State of New York be suspended for two years upon the first specification of the charges of which respondent is guilty, as aforesaid, and that execution of said suspension be stayed and respondent be placed on probation for two years under the terms prescribed by the Regents Review Committee;

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

and it is

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

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

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

Thomas Sobol

Commissioner of Education