The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

MICHAEL F. MORRISSEY **No. 11348**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

MICHAEL F. MORRISSEY, 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 and on March 6, March 20, April 3, April 27, and May 2, 1990 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

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

The hearing committee concluded that respondent was guilty of the second through fourth specifications of the charges to the

extent indicated in its report, and not guilty of the first, fifth, and sixth specifications of the charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions, and recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On December 3, 1990 respondent appeared before us in person, and was represented by an attorney, Anthony Z. Scher, Esq., who appeared before us and presented oral argument on respondent's behalf. Dianne Abeloff, Esq., presented oral argument on behalf of the Department of Health.

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

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was: one year suspension, execution stayed, probation one year with a special term that all surgical cases requiring general anesthesia or conscious sedation be done in a hospital.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's October 22, 1990 memorandum; respondent's November 19, 1990 letter, without attachment; petitioner's November 27, 1990 letter; and the November 30, 1990 letter forwarded to the parties herein on our behalf.

We agree with the hearing committee's findings and conclusions and find that they are appropriately based on the evidence in the record and that they reflect a proper evaluation of respondent's actions.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 48 findings of fact, conclusions as to the question of respondent's guilt, and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to those findings of fact, conclusions, and recommendation be accepted;
2. Respondent be found guilty, by a preponderance of the evidence, of the second through fourth specifications of the charges to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and
3. Respondent's license to practice as a physician in the

State of New York be revoked upon each specification of the charges of which we recommend respondent be found guilty.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: 1/15/91

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
MICHAEL F. MORRISSEY, M.D.	:	CHARGES

----------X

MICHAEL F. MORRISSEY, M.D., the Respondent, was authorized to practice medicine in New York State on February 15, 1961 by the issuance of license number 085676 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, 1989 through December 31, 1991 from 45 Ludlow Street, Yonkers, New York 10705.

FACTUAL ALLEGATIONS

A. On or about July 10th, 1987, Patient A, (Patients A & B are identified in the attached appendix), a 34 year old woman, went to Respondent Morrissey's office located at 138 Old Town Road, Southampton, New York, for a consultation concerning breast augmentation surgery. On or about July 17, 1987, Patient A went to Respondent Morrissey's office for bilateral breast augmentation to be performed under local anesthesia by Respondent Morrissey.

EXHIBIT "A"

At or about 7:30 a.m., on July 17th, Respondent Morrissey administered Versed 7.5 mg and Demerol 50 mg I.V. The patient while on an EKG monitor and pulse monitor was given nasal oxygen. At or about 7:30 a.m. Patient A's pulse was 63 and her blood pressure was 123/79. At or about 8:00 a.m. Respondent Morrissey injected 500 mg. Xylocaine with 1:200,000 epinephrine. This injection was followed by facial twitching, clonic movements and a bradycardia of 40.

Respondent Morrissey then injected her with Atropine .4mg I.V. at which point the patient was noted to be apneic. At or about 8:30 a.m. the patient was intubated and oxygen was given by an ambu bag. Respondent Morrissey then administered CPR to patient A. She was transfered to Southampton Hospital at 9:00 a.m. where she died on July 29, 1987.

1. Respondent Morrissey failed to perform an adequate pre-operative laboratory evaluation prior to surgery.

2. Respondent Morrissey administered an excessive amount of Versed for this patient's body weight, which at the time of autopsy was 87 pounds. The dose of Versed was excessive particularly in that it was combined with the narcotic Demerol.

3. Respondent Morrissey also administered an excessive amount of Xyclocaine to the patient based upon her body weight, which at the time of autopsy was 87 pounds.

4. From at or about 7:30 a.m. and continuing throughout the procedure, Respondent Morrissey failed to adequately monitor Patient A or to arrange for the appropriate monitoring of the patient's vital signs.

B. On or about April 27, 1988, Patient B, a 21 year old woman, went to Respondent Morrissey's office, located at 45 Ludlow Street, Yonkers, New York, for a consultation concerning breast augmentation surgery. On or about May 9, 1988, at approximately 7:30 a.m., Patient B returned to Respondent Morrissey's office for bilateral breast implants to be inserted under general anesthesia.

Respondent Morrissey hired Mobile Anesthesia Equipment Services, Inc. to administer anesthesia to Patient B. Mr. Sherwood, a certified registered nurse anesthetist (C.R.N.A.) was sent by that organization to administer the anesthesia. Mr. Sherwood began the anesthesia at or about 8:00 a.m. on May 9th with Droperidol 1.25 mg. and 50 mcg Fentanyl I.V. twice. A few minutes later oxygen was started, and at 8:05 a.m. Surital 200 mg. I.V.was given; at 8:10 a.m. Nitrous Oxide was started. From on or about 8:30 to 8:45 a.m.,

pursuant to the Respondent Morrissey's directions, the C.R.N.A. administered 2 grams of Kefzol by piggyback I.V.

Respondent Morrissey began surgery at or about 8:20 a.m. At or about 8:45 a.m., due to either an insufficient level of anesthesia or an anaphylatic shock reaction to Kefzol, the patient suffered a laryngospasm and the C.R.N.A. could not ventilate the patient. At or about this time, the C.R.N.A. administered Anectine 20 mg. and intubated the patient. At this point the C.R.N.A stopped administering anesthesia and administered 100% oxygen. The C.R.N.A. was unable to obtain the patient's blood pressure. At or about 8:50 a.m. he administered epinephrine. At or about this time the drapes were removed, the stomach was found to be distended, and Respondent Morrissey began cardiac massage. At or about 9:00 a.m. neither a blood pressure nor a pulse were obtainable and Respondent Morrissey resumed cardiac massage.

At or about 9:25 a.m., Mikhail I. Zalmonov, M.D. the President of Mobile Anesthesia Equipment Services, Inc. was called about this incident. Despite the emergent condition of the patient, it was not until 3:30 p.m. that she was transferred by private ambulance to Physician's Hospital in Queens, New York. Patient B never regained consciousness and died on May 12, 1988.

1. Respondent Morrissey failed to perform an adequate pre-operative laboratory evaluation prior to surgery.

2. Respondent Morrissey failed to determine whether Michael Sherwood was a physician or a C.R.N.A. prior to the start of surgery.

3. The C.R.N.A. failed to intubate the patient prior to surgery.

4. Respondent Morrissey failed to require the C.R.N.A. the use a pulse oximeter to monitor Patient B.

5. The C.R.N.A. failed to use sufficiently potent inhalational agents to place the patient under general anesthesia.

6. Respondent Morrissey failed to have hospital backup arrangements in place at all times for all emergency conditions.

7. Respondent Morrissey failed to have Patient B transferred to the hospital immediately after she experienced cardiac arrest and CPR was administered.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent Morrissey is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law Section 6509 (2) (McKinney 1985) in that Petitioner charges:

1. The facts in Paragraphs A, A.1 through A.4.

2. The facts in Paragraphs B, B.1 through B.7.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent Morrissey is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509 (2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in Paragraphs A, A.1 through A.4., and/or B, B.1 through B.7.

FOURTH AND FIFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent Morrissey is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law Section 6509 (2) (McKinney 1985) in that Petitioner charges:

4. The facts in Paragraphs A., A.1 through A.4.

5. The facts in Paragraphs B., B.1 through B.7.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent Morrissey is charged with professional misconduct by reason of practicing the profession of medicine

with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509 (2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

6. The facts in Paragraphs A., A.1 through A.4, and/ or B., B.1. through B.7.

DATED: New York, New York
3/2/96

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Medical Conduct

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
MICHAEL F. MORRISSEY, M.D.	:	COMMITTEE

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

Charles J. Vacanti, M.D., Chairperson, Irving J. Lewis, and Robert J. O'Connor, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Debra L. Smith, Esq. served as the Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges on Respondent:	February 14, 1990
Prehearing conference:	February 28, 1990
Hearing dates:	1990: March 6, March 20, April 3, April 27, May 2
Deliberations:	June 14, 1990

EXHIBIT "B"

Place of hearing:	Offices of New York State Department of Health 8 East 40th Street New York, New York
Department of Health appeared by:	Dianne Abeloff, Esq. 8 East 40th Street Third Floor New York, NY 10016
Respondent appeared by:	Anthony Z. Scher, Esq. Wood & Scher The Harwood Building Scarsdale, NY 10583
Witnesses for Department of Health:	Michael Sherwood David J. Hammer, M.D. Mikhail I. Zalmanov, M.D. Dr. Armand V. Simone
Witnesses for Respondent:	Michael F. Morrissey, M.D. (Respondent) Dr. Benito B. Rish Martha Covi, R.N.
Hearing Committee absences:	
Charles J. Vacanti, M.D.	Briefly at beginning of May 2, 1990 hearing date. Dr. Vacanti affirms that he has read and considered any evidence introduced and the transcript of that portion of that hearing date.
Key ruling by Administrative Officer:	
Respondent's request to reopen record (to receive in evidence additional exhibit and, if necessary, to hear additional testimony) made by letter dated May 25, 1990 and denied	May 30, 1990 (telephone conference call with attorneys)

This matter was originally scheduled as a joint hearing captioned "In the Matter of Michael F. Morrissey, M.D. and Mikhail I. Zalmanov, M.D." On February 28, 1990 the administrative officer heard oral argument on the motion of Dr. Zalmanov's attorney to sever that matter. On that same date the administrative officer granted that motion. The Hearing Committee was so informed and was given instructions concerning that severance on March 6, 1990 (T: 6-9).

SUMMARY OF CHARGES

In the Statement of Charges (Ex. 1 - copy attached), the Respondent, Michael F. Morrissey, M.D., was charged with professional misconduct pursuant to Education Law §6509. The specific charges were practicing the profession with gross negligence (Education Law §6509(2)) (First and Second Specifications); practicing the profession with negligence on more than one occasion (Education Law §6509(2)) (Third Specification); practicing the profession with gross incompetence (Education Law §6509(2)) (Fourth and Fifth Specifications); and practicing the profession with incompetence on more than one occasion (Education Law §6509(2)) (Sixth Specification).

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Michael F. Morrissey, M.D., the Respondent, was authorized to practice medicine in the State of New York on February 15, 1961 by the issuance of license number 085676 by the New York State Education Department. The Respondent is registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991 from 45 Ludlow Street, Yonkers, New York 10705. (Ex. 2)

Patient A

2. On July 17, 1987, Patient A, a 34 year old woman, went to the Respondent's office located at 138 Old Town Road, Southampton, New York for bilateral breast augmentation to be performed under local anesthesia by the Respondent. (Ex. 6)

3. The Respondent did not perform a pre-operative laboratory evaluation prior to the surgery planned for Patient A. (T: 744; Ex. 6)

4. At or about 7:30 a.m. on July 17, 1987, the Respondent administered Versed 7.5 mg. and Demerol 50 mg. I.V.

While the patient was on an EKG monitor and pulse monitor, she was given nasal oxygen. At or about 7:30 a.m. Patient A's pulse was 63 and her blood pressure was 123/79. (Ex. 6)

5. As reflected in his medical record, at or about 8:00 a.m. the Respondent injected Patient A with 550 mg. Xylocaine with 1:200,000 epinephrine. Following this injection, the patient had facial twitching, clonic movements and a bradycardia of 40. (Ex. 6)

6. The Respondent then injected Patient A with Atropine .4 mg. I.V. The patient was noted to be apneic. (Ex. 6)

7. At or about 8:30 a.m. the patient was intubated and oxygen was given by an ambu bag. The Respondent then administered CPR to Patient A. (Ex. 6)

8. From at or about 7:30 a.m. Patient A's vital signs were monitored by the Respondent through the use of his Datascope 2100 monitor and pulse oximeter, and by his nursing staff. (T: 635-638; Ex. 6)

9. Patient A was transferred to Southampton Hospital at or about 9:00 a.m. She died there on July 29, 1987. (Exs. 6, 15)

10. Patient A reportedly weighed in the range of 89-115 pounds. Her weight at the time of her autopsy was 89 pounds. (Exs. 8, 10)

11. Patient A's actual body weight is not recorded in the Respondent's medical record for her. The Respondent did not weigh Patient A. The Respondent uses a standard weight of 60 kg. for all female patients. (Ex. 6, T: 738-740)

12. Prior to performing breast augmentation surgery, a physician should obtain laboratory tests. If a physician does not have this information available, he will not know if there is an abnormality which could preclude elective surgery or require the exercise of added precautions with surgery. The Respondent's failure to perform these pre-operative tests falls below the accepted standards of medicine. (T: 512, 539)

13. With Patient A's weight of 115 pounds (52 kilograms) and her premedication with Demerol, the appropriate amount of Versed for Patient A was 5.8 milligrams. 5.8 milligrams of Versed is based on the following calculations. A 52 kilogram person times .15 milligrams per kilogram (the recommended dosage) equals 7.8 milligrams. This 7.8 mg. figure needs to be reduced by 25% to 30% because Patient A was premedicated with Demerol. Consequently, the maximum safe dose of Versed for Patient A was 5.8 milligrams, not the 7.5 mg. dosage administered by the Respondent. (T: 306-308; Ex. 6)

14. The Respondent claims to have based his calculated dose of Versed on the following sentence in the usual adult dose section of the package insert: "In rare cases, a total dose of

up to .2 mg/kg may be necessary, particularly when concomitant narcotics are omitted." Based on this sentence, the Respondent administered 7.5 milligrams of Versed to Patient A. In order to give that large a dosage of Versed, the patient should not be premedicated and she should be a rare case. Patient A was premedicated. The Respondent's medical record for Patient A has no indication that she was anything but a totally healthy young woman prior to her surgery. Consequently, the only logical way to determine the amount of Versed to be administered is to rely on the following sentence (which preceded the one that the Respondent relied on): "Generally, a total dose of up to 0.1 to .15 mg/kg is adequate in average healthy adults."
(Exs. 6, 13, 13A, 13B; T: 319-320, 605)

15. The 1985, 1986, and 1987 package inserts and the PDR entry for Versed all indicate that an excessive dosage of Versed could cause respiratory depression, possibly apnea and cardiovascular depression, low blood pressure and pulse.
(T: 296-298, 308; Exs. 12, 13, 13A, 13B)

16. This dose of 7.5 mg. of Versed for Patient A resulted in hypoxia, which intensified Patient A's reaction to the subsequent injections of Xylocaine. (T: 312; Ex. 6)

17. At the time of the Respondent's surgery on Patient A, Versed had been on the market for only about two years.
(Ex. 13)

18. The Respondent testified that in Patient A he injected 300 milligrams of Xylocaine (150 mg. around each breast) and an additional 25 milligrams in each axilla. The Respondent gave no explanation as to why his medical record for Patient A, by being inconsistent with this testimony, was incorrect. (T: 630-631, 711-713)

19. 355-365 milligrams of Xylocaine with a vasoconstrictor, such as adrenaline, is the maximum dosage of Xylocaine for a woman who weighs 115 pounds. (T: 310, 571)

20. 550 milligrams of Xylocaine for a woman of Patient A's weight is excessive. (T: 310, 598)

21. Tachycardia followed by bradycardia, hypertension followed by hypotension, seizures, and tinnitus (ringing in ears) are all signs of an excessive dose of Xylocaine. (T: 311, 573)

22. Patient A's reaction to the Xylocaine (facial twitches, clonic movements, and bradycardia of 40 and then cardiac arrest immediately after the injections) indicates that she was given an excessive dose of Xylocaine. (T: 312-313, 573-574)

23. The Respondent has used Xylocaine for 25 to 30 years. (T: 711)

24. The record does not establish, by a preponderance of the evidence, that the Respondent's process of monitoring Patient A (Finding of Fact 8) was not adequate. (Record as whole concerning Patient A)

Patient B

25. On April 27, 1988, Patient B, a 21 year old woman, went to the Respondent's office located at 45 Ludlow Street, Yonkers, New York for a consultation concerning breast augmentation surgery. (Ex. 3)

26. On May 9, 1988, at approximately 7:30 a.m., Patient B returned to the Respondent's office for the insertion of bilateral breast implants under general anesthesia. (Ex. 3)

27. The Respondent sought the services of Mobile Anesthesia Equipment Services, Inc. to administer anesthesia to Patient B. Michael Sherwood, a certified registered nurse anesthetist (C.R.N.A.), was sent by that organization to administer the anesthesia. (T: 35, 38, 759-760; Ex. 3)

28. The Respondent did not determine whether Michael Sherwood was a physician or a C.R.N.A. prior to the start of Patient B's surgery. The Respondent did not ask Mr. Sherwood for any identifying documents or any licensure information. The Respondent did not ask whether Mr. Sherwood was a physician or a nurse. The Respondent had not seen Mr. Sherwood before May 9, 1988. (T: 761, 763-764, 881-882)

29. The Respondent had not previously performed this type of surgery under general anesthesia in his office. (T: 883)

30. The Respondent had not previously used the services of Mobile Anesthesia Equipment Services, Inc. (T: 753-760)

31. At or about 8:00 a.m. on May 9, 1988, Mr. Sherwood began the anesthesia for Patient B with Droperidol 1.25 mg. and 50 mcg Fentanyl I.V. twice. A few minutes later oxygen was started, and at or about 8:05 a.m. Surital 200 mg. I.V. was given. At or about 8:10 a.m. Nitrous Oxide was started. From on or about 8:30 to 8:45 a.m., pursuant to the Respondent's directions, Mr. Sherwood administered 2 grams of Kefzol by piggyback I.V. (T: 57; Ex. 3)

32. Mr. Sherwood did not intubate Patient B prior to surgery when he induced anesthesia. Mr. Sherwood used a face mask. (T: 206; Ex. 3)

33. On the day of Patient B's surgery, the Respondent had a pulse oximeter in his office. The Respondent did not require Mr. Sherwood to use a pulse oximeter to monitor Patient B. (T: 763, 766-768, 830, 840-841)

34. The Respondent began surgery on Patient B at or about 8:20 a.m. (Ex. 3)

35. At or about 8:45 a.m., the patient suffered a laryngospasm and Mr. Sherwood could not ventilate the patient. At or about this time, Mr. Sherwood administered Anectine 20 mg. and intubated the patient. At this point Mr. Sherwood stopped administering anesthesia and administered 100% oxygen. Mr.

Sherwood was unable to obtain the patient's blood pressure. At or about 8:50 a.m. Mr. Sherwood administered epinephrine. At or about this time the drapes were removed, the stomach was found to be distended, and the Respondent began cardiac massage. (T: 59-62, 64, 777-778; Ex. 3)

36. At or about 9:00 a.m. neither a blood pressure nor a pulse were obtainable and the Respondent resumed cardiac massage. (Ex. 3)

37. At or about 9:25 a.m., Mikhail I. Zalmanov, M.D., the President of Mobile Anesthesia Equipment Services, Inc., was called about this incident. (Ex. 3)

38. It was not until 3:30 p.m. that Patient B was transferred by private ambulance to Physician's Hospital in Queens, New York. (Ex. 3)

39. The Respondent was affiliated with Yonkers General Hospital, St. John's Hospital and St. Joseph's Hospital, all located in Yonkers, New York. (T: 614)

40. Patient B never regained consciousness and died on May 12, 1988. (Exs. 4, 5)

41. The Respondent failed to perform an adequate pre-operative laboratory evaluation prior to Patient B's surgery. This failure is evidenced by the fact that there are no pre-operative test results in the Respondent's medical record for Patient B. Ordering the tests and failing to get the results also

indicate a lack of understanding as to why the tests were originally ordered or a lack of concern with what the results of the tests were. (T: 227, 512; Ex. 3)

42. The Respondent's failure to ascertain anything about Mr. Sherwood's credentials or affiliation deviates from accepted standards, particularly in light of the following fact. The Respondent was allowing Mr. Sherwood to administer anesthesia, which has numerous well-known life threatening risks associated with its administration, to one of the Respondent's patients. In addition, if a plastic surgeon is working with a C.R.N.A., the plastic surgeon is responsible for supervising the C.R.N.A. (T: 202-206, 517-519)

43. When a M.D. surgeon works with a M.D. anesthesiologist, the surgeon's responsibility to the patient is not diminished. (T: 515)

44. A patient should be intubated when breast augmentation surgery is performed. Intubation is much safer than a mask because intubation avoids airway obstruction. In addition, with breast augmentation surgery, the drapes are high and it is not easy for the anesthetist to get into the airway during the procedure. Since the Respondent was responsible for Mr. Sherwood's actions, the Respondent had the responsibility to require Mr. Sherwood to intubate Patient B. (T: 206)

45. Mr. Sherwood failed to use sufficiently potent inhalational agents to place Patient B under general anesthesia. This insufficient level of anesthesia caused the patient to respond with a laryngospasm, bucking or coughing, an elevation in blood pressure or pulse. (T: 211-212; Ex. 3)

Additional Findings

46. When asked what he would do differently today in providing care to Patient A, the Respondent testified that he now does most of his surgery in the hospital, that he now uses an anesthesiologist, and that he would not use Versed. The Respondent did not say anything about Xylocaine. (T: 741-743)

47. When asked what he would do differently in providing care to Patient B, the Respondent testified that he now does most of his surgery in the hospital. The Respondent did not say anything about checking the credentials of a person who was to perform medical procedures on one of the Respondent's patients. (T: 883)

48. Martha Covi, R.N., who works for the Respondent, testified that there has been no decrease from mid-1988 to the present in the number of surgeries that the Respondent has performed in his office. (T: 950, 986-987)

CONCLUSIONS

The Hearing Committee first determined whether the factual allegations set forth in the Statement of Charges were sustained and then determined whether any sustained factual allegation constituted professional misconduct as charged.

Negligence was defined as a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Incompetence was defined as a lack of the skill or knowledge necessary to practice medicine.

Occasion, in the phrase "on more than one occasion", was defined as an event of some duration, occurring at a particular time and place, and not simply a discrete act which can occur in an instant. This definition is from Rho v. Ambach 74 N.Y. 2d 318 (1989).

Gross negligence was defined as negligence with a disregard of the consequences and an indifference to the rights of others. Gross incompetence was defined as unmitigated incompetence.

The Hearing Committee unanimously reached each of the following conclusions unless otherwise noted.

Patient A (First, Third, Fourth and Sixth Specifications)

The factual allegation set forth in paragraph A of the Statement of Charges should be sustained with three exceptions

(Findings of Fact 2, 4-7, 9). First, the Hearing Committee made no determination about the portion of the first sentence of paragraph A concerning an alleged visit by Patient A to the Respondent's office on July 10, 1987. Second, the Hearing Committee determined that the Respondent injected Patient A with 550 mg. Xylocaine (Finding of Fact 5), rather than 500 mg. Xylocaine as alleged in the sixth sentence of paragraph A. Third, the Hearing Committee made no determination about the words "at which point" in the eighth sentence of paragraph A.

The factual allegation set forth in paragraph A.1 should be sustained (Findings of Fact 3, 12). This failure by the Respondent to perform an adequate pre-operative laboratory evaluation constitutes negligence. It does not constitute gross negligence, as defined. It also does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph A.2 should be sustained with one exception (Findings of Fact 4, 10, 11, 13-16). The exception is that the Hearing Committee determined that Patient A's weight at the time of autopsy was 89 pounds (Finding of Fact 10), rather than 87 pounds as alleged. It should also be noted that the Hearing Committee's findings of fact concerning the appropriate amount of Versed are based on a patient weight of 115 pounds, the highest figure in the range (Findings of Fact 10, 11, 13). The administration of this excessive amount

of Versed by the Respondent constitutes incompetence. This conclusion concerning incompetence was based on the Respondent's calculated dose of Versed which demonstrated his lack of sufficient pharmacological knowledge about a medication which he was administering. In light of the fact that Versed was a relatively new medication in 1987 (Finding of Fact 17), this administration by the Respondent does not constitute gross incompetence. By a 2-1 vote, the Hearing Committee concluded that this administration by the Respondent does not constitute negligence. As it does not constitute negligence, it does not constitute gross negligence.

The factual allegation set forth in paragraph A.3 should be sustained with one exception (Findings of Fact 5-7, 10, 11, 19-22). The exception is the same as the exception to paragraph A.2 of the charges. Again it should be noted that the Hearing Committee's findings of fact concerning the appropriate amount of Xylocaine are based on a patient weight of 115 pounds, the highest figure in the range (Findings of Fact 10, 11, 19, 20). The Hearing Committee understood the Respondent's explanation concerning his administration of Xylocaine to Patient A but did not credit it (Finding of Fact 18). The administration of this excessive amount of Xylocaine by the Respondent constitutes incompetence. This conclusion concerning incompetence was based on the Respondent's calculated dose of Xylocaine which demonstrated his lack of

sufficient pharmacological knowledge about a medication which he was administering. In light of the fact that this administration was so excessive (550 mg. rather than maximum dose of 365 mg. - Findings of Fact 5, 19) and that the Respondent had been using this medication for many years (Finding of Fact 23), this administration by the Respondent constitutes gross incompetence. This administration does not constitute negligence, on one occasion or gross.

The factual allegation set forth in paragraph A.4 should not be sustained (Findings of Fact 8, 24).

Patient B (Second, Third, Fifth and Sixth Specifications)

The factual allegation set forth in paragraph B of the Statement of Charges should be sustained with three exceptions (Findings of Fact 25-27, 31, 34-38, 40). First, in the third sentence of paragraph B, the Hearing Committee found that the Respondent sought the services of Mobile Anesthesia Equipment Services, Inc. (Finding of Fact 27) and made no determination about the word "hired" in that sentence. Second, the Hearing Committee made no determination about the words "due to either an insufficient level of anesthesia or an anaphylatic shock reaction to Kefzol" in the ninth sentence of paragraph B. Third, the Hearing Committee made no determination about the words "[d]espite

the emergent condition of the patient" in the seventeenth sentence of paragraph B.

The factual allegation set forth in paragraph B.1 should be sustained (Finding of Fact 41). This failure by the Respondent to perform an adequate pre-operative laboratory evaluation constitutes negligence. It does not constitute gross negligence, as defined. It does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph B.2 should be sustained (Findings of Fact 28-30, 42). This failure by the Respondent to determine whether Michael Sherwood was a physician or a C.R.N.A. before surgery constitutes negligence. It also constitutes gross negligence for the following reasons. By failing to check the credentials of Michael Sherwood and to determine who he was, the Respondent could have provided the opportunity for an unlicensed and totally untrained person to perform medical procedures on the Respondent's patient, Patient B. The Respondent's inaction was more serious in light of the facts that he had not previously used Mobile Anesthesia Equipment Services, Inc. and that the Respondent had not previously performed this type of surgery under general anesthesia in his office. This failure by the Respondent does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph B.3 should be sustained (Findings of Fact 32, 44). This failure by the Respondent to ensure that Patient B was intubated before surgery constitutes negligence for two different reasons. First, because the Respondent failed to determine who Mr. Sherwood was and because the Respondent was the only physician present, the Respondent had the responsibility to supervise Mr. Sherwood and was responsible for Mr. Sherwood's subsequent actions (see preceding paragraph including Finding of Fact 42, last sentence). Second, even if Michael Sherwood had been a physician anesthesiologist, the Respondent had a responsibility to Patient B which he failed to meet (Finding of Fact 43). This failure by the Respondent also constitutes gross negligence for the same reasons as those set forth in the preceding paragraph concerning gross negligence. It does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph B.4 should be sustained (Finding of Fact 33). This failure by the Respondent to require Michael Sherwood to use a pulse oximeter constitutes negligence for the two reasons set forth in the preceding paragraph. It also constitutes gross negligence for the same reasons as set forth in the preceding paragraphs. It does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph B.5 should be sustained (Findings of Fact 31, 45). This failure by the Respondent to ensure that Michael Sherwood used sufficiently potent inhalational agents constitutes negligence for the first of the two reasons set forth in the next to the last preceding paragraph (the above paragraph concerning the factual allegation set forth in paragraph B.3). It does not constitute gross negligence, as defined. It does not constitute incompetence, on one occasion or gross.

The factual allegation set forth in paragraph B.6 should not be sustained. The Respondent's hospital affiliations were appropriate backup arrangements (Finding of Fact 39).

The factual allegation set forth in paragraph B.7 should be sustained (Findings of Fact 35, 36, 38). This failure by the Respondent to have Patient B transferred to the hospital immediately constitutes negligence. In light of the extraordinary amount of time before the patient was transferred, this failure by the Respondent constitutes gross negligence. It does not constitute incompetence, on one occasion or gross.

Specifications

As set forth above and to the extent set forth above, the following specifications should or should not be sustained. The First Specification (practicing the profession with gross

negligence - Patient A) should not be sustained. The Second Specification (practicing the profession with gross negligence - Patient B) should be sustained as to paragraph B with paragraphs B.2, B.3, B.4 and B.7, and otherwise should not be sustained. The Third Specification (practicing the profession with negligence on more than one occasion) should be sustained as to Patient A (paragraphs A and A.1) and as to Patient B (paragraph B with paragraphs B.1, B.2, B.3, B.4, B.5 and B.7), and otherwise should not be sustained. As allegations of negligence concerning two patients should be sustained, there is negligence on more than one occasion. The Fourth Specification (practicing the profession with gross incompetence - Patient A) should be sustained as to paragraphs A and A.3, and otherwise should not be sustained. The Fifth Specification (practicing the profession with gross incompetence - Patient B) should not be sustained. The Sixth Specification (practicing the profession with incompetence on more than one occasion) should not be sustained. Although the allegations of paragraph A with paragraph A.2 and with paragraph A.3 constitute incompetence, paragraphs A.2 and A.3 involve only one occasion, as defined.

RECOMMENDATIONS

As set forth above and to the extent set forth above, the Hearing Committee unanimously recommends that the following

specifications be sustained: Second (practicing the profession with gross negligence), Third (practicing the profession with negligence on more than one occasion) and Fourth (practicing the profession with gross incompetence). As set forth above, the Hearing Committee recommends that the other specifications (First as to practicing the profession with gross negligence, Fifth as to practicing the profession with gross incompetence, and Sixth as to practicing the profession with incompetence on more than one occasion) not be sustained.

The Hearing Committee recognized the nature and seriousness of the charges which should be sustained, including the sustained charges of gross negligence and gross incompetence. In particular, the Respondent's failure to determine the professional identity of Michael Sherwood and the Respondent's failure to transfer Patient B to a hospital immediately after cardiac arrest constitute egregious misconduct. Furthermore, based on the Respondent's lack of insight into the problems with his care to these patients and the Respondent's lack of credibility, the expectation is that similar misconduct by the Respondent will occur in the future. This continuing lack of insight and credibility is shown by Findings of Fact 46-48.

Therefore, after consideration of all of the possible sanctions, the Hearing Committee unanimously recommends that the Respondent's license to practice medicine be revoked.

DATED: Pittsford, New York
2 AUGUST 1990

Respectfully submitted,

Charles J. Vacanti

Charles J. Vacanti, M.D., Chairperson

Irving J. Lewis
Robert J. O'Connor, M.D.

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

IN THE MATTER :

OF :

MICHAEL F. MORRISSEY, M.D. :

COMMISSIONER'S

RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on March 6, 1990, March 20, 1990, April 3, 1990, April 27, 1990 and May 2, 1990. Respondent, Michael F. Morrissey, M.D., appeared by Anthony Z. Scher, Esq. The evidence in support of the charges against the Respondent was presented by Dianne Abeloff, 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 accepted; and

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.

EXHIBIT "C"

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

DATED: Albany, New York
September 14, 1990

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

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

MICHAEL F. MORRISSEY

CALENDAR NO. 11348

The University of the State of New York

IN THE MATTER

OF

MICHAEL F. MORRISSEY
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11348

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11348, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (February 21, 1991): That, in the matter of MICHAEL F. MORRISSEY, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 48 findings of fact, conclusions as to the question of respondent's guilt, and recommendation as to the measure of discipline be accepted, and the Commissioner of Health's recommendation as to those findings of fact, conclusions, and recommendation be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the second through fourth specifications of the charges to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and
3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty;

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 4th day of March 1991.

Thomas Sobol

Commissioner of Education