STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

February 16, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel T. Roach, Esq.
Maloney, Gallup, Roach,
Brown, & McCarthy, P.C.
1620 Liberty Building
420 Main Street
Buffalo, New York 14202

Cindy Fascia
Associate Counsel
NYS Department of Health
Division of Legal Affairs
ESP - Corning Tower, Rm. 2429
Albany, New York 12237

Donald J. Nenno, M.D.
50 High Street
Suite 1207
Buffalo, New York 14203

RE: In the Matter of Donald J. Nenno, M.D.

Dear Mr. Roach, Dr. Nenno, and Ms. Fascia:

Enclosed please find the Determination and Order (No. 93-187) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Very truly yours,

Tyrone T. Butler/lav

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:
Enclosure

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

IN THE MATTER : ADMINISTRATIVE REVIEW BOARD DETERMINATION AND ORDER ARB NO.93-187

OF :

DONALD J. NENNO, M.D. :

The Administrative Review Board for Professional Medical Conduct (Review Board), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D. and WILLIAM A. STEWART, M.D. held deliberations on January 11, 1994 to review the Professional Medical Conduct Hearing Committee's (Committee) November 12, 1993 Determination finding Dr. Donald J. Nenno guilty of professional misconduct. The Respondent requested the review through a Notice which the Review Board received on November 19, 1993. James F. Horan served as Administrative Officer to the Review Board. Daniel T. Roach, Esq. submitted a brief for the Respondent on December 23, 1993. Cindy M. Fascia, Esq. submitted a brief on behalf of the Office of Professional Medical Conduct (Petitioner) on December 20, 1993.

SCOPE OF REVIEW

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

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

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

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

HEARING COMMITTEE DETERMINATION

The Petitioner charged Dr. Nenno with gross negligence, negligence on more than one occasion and failure to maintain adequate records. The charges involved the care which the Respondent, a surgeon, provided to three patients, A through C. The Hearing Committee found the Respondent guilty of gross negligence in the treatment of Patients A and B; of negligence on more than one occasion in the treatment of Patients A through C; and, of maintaining abysmally substandard records for Patients A through C.

As to Patient A, the Hearing Committee found that the Respondent, who was performing a left hip replacement, commenced surgery on the wrong hip, failed to perform an adequate

examination prior to surgery, disregarded the patient chart and commenced surgery on the wrong hip despite a warning from the anesthesiologist. As to Patient B, the Hearing Committee found that the Respondent injured Patient B's artery during knee surgery. The Committee found that the Respondent failed to recognize clear evidence of vascular injury, and did not adequately monitor the vascular status on the leg. The Hearing Committee found that the Respondent ignored classic symptoms of complications, and that his failure was a glaring and flagrant deviation from accepted standards of prudence. Patient B's leg was eventually amputated due to the vascular injury and the failure to provide timely care to the injury. As to Patient C, the Hearing Committee found that, after the Respondent performed a hip replacement, the replacement became infected and the Respondent waited eight days to perform a procedure to clean the wound. The Committee found that the Respondent should have performed the procedure to clean the wound sooner, because signs were present of an ongoing infection which was not responding to conservative antibiotic treatment.

The Hearing Committee determined, based upon their findings on the charges and based upon their observation that the Respondent showed no contrition or remorse for his conduct, that the Respondent's license to practice medicine in New York State should be suspended for one year, with six months of the suspension stayed. The Committee ordered further that the Respondent undergo ninety hours of courses in retraining. The

Committee also placed the Respondent on probation for two years following the completion of the period of suspension and retraining.

REQUEST FOR REVIEW

The Respondent has requested that the Review Board overturn the Determination of the Hearing Committee that the Respondent was guilty of gross negligence and negligence on more than one occasion because, the Respondent alleges, the Determination was not supported by the Committee's findings of fact. The Respondent requests that, if the Board does not overrule the Committee's Determination on the charges, that the Review Board modify the Committee's Determination because the penalty is inappropriate. The Respondent contends that the Committee failed to consider mitigating factors such as the Respondent's unblemished record since 1985, the year the Respondent provided the care to all three patents. The Respondent also alleges that the Committee's judgement of the Respondent's demeanor at the hearing improperly colored the Committee's Determination as to the penalty.

The Petitioner urges the Review Board to sustain the Hearing Committee's Determination. The Petitioner contends that the Hearing Committee's findings are consistent with their Determination that the Respondent was guilty of gross negligence and negligence on more than one occasion, and that the Hearing Committee's penalty is consistent with the Committee's finding and is appropriate.

REVIEW BOARD DETERMINATION

The Review Board has reviewed the entire record in this case and the briefs of the parties. The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was guilty of gross negligence in the treatment of Patient's A and B, of negligence on more than one occasion in the treatment of Patients A through C, and of failing to maintain adequate records for Patients A through C. The Committee's findings and conclusions are consistent with their Determination on the charges.

The Review Board votes to sustain the Hearing Committee's Determination to suspend the Respondent's license to practice medicine in New York State for six months, to order the Respondent to undergo ninety hours of retraining courses and to place the Respondent on probation for two years following the suspension and the retraining period. The Committee's penalty is consistent with the Committee's findings that the Respondent was guilty of repeated, and in two instances gross, acts of negligence and the penalty is appropriate in view of the repeated and severe nature of the Respondent's misconduct.

The repeated and the severe nature of the Respondent's negligence would justify the revocation of the Respondent's license to practice medicine in New York State. The Review Board finds, however, that the Hearing Committee's conclusion to impose a penalty less severe than revocation was consistent with the Committee's conclusion that there were mitigating factors in Dr.

Nenno's case, such as the Respondent's unblemished record since the treatment of Patient's A through C in 1985.

The repeated and serious nature of the Respondent's negligence, and the severity of the outcome in the case of Patient B, do require a penalty that would discipline the Respondent for his misconduct, impress upon him the seriousness of his misconduct, assure that the public will be protected and assure that the Respondent will receive guidance in correcting the deficiencies in his practice. The Committee's Determination to suspend the Respondent's license is an appropriate penalty to discipline the Respondent and impress upon the Respondent the serious nature of his misconduct. The Determination to require the Respondent to complete retraining courses and to place the Respondent on probation with a monitor is an appropriate penalty to protect the public and assure that the Respondent will receive guidance in correcting the deficiencies in his practice.

ORDER

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

1. The Review Board sustains the Hearing Committee's November 19, 1993 Determination finding Dr. Donald J. Nenno guilty of professional misconduct.

2. The Review Board sustains the Hearing Committee's Determination to suspend the Respondent's license to practice medicine for six months, to order the Respondent to undergo ninety hours of retraining courses and to place the Respondent on probation for two years following the period of suspension and retraining.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD C. SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF DONALD J. NENNO, M.D.

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

DATED: Albany, New York
Jan 27, 1994

ROBERT M. BRIBER

IN THE MATTER OF DONALD J. NENNO, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Nenno.

DATED: Albany, New York
Feb. 2, 1994

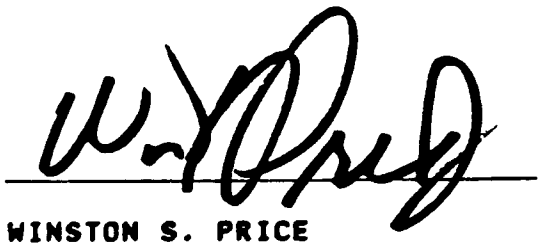
Maryclaire B. Sherwin
MARYCLAIRE B. SHERWIN

IN THE MATTER OF DONALD J. NENNO, M.D.

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

DATED: Brooklyn, New York

, 1994



WINSTON S. PRICE

IN THE MATTER OF DONALD J. NENNO, M.D.

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

DATED: Albany, New York

Febuy 7, 1994

Edward C Sinnott

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF DONALD J. NENNO, M.D.

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

DATED: Albany, New York

, 1994

William A Stewart

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

November 12, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy Fascia, Esq.
NYS Department of Health
Bureau of Professional
Medical Conduct
Corning Tower - Room 2429
Empire State Plaza
Albany, New York 12237

Daniel T. Roach, Esq.
Maloney, Gallup, Roach,
Brown, & McCarthy, P.C.
1620 Liberty Building
420 Main Street
Buffalo, New York 14202-3511

Donald J. Nenno, M.D.
50 High Street
Suite 1207
Buffalo, New York 14203

RE: In the Matter of DONALD J. NENNO, M.D.

Dear Ms. Fascia, Dr. Nenno and Mr. Roach:

Enclosed please find the Determination and Order (No. 93-187) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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Albany, New York 12237

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

As prescribed by the New York State Public Health Law, §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rg
Enclosure

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

IN THE MATTER OF DONALD J. NENNO, M.D.	DETERMINATION AND ORDER OF THE HEARING COMMITTEE ORDER NO. BPMC-93-187

The undersigned Hearing Committee consisting of **MICHAEL R. GOLDING, M.D., Chairperson, CYRIL J. JONES, M.D., and ANN SHAMBERGER,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES,** Administrative Law Judge, served as Administrative Officer.

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

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

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges:	July 2, 1992
Notice of Hearing returnable:	December 16, 1992
Place of Hearing:	Buffalo, New York Syracuse, New York Albany, New York
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	Cindy M. Fascia, Esq. Associate Counsel Bureau of Professional Medical Conduct Room 2429 Corning Tower Empire State Plaza Albany, New York
Respondent appeared in person and was represented by:	Daniel T. Roach, Esq. Maloney, Gallup, Roach, Brown and McCarthy 1620 Liberty Building 420 Main Street Buffalo, New York 14202-3511
Respondent's present address:	50 High St. Buffalo, New York 14120
Hearings held on:	February 9, 1993 March 22 and 29, 1993 May 17, 1993 July 27, 1993
Conferences held on:	January 26, 1993 February 9, 1993 March 29, 1993 May 17, 1993 July 27, 1993
Closing briefs received:	August 30, 1993
Record closed:	August 30, 1993

Deliberations held: September 14, 1993

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with gross negligence, negligence on more than one occasion and that he failed to maintain appropriate patient records. The allegations arise from the treatment of three patients in 1985. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Robert G. Leupold, M.D.	Expert Witness
Richard Ament, M.D.	Fact and Expert Witness

Respondent testified in his own behalf and called these witnesses:

Eugene Mindell, M.D.	Expert Witness and Character Witness
Richard M. Peer, M.D.	Expert Witness and Character Witness

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Committee that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state.

Gross negligence was defined as a single act of negligence of

egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart and be able to understand a practitioner's course of treatment and the basis for same.

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

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

The Committee was instructed with regard to the testimony herein having to do with a Departmental Review Committee at the Department of Orthopedics at Buffalo General Hospital and its conclusions regarding Respondent's treatment of these three patients. The Committee was reminded that it was not bound in any way by the prior body's conclusions. It was explained to the Committee that the issues and law considered by the hospital review committee were different from the issues and law to be considered by this panel. The Committee was reminded that it is the only trier of fact in this matter and that this panel must not substitute the judgments of a prior body for its judgement in this proceeding. Finally, this Committee was further reminded that it is vital that they not allow the decision of others to take from them the responsibility that they have to impartially consider the evidence in this proceeding.

The Committee was also instructed regarding character evidence. It was noted that Dr. Mindell and Dr. Peer gave testimony regarding the overall character of Respondent. Respondent also described his appointments to various positions and his accomplishments prior to and after 1985. The Committee was instructed that this type of testimony constitutes character evidence and as such cannot be considered when deliberating whether or not the acts alleged were proven, and if so whether the acts proven constitute medical misconduct as charged. However, it was further explained to the Committee that if the Committee were to make a finding of misconduct, the Committee members may

consider character testimony when determining what, if any, penalty should be imposed.

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

FINDINGS OF FACT WITH REGARD TO PATIENT A

1. Patient A was a 79 year old woman who was admitted to Buffalo General Hospital on June 28, 1985. (Ex. 3, pp. 1, 15; T. 25) Patient A presented with a history of having slipped and fallen onto her left side, with subsequent inability to ambulate because of pain in her left hip. (Ex. 3; T. 25-26) Her admitting diagnosis was fractured left hip. (Ex. 3, pp. 11-16; T. 25)

2. Patient A's orthopedic history and physical were performed and recorded on June 28 by Dr. Van Gorder. (Ex. 3, pp. 15-16; T. 25-26) Dr. Van Gorder noted that Patient A's left

leg was shortened and externally rotated, and that there was pain with movement. Dr. Van Gorder further noted that x-rays revealed a displaced left subcapital hip fracture. Dr. Van Gorder's note indicates that Respondent was notified. Surgery was scheduled for July 1, 1985. (Ex. 3, pp. 15-16; T. 25-27)

3. Patient A was admitted to Respondent's service on June 28, 1985. (Ex. 3) Patient A was admitted to Buffalo General on a Friday (June 28). Surgery was scheduled to be performed on Monday (July 1). (Ex. 3; T. 27)

4. Respondent did not record any progress notes on Patient A's chart prior to performing surgery on Patient A on July 1, 1985. He did not record any progress notes on June 28, 29, or 30. There is no indication in the nurses' notes that Respondent went to see Patient A at any time prior to the surgery he performed on July 1. (Ex. 3, T. 26-28)

5. The record does not disclose any physical examination of Patient A prior to performing surgery on her on July 1, 1985. Patient A's medical record does not reflect Respondent's presence until the date of the surgery he performed on Patient A. Respondent did not record any note indicating that he had performed his own history and physical of Patient A prior to surgery. (Ex. 3; T. 26-28) Respondent, at some point, initialed Dr. Van Gorder's history and physical. Respondent did not write his own admission note. (Ex. 3; T. 27)

6. The admission assessments, nursing history, Dr. Van Gorder's orthopedic history and physical, and every preoperative

progress note indicates Patient A's left hip was fractured. (Ex. 3, pp. 11, 13, 15-16, 18-19; T. 29-32) Patient A signed a surgical consent form on June 30, 1985, which form listed "left hip replacement" as the surgery to be performed. (T. 29-30; Ex. 3, p. 6) Surgical clearance for Patient A was obtained on June 29 from Dr. Bistany, who prepared a Report of Consultation for Respondent, Patient A's attending physician. In that Report, Dr. Bistany indicated that Patient A's left hip was fractured. (Ex. 3, p. 38; T. 30-31)

7. Patient A was placed in Buck's traction on June 28. Progress notes by the nursing staff indicate that Buck's traction was applied to and maintained on her left leg. (Ex. 3, pp. 17-18; T. 286-287)

8. Patient A was a conscious, alert, coherent patient who would have been able to express her symptoms to any health care professional who examined her. (Ex. 3; T. 284-286) In fact, the nurses' notes of June 29 indicate that Patient A had complained of pain in her left hip, which was the hip that was fractured. (Ex. 3, T. 284-286)

9. Patient A's left leg, was shortened and externally rotated due to the fracture of her left hip. Dr. Van Gorder, who performed the orthopedic history and physical on the day of her admission to Buffalo General Hospital, noted that the shortening and external rotation were visible. (Ex. 3) The shortening and external rotation of Patient A's left leg were noted by the nurses to be present and visible on June 29. (Ex. 3, T. 285-286)

10. On June 30, the day prior to surgery, Patient was evaluated preoperatively for anesthesia. The anesthesia evaluation noted that the patient's diagnosis was left hip fracture. (Ex. 3, p. 75)

11. On July 1, Patient A was brought to the operating room for surgery. The anesthesiologist for the procedure, Dr. Richard Ament, and the assisting anesthesia resident Dr. Whitmer, checked Patient A's medical record, had some discussion with Patient A, and administered general anesthesia to Patient A. (Ex. 3; T. 239-240)

12. Respondent entered the operating room after Patient A had been put to sleep. (T. 240) Respondent then directed the operating room staff to position Patient A with her right hip elevated. (T. 240; T. 290-291) The medical record indicates that Respondent ordered the patient positioned for a right hip fracture. (Ex. 3, pp.76)

13. Dr. Ament, the anesthesiologist for the procedure, told Respondent that Patient A's chart indicated that it was her left hip, not her right hip, that was fractured. Dr. Ament told Respondent all the entries in Patient A's record indicated this. (T. 240)

14. Patient A's chart was present in the operating room at the time this discussion took place between Respondent and Dr. Ament. (T. 241) It was the general practice at Buffalo General Hospital to have the patient's chart available in the operating room at the time of surgery. (T. 288; T. 240-241)

Respondent knew, at the time he performed surgery on Patient A, that it was the practice at Buffalo General Hospital to have the patient's chart available in the operating room. (T. 288)

15. Respondent told Dr. Ament that it was the right hip that was fractured. Respondent told Dr. Ament that Patient A's x-rays showed a right hip fracture. (T. 240) Respondent pointed to an x-ray that was up on the x-ray box. (T. 240)

16. There was a labeling error on the AP view of Patient A's hip. (T. 271-278, 288-290) The pelvis film, which was in the same x-ray folder and was available to Respondent in the operating room the day of surgery, was correctly labeled, and showed that the left hip, not the right hip, was fractured. (T.288-289; T. 35-38 ; Ex. 8A and 8B; B2 - B4)

17. On the original x-ray films for Patient A, the positioning of the name plate on the mislabeled AP hip film was correct. The positioning of a nameplate on an x-ray film is an important guide, used by physicians to help orient the film. The position of the name plate on this film was contrary to the other label and thus would raise a question as to whether the film was mislabeled as was indeed the fact here. (T. 271-278, 288-290, 296-298)

18. Respondent did not review Patient A's hospital record to confirm which hip was fractured. (T. 291-292)

19. Respondent did not request that a portable x-ray be taken in the operating room to confirm which hip was fractured. Portable x-rays were available to him at that time at the Buffalo

General Hospital. (T. 294-295; T. 252)

20. Respondent commenced surgery on Patient A's right hip. (T. 290-294)

21. Respondent teed (incised and opened) the capsule of the hip along the trochanter and exposed the femoral neck. (T. 291, 305-306; Ex. 3, p. 76) When Respondent saw that there was no blood in the capsule, he realized that the right hip was not fractured, and that the hip he had opened was not the injured hip. (T. 291, 305-306; Ex. 3, p. 76) Respondent then closed the hip capsule, the fascia, and skin. He then ordered that Patient A be repositioned and commenced surgery on the left hip. (T. 242; T. 305-306; Ex. 3, p 76) Respondent alleged he saw Patient A on June 29 and 30. There is no note supporting this assertion either by Respondent or the nurses.

CONCLUSIONS WITH REGARD TO PATIENT A

The State has leveled four factual allegations against Respondent arising from the treatment of Patent A. In brief synopsis, they are: 1) He commenced surgery on the right hip when it was the left which warranted care; 2) He failed to perform or record an adequate physical examination on this patient prior to surgery; 3) He disregarded the patient chart which contained numerous references to the left (correct) hip; 4) He commenced surgery on the wrong hip despite warnings from the anesthesiologist. The Committee sustains each of the allegations and finds that each constitutes an act of gross negligence.

In so finding, the Committee turns first to Allegation A.2 (failure to examine prior to surgery). The Committee finds that notwithstanding Respondent's testimony to the contrary, he did not visit this patient prior to the surgery and did not examine her. Neither Respondent's records nor the nursing notes show that Respondent was present. One would have expected at least one or the other keepers of the patient record to have noted a visit by Respondent had Respondent actually visited this patient. In the absence of any record, and considering the unlikelihood that both Respondent and the nurses would fail to record that a visit took place, the Committee finds that Respondent did not visit this patient prior to surgery and hence, no physical examination occurred.

Therefore, based upon the above conclusions:

FACTUAL ALLEGATION A.2 IS <u>SUSTAINED</u>

With regard to Allegations A.1 (commencing surgery on the wrong hip), A.3 (failure to review chart information regarding correct hip) and A.4 (commencing surgery on wrong hip despite warning from anesthesiologist), these allegations fall within the same pattern of substandard care and will be addressed together. There can be no doubt that Respondent commenced surgery on the wrong side of this patient's body. It is also beyond dispute that the patient record was available to Respondent and that this document was clear as to which hip was to receive care. Respondent simply did not review the chart prior to the surgery. Nor did he take any other steps to confirm the patient's

orientation such as a portable x-ray. Finally, there can be no doubt that Respondent was warned by the anesthesiologist, also a physician, that he was about to perform surgery on the wrong hip yet chose to ignore the warnings.

Therefore, based upon the above conclusions:

FACTUAL ALLEGATION A.1 IS SUSTAINED
FACTUAL ALLEGATION A.3 IS SUSTAINED
FACTUAL ALLEGATION A.4 IS SUSTAINED

Having sustained the factual allegations, the Committee now turns its attention to the specifications. The First Specification alleges that the above acts constitute gross negligence. The Committee sustains this Specification and finds that each of the four acts sustained constitutes a separate act of gross negligence. In so finding, the lesser included offense of negligence on more than one occasion is also sustained.

It is the conclusion of this Committee that the failure of Respondent to perform even a limited examination of the area which was about to undergo surgery was a flagrant violation of basic standards of medicine. The Committee finds that except in an emergency, the most basic standards of prudence would warrant that the surgeon visit the patient prior to surgery and satisfy himself as to the nature of the patient's condition and the state of the anatomy prior to bringing the patient to surgery. Respondent's failure to examine this patient may well have contributed to the very serious error which indeed took place. Whether or not examining the patient prior to surgery might have avoided the problem which arose, it was a glaring lapse of basic medical

standards for Respondent to fail to examine this patient prior to surgery.

In finding Respondent grossly negligent based upon the three remaining allegations, the Committee is mindful that physicians are human and are thus capable of error. That is why hospitals and physicians have procedures whereby checks and balances exist. Fundamental prudence therefore dictates that a physician rely upon the checks and balances to avoid potentially disastrous results. In this case, Respondent had repeated warnings that he was about to operate on the wrong side of the body. He ignored these warnings. His actions constitute professional hubris of the highest degree. Where another physician calls one's attention to something as fundamental as which side of the body one is about to perform surgery on, the surgeon has an inescapable duty to listen and confirm which side of the body warrants care. Respondent failed in this most basic duty.

Part of Respondent's defense was that one of the X-Rays in this case was mislabeled. The Committee finds this defense of no merit for two reasons: First, the nameplate on the X-Ray acted to orient the film. A prudent practitioner, particularly one whose attention had been flagged by another physician, would have noted a discrepancy between the letter indicating the orientation of the film and the name plate. It follows that a prudent physician, noting a discrepancy, would have obtained confirmation as to which side of the patient warranted care by reviewing the patient record or taking other action as warranted to assure himself that he was

about to work on the correct limb. It is in this regard that the second reason arises which defeats respondent's defense: The patient record was available to Respondent and was completely clear as to which side of the body was to have the surgery. Thus, by performing the most rudimentary follow-up, based upon the warnings of a colleague, Respondent could have avoided what was at least a painful mistake for the patient and one which certainly exposed the patient to unwarranted risks of needless surgery.

Having weighed the seriousness of the consequences, surgery to the wrong body part, against the ease and simplicity of the steps for confirmation, review of an available patient record which was clear and unequivocal, the Committee finds Respondent's acts to constitute dramatic and flagrant violations of accepted standards of care and diligence, and hence, gross negligence. Having found gross negligence, the lesser included offense of simple negligence is also sustained for one occasion.

Therefore, based upon the above conclusions:

The FIRST SPECIFICATION IS <u>SUSTAINED</u>
The THIRD SPECIFICATION IS <u>SUSTAINED</u>

Finally, the Committee turns its attention to the Fourth Specification which alleges Respondent kept substandard records. State regulations and accepted standards of medicine require practitioners to keep patient records which are sufficient to inform substitute physicians or future reviews what care was rendered and the thinking of the practitioner which led to the care. In this case, as in the other two presented, it is impossible to ascertain from Respondent's notes what his

intentions were much less what he was thinking. While the orders give some insight into Respondent's analysis of the situation at the time, this is not sufficient to meet acceptable standards.

Therefore, based upon the above conclusions

The FOURTH SPECIFICATION IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Patient B was a 42 year old woman who was admitted to Buffalo General Hospital on September 8, 1985. (Ex. 4, p.3; T. 75) She was admitted for surgery on her left knee. Patient B was a registered nurse and had injured her knee at work while attempting to restrain a psychiatric patient. (Ex. 4, p. 18) Since that injury she had knee pain with a loss of flexion and "giving out" of the knee, with periodic swelling and frequent "clicking and popping". She was taking Motrin 400 mg. p.r.n. (Ex. 4)

2. On September 9, 1985, Respondent performed surgery on Patient B at Buffalo General Hospital. (Ex. 4) Respondent's assistant in the surgery was a resident, Dr. Lawrence Lee. The surgery Respondent performed on Patient B consisted of an arthroscopic medial and lateral partial meniscectomy. Respondent's preoperative diagnosis for Patient B had been "torn medial meniscus, left knee". His postoperative diagnosis was "torn medial and lateral menisci", as well as torn anterior cruciate ligament. (Ex. 4, p. 167)

3. In the Operative Report of the surgery Respondent performed on Patient B on September 9, 1985, it is noted that when the partial meniscectomy of the lateral meniscus was being performed "from the middle third posteriorly", the procedure was "rendered somewhat difficult by continued oozing from the resected synovium". (Ex. 4, p. 167; T. 343-345)

4. The "oozing" mentioned in the Operative Report was blood. The blood was "oozing" in sufficient quantity to make visualization difficult in the operative field. At the time, Respondent believed that the source of the substantial bleeding was the synovial lining of the knee. (T. 344-345)

5. A tourniquet was utilized for the surgery Respondent performed on Patient B on September 9, 1985. The tourniquet was placed at the level of mid-thigh. (Ex. 4, p. 167; T. 75; T. 316-317) The purpose of a tourniquet in such a surgery is to keep blood from flowing into the extremity so that the surgeon can better visualize the operative field. Bleeding makes visualization more difficult. (T. 75-76; T. 346)

6. Respondent ordered that the tourniquet pressure be set at 400 millimeters of mercury. (Ex. 4, T. 316-317) This is a high setting for a tourniquet. (T. 123-124) A tourniquet at that setting cuts all blood flow to the leg. (T. 169) Respondent chose this high tourniquet pressure because of the size of the patient's leg. (T. 317, 346) This was a higher tourniquet setting than usual. (T. 346-347; T. 123-124)

7. The tourniquet time for the surgery Respondent

performed on Patient B was two hours and twenty minutes. (Ex. 4, p. 210; T. 347; T. 124-125) This is a longer tourniquet time than usual for arthroscopic meniscectomy. (T. 124) It was longer than Respondent had previously used, for a bilateral meniscectomy with a torn cruciate ligament. This was the condition that Patient B had. (T. 347-348)

8. When the tourniquet was deflated at the conclusion of the surgery, there was brisk, heavy oozing of blood from the stab incisions in Patient B's knee. The bleeding from the wounds was of a sufficient quantity that it interfered with closure of the wounds. Because of the brisk bleeding from the wounds, Respondent ordered that the tourniquet be re-inflated to accomplish closure of the wounds. When the tourniquet was re-inflated, the bleeding stopped, and the wounds were sutured. (T. 443-444, T. 348-349, T. 421-427)

9. It is unusual for re-inflation of a tourniquet to be necessary to close a wound. (T. 444, 423-424) The amount of the bleeding caused Respondent to decide to re-inflate the tourniquet. (T. 424) Respondent sutured and dressed the wound. Respondent did not investigate the cause of the bleeding. (T. 348-349, 427-428)

10. According to the Operative Note, "some retardation of capillary filling was noted initially, followed by a degree of cyanosis noted in the toes". (Ex. 4, p. 167) These were unusual findings. (T. 76) Cyanosis is a bluish discoloration caused by a lack of oxygenated arterial blood to an area. (T. 76)

11. Patient B was brought to the PARR (Recovery Room) on September 9 following the surgery performed by Respondent. The Recovery Room nurse noted that Patient B's left foot was cyanotic and there was no dorsalis pedis pulse. Respondent was made aware of these findings. (Ex. 4, p. 23; T. 342-343)

12. At approximately 1 p.m. on September 9, 1985, Patient B was brought from the Recovery Room to her room on the unit. Patient B complained of "extreme pain" in the left calf area. Her toes were cool. She denied any feeling in her toes, and was unable to wiggle them. (Ex. 4, p. 23) Various pain medications were administered to Patient B. Initially, 20 mg. of Nubain by intramuscular injection (IM) were given without effect, then 25 mg. of Demerol were administered at 2 p.m. Patient B, despite these medications, continued to complain of "excruciating, intolerable pain" in the left calf area. Throughout the shift, the patient was noted to be "quite expressive about pain when alert". (Ex. 4, p. 23)

13. At change of shift, Patient B was "crying out in pain", and complaining of "severe pain" in her left leg from mid thigh to ankle, with no feeling in her foot. She was unable to wiggle her toes. "Slightly sluggish capillary return" was noted in the left great toe. Patient B complained of a "burning sensation" in her lower leg. Respondent was made aware of the Patient's complaints, and he changed the orders for pain medication for Patient B to morphine sulfate. (Ex. 4, p. 23, 245) Patient B received 8 mg. of morphine sulfate IM at 3:15 p.m.,

with no relief of her pain. At 4:15 p.m., because of the patient's complaints of "excruciating pain", she was given another 4 mg. of morphine sulfate, and was coached in breathing and muscle relaxation. At 7:30 p.m., another 12 mg. of morphine sulfate was administered IM, which temporarily controlled the patient's pain to a "tolerable level." However, by 9 p.m., the patient was again complaining of a "burning sensation" in her lower leg, and numbness of her foot. (Ex. 4, p. 23)

14. During the 11 p.m. - 7 a.m. shift, Patient B's pain persisted. At 2 a.m. on September 10, she received 8 mg. of morphine sulfate. Less than three hours later, at 4:20 a.m., she was "crying in pain" and given an additional 4 mg. of morphine with only "slight relief". Patient B stated that she usually had a high pain tolerance. She continued to complain of numbness of her foot and toes. (Ex. 4, p. 24)

15. On September 10, 1985, the day after Respondent performed the arthroscopic surgery, Patient B's presentation continued to be abnormal for post-surgical arthroscopic meniscectomy. (T. 88, 91) During the 7 a.m. - 3 p.m. shift, the nurse noted that Patient B continued to complain of pain in her left calf area. She denied feeling in her toes, and was unable to wiggle her toes. She continued to receive morphine sulfate (10 mg. at 12:15 p.m.) for pain. (Ex. 4, p. 24)

16. Dr. Failla, a resident, saw Patient B on the morning of September 10. He noted Patient B's complaint of knee pain. Respondent initialed the resident's note, but did not write his

own note. (Ex. 4, p. 24; T. 87)

17. At 5 p.m. on September 10, the resident, Dr. Failla, was called to see Patient B because of her continued pain in her left knee and calf despite shots of morphine sulfate. Dr. Failla's findings were that the patient's left foot was cooler than her right foot, with decreased pinprick sensation in the left foot. The patient had pain with passive extension of her left foot. Her left calf was tender and swollen, and greater in circumference than her right calf. (Ex. 4, p. 25; T. 92-93, 102)

18. Respondent was notified of Patient B's condition. The Resident, Dr. Failla, suspected compartment syndrome at that time as the cause of Patient B's problems. At approximately 7:30 p.m. on September 10, Patient B was brought to the Operating Room. Respondent measured the compartment pressures of Patient B's left leg and performed fasciotomies on the patient's leg. (T. 101-103; Ex. 4, pp. 25-26)

19. After the fasciotomy, however, the status of Patient B's leg did not improve. The nurse noted at 8:30 p.m. that Patient B's foot was cool and pale. (Ex. 4, p. 26; T. 105) Patient B was admitted to the PARR (Recovery Room) at 8:35 p.m. The Recovery Room nurse noted that Patient B's foot was cool to the touch. At 10:05 p.m., Patient B was returned to her room on the unit. The nurse's note indicates that the toes of Patient B's left foot were "cool and mottled". She continued to receive pain medications. (Ex. 4, p. 27; T.105)

20. Respondent did not write any contemporaneous notes in Patient B's chart regarding the compartment pressure measurements or the fasciotomy he performed on September 10. He did not write any notes regarding his suspected diagnosis of compartment syndrome, or his plan of treatment for Patient B. (Ex. 4, T. 109)

21. Respondent on January 10, 1986, dictated an Operative Report ("Report of Findings and Procedure") for the surgery he performed on September 10. In this note, dictated four months after the procedure, Respondent stated that after the fasciotomy, the color of the patient's foot was "satisfactory, with good capillary refill". (Ex. 4, p. 190) Respondent's operative note, dictated four months after the surgery, is inconsistent with the notes made in Patient B's record on September 10, shortly after surgery was performed, which do not describe the status of her foot favorably. (Ex. 4, p. 27; p. 190; T. 406-409) At the time that Respondent dictated this operative note, he knew that Patient B had undergone amputation of her left leg. (T. 407)

22. On September 11, 1985, at 1:00 a.m., Dr. Failla again examined Patient B. She continued to have pain in her left calf, and had been receiving analgesics every three hours. Dr. Failla found Patient B's left foot to be cyanotic and cool. Pinprick sensation was absent in the left foot. She had active toe extension, but no toe flexion. Both the dorsalis pedis and the posterior tibial pulses were absent, by palpation and with

the use of a Doppler. (Ex. 4, p. 27) Respondent was notified, and requested "a consult by Dr. Peer's service ASAP". Dr. Peer is a vascular surgeon. (Ex. 4, p. 27; T. 111)

23. An emergency left femoral arteriogram was performed on Patient B in the early morning hours of September 11, 1985. The study showed "complete occlusion of the proximal left popliteal artery without any reconstitution of the distal calf vessels noted." At that time, it was thought that this was "most likely due to acute thrombosis". (Ex. 4, pp. 28, 114; T. 609-610)

24. Dr. Peer, a vascular surgeon, examined Patient B, her left leg was "very cool, cold, cyanotic and pulse-less". Her leg was actually anesthetic, and was ischemic. In Dr. Peer's opinion, Patient B's leg had been without circulation for at least twelve and up to thirty hours. (T. 616-617)

25. The best possibility of successful repair after a vascular injury is within the first six hours. (T. 622-623)

26. Patient B was again brought to the operating room at approximately 6:30 a.m. on September 11. Dr. Peer performed an exploration of the left femoral artery. He attempted to pass a Fogarty catheter to remove clots and restore circulation to the limb, but the catheter could not be passed beyond the level of the knee to the popliteal artery. Attempts to use a stylet and a small Fogarty were also unsuccessful. A below the knee exploration of the popliteal artery was then performed by Dr. Peer. He found "a great deal of ecchymosis in the area of the neurovascular bundle". (T. 3, 4, p. 210; T. 609-610) The

popliteal space was filled with hematoma, old dark blood, and clots. (T. 619, 626) Dr. Peer found the popliteal artery, which appeared to have been transected. (Ex. 4, pp. 210; T. 610, 626-627)

27. In an attempt to restore circulation, Dr. Peer performed a left proximal popliteal to posterior tibial bypass using saphenous vein. Later in the day on September 11, Patient B was returned to the Operating Room, where Dr. Peer performed an exploration of the bypass graft to rule out thrombosis. The attempts to restore circulation to Patient B's lower leg were unsuccessful. On September 20, 1985, Patient B's left leg was amputated below the knee. (Ex. 4, pp. 199, 217; T. 610-611, 628-629)

CONCLUSIONS WITH REGARD TO PATIENT B

The State has alleged four factual allegations arising from the care of Patient B. In brief summary they are: 1) failure to recognize or address the presence of a vascular injury in a timely manner; 2) failure to adequately monitor the vascular status of the left leg; 3) failure to obtain a timely consultation with a vascular surgeon; 4) inadequate progress notes. The Committee sustains each of the allegations.

This patient had relatively minor surgery which eventually cost her leg. During the post operative course, the patient showed clear signs and symptoms of arterial insufficiency.

Respondent chose to ignore the patient's complaints of severe pain and the reports of intermittent failure to obtain a dorsal pulse, lack of feeling, cyanosis and coolness to touch. These factors would have led a prudent physician to act on an urgent basis rather than waiting almost 30 hours after the surgery. Respondent should have suspected arterial insufficiency and taken steps to confirm this diagnosis or rule out others. Arterial insufficiency is so significant a condition that it would warrant immediate attention. There was credible expert testimony that if this patient's condition had been treated sooner, her leg may have been saved. This was not a situation in which conservative treatment was appropriate since time was of the essence. Yet, Respondent did not arrange for a vascular consultation until September 11, by which time it was too late.

It is the conclusion of this Committee that Respondent had clear evidence of a vascular injury to the patient's left leg, but did not recognize it. Part of the reason the injury was not recognized is that Respondent did not adequately monitor the vascular status of the patient's leg, opting instead to treat compartment syndrome when a vascular surgical consultation was called for. In the same line, based upon the existence of the symptoms reported, a vascular surgeon should have been consulted well prior to September 11. Finally, Respondent did not keep contemporary notes in this case.

Therefore, based upon the above conclusions:

FACTUAL ALLEGATION B.1 IS SUSTAINED
FACTUAL ALLEGATION B.2 IS SUSTAINED

FACTUAL ALLEGATION B.3 IS SUSTAINED
FACTUAL ALLEGATION B.4 IS SUSTAINED

Having sustained the factual allegations, the Committee now turns its attention to the Second, Third and Fourth Specifications. The Committee finds that each of the factual allegations supports a finding of gross negligence. Vascular injury is a well known complication of meniscectomy. The patient demonstrated classic signs and symptoms of this known complication yet Respondent failed, until it was too late, to address the condition. Part of the reason that he may have failed to consider vascular injury is that he relied upon the nurses' representations that pulses could be felt in the left leg. However, obtaining an accurate pulse in this region is quite difficult. Given the extraordinary amount of pain and intermittent reports of cyanosis, coolness to touch and other enumerated symptoms, Respondent had a duty to investigate himself and confirm his examination by doppler. Respondent utterly failed in this regard. In weighing the gravity of the harm, the ease of follow-up and the obvious nature of the symptoms of a known complication, the Committee finds Respondent's failure to constitute a glaring and flagrant deviation from accepted standards of prudence. Consequently gross negligence is established.

By the time Respondent obtained a vascular consultation, the limb was basically damaged beyond repair and could not be saved. Respondent, in his defense, suggested that it may have been the vascular surgeon who actually severed the artery in this case. The question of who actually severed the artery is irrelevant.

What is relevant is that this patient showed clear signs and symptoms of arterial insufficiency virtually from the time she was moved to the recovery room. It is Respondent's failure to address the arterial insufficiency which is at issue and which is the basis of his culpability. Again, as set forth above, given the extreme nature of the possible consequences weighed against the obvious nature of the symptoms and the ease of follow-up, the Committee finds Respondent's failure to act an extreme deviation from basic and fundamental standards of prudence and hence, gross negligence.

Finally, as was stated earlier, Respondent's patient records in this case as in the others leaves the Committee to surmise what he was thinking. This is a clear violation of accepted standards.

Therefore, based upon the above conclusions:

The SECOND SPECIFICATION IS SUSTAINED
The THIRD SPECIFICATION IS SUSTAINED
The FOURTH SPECIFICATION IS SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. Patient C was a fifty-two year old man who was admitted to Buffalo General Hospital on May 19, 1985 for a revision of his left total hip replacement. (Ex. 6; T. 196) Respondent was Patient C's attending physician. (Ex. 6; T. 196)

2. On May 20, 1985, Respondent performed surgery on Patient C at Buffalo General Hospital. The surgery performed on that date was a revision of Patient C's left total hip replacement

to a PCA non-cemented hip replacement. (Ex. 6, p. 54-55; T. 196-197).

3. On May 23, 1985, Patient C was noted to have an alteration in comfort, with increased pain of his left hip. The nurses noted that there was a "small amount" of "serous sanguinous drainage". On the following day, May 24, a "small amount of serous sanguinous drainage" was noted. On May 25, Patient C had a low-grade temperature, and a small amount of serous drainage was again noted. The following day, May 26, the wound site was draining small amounts of yellow secretions. On May 27, the wound was described as "fine", and on May 28 it was described as "benign". On May 29, "slight redness at the proximal portion of wound was noted. "Scant drainage" was noted on May 30. The physical therapist noted that the patient complained of greater discomfort in the hip region. (Ex. 6, pp. 15-21; T. 197-198)

4. Patient C was discharged from Buffalo General Hospital on May 30, 1985. (Ex. 6; T. 198)

5. On June 1, two days after his discharge, Patient C was re-admitted to Buffalo General Hospital. On re-admission, Patient C was complaining of severe pain in his left hip, radiating down his left leg. (Ex. 5, p. 5; T. 199) The pain had progressed to the point that he was unable to ambulate. The patient also complained of chills, and when his temperature was taken at Buffalo General Hospital his fever was 103.5. (Ex. 5, pp. 9-10) The hip wound was noted to have a large amount of

drainage, with a liquefying hematoma. (Ex. 5, p. 9)

6. Patient C was admitted to Respondent's service on July 1, 1985. Respondent was the attending physician for Patient C for this re-admission. Respondent was notified of the patient's condition on admission. (Ex. 5; T. 200, T. 462-464)

7. According to the admission history and physical, the impression was that Patient C had an infected left total hip replacement. (Ex. 6, p. 9; T. 200)

8. Patient C's left hip was incised and drained in the Emergency Room on June 1. Afterward, the wound was noted to be draining moderate amounts of sero-sanguinous fluid. Areas of redness were noted. Patient C's left leg was noted to be swollen from foot to thigh. (Ex. 5, p. 10; T. 200-201)

9. On June 2, the day after Patient C's readmission, the left hip was draining moderate amounts of sero-sanguinous drainage. Patient C's leg was noted to appear "swollen, especially at the ankle". Another nursing note on June 2 states that the hip dressing was changed, with a large amount of "purulent" drainage. The left leg was "edematous". (Ex. 5, p. 11) On June 3, the hip dressing was changed for a "moderate amount of purulent" drainage. The left leg was noted to remain "edematous and hard around left hip wound." (Ex. 5, p. 12)

10. On June 2, Respondent noted in the patient's chart "must worry about deep wound infection", and that he would check the cultures and prescribe accordingly. (Ex. 5, p. 11) On June 3, Respondent noted that Patient C had a low grade temperature.

Cultures were positive for staph aureus. Respondent noted that he would "continue Ancef and follow wound."

11. On June 4, the 3-11 shift noted Patient C had a temperature of 99.6. Warm soaks were applied to the hip incision, with a "scant amount of yellow drainage" from the incision site. Several reddened areas were noted along the incision. On June 6 and 7, the patient was afebrile, with no drainage described, but the patient complained of pain in his left hip with movement or weight-bearing. (Ex. 5, pp. 12-13)

12. On June 8, Patient C was complaining of persistent pain in his left hip. During the morning of June 8, there was "copious drainage" from the hip wound. During the 7-3 shift on June 8, the hip dressing was changed three times, with a "large amount of yellow-brown secretions" from the wound site. Respondent was notified about the drainage, and a decision was eventually made on June 8 to debride the hip wound. (Ex. 6, p. 14)

13. Respondent performed a debridement of Patient C's infected left total hip replacement on June 9, 1985. The prothesis was removed. Significant granulation tissue and necrotic tissue were noted. (Ex. 6, p. 146; T. 203-204)

14. Debridement is a procedure in which the surgeon cleans the infected wound. The wound is drained and washed out, and necrotic tissue is cut away so that only normal tissue remains. Indications for debridement of a wound are the presence of wound infection, foreign material, dead or devitalized tissue

in the wound. (T. 203-204)

15. Respondent did not debride Patient C's infected left total hip replacement until June 9, 1985. (Ex. 5; T. 203-208; 211-212)

CONCLUSIONS WITH REGARD TO PATIENT C

The Factual Allegations brought regarding Patient C are simple and straight forward: Respondent should not have waited until June 9 to debride the infection and the patient records were inadequate. The Committee sustains both allegations.

While the Committee does not believe that the incision and drainage in the emergency room was inappropriate, given the obvious symptoms of deep wound infection, Respondent should have debrided the wound well before he did on June 9. This patient had a high fever, chills, severe hip pain and significant wound drainage. All were signs of an ongoing infection process which was not responding to conservative antibiotic treatment.

With regard to the patient records, again, the Committee was left to surmise what Respondent was thinking in the care and treatment of this patient. As stated previously, patient records must contain a clear statement of the care rendered and the analysis which led to the care. Respondent failed to meet this standard.

Therefore, based upon the above conclusions:

FACTUAL ALLEGATION C.1 IS SUSTAINED
FACTUAL ALLEGATION C.2 IS SUSTAINED

With regard to Patient C, Respondent is charged under the

Third Specification with simple negligence and under the Fourth Specification with substandard records. The Committee sustains both specifications for the reasons stated above: Respondent had clear evidence of an ongoing infectious process which warranted debridement. He chose to ignore the obvious signs and symptoms. Hence, he failed to demonstrate that level of care and diligence expected of a prudent physician in this state. Negligence is therefore established.

With regard to the patient record, as set forth above, Respondent failed both in quantity and quality of information provided. There is a clear deviation from accepted standards of record keeping as set forth in the Education Law.

Therefore, based upon the above conclusions;

The THIRD SPECIFICATION IS SUSTAINED
The FOURTH SPECIFICATION IS SUSTAINED

CONCLUSIONS WITH REGARD TO PENALTY AND ORDER

This Committee has found two counts of gross negligence and three counts of ordinary negligence. The Committee found three examples of abysmally substandard records. Respondent's lapses were clearly egregious acts of substandard care. Moreover, the gravity of the outcome to Patient A is relevant with regard to penalty. During this proceeding, Respondent showed no signs of contrition or remorse. If this has been a sobering experience for Respondent, it was neither stated nor demonstrated in his demeanor. Yet, the Committee was favorably impressed with

Respondent's most recent successful medical practice. Accordingly, the Committee believes that while the seriousness of these cases amount to revocable offenses, revocation would not serve either the public or Respondent. Rather, the Committee believes that a period of suspension, retraining, and probation would serve all interests well.

Therefore, it is hereby **ORDERED:**

That Respondent's license shall be immediately **SUSPENDED**, for a period of **ONE YEAR.**

Furthermore, it is hereby **ORDERED THAT;**

SIX MONTHS of the said **SUSPENSION** shall be **PERMANENTLY STAYED** for a net **SUSPENSION OF SIX MONTHS.** On condition of successful completion of **RETRAINING** as set forth below.

Furthermore, it is hereby **ORDERED THAT;**

Respondent shall successfully complete a course of **RETRAINING** to consist of **NINETY (90) HOURS** of courses selected by Respondent, sanctioned by the American Academy of Orthopedics and approved by the director of the office of professional medical conduct. Furthermore, the said **NINETY (90) HOURS** shall be completed **WITHIN SIX (6) MONTHS** of commencement of retraining.

Furthermore, it is hereby **ORDERED THAT;**

Upon successful completion of the above period of **SUSPENSION AND RETRAINING**, Respondent shall be subject to a period of **PROBATION** of not less than **TWO YEARS.**

Furthermore it is hereby **ORDERED THAT;**

During the period of **PROBATION**, Respondent shall be **MONITORED**

pursuant to Section 230 (18)(a)(i),(ii),(iii) and (vi) of the Public Health Law. In summary, these provisions state that Respondent shall be subject to review by selection of records pertaining to patients, may be required to visit members of the board, shall obtain a practice monitor, and additional training may be required.

Furthermore it is hereby **ORDERED THAT;**

All of the above shall be at Respondent's expense.

Dated: New York, New York
9 November 1993

MICHAEL R. GOLDING, M.D.
Chairperson

CYRIL J. JONES M.D.
ANN SHAMBERGER

APPENDIX I

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

----------X

IN THE MATTER : STATEMENT

OF : OF

DONALD J. NENNO, M.D. : CHARGES

----------X

DONALD J. NENNO, M.D., the Respondent, was authorized to practice medicine in New York State on March 7, 1980, by the issuance of license number 141376 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from 50 High Street, Suite 1207, Buffalo, New York 14203.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (Patients are identified in the Appendix) from July 1, 1985 through July 27, 1985, at Buffalo General Hospital, 100 High Street, Buffalo, New York [hereinafter "Buffalo General Hospital"]. Patient A had been admitted to Buffalo General Hospital on June 28, 1985, with a diagnosis of a fractured left hip.

1. Respondent, on July 1, 1985, commenced surgery on Patient A's right hip when, in fact, it was Patient A's left hip that was fractured.

2. Respondent, subsequent to Patient A's admission and prior to commencing surgery on Patient A's right hip, failed to perform an adequate physical examination of Patient A and/or failed to adequately record the result of any physical examination he performed on Patient A prior to surgery.

3. Respondent, prior to commencing surgery on Patient A's right hip, failed to review and/or disregarded Patient A's hospital record, which contained numerous references to the patient's fractured left hip.

4. Respondent, when he was positioning Patient A for surgery, was advised by the anesthesiologist that Patient A's hospital record indicated that the left hip was fractured. Respondent, despite the anesthesiologist's advice and without confirming which hip was fractured, commenced surgery on Patient A's right hip.

B. Respondent provided medical care to Patient B at Buffalo General Hospital from September 8, 1985 until on or about September 11, 1985. Respondent, on September 9, 1985, performed an arthroscopic medial and lateral partial meniscectomy on Patient B's left knee. Patient B's left leg was amputated below the knee on September 20, 1985 at Buffalo General Hospital.

1. Respondent, subsequent to the September 9, 1985 surgery, did not recognize and/or failed to address in a timely manner the presence of a vascular injury in Patient B's left leg.

2. Respondent, subsequent to the September 9, 1985 surgery, did not adequately monitor the vascular status of Patient B's left leg.

3. Respondent did not consult a vascular surgeon until September 11, 1985, which was not in a timely manner.

4. Respondent failed to record adequate progress notes following the surgery he performed on Patient B on September 9, 1985, in that Respondent failed to adequately record his findings and/or assessment and/or plan of treatment of Patient B.

C. Respondent provided medical care to Patient C at Buffalo General Hospital from May 19, 1985 through May 30, 1985. Respondent, on May 20, 1985, performed a revision of a left total hip replacement on Patient C. Patient C was discharged from Buffalo General Hospital on May 30, 1985 and readmitted on June 1, 1985, with an infected left total hip replacement.

1. Respondent did not debride Patient C's infected left total hip replacement until June 9, 1985, which was not in a timely manner.

2. Respondent failed to record adequate progress notes regarding Patient C.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law §6530(4) (McKinney Supp. 1992) in that Petitioner charges:

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

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

THIRD SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) in that Petitioner charges that Respondent has committed two or more of the following:

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

FOURTH SPECIFICATION

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1992) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

4. The facts in Paragraphs A and A.2, B and B.4, and/or C and C.2.

DATED: Albany, New York
October 20, 1992

Peter D. Van Buren

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