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

August 13, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jean B. Poulard, M.D.
c/o Queens Hospital Center
Department of Surgery
82-64 164th Street
Jamaica, New York 11432

Gordon Haesloop, Esq.
Bower & Gardner
110 East 59th Street
New York, New York 10022

Terrence Sheehan, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

EFFECTIVE DATE 08/20/92

RE: In the Matter of Jean B. Poulard, M.D.

Dear Dr. Poulard, Mr. Haesloop and Mr. Sheehan:

Enclosed please find the Determination and Order (No. BPMC-92-69) 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.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

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, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN		
THE MATTER	:	AND ORDER
OF	:	OF THE
JEAN B. POULARD	:	HEARING
		COMMITTEE

ORDER NO. BPMC-92-69

The undersigned Hearing Committee consisting of **TERRI L. WEISS, ESQ., (Chairperson), JOSEPH B. CLEARY, M.D.,** and **ALEXANDER M. DELAGARZA, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. On April 28, 1992, **FRANK E. IAQUINTA, M.D.** replaced Dr. DeLaGarza. Dr. Iaquinta filed a statement pursuant to Section 230(10)(f) that he has read this entire transcript and reviewed all evidence in this matter. **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 Public Health Law and sections 301-307 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 Jean B. Poulard, 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 PROCEEDINGS

Original Notice of Hearing and Statement of Charges dated:	January 7, 1992
Notice of Hearing returnable:	February 6, 1992 February 13, 1992
Amended Statement of Charges dated:	April 20, 1992
Place of Hearing:	New York, N.Y.
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	Terrence Sheehan, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York
Respondent appeared in person and was Represented by:	Bower & Gardner, Esqs. 110 East 59th Street New York, New York E. Gordon Haesloop, Esq. and Michelle Merchant, Esq. of Counsel
Hearings held on:	February 13, 1992 February 27, 1992 March 5, 1992 March 17, 1992 April 21, 1992
Conferences Held:	February 13, 1992 March 17, 1992 April 21, 1992

Closing briefs received: June 4, 1992

NOTE: Respondent waived the 60 day time limit set forth in §230(10)(h) of the Public Health Law (see post-hearing conference, April 21, 1992, pp. 8-11).

SUMMARY OF PROCEEDINGS

The amended Statement of Charges alleges that Respondent has practiced medicine with gross negligence and failed to maintain accurate patient records. The allegations arise from treatment of one patient between November 20, 1987 and February 27, 1988. The allegations are more particularly set forth in the amended Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Norman Roome, M.D	Expert Witness
Mother of Patient A	Fact Witness
Andrea Gay Goldstein	Fact Witness

Respondent testified in his own behalf and called these witnesses:

Richard Seropian, M.D.	Expert Witness
Irving Margolis, M.D.	Fact/Expert Witness
John Cordice, M.D.	Fact/Expert Witness
Daniel Buchak	Fact/Expert Witness
Maryann Tinker, M.D.	Fact/Expert Witness

Walter John Barry Hodgson, M.D.	Expert Witness
Terry Flexer	Fact/Character

In lieu of testimony Respondent submitted affidavits from the following witnesses:

Leslie Wise, M.D.	Fact/Character Witness
Stephen Grabel, M.D.	Fact/Character Witness
Theodore Robinson, M.D.	Fact/Character Witness
Gregory Tan, M.D.	Fact/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 Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable 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 means a conspicuously bad act or severe deviation from standards.

With regard to the expert testimony herein, including Respondents, 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.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

FINDINGS OF FACT

WITH REGARD TO

PATIENT A

The following findings of fact were made after review of the entire record. Numbers in parenthesis (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 Petitioner 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 unanimqus unless otherwise noted.

1. Respondent was authorized to practice medicine in New York State on March 14, 1980 by the issuance of license number 141398 by the New York State Education Department. 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 6 Stonehurst Lane, Dix Hill, New York 11746.

2. Between November 20, 1987 and February 27, 1988, Patient A was hospitalized at Queens Hospital Center ("QHC"), 82-68 164th Street, Jamaica, New York. (Ex. 2)

3. On November 20, 1987, Dr. Leal admitted Patient A to QHC through the QHC out-patient clinic, for further evaluation and repair of what was thought to be a Morgagni Hernia. (Ex. 2, P. 7)

4. A physical examination of Patient A was performed by a third-year medical student on November 20, 1987. (Ex. 2, P. 18-23)

5. Patient A suffered from moderate retardation and impaired speech. He was uncommunicative. As a consequence, the medical student was unable to obtain a history from this patient. (Ex. 2, P. 18-23)

6. During the physical examination of Patient A, 3 scars were noted, two of which ran longitudinally. One of the scars ran the length of Patient A's abdomen. (Ex. 2, P. 22)

7. During the physical examination of Patient A,

the abdomen was noted as soft, mildly distended and non-tender. The absence of guarding or rebound was also noted. Bowel sounds were present. (Ex. 2, P. 22)

8. The form entitled "Indications for Surgery," dated November 20, 1987 and signed by Dr. Poulard, contains a notation that abdominal distension had been present in Patient A for nine years. (Ex. 2, P. 193)

9. The nursing history upon admission notes the weight of Patient A as 174 pounds. Patient A's appetite was noted as good and diet was listed as regular. The patient's temperature was 98.6, pulse was 86 and blood pressure was 110/70. (Ex. 2, P. 398)

10. A witnessed telephone consent for surgery was obtained from Patient A's mother on November 22, 1987. (Ex. 2, P. 13)

11. Patient A had received prior treatment at QHC. (Ex. 2)

12. Among the relevant aspects of Patient A's prior treatment at QHC were the following:

(a) On February 18 and 19, 1987, chest x-rays of Patient A were done at QHC. The x-ray reports allude to the possibility that a colonic interposition had been performed on Patient A. (Ex. 2, P. 861; Ex. A)

(b) An upper G.I. series was done on February 20, 1987 at QHC, which demonstrated that a colonic interposition had been performed on Patient A. (Ex. A, P.

67, 69 and 99; Ex. 2, P. 863)

(c) On September 21, 1987, another upper G.I. series was performed on Patient A at QHC. This series again demonstrated the presence of a colonic interposition. (Ex. 2, P. 966)

(d) Patient A also had a history of suspected tuberculosis in 1986 (T. 1138; Ex. A at 58). There is no record that Respondent or any other treating physician considered tuberculosis in connection with Patient A's admission to QHC in November 1987. (Ex. A; T. 1137-8)

13. In November 1987, the Medical Records Department of QHC was in the process of moving. As a consequence, medical records were very difficult, although not impossible, to obtain. (See testimony of Daniel Buchak generally, and especially T. 1016-17; T. 1053-1057)

14. Patient A's prior medical records were not obtained by the QHC surgical staff prior to the surgery at issue in this case. (T. 1045-1046)

15. Patient A's private physician at the Bernard Fineson home (Patient A's residence) was contacted as part of a medical clearance on November 23, 1987 by a member of the QHC staff. No one on the QHC surgical service ever spoke directly with Patient A's private physician (Ex. 2, PP. 187-189). Further to the communication by the hospital staff with Patient A's private physician, the Report of Consultation dated November 23, 1987 notes that Patient A

reportedly ingested lye when he was 8 years old and had an esophageal stricture. (Ex. 2, P. 189)

16. On November 12, 1987, a barium enema and G.I. Series had been performed on Patient A by an outside radiologist, Dr. Tan, who concluded from those studies that Patient A had a Morgagni Hernia. The esophagus was not visualized on these studies. (Ex. A at 18)

17. On November 22, 1987, another chest x-ray of Patient A was performed at QHC. The radiologist who reviewed that study concluded in his report that the x-ray demonstrated the "clinically known" Morgagni hernia. (Ex. 4A)

18. Dr. Leal, who had admitted Patient A to QHC, functioned as an attending physician. He could admit patients to QHC, treat them and perform surgery on them. His functions, however, were restricted in that a back-up physician was required to be available whenever Dr. Leal was to perform surgery (T. 816-17). Dr. Leal was the only physician on staff at QHC at the time who was under such restriction and required such back-up assistance. (T. 889)

19. Respondent was senior in the hospital hierarchy to Dr. Leal. (T. 904)

20. Dr. Leal and/or Calabro discussed Patient A with Respondent for the first time on November 24, 1987 and requested that Respondent act as back-up surgeon in connection with the planned surgery on Patient A. (T. 662-4)

21. At this point, Respondent became the required back-up physician to Dr. Leal in the manner prescribed by the restrictions placed on Dr. Leal. (T. 816-817)

22. Respondent, who is not a radiologist, relies upon reports of radiologists in arriving at medical conclusions. (T. 598-600, 685-88)

23. On November 24, 1987, Respondent reviewed Patient A's studies which had been done on November 12, 1987, but he did not see the radiologist's report. (T. 687-88, 709-10.) Respondent also read the chest x-ray of November 22, 1987. Despite this, Dr. Poulard concluded that Patient A had a Morgagni Hernia, even though the esophagus was not visualized on the November 12, 1987 studies. (Ex. 2, P. 30, T. 598; Ex. A, P. 18). Respondent admits that this conclusion was erroneous. (T. 600, 609.)

24. Respondent did not review Patient A's chart at any time prior to surgery. He relied solely upon the presentation of the case which was made to him by Dr. Leal and Dr. Calabro, his review of the November 12, 1987 upper G.I. series and barium enema provided to him by those doctors, and the chest x-ray dated November 22, 1987. (T. 602-605.) Respondent admits that he made no physical examination of Patient A. The first time that Respondent saw this Patient was at the time of surgery on November 25, 1987. (T. 702.)

25. On November 25, 1987, surgery was performed

on Patient A for a purported Morgagni-type hernia. (Ex. 2, P. 202.)

26. The surgery on Patient A, which was to be a laparotomy and repair of a diaphragmatic hernia (See Ex. 2. P. 202), was commenced at 1:30 p.m. on November 25, 1987 by Dr. Leal and Dr. Calabro. Respondent was not in attendance. On the day of the surgery, the anesthesiologist asked that the surgery be deferred because of certain abnormal laboratory results. Respondent, as Dr. Leal's superior, then gave the requisite approval to proceed with the surgery. (T. 715-719; Ex. 2, P. 30.)

27. Dr. Leal and Dr. Calabro then proceeded to dissect around the bowel which was seen to be entering Patient A's chest cavity. Approximately 2 hours into the surgery, Respondent was called to scrub and participate. (T. 689-90, see Ex. 2, P. 202.)

28. At that point, with Respondent's direct assistance and participation, dissection continued into Patient A's chest. There were multiple thick adhesions through the abdomen. The surgeons could not visualize any tissue above the diaphragm (T. 691, 721-724). There came a point where what was thought to be an adhesion was released. This release resulted in disconnecting what was then determined to be a colonic interposition from its attachment to the upper esophagus. (T. 691-2)

29. Upon examination, it was discovered that the

removed part was actually an interposition of the colon leading from the stomach to the esophagus. (T. 692-693)

30. When the interposition was discovered, dissection was continued in the opposite direction toward the stomach. It was then confirmed that the removed part was indeed a colonic interposition. (T. 692-3)

31. At that point, Dr. Cordice, head of QHC's Thoracic Service, was called to come into the operating room, evaluate Patient A, and give his assessment. (T. 694, 724)

32. There is no mention of Dr. Cordice's involvement in the operating report of this surgery. (Ex. 2, P. 202)

33. Dr. Cordice performed an esophagoscopy on Patient A and observed Drs. Poulard, Leal and Calabro as they sorted out the anatomy of Patient A. (T. 982, 999)

34. At Dr. Cordice's suggestion, and with the agreement of Drs. Poulard, Leal and Calabro, it was decided to bring out both disconnected ends of the former colonic interposition onto the surface of the neck. This would have established two openings on Patient A's neck. One opening would lead up to the throat and mouth. The other would lead down through what had been the colonic interposition into the stomach. The surgeons planned to re-connect the two exteriorized ends in the future, reconstructing the link between the esophagus and stomach in a subsequent operation.

At this point, Dr. Cordice left the operation. (T. 724, 983-4)

35. The surgeons thereafter attached both disconnected ends on to the surface of Patient A's neck, as planned. However, upon further inspection, Drs. Poulard, Leal and Calabro determined that one end, which was the end of the bowel, was non-viable, and therefore removed it from the neck. (T. 724-6)

36. The surgeons cut away the portion of the colonic interposition which they believed was not viable, and were left with an insufficient length of bowel with which to traverse the distance between the neck and stomach as previously planned. Therefore, the surgeons brought what was left of that portion of the bowel (colonic interposition) onto the surface of the abdominal wall. This established a conduit from the surface of Patient A's abdominal wall to the stomach (T. 725-6). Dr. Cordice was not advised of this change in plan and procedure until the day following surgery. (T. 984) He did not take exception to the fact that he was not contacted when the bowel was found to be non-viable. (T. 993) The surgery was then completed and Patient A was transported to the recovery room. (T. 694-5)

37. Respondent admits that he was responsible for supervising the post-operative care of Patient A. (T. 640)

38. Respondent saw Patient A during the post-

operative period on approximately a weekly basis. (T. 100, 102, 738.)

39. Following surgery, Patient A had serious behavioral problems. He repeatedly removed his feeding tube and was sedated with Haldol. (Ex. 2, PP. 36-37; T. 727-28, 739.)

40. Patient A was receiving nutrition by a gastrostomy tube. This tube leaked. There was no special intra-venous feeding (hyperalimentation) of this patient until February 24, 1988. (Ex. 2, P. 170)

41. Patient A's weight fell from 147 pounds on December 17, 1987, to 123 pounds on February 10, 1988, for a loss of 24 pounds (T. 100, 102; Ex. 2, P. 776). On February 24, 1988, a hospital dietician noted that Patient A had lost 35% of his actual body weight, and that he had weighed 110 pounds on February 18, 1988. (Ex. 2, P. 168)

42. There is no mention in the progress notes or the notes made by the QHC residents of any discussion by or with Respondent regarding Patient A's post-operative condition. (Ex. 2, T. 210)

43. Patient A's hospital chart contains house staff notes dated January 29, 1988, February 2, 1988, February 6, 1988, February 9, 1988, February 20, 1988, and February 25, 1988. There are no house notes between those dates, nor is there any note on February 26, 1988. (Ex. 2, P. 172-175)

44. Medical records for Patient A regarding his earlier admissions to QHC were at no time obtained by Respondent even after surgery. (T. 774-5)

45. Patient A died on February 27, 1988. The certificate of death states the cause of death as cardiac failure due to respiratory failure resulting from lobar pneumonia. (Ex. 2, P. 4-5)

46. Respondent states that he signed the history and physical portion of Patient A's chart several months after the patient expired. (T. 564)

47. Respondent appears to enjoy an excellent reputation among his colleagues. (see testimony of Drs. Margolis and Tinker, generally; Ex. D, E, F and G.)

CONCLUSIONS

WITH REGARD TO

FACTUAL ALLEGATIONS

In the original statement of charges there were twenty-three consecutively numbered factual allegations. On March 17, 1992, the Administrative Law Judge granted the State's motion to add two more factual allegations. Each of the twenty-five factual allegations set forth in the amended Statement of Charges will be discussed individually:

A. Except as otherwise stated below, this allegation is sustained with a correction as follows: Patient A was treated at QHC until February 27, 1988, and not 1987, as alleged.

1. This allegation is sustained with an explanation: The facts establish that Patient A was admitted to the general surgery service at QHC on November 20, 1987. On November 25, 1987, Patient A was operated on for a purported Morgagni-type hernia, as alleged. However, Respondent was not Patient A's attending physician on November 20, 1987, when Patient A was admitted to QHC. While Respondent was listed as the attending physician upon admission, he had no knowledge of this patient until Dr. Leal and Dr. Calabro briefed him on November 24, 1987. It is only on November 24, 1987, when Respondent agreed to become the back-up physician for Dr. Leal, as required by hospital protocol, that Respondent became the most senior attending physician to Patient A. Neither he nor any member of his service obtained a complete past medical and surgical history, as alleged. Allegation one, as explained, is **SUSTAINED.**

2. Patient A had three scars which were noted in the patient's record. The nature of the scars should have led Respondent to suspect prior surgery and hence, to obtain a surgical history. Neither he, nor any member of his staff, obtained such a history.
Allegation two is **SUSTAINED.**

3. In this allegation, it is asserted that Respondent incorrectly read a chest x-ray dated November 22, 1987, which purportedly showed a Morgagni-type hernia.

Respondent admits he saw the November 22, 1987 x-ray and erroneously read it.

Allegation 3 is **SUSTAINED.**

4. Respondent admits he did not review the QHC records of Patient A's prior admissions. His defense was that QHC's Medical Records Department was in turmoil due to a move in progress, and that the records thus could not be obtained. While the Committee recognizes that the Medical Records Department was, in fact, being moved at the time, and records were difficult to obtain, they were not impossible to obtain. The Committee finds no evidence of any effort by Respondent to obtain the records, which would have disclosed the colonic interposition and avoided this entire matter.

Allegation 4 is **SUSTAINED.**

Allegations 5 and 6. In these allegations it is alleged that neither Respondent (allegation 5) nor any "licensed member" of the General Surgery Service (allegation 6) performed a physical examination of Patient A prior to surgery. Rather, the only physical examination of this patient was by a third-year medical student. These factual allegations were never denied by Respondent. The Committee notes that in and of itself, physical examination by a third-year medical student is not a violation of standards.

Allegation 5 is **SUSTAINED.**

Allegation 6 is **SUSTAINED.**

7. Allegation 7 states that Respondent "failed" to evaluate Patient A's tuberculosis and rule it out as an etiological factor in this patient's condition. It has already been established that Respondent did not obtain the charts of this patient's prior admissions to QHC. Had Respondent obtained the charts and overlooked or ignored this patient's history, this allegation might be sustained. However, as drafted, the Allegation cannot be sustained since Respondent had no way of knowing Patient A's history. Allegation 7 is **NOT SUSTAINED.**

8. This allegation alleges that Respondent did not obtain the informed consent of Patient A's mother prior to surgery. Exhibit 2, Page 12 and 13, contains a witnessed consent form which appears, on its face, to be properly executed and appropriate. This creates a strong but rebuttable presumption in Respondent's favor on this issue. While the Committee has considered the testimony of Patient A's mother, it does not find the testimony to be sufficiently convincing to rebut the existing presumption in Respondent's favor.

Allegation 8 is **NOT SUSTAINED.**

Allegations 9 and 10. In these allegations, Respondent is alleged to have failed to order gas contrast studies (allegation 9) and a G.I. series (allegation 10). The Committee sustains both allegations with the following analysis: Respondent was briefed on this patient on

November 24, 1987, when he was asked and then agreed to become the back-up surgeon for Dr. Leal. In his position as back-up and senior physician to Dr. Leal, Respondent had a duty to familiarize himself with Patient A's condition and history. Respondent said that he did so by accepting the presentation made by Dr. Leal and Dr. Calabro, and by reviewing an upper G.I. series and barium enema supplied to him by Dr. Leal and Dr. Calabro. While the Committee accepts Respondent's statements as to how he prepared for Patient A's surgery as true, it also notes that the existing x-ray studies were flawed in that the esophagus was not visualized. Thus the studies were inadequate. It follows then, that Respondent had a duty to order additional or repeat studies to complete the record and to prepare appropriately for his role in the surgical procedure. While any physician reviewing these flawed studies would have a duty to point out their inadequacy, Respondent, in both his senior and supervisory positions over Dr. Leal, had a particular duty to correct shortcomings in the pre-operative work-up of this patient.

Allegation 9 is SUSTAINED.

Allegation 10 is SUSTAINED.

11. In this allegation, Respondent is cited for his participation in a laparotomy and repair of a diaphragmatic hernia, which were not indicated for this patient. The Committee sustains this allegation.

Consistent with the previous conclusions and those which follow, the Committee finds that Respondent, along with Dr. Leal and Dr. Calabro, thought that Patient A had a Morgagni Hernia. Had he investigated the existing abdominal scars, and/or ordered a repeat of the existing but flawed studies, and/or obtained this patient's prior history, he would have known that Patient A had a colonic interposition and did not have a Morgagni Hernia. He then would have known that the laparotomy and hernia repair were not indicated for this patient.

Allegation 11 is **SUSTAINED.**

12. In allegation 12, Respondent is cited for failing to postpone the surgical procedure as suggested by an anesthesiologist, who referred Respondent to certain abnormal laboratory test results for Patient A. Respondent has admitted that the anesthesiologist wanted to defer surgery on this patient. Respondent asserted that Patient A's condition warranted immediate surgery. Respondent's assertion regarding Patient A's condition is contrary to the facts. The pre-operative physical findings show no signs of an acute condition. Indeed, the record shows that this patient's physical findings were all within normal limits. He was content to take food orally and showed no sign of bowel obstruction as suggested by Respondent.

Allegation 12 is **SUSTAINED.**

13, 14, 15, 16 and 17. These allegations go

through the steps of the surgery on Patient A. Allegation 13 states that Respondent failed to recognize a colonic interposition. Allegation 14 states that Respondent allowed it to be taken down. These allegations were admitted by Respondent. Allegation 15 refers to the intervention by QHC's Thoracic Surgical Service. The Committee rejects part of the fourth sentence of this charge which states, "After extensive preliminary work, the chest surgeon(s) replaced the colon in its previous location." The Committee refers to Findings of Fact 33 and 34, which state that Dr. Cordice performed an esophagoscopy, assisted the surgeons (Respondent, Dr. Leal and Dr. Calabro) in sorting out Patient A's anatomy, and developed a plan for a temporary solution to this patient's condition, that is, exteriorizing both ends, to be followed by subsequent surgery. With the exception of that one phrase, allegation 15 was also virtually admitted by Respondent and is supported by the evidence. In allegations 16 and 17, Respondent is alleged to have failed to follow the plan suggested by Dr. Cordice and to have failed to notify Dr. Cordice of the change in approach. As set forth in Findings of Fact 35 and 36, Respondent, Dr. Leal and Dr. Calabro began the agreed-upon procedure, at the suggestion of Dr. Cordice. However, after Dr. Cordice left the operating room, and the remaining surgeons began to execute that procedure, the tissue at the proximal end of the colonic interposition became non-viable.

The surgeons therefore disconnected the proximal end from where it was already sutured, excised the useless tissue, which left an insufficient length of bowel to carry out the previously agreed-upon procedure. Respondent, Dr. Leal and Dr. Calabro therefore had no choice other than the one they then made. As the situation developed, Respondent was entirely justified in his actions. Furthermore, Respondent had no duty to inform Dr. Cordice of the change in Patient A's condition and the concomitant change in procedure. In his testimony, Dr. Cordice took no exception to the change in procedure based upon emerging facts, and did not protest the lack of further consultation. Accordingly, while parts of the factual allegations in allegations 16 and 17 are accurate, the essential theory of these allegations, that Respondent acted improperly, is not sustained.

Allegation 13 is **SUSTAINED.**

Allegation 14 is **SUSTAINED.**

Allegation 15 is **SUSTAINED.** (with exception noted above)

Allegation 16 is **NOT SUSTAINED.**

Allegation 17 is **NOT SUSTAINED.**

18. In this allegation, it is alleged that Respondent's operative note is inaccurate and incomplete. Respondent countersigned this note. Therefore, regardless of whether he actually drafted it, he is responsible for its contents. This note is significantly inaccurate in that it fails to mention the involvement of Dr. Cordice in the

operative procedures performed on Patient A. The omission of any mention in the operative note of Dr. Cordice's participation was unjustifiable. While the Committee sustains the essential theory of this allegation, it takes exception to the last phrase of the allegation: While the surgical procedure for this patient was altered after Dr. Cordice left the operating room, there was only one chest surgeon, i.e., Dr. Cordice, involved in this case. Furthermore, as noted previously, the planned procedure was arrived at by the mutual consent of Respondent, Dr. Leal, Dr. Calabro and Dr. Cordice. It was neither arrived at nor imposed upon Respondent by Dr. Cordice alone.
Allegation 8 is **SUSTAINED.**

19, 20 and 21. These three allegations relate to Respondent's post-operative management of Patient A. Allegation 19 cites Respondent for grossly deficient post-operative management of Patient A and refers to a loss of one-third of this patient's body weight. In allegation 20, Respondent is alleged to have failed to obtain the chart of Patient A's earlier admissions. Allegation 21 alleges that Respondent failed to supervise properly the third-year medical student, residents, junior attendings, and other QHC staff providing care to Patient A. Each of these allegations is sustained. Respondent admitted that he made no effort to obtain Patient A's prior medical chart (See Finding of Fact 44). With regard to patient management,

Respondent clearly failed to take adequate and timely measures to care for Patient A. While Respondent saw Patient A on a weekly basis after surgery, he took little or no action to correct the patient's severe weight loss. Patient A lost twenty-four pounds between December 17, 1987, and February 10, 1988, yet no definite care plan or action was developed by Respondent. During testimony, Respondent pointed out that this patient had problems with his feeding tube. The Committee finds that Respondent's explanation for the problems with the feeding tube and Patient A's nutrition, and his lack of specific action in dealing with these problems, given the seriousness of the situation, are entirely inadequate (Findings of Fact 39, 40 and 41). Likewise, Respondent admitted that he was responsible for supervising this patient's post-operative care (Finding of Fact 37). Respondent has argued that at QHC, the primary responsibility for day-to-day patient care was that of the residents (T. 580). However, when it was clear that the care of Patient A was failing (Findings of Fact 40 and 41), there is no convincing documentation in the chart that Respondent had any discussions with the residents or QHC staff (Finding of Fact 42). In addition, there is no convincing documentation in the chart that Respondent ordered appropriate treatment for Patient A, notwithstanding the fact that Respondent admitted his responsibility for that patient. Accordingly, the Committee

sustains allegation 19. The Committee notes that the precise body weight of Patient A and his weight loss, as alleged, is inaccurate. However, the substance of the allegation is sustained (Finding of Fact 40 and 41). Allegation 20 was admitted (Finding of Fact 42 and 44). Allegation 21 is sustained, in that there is no evidence in Patient A's chart that Respondent properly supervised the care and treatment of Patient A, despite his admitted duty to do so.

Allegation 19 is **SUSTAINED.**

Allegation 20 is **SUSTAINED.**

Allegation 21 is **SUSTAINED.**

22. This allegation alleges that Respondent failed to maintain an accurate medical record for Patient A. While the Committee acknowledges that Respondent was not responsible for actually making all the necessary entries in Patient A's hospital chart, he was clearly responsible for ensuring that the necessary entries were made. This chart contains serious lapses. The "pre-operative history by surgeon" and "operative report" are inaccurate, incomplete and hence substandard. In addition, there are significant periods where no notes whatsoever were made in Patient A's chart by the house staff over which Respondent had direct charge. The most noteworthy gap is one of five days' duration between February 20, 1988, and February 25, 1988, but other gaps exist. (Finding of Fact 43)

Allegation 22 is **SUSTAINED.**

23. This allegation is not sustained. While Patient A expired, the date was February 27, 1988, and not February 26, 1987, as alleged. Also, the causes of death stated in this allegation are inaccurate. (Finding of Fact 45)

Allegation 23 is **NOT SUSTAINED.**

24 and 25. These two allegations were added to this proceeding by amendment on March 17, 1992. They relate to the pre-operative preparation of Patient A by Respondent as discussed in allegations 9 and 10. More specifically, allegation 24 refers to an upper G. I. series performed outside QHC by an unaffiliated radiologist. According to allegation 24, Respondent failed to obtain or review the x-rays prior to surgery. In allegation 25, Respondent is cited for failing to ensure that a copy of the films and radiologist's report were included in the QHC record of Patient A.

The Committee concludes that Respondent did review the x-rays in question. However, the Committee further concludes that Respondent did not properly interpret and evaluate the films. In addition, the esophagus was not visible in the upper GI series and barium enema. Therefore, those films were not adequate. As an incomplete study, the films in question should not have been relied upon by Respondent. Yet Respondent based his pre-operative

diagnosis, at least in part, on the x-rays in question. Thus allegation 24 is sustained.

With regard to allegation 25, at some point the films in question were available to Respondent and were reviewed by a QHC radiologist. At the time of this proceeding, the films were no longer part of Patient A's record. The loss of a part of the record is not Respondent's responsibility.

Allegation 24 is **SUSTAINED.**

Allegation 25 is **NOT SUSTAINED.**

DISPOSITION OF ALLEGATIONS

Allegation A - sustained

Allegation 1 - sustained - (Patient admitted/inadequate history)

Allegation 2 - sustained - (3 scars not investigated)

Allegation 3 - sustained - (chest x-ray incorrectly read)

Allegation 4 - sustained - (failure to review prior charts before surgery)

Allegation 5 - sustained - (no pre-surgery physical by Respondent)

Allegation 6 - sustained - (pre-surgical physical by medical student)

Allegation 7 - not sustained - (did not consider tuberculosis)

Allegation 8 - not sustained - (no informed consent)

Allegation 9 - sustained - (no gas contrast study)

Allegation 10 - sustained - (no G.I. series)

Allegation 11 - sustained - (performance of non-indicated surgery)

Allegation 12 - sustained - (anesthesia sought deferral)

Allegation 13 - sustained - (did not recognize colonic interposition)

Allegation 14 - sustained - (colonic interposition taken down)

Allegation 15 - sustained - (thoracic surgeon consulted)

Allegation 16 - not sustained - (proximal colon non-viable)

Allegation 17 - not sustained - (did not advise thoracic surgeon)

Allegation 18 - sustained - (sub-standard operative note)

Allegation 19 - sustained - (post-operative care sub-standard)

Allegation 20 - sustained - (past medical history not obtained)

Allegation 21 - sustained - (failure to supervise)

Allegation 22 - sustained - (inadequate record)

Allegation 23 - not sustained - (death and cause)

Allegation 24 - sustained - (upper G.I. series performed outside QHC)

Allegation 25 - not sustained - (upper G.I. series not in chart)

CONCLUSIONS WITH REGARD TO SPECIFICATIONS

Having sustained all factual allegations except allegations 7, 8, 16, 17, 23 and 25, the Committee now turns its attention to the first and second specifications. In the first

Specification, Respondent is charged with gross negligence based upon the twenty-five allegations previously discussed. The Committee sustains this specification and finds that Respondent committed multiple acts of negligence that cumulatively amount to egregious conduct. In so finding, the Committee refers to the factual allegations which have been sustained. Each constitutes a negligent or sub-standard act performed by Respondent, or such an act for which he was responsible. The Committee finds that Respondent's conduct constitutes a series of acts which deviate from accepted standards of care and diligence. Hence gross negligence is concluded.

Specification one **SUSTAINED.**

In the Second Specification, Respondent is charged with failure to maintain accurate records based upon factual allegations 22 and 24. The Committee has sustained both of these factual allegations and, for the reasons stated above in paragraphs 22 and 24, finds that the Respondent did in fact fail to maintain accurate records as charged.

Specification two **SUSTAINED.**

ORDER

The penalty stated herein is based upon a split vote of the Committee. The minority believed that there was sufficient mitigation to offset the very serious nature of the findings herein, as would warrant supervised probation of Respondent.

However, the majority concluded that a more stringent penalty was appropriate. Therefore, by ruling of the majority of this Committee, it is hereby **ORDERED THAT:**

The license to practice medicine of Respondent **JEAN B. POULARD** shall be **SUSPENDED** for **ONE YEAR**; and that, the said suspension shall be **STAYED INDEFINITELY**; and that,

The said Respondent shall pay as a civil penalty the sum of **TEN THOUSAND DOLLARS ($10,000)**; and that,

This Order shall take effect thirty (30) days from the date of service upon Respondent's counsel by personal service or certified or registered mail.

DATED: White Plains, New York

August 12, **1992**

BY: Terri L. Weiss

TERRI L. WEISS, ESQ.
(Chairperson)

JOSEPH R. CLEARY, M.D.
FRANK E. IAQUINTA, M.D.

APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JEAN B. POULARD, M.D.	:	CHARGES

----------X

JEAN B. POULARD, M.D., the Respondent, was authorized to practice medicine in New York State on March 14, 1980 by the issuance of license number 141398 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 6 Stonehurst Lane, Dix Hill, New York 11746.

FACTUAL ALLEGATIONS

A. Between on or about November 20, 1987 and on or about February 27, 1987, Respondent treated or was responsible for the treatment of Patient A (whose name is contained in the Appendix) for abdominal distension at Queens Hospital Center, 82-68 164th Street, Jamaica, New York.

1. On or about November 20, 1987, Patient A was admitted to the General Surgery Service at Queens Hospital

Center. Respondent was Patient A's attending physician. On or about November 25, 1987, Patient A was operated on for a purported Morgagni-type hernia. Respondent authorized this operation prior to the operation, Respondent failed to obtain, or to have a member of his Service obtain, complete past medical and surgical histories for Patient A.

2. After admission to the hospital Patient A was observed to have three surgical scars on his abdomen. Prior to authorizing and performing abdominal surgery on November 25, 1987, Respondent failed to ascertain the nature of the operation or operations which caused those scars.

3. Respondent incorrectly read a chest X-ray dated November 22, 1987, of Patient A as showing a Morgagni hernia.

4. Prior to performing the November 25, 1987 operation, Respondent failed to review the chart and X-rays of Patient A's two previous admissions in 1987 at Queens General Hospital. Such a review would have revealed that the November 22, 1987 chest x-ray did not describe a hernia but rather a colonic interposition

which had been surgically created years earlier due to ingestion of lye by Patient A.

5. Respondent failed to perform a physical examination of Patient A prior to surgery.

6. Respondent failed to have any licensed member of the General Surgery Service perform a physical examination of Patient A prior to surgery. The only examination Patient A received was performed by a third year medical student.

7. Respondent failed to evaluate Patient A's tuberculosis and to rule it out as an etiological factor in Patient A's condition.

8. Respondent failed to obtain the informed consent of Patient A's parent.

9. Respondent failed to order gas contrast studies.

10. Respondent failed to order a G.I. series.

11. On November 25, 1987, Respondent performed and/or authorized the performance of a laparotomy and repair of a diaphragmatic hernia. These procedures were not indicated.

12. On November 25, 1987, Dr. Cricklow, an anesthesiologist, spoke with Respondent concerning certain abnormal laboratory test results for Patient A. He suggested that the procedure be deferred. Respondent replied that the procedure could not be deferred. Given the elective nature of the contemplated procedure, Respondent should have deferred the operation.

13. During the course of the operation, Respondent failed to recognize that Patient A had a colonic interposition in place.

14. During the operation Respondent took down, or failed to prevent the taking down of, the colonic interposition.

15. Once Respondent realized that the interposition has been destroyed, Respondent requested the assistance of the Thoracic Surgical Service. Dr. J.W.V. Cordice and/or one or more other chest surgeons arrived at the operating room. The chest surgeon(s) decided that the segment of proximal colon which had been taken down was still viable. After extensive preliminary work, the chest surgeon(s) replaced the colon in its previous location and planned to

exteriorize both ends preliminary to performing a repeat esophagocolostomy in the neck in the future. The chest surgeon(s) then scrubbed out and left the Respondent and the other general surgeons to close the abdomen after draining the chest.

16. Respondent improperly failed to follow the plan of the chest surgeon(s). Respondent decided, without justification, that the segment of proximal colon was not viable. As a result, the colon was taken back down and a shorter colonic segment was placed in the right upper abdomen. This procedure was not indicated.

17. Respondent should have advised the chest surgeon(s) of his decision to alter their plan of treatment and of his determination, contrary to their finding, that the segment of proximal colon was not viable.

18. Respondent's operative note is inaccurate and incomplete in that it fails to mention that the Thoracic Surgical Service was contacted during the procedure; that one or more members of the Thoracic Surgical Service participated in the operation and that Respondent, after the chest surgeon(s) left the

operating room, decided to alter the treatment plan the chest surgeon(s) had arrived at.

19. Respondent's post operative management of Patient A was grossly deficient. Patient A was allowed to lose 36 pounds, approximately one third of his body weight, over a period of three months. Respondent failed to take any measure to counteract the Patient's downhill clinical course.

20. Respondent failed, during Patient A's three post operative months in the hospital, to obtain and review the chart of the patient's earlier admissions to Queens General Hospital.

21. Respondent failed to properly supervise the third year medical student, residents and junior attendings and other staff who cared for Patient A.

22. Respondent failed to maintain a medical record for Patient A which accurately reflects his patient histories, examination, assessment, diagnoses, tests, treatment plan, operative reports and discharge summary.

23. On February 26, 1987, Patient A died at Queens Hospital Center. According to the Patient's discharge summary the causes of death were bilateral pneumonia and sepsis.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

Practicing with gross negligence

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

1. The facts in paragraphs A and A.1.-A.23.

SECOND SPECIFICATION

Failure to maintain accurate records

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

2. The facts in paragraphs A and A.22.

DATED: New York, New York
January 7, 1992

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct