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

November 2, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

T. Lawerence Talbak, Esq.
Goldsmith, Tabak &
Richman, P.C.
747 Third Avenue
New York, NY 10017

Simon Wapnick, M.D.
1180 Morris Park Avenue
Bronx, New York 10461

RE: In the Matter of Simon Wapnick, M.D.

Dear Ms. Abeloff, Mr. Tabak and Dr. Wapnick:

Enclosed please find the Determination and Order (No. BPMC-92-97) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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	DETERMINATION
OF	AND
SIMON WAPNICK, M.D.	ORDER

ORDER NO. BPMC-92-97

A Notice of Hearing and Statement of Charges, both dated March 11, 1992, were served upon the Respondent, Simon Wapnick, M.D. **STANLEY L. GROSSMAN, M.D. (Chair), PRISCILLA R. LESLIE, R.N.,** and **GERALD S. WEINBERGER, M.D.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ESQ., ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Dianne Abeloff, Esq., Associate Counsel. The Respondent appeared by Goldsmith, Tabak & Richman, P.C., I. Lawrence Tabak, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination.

SUMMARY OF PROCEEDINGS

Date of Service of Notice of Hearing and Statement of Charges against Respondent	March 20, 1992
Answer to Statement of Charges:	None
Pre-Hearing Conference:	April 2, 1992
Dates of Hearing:	April 13, 1992 May 26, 1992

	May 27, 1992[1] June 3, 1992 June 10, 1992
Department of Health appeared by:	Dianne Abeloff Associate Counsel
Respondent appeared by:	Goldsmith, Tabak & Richman, P.C. 747 Third Avenue New York, NY 10017 T. Lawrence Tabak, Esq., of Counsel
Witnesses for Department of Health:	Norman S. Roome, M.D.
Witnesses for Respondent:	David Befeler, M.D. Simon Wapnick, M.D.
Received Department's Proposed Findings of Fact, Conclusions of Law and Proposed Sanction:	July 17, 1992
Received Respondent's Post Hearing Statement:	July 17, 1992
Deliberations Held:	July 28, 1992

STATEMENT OF CASE

The Department has charged Respondent with gross negligence, negligence on more than one occasion, gross incompetence and incompetence on more than one occasion. The charges relate to the surgical care and treatment of six patients. A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

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[1] Gerald H. Liepshutz, Esq., Administrative Law Judge, substituted as the Administrative Officer on May 27, 1992.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Simon Wapnick, M.D. (hereinafter "Respondent") was authorized to practice medicine in New York State on February 7, 1975 by the issuance of license number 122882 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 1180 Morris Park Avenue, Bronx, New York 10461. (Pet. Ex. #2).

Patient A

2. On or about June 22, 1986, Respondent admitted Patient A, a 43 year-old woman to St. Barnabas Hospital with a diagnosis of acute cholecystitis. (Pet. Ex. #3).

3. Respondent performed a cholecystectomy on June 24, 1986. (Pet. Ex. #3).

4. On July 3, 1986, a consultant in gastroenterology found that the patient had prolonged post-operative abdominal pain, low grade fever and an elevated white blood count. The consultant suggested that the following diagnoses needed to be ruled out: pancreatitis, retained duct stone, and/or subphrenic

abscess. The consultant ordered several different laboratory tests to be performed on Patient A. (Pet. Ex. #3, pp. 30, 32).

5. Patient A was discharged from St. Barnabas Hospital on July 4, 1986. The July 4th handwritten lab values show that Patient A's bilirubin was 4 mg/dl. All of the liver chemistries were abnormally elevated. (Pet. Ex. #3, p. 40).

6. On July 2, 1986, Respondent ordered a GI series to be done if there was a recurrence of pain. On July 3, there was a recurrence of pain and the GI series was done. The GI series was normal. On July 3, 1986, the consultant in gastroenterology recommended additional tests to be done. On July 4, the patient was discharged. (Pet. Ex. #3, pp. 28-29).

7. The discharge summary dictated by Respondent on February 17, 1987 includes as a diagnosis possible post-operative pancreatitis. He made no reference to the abnormal liver function tests. (Pet. Ex. #3, p.2).

8. Patient A was admitted to Montefiore Hospital on July 6, 1986. (Pet. Ex. #3).

9. Respondent re-operated on Patient A on July 10, 1986, at which time an obstruction was found. The obstruction was at the level where the cystic duct had been ligated. The common hepatic duct had been completely obliterated. (Pet. Ex. #3, pp. 396-397).

10. Ductal injuries are part of the dangers of cholecystectomies, which is why surgeons need to identify each and every structure before ligating or dividing anything. (27, 43).

11. Nothing in the record indicated that Respondent carefully identified the ducts. Respondent does not recall doing that in this specific case. (47, 560-562, 728, 771; Pet. Ex. #3).

12. At the time of the second operation on July 10, 1986, Respondent had to divide the common bile duct, and restore continuity with the intestinal tract. (25; Pet. Ex. #3-Montefiore record, p. 396).

13. Respondent attempted to restore continuity with the intestinal tract by bringing a loop of small intestine up in a Roux-en-Y fashion, freeing a loop of jejunum and creating an anastomosis with the common bile duct in an end-to-side fashion. However, this anastomosis was created in the proximal curve of the small bowel, which left a large free end of blind loop. (25, 60-61, 68).

14. Subsequent to July 10, 1986, Patient A complained of persistent abdominal bloating, nausea and vomiting. (29; Pet. Ex. #3 - Montefiore record).

15. Patient A was readmitted to Montefiore Hospital, where another surgeon performed an exploratory operation. At the time of the exploratory operation, the subsequent surgeon found that Respondent had created a 15 inch-long blind loop. The blind loop does not go anyplace. Therefore, the blind loop became a site of stasis and infection. (30, 571-573; Pet. Ex. #3-Montefiore record, pp. 27, 62).

16. Creation of a blind loop by a surgeon is a deviation from accepted medical standards. (31).

Patient B

17. Respondent admitted Patient B, an 89 year-old man, to St. Barnabas Hospital on April 16, 1987 for treatment of post-traumatic right pneumothorax. (Pet. Ex. #4).

18. On April 19, 1987, a note in the physician's progress section of Patient B's record indicated that Patient B had a PO_2 of 40.4, an oxygen saturation of 72%, a PCO_2 of 65.6 and a pH of 7.34 - all of which are abnormal values. Patient B was not aerating properly. Respondent did not see the patient on April 19, 1987. Respondent wrote a note dated April 20, 1987 acknowledging a Dr. Torrecampo's coverage for the 19th. Respondent's note of April 20 appears in the record after a note of April 18 and before two notes dated April 19, 1987. (76-77; Pet. Ex. #4, pp. 20-21, 28).

19. On April 20, 1987, Respondent ordered a chest x-ray, which was done and still showed a pneumothorax. (Pet. Ex. #4, pp. 22, 33).

20. Respondent did not address the abnormal arterial blood gasses which were drawn on April 19, 1987. (Pet. Ex. #4, p. 22).

21. In Respondent's second progress note dated April 20, 1987, he requested a pulmonary consultation. There is no documentation in the chart that a pulmonary consultation occurred. In a note dated April 21, 1987, Respondent wrote that he will discuss removal of the chest tube with a pulmonary consultant. In the same note, he indicated that Patient B was confused, sweating

and hypotensive. He ordered restraints and sedation. In addition, he ordered STAT arterial blood gasses sometime after 5:30 p.m. (Pet. Ex. #4, pp. 22, 38, 56).

22. Respondent failed to recognize that as of April 19th, Patient B was hypoxic. (78-79).

23. On April 21, 1987, Respondent was standing by the nurses' station when he noticed that Patient B was standing in the doorway to his room and was confused. Respondent again did not recognize that the patient was hypoxic and indeed was demonstrating signs of hypoxia: confusion and difficulty breathing. (79, 852; Pet. Ex. #4).

24. Restraining and ordering a sedative for an hypoxic patient and failing to ascertain results of STAT blood gases indicated that Respondent did not recognize and appropriately treat Patient B's hypoxia. (110, 860-863).

25. Patient B was found to be unresponsive at 8:45 p.m. on April 21, 1987. The patient was pronounced dead at 9:30 p.m. (Pet. Ex. #4, p. 57).

Patient C

26. Patient C was a 68 year-old male Jehovah's Witness, admitted to St. Barnabas Hospital on May 16, 1987 with a diagnosis of possible appendicitis. (Pet. Ex. #5).

27. On May 16, Respondent performed an exploratory procedure, a right hemicolectomy and an ileo-transverse colostomy. (Pet. Ex. #5).

28. On or about the sixth post-operative day, while Respondent was on vacation, the patient spiked a temperature, and his abdomen was distended and tender. (116; Pet. Ex. #5, pp. 26, 101, 379).

29. Respondent returned to the hospital on May 26, 1987. He acknowledged at that point that there was a fecal fistula. He noted that he intended to follow the current approach, observe and begin peripheral hyperalimentation. (118; Pet. Ex. #5, pp. 30).

30. The patient continued to experience post-operative complications: low grade fever, increased white blood count, peritonitis and draining of a large quantity of fecaloid material from the wound. The infectious disease consultant continuously referred to the problem as sepsis. (Pet. Ex. #5, pp. 31, 107).

31. The fistula continuously spilled into the peritoneal cavity, creating any abscess. Respondent did not supplement the patient with sufficient hyperalimentation to facilitate the healing process. (124, 129, 162, 170-172, 175, 624, 627-628, 838; Pet. Ex. #5, p. 284).

32. A gastrografin study would have informed Respondent

that there was a large intra-peritoneal collection. (147-150, 169-172).

33. Another surgeon took over the management of the case and operated immediately. However, Respondent testified that he would handle this problem today the same way he handled it in 1987. (824-825; Pet. Ex. #5).

Patient D

34. Patient D, a 90 year-old female, was admitted to St. Barnabas Hospital with rectal bleeding and rectal prolapse. (Pet. Ex. #6, p. 14).

35. On December 23, 1986, Respondent attempted to correct the rectal prolapse by fixing the sigmoid colon to the anterior abdominal wall. He described this procedure as the Lanaut procedure. (Pet. Ex. #6, p. 194).

36. On January 2, 1987, Dr. Fleurant performed an exploratory laparotomy, right hemicolectomy and left colon resection and colostomy. He found a volvulus of the cecum with perforation and rectal prolapse. (Pet. Ex. #6, pp. 196-198).

37. On January 21, 1987, Dr. Fleurant and Dr. Gutwein performed a percutaneous endoscopic gastrostomy. (Pet. Ex. #6, p. 199).

38. On March 17, 1987, Dr. Ader replaced the gastrostomy tube. (Pet. Ex. #6, p. 200).

39. On or about March 30, 1987, the gastrostomy tube fell out. Dr. Murani unsuccessfully attempted to reinsert the gastrostomy tube. He called Respondent to help because he had a

difficult time reinserting the tube. Respondent dilated the tract with a Q-tip and lubrication and reinserted the tube. Dr. Murani attempted to flush the tube but was unsuccessful..An X-ray was ordered to determine the location of the tube. Feedings were held pending the result of the X-ray examination. (Pet. Ex. #6, pp. 123-125, 643).

40. At 2:00 p.m. the feedings were held, pending the results of the X-rays. At 6:00 p.m., Respondent was called. He saw the patient and ordered the resumption of the tube feedings. The feeding was re-started. Patient D complained of excruciating abdominal pain. (Pet. Ex. #6, pp. 643-644).

41. On March 31, 1987, Patient D still had abdominal pain. An examination revealed abdominal tenderness around the site of the tube insertion. (Pet. Ex. #6, pp. 123-126, 644).

42. On March 31, 1987, gastrografin was inserted into the gastrostomy tube and was seen to extravasate into the peritoneal cavity. (Pet. Ex. #6, p. 307).

43. On March 31, 1987 at 3:00 p.m., the patient was transferred to the ICU, and a Swan-Ganz catheter was inserted. (Pet. Ex. #6, pp. 128, 646).

44. At 10:00 p.m. on April 1, Patient D was taken to the operating room for the emergency closure of a perforated stomach. (Pet. Ex. #6, pp. 202, 648).

Patient E

45. On or about July 16, 1986, Respondent admitted Patient E, a 78 year-old male, to Montefiore Medical Center for

evaluation of a possible cyst in the head of the pancreas. (Pet. Ex. #7, p. 5).

46. On July 17, 1986, the patient had abdominal angiography. The findings were compatible with either a pancreatic tumor or pancreatitis. The main splenic vein appeared compromised. An abdominal sonogram performed on July 18, 1986 indicated cholelithiasis and chronic cholecystitis. The pancreas was thickened and edematous, consistent with pancreatitis. (Pet. Ex. #7, pp. 25-27).

47. On July 18, 1986, Patient E was discharged from Montefiore in order to have an endoscopic retrograde pancreatography (ERCP) at Beth Israel Hospital. Following this procedure, the patient was returned to Montefiore and subsequently discharged on July 22, 1986. (Pet. Ex. #7, pp. 2, 5).

48. Patient E was readmitted to Montefiore on August 4, 1986. Respondent reported that the ERCP showed narrowing of the distal common bile duct. He planned to do a choledocojejunostomy or a possible Puestow (pancreatic duct/small intestine anastomosis) operation. The pre-operative diagnosis was possible chronic pancreatitis. (Pet. Ex. #7, pp. 76-77).

49. On August 4, 1986, Respondent performed an exploratory laparotomy, cholecystectomy, cholangiogram through the cystic duct, biopsy of the pancreas and a biopsy of a paracholedochal node. (Pet. Ex. #7, pp. 94-95).

50. The cholangiogram showed no evidence of obstruction or residual stones. The distal common bile duct was inadequately

visualized, so abnormalities in that region could not be excluded. (Pet. Ex. #7, p. 98).

51. The pathology report of the specimen removed revealed chronic cholecystitis and cholelithiasis, a fragment of pancreas revealed fibrosis and extensive autolysis, and the lymph node revealed sinus histiocytosis. (Pet. Ex. #7, p. 96).

52. Given the findings of the ERCP and the cholangiogram that the common bile duct was inadequately visualized, Respondent needed to do more in order to visualize this duct and ascertain the pathology that was occurring. At the time of the August 4th surgery, Respondent needed to open the duct to make a diagnosis, or at a minimum visualize the duct more carefully. (264).

53. On August 7, 1986, a CT scan of the abdomen and pancreas was performed, but did not contribute towards establishing a diagnosis for Patient E. (Pet. Ex. #7, pp. 99-100).

54. Patient E was discharged from the hospital on August 8, 1986. He returned two months later on October 18, 1986 because of jaundice and epigastric pain. (269; Pet. Ex. #7, pp. 137, 148).

55. A CT scan of the abdomen performed on October 18, 1986 revealed pancreatic head enlargement and increased dilatation of both the pancreatic and bile ducts, strongly raising the suspicion of growing pancreatic or ampulary carcinoma. (Pet. Ex. #7, p. 213).

56. On October 20, 1986, a percutaneous trans-hepatic

cholangiogram and biliary drainage were performed. This revealed complete obstruction of the distal common bile duct. The obstruction appeared to be extrinsic. (Pet. Ex. #7, pp. 157, 210).

57. On October 24, 1986, a coeliac angiogram revealed encasement of the mid-gastroduodenal artery and a segment of the splenic vein. This was indicative of neoplasm of the pancreatic head. This was not a resectable cancer. (279, 287-289; Pet. Ex. #7, pp. 212).

58. On October 30, 1986, Respondent performed an exploratory laparotomy, division of the common bile duct and gastrojejunostomy. Respondent considered the tumor to be resectable. (Pet. Ex. #7, pp. 204-205).

59. During the course of performing the surgery on October 30th, Respondent lacerated the portal vein. He got into increasing difficulty with bleeding and the patient exsanguinated. (276, 278, 280-281, 307, 309; Pet. Ex. #7, pp. 195-197, 204-205).

Patient F

60. On May 17, 1884 Patient F, a 72 year-old female, was admitted to Montefiore Hospital with ascites. She was a former alcohol abuser with complications of peptic ulcer disease, pancreatitis and liver disease. (Pet. Ex. #8, pp. 30-36).

61. The admitting diagnoses were cirrhosis, possible pancreatic ascites, and possible fatty liver. Therapeutic paracenteses, a possible peritoneo-venous shunt and a liver biopsy were planned. (Pet. Ex. #8, p. 38).

62. On May 24, 1984, an ERCP was performed. This revealed leakage from the pancreatic duct into the peritoneal cavity. (Pet. Ex. #8, p. 45).

63. Plans were made to begin hyperalimentation in order to prepare the patient for an anastomosis of the pancreatic duct to the small intestine. (Pet. Ex. #8, pp. 45-46).

64. Respondent operated upon Patient F on June 19, 1984. Respondent encountered considerable bleeding at which time he elected to do a distal pancreatectomy. The patient was discharged to the ICU and died on June 20, 1984. (Pet. Ex. #8, p. 174).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. Numbers in parentheses refer to the specific Findings of Fact which support each conclusion.

FACTUAL ALLEGATIONS

The Hearing Committee concluded that the following Factual Allegations should be sustained:

--Paragraph A: (2-5, 8-9);

--Paragraph A.2: (2-5, 9-11);

--Paragraph A.3: (12-16);

--Paragraph B: (17-18, 25);

--Paragraph B.1: (17-25);

--Paragraph C: (26-33);

--Paragraph C.1: (29-33);

--Paragraph D: (34-39, 42);

--Paragraph D.2: (39-42);

--Paragraph D.3: (40-44);

--Paragraph E: (45-59);

--Paragraph E.1: (47-48);

--Paragraph E.2: (55-59);

--Paragraph E.3: (55-59);

--Paragraph F: (60, 64).

The Hearing Committee further concluded that the following Factual Allegations should not be sustained:

--Paragraph A.1: (4, 6-7, 12-13);

--Paragraph D.1: (35);

--Paragraph F.1: (60-63);

--Paragraph F.2: (61);

--Paragraph F.3: (60-62);

--Paragraph F.4: (60-64).

SPECIFICATION OF CHARGES

The Hearing Committee concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each specification:

--Second Specification: (Gross Negligence - Patient A: Paragraphs A, A.2 and A.3);

--Fourth Specification: (Gross Negligence - Patient D: Paragraphs D, D.2 and D.3);

--Fifth Specification: (Gross Negligence - Patient E: Paragraphs E, E.1, E.2 and E.3) (2-1 vote);

--Seventh Specification: (Negligence on More Than One Occasion: Paragraphs A, A.2, A.3, B, B.1, C, C.1, D, D.2, D.3, E, E.1, E.2 and E.3);

--Ninth Specification: (Gross Incompetence - Patient B: Paragraphs B, B.1);

--Tenth Specification: (Gross Incompetence - Patient C: Paragraphs C and C.1);

--Eleventh Specification: (Gross Incompetence - Patient D: Paragraphs D, D.2 and D.3);

--Twelfth Specification: (Gross Incompetence - Patient E: Paragraphs E, E.1, E.2 and E.3);

--Fourteenth Specification: (Incompetence on More Than One Occasion: Paragraphs A, A.2, B, B.1, C, C.1, D, D.2, D.3, E, E.1, E.2 and E.3).

The Hearing Committee further concluded that the following Specifications should not be sustained:

--First Specification: (Gross Negligence - Patient A) (2-1 vote);

--Third Specification: (Gross Negligence - Patient C);

--Sixth Specification: (Gross Negligence - Patient F);

--Eighth Specification: (Gross Incompetence - Patient A);

--Thirteenth Specification: (Gross Incompetence - Patient F).

DISCUSSION

Respondent is charged with fourteen specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct under the New York Education Law" sets forth suggested definitions for gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion.

The following definitions were utilized by the Hearing Committee as a framework for its deliberations:

(1) **Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances;

(2) **Gross Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad;

(3) **Incompetence** is a lack of the skill or knowledge necessary to practice the profession;

(4) **Gross Incompetence** is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the

licensee in the practice of medicine.

All conclusions reached by the Hearing Committee were made based upon the preponderance of the evidence. The rationale underlying the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made an evaluation of the credibility of the expert witnesses presented by the parties. The Department presented one expert - Norman S. Roome, M.D. Dr. Roome is an assistant professor of clinical surgery at Cornell University. (T. 15). Respondent also presented one expert- David Befeler, M.D. Dr. Befeler is an associate professor of clinical surgery at Columbia College of Physicians and Surgeons. (T. 525). In addition, Respondent testified on his own behalf.

Neither of the experts presented by the parties has any personal stake in the outcome of these proceedings. The Hearing Committee found them to be generally credible, but prone to hyperbole. As a result, the Committee depended in large part on the documentation in the medical records for its factual determinations. Where the experts' testimony conformed with the documentary evidence, it was given credence.

On the other hand, Respondent's testimony was often at variance with the information in the medical records. Given his obvious stake in the outcome of the hearing, the Committee did not place great weight upon his testimony.

The Hearing Committee was presented with fact patterns in five out of the six cases at issue in this proceeding where Respondent demonstrated repeated carelessness and inattention to

detail. This carelessness resulted in errors which would not have been made by a reasonably prudent surgeon. In addition, Respondent's treatment of these patients, combined with his testimony at the hearing, demonstrated a lack of the basic skill and knowledge necessary to meet minimally acceptable standards of practice. Each of the six cases will be discussed separately, below.

Patient A

Respondent performed a cholecystectomy on Patient A, a 43 year-old woman, on June 24, 1986. During the course of the surgery, Respondent ligated the common hepatic duct. Such ductal injuries are a known complication in cholecystectomies. Consequently, it is the standard of practice to carefully identify the ducts before ligating or dividing them. However, the record contains no evidence that Respondent did identify the duct.

There were sufficient post-operative signs and symptoms indicating that the duct had been damaged which should have alerted Respondent to investigate the patient's condition more thoroughly. Nevertheless, the patient was discharged from the hospital on July 4, 1986 despite abnormal liver chemistries. Respondent attempted to infer that the patient was not discharged at his direction, and that another physician was responsible for checking on the liver chemistries. The Hearing Committee concluded that Respondent did not fulfill his responsibility to the patient in this regard.

Respondent re-operated on Patient A on July 10, 1986, in

an attempt to correct the damage caused by the initial surgery. Respondent attempted to restore continuity with the intestinal tract by bringing a loop of small intestine up in a Roux-en-Y fashion, freeing a loop of jejunum and creating an anastomosis with the common bile duct in an end-to-side fashion. However, he created the anastomosis in the proximal curve of the small bowel, leaving a large, free end of blind loop. The creation of the blind loop caused additional complications for the patient, necessitating a third operation to correct the problems. The Hearing Committee concluded that Respondent's conduct in the care and treatment of Patient A demonstrated a lack of the skill and knowledge necessary to perform surgery on the patient. Consequently, the Committee found that Respondent's conduct demonstrated incompetence, but did not rise to the level of gross incompetence. Therefore, the Committee did not sustain the Eighth Specification. In addition, the Hearing Committee further concluded that Respondent was negligent in his treatment of this patient, but that his negligence was not sufficiently egregious so as to warrant a finding of gross negligence. As a result, the Committee did not sustain the First Specification.

Patient B

On April 16, 1987, Respondent admitted Patient B, an 89 year-old man, to the hospital for treatment of post-traumatic right pneumothorax. Despite arterial blood gas levels which indicated that the patient was not aerating properly, Respondent failed to recognize the serious nature of the patient's hypoxia.

He failed to provide appropriate pulmonary support. On April 21, 1987, Respondent saw the patient, who was confused, sweating and hypotensive - the classic signs of hypoxia. Nevertheless, Respondent's approach to the situation was to order restraints and sedation, in the absence of appropriate pulmonary support. Respondent's actions confirmed the fact that he failed to recognize and appropriately treat the patient's hypoxia. The patient expired several hours following Respondent's last visit to the patient.

The Hearing Committee concluded that Respondent's conduct demonstrated an egregious failure to exercise that care that would be exercised by a reasonably prudent surgeon under the circumstances. As a result, the Committee sustained the Second Specification (Gross Negligence). In addition, the Committee found that Respondent demonstrated an unmitigated lack of skill or knowledge warranting a finding of gross incompetence. Therefore, the Committee sustained the Ninth Specification.

Patient C

On May 16, 1987, Respondent performed a right hemicolectomy and ileo-transverse colostomy on Patient C, a 68 year-old man. On or about the sixth post-operative day, the patient spiked a temperature and had a tender and distended abdomen. The patient's course was followed by another physician at that time. Upon Respondent's return to the hospital on May 26, 1987, Respondent noted that a fecal fistula had developed. He noted that he intended to follow the current approach, observe the

patient and begin hyperalimentation.

The patient's post-operative complications continued. The fistula spilled into the peritoneal cavity, creating an abscess. Large quantities of fecaloid material drained from the wound.

These post-operative complications were not dealt with in an integrated, organized fashion. Drainage of the abscess at an appropriate time, adequate nutrition, and surgical intervention were necessary, yet Respondent appeared not to have formulated a plan of therapy to treat the patient. His own expert, Dr. Befeler, indicated that the nutritional support provided to the patient was inadequate to facilitate the healing process. He also agreed that Respondent's treatment of this high-output fistula was insufficient.

Based upon the above, the Hearing Committee concluded that Respondent's conduct with regard to Patient C constituted gross incompetence, and sustained the Tenth Specification. The Committee further concluded that Respondent's conduct also constituted negligence, but did not rise to the level of gross negligence. As a result, the Committee did not sustain the Third Specification.

Patient D

Patient D, a 90 year-old woman, was admitted to the hospital by Respondent for the repair of a rectal prolapse. On December 23, 1986, Respondent attempted to correct the rectal prolapse by fixing the sigmoid colon to the anterior abdominal wall. He described this procedure as the Lahaut procedure. On

January 2, 1987, another surgeon performed an exploratory laparotomy, right hemicolectomy and left colon resection and colostomy. He found a volvulus of the cecum with perforation and rectal prolapse.

The choice of procedure for treatment of a rectal prolapse is up to the judgment of the individual surgeon. The post-operative complications following the initial surgery could not have been reasonably anticipated. As a result, the Hearing Committee did not sustain Factual Allegation D.1.

On January 21, 1987, a gastrostomy tube was inserted by Drs. Fleurant and Gutwein, in order to provide nutritional support to the patient. The tube was successfully replaced by Dr. Ader on March 17, 1987. On or about March 30, 1987, the gastrostomy tube fell out. Dr. Murani unsuccessfully attempted to reinsert the tube. He called Respondent to assist him. Respondent reinserted the tube. He ordered an X-ray to determine the location of the tube. At or about 2:00 p.m. the feedings were held, pending the results of the X-ray examination. At 6:00 p.m. Respondent saw the patient and ordered the resumption of the tube feedings. Upon re-starting the feedings, Patient D complained of excruciating pain. On March 31, 1987, the patient still felt abdominal pain. An examination revealed abdominal tenderness around the insertion site. A gastrografin study demonstrated that fluid extravasated from the gastrostomy tube into the peritoneal cavity. On April 1, 1987, the patient was transferred to the ICU. Later that day, she was taken to the operating room for the emergency closure of a

perforated stomach.

It is not at all unusual for a gastrostomy tube to become dislodged and require replacement. However, in this instance, the replacement was not a simple procedure. This should have alerted Respondent to ascertain the correct location of the tube. He failed to do this before resuming the tube feedings. Upon the patient's development of symptoms of peritonitis, Respondent ordered the gastrografin study which confirmed the leakage on March 31. Nevertheless, nothing was done to correct the situation until late in the evening on April 1. The Hearing Committee found this delay to be totally unacceptable. The Committee concluded that Respondent's conduct with regard to Patient D constituted gross negligence as well as gross incompetence. As a result, the Committee sustained the Fourth and Eleventh Specifications.

Patient E

On or about July 16, 1986, Respondent admitted Patient E, a 78 year-old man, for evaluation of a possible cyst in the head of the pancreas. Abdominal angiography revealed findings compatible with either a pancreatic tumor or pancreatitis. An abdominal sonogram indicated cholelithiasis and chronic cholecystitis. The pancreas was thickened and edematous, consistent with pancreatitis.

Endoscopic retrograde pancreatography (ERCP) showed narrowing of the distal common bile duct. Respondent's pre-operative diagnosis was possible chronic pancreatitis.

On August 4, 1986, Respondent performed an exploratory

laparotomy, cholecystectomy, cholangiogram through the cystic duct, biopsy of the pancreas and a biopsy of a paracholedochal node. The cholangiogram showed no evidence of obstruction or residual stones. However, the distal common bile duct was inadequately visualized.

Patient E represented a difficult diagnostic problem. Unfortunately, Respondent did not address the abnormality in the lower end of the common bile duct. Given the findings on the ERCP and the cholangiogram indicating that the common bile duct was inadequately visualized, it was incumbent upon Respondent to identify the abnormality at the lower end of the common duct at the time of the first surgery. This was not done.

Patient E was discharged from the hospital on August 8, 1986. He returned two months later on October 18, 1986 because of jaundice and epigastric pain. A CT scan of the abdomen performed on October 18, 1986 revealed pancreatic head enlargement and increased dilatation of both the pancreatic and bile ducts, strongly raising the suspicion of growing pancreatic or ampulary carcinoma. On October 20, a percutaneous trans-hepatic cholangiogram and biliary drainage were performed, revealing complete obstruction of the distal common bile duct. In addition, a coeliac angiogram performed on October 24, revealed encasement of the mid-gastroduodenal artery and a segment of the splenic vein. This was indicative of neoplasm of the pancreatic head. This was a non-resectable cancer.

On October 30, 1986, Respondent performed an exploratory

laparotomy, division of the common bile duct and gastrojejunostomy. He was attempting to resect the tumor. During the course of the surgery, Respondent lacerated the portal vein. The patient ultimately bled to death.

The Hearing Committee concluded that there was sufficient evidence prior to the second surgery that the patient's carcinoma was not resectable. A prudent surgeon would have recognized this at the time of surgery. Respondent failed to appreciate the situation, resulting in a catastrophe for the patient.

The Hearing Committee further concluded that Respondent's conduct with regard to Patient E constituted gross negligence, as defined above (2-1 vote), as well as gross incompetence (unanimous vote). Consequently, the Hearing Committee sustained the Fifth and Twelfth Specifications.

Patient F

Patient F, a 72 year-old female, was admitted to Montefiore Hospital on May 17, 1984 with ascites. She was a former alcohol abuser with complications of peptic ulcer disease, pancreatitis and liver disease. Her admitting diagnoses were cirrhosis, possible pancreatic ascites, and possible fatty liver. Several diagnostic procedures were planned.

An ERCP performed on May 24, 1983 revealed leakage from the pancreatic duct into the peritoneum. Respondent operated upon Patient F on June 19, 1984, in order to perform an anastomosis of the pancreatic duct to the small intestine. Respondent encountered considerable bleeding and elected to do a distal

pancreatectomy. Following surgery, the patient was discharged to the ICU, where she died on June 19, 1984.

The Hearing Committee concluded that the Department's concern about the treatment of a pseudo-cyst, as reflected in the testimony of Dr. Roome, was unwarranted. There was adequate documentation in the medical record that this seriously ill patient required treatment for pancreatic ascites. All concerned were aware that this would constitute extensive surgery in a debilitated patient. Respondent's planned course of treatment for this patient fell within the realm of acceptable medical judgement. Consequently, the Hearing Committee did not sustain either the Sixth Specification (gross negligence) or the Thirteenth Specification (gross incompetence).

Negligence On More Than One Occasion

Incompetence On More Than One Occasion

As was set forth more specifically above, the Hearing Committee sustained three specifications of gross negligence (Patients B, D and E) and further concluded that Respondent's treatment of Patients A and C constituted negligence. Therefore, it is axiomatic, then, that the Committee sustained the Seventh Specification (negligence on more than one occasion). Similarly, the Committee sustained four specifications of gross incompetence (Patients B, C, D and E). In addition, the Committee concluded that Respondent's treatment of Patient A constituted incompetence. Therefore, the Hearing Committee sustained the Fourteenth Specification (incompetence on more than one occasion).

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in the State of New York should be revoked. The Committee further determined that the revocation of Respondent's license shall be stayed, with Respondent placed on probation for a period of five years, commencing on the effective date of this Order. The complete terms of probation are contained in Appendix II, which is attached to this Determination and Order and incorporated herein. The Hearing Committee's determination as to the penalty to be imposed was reached after due consideration of the full spectrum of available penalties, including revocation, suspension, probation, censure and reprimand, or the imposition of civil penalties of up to $10,000 per specification of charges sustained.

The Hearing Committee found that Respondent demonstrated a pattern of carelessness and inattention to detail in his care of five out of the six patients charged. Respondent's failure to exercise the care that a reasonable physician would, under the circumstances, rose to the level of gross negligence in three cases. Further, Respondent demonstrated gross incompetence with regard to his management of four out of the six cases charged. It is apparent to the Hearing Committee that Respondent is not competent to practice the profession, in the absence of a significant period of monitoring and rehabilitation.

Nevertheless, the Committee does believe that Respondent

is a candidate for such rehabilitation. Consequently, the terms of probation include a requirement that Respondent obtain a monitoring physician, acceptable to the Office of Professional Medical Conduct, at each hospital where he maintains surgical privileges. The monitoring physician, or physicians, shall be required to render second opinions on all cases scheduled for surgery by Respondent. In addition, the monitoring physician, or physicians, shall supervise Respondent during surgery. The Hearing Committee believes that successful compliance with these terms of probation shall provide Respondent with the necessary skills and judgement necessary to practice the profession safely and effectively.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Second, Fourth, Fifth, Seventh, Ninth, Tenth, Eleventh, Twelfth and Fourteenth Specifications of professional misconduct contained within the Statement of Charges (Pet. Ex. #1) are **SUSTAINED**;

2. The First, Third, Sixth, Eighth and Thirteenth Specifications are **NOT SUSTAINED**, and

3. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**. The revocation of Respondent's license shall be stayed, and Respondent is hereby placed on probation for a term of five years commencing on the effective date of this Determination and Order, subject to the terms of probation contained in Appendix II, which is attached to and incorporated into this Determination and Order.

DATED: Albany, New York
Nov. 2, 1992

STANLEY L. GROSSMAN, M.D. (Chair)

Priscilla R. Leslie, R.N.
Gerald S. Weinberger, M.D.

TO: Simon Wapnick, M.D.
1180 Morris Park Avenue
Bronx, New York 10461

Dianne Abeloff, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001

T. Lawrence Tabak, Esq.
Goldsmith, Tabak & Richman, P.C.
747 Third Avenue
New York, New York 10017

APPENDIX I

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

IN THE MATTER

OF

SIMON WAPNICK, M.D.

: NOTICE

: OF

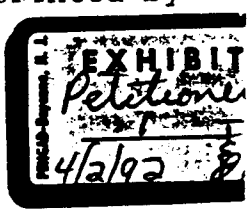
: HEARING

TO: SIMON WAPNICK, M.D.
1180 Morris Park Avenue
Bronx, N.Y. 10461

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, as amended by ch. 606, Laws of 1991 and N.Y. State Admin. Proc. Act Secs. 301-307 and 401 (McKinney 1984 and 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 13 day of April, 1992 at 10:00 in the forenoon of that day at 5 Penn Plaza, 6th fl., N.Y., N.Y. and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by



counsel. You have the right to produce witnesses and evidence on your behalf, to have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230, as amended by ch. 606, Laws of 1991, you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department

of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a, AS ADDED BY CH. 606, LAWS OF 1991. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: N.Y., N.Y., New York

March 19, 1992

Chris Stern Hyman

Chris Stern Hyman
Counsel

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
5 Penn Plaza
N.Y., N.Y. 10001

Telephone No.: 212-613-2615

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
SIMON WAPNICK, M.D.	:	CHARGES

----------X

SIMON WAPNICK, M.D., the Respondent, was authorized to practice medicine in New York State on February 7, 1975 by the issuance of license number 122882 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 1180 Morris Park Ave., Bronx, N.Y. 10461.

FACTUAL ALLEGATIONS

A. On or about June 22, 1986, Respondent admitted Patient A (the patients' identities are contained in the attached appendix), a 43 year old woman, to St. Barnabas Hospital, Bronx, N.Y. with a diagnosis of acute cholecystitis. Respondent performed a cholecystectomy on June 24, 1986. On or about July 4, 1986, Patient A was discharged from the St. Barnabas Hospital

despite persistent post-operative abdominal pain and elevated liver chemistries. On or about July 6, 1986, Respondent admitted Patient A to Montefiore Hospital, Bronx, New York. Respondent reoperated on Patient A on July 10, 1986. At the time of reoperation the following findings were made: ligation of the common bile duct; leakage of an accessory duct; and an obstruction at the upper level of the common bile duct. Respondent performed a Roux-y choledochojejunostomy.

amended by Pet. 4/13/92

1. Respondent failed to recognize or correct Patient A's serious post-operative complications from the June 24th surgery.

2. During the course of the June 24th surgery, Respondent ligated Patient A's common duct.

3. During the course of the July 10th surgery, Respondent created a small bowel blind loop.

B. Respondent admitted Patient B, a 89 year old man, to St. Barnabas Hospital on April 16, 1987 for treatment of post-traumatic right pneumothorax. Patient B's pulmonary status steadily deteriorated until on or about April 19, 1987, when he had a PO2 of 40.4 and an oxygen saturation of 72%. Patient B died on April 21, 1987.

1. Respondent failed to recognize and/or treat Patient B's progressive hypoxia.

C. Patient C, a 58 year old man, was admitted to St. Barnabas Hospital on May 16, 1987 for acute appendicitis. Respondent performed a right hemicolectomy and transverse colostomy. One week postoperatively Respondent described a fecal fistula. This condition was treated with antibiotics for nine days when another physician finally operated.

1. Respondent failed to timely re-explore and resect a disrupted anastomosis given the laboratory data and clinical findings of infection.

D. On or about December 21, 1986, Respondent admitted Patient D, a 90 year old woman, to St. Barnabas Hospital for repair of a rectal prolapse. About one month later, Patient D developed signs of intestinal obstruction. On or about January 20, 1987, ~~Respondent inserted~~ was inserted a feeding gastrostomy tube. On or about March 30, 1987, Patient D's feeding gastrostomy tube fell out. Respondent used force to reinsert the tube. The tube became lodged in Patient D's peritoneal cavity.

amended by Pet. 6/10/92. fbb

1. Respondent performed the wrong procedure to repair Patient D's rectal prolapse.

2. Respondent failed to document the location of the feeding gastrostomy tube.

3. Respondent failed to perform or recommend immediate surgery for Patient D despite the finding of food intra-peritoneally.

E. On or about July 16, 1986, Respondent admitted Patient E, a 74 year old male, to Montefiore Hospital, Bronx, N.Y. for suspected cancer of the pancreas. Patient E was discharged for an endoscopic retrograde pancreatography (ERCP) to be performed at a different institution. The ERCP showed a stricture of the lower end of the common bile duct. On or about August 4, 1986, at Montefiore Hospital, Respondent performed a laparotomy and a cholecystectomy on Patient E. Respondent found that the pancreas revealed changes consistent with chronic pancreatitis and not neoplasm. Patient E was discharged on August 8, 1986. He returned two months later because of obstruction and jaundice. On or about October 30, 1986, Respondent attempted a pancreatectomy on Patient E at Montefiore Hospital. The patient experienced massive hemorrhage and died subsequent to the operation.

amended by Pet. 6/10/92 JBS

1. On or about August 4, 1986, Respondent failed to recognize or diagnosis that Patient E had pancreatic cancer despite the ERCP findings.

2. Respondent should have performed a pancreatic bypass rather than a pancreatectomy.

3. At the October 30, 1986 operation, the attempted pancreatectomy should have been aborted as the tumor had already invaded the portal vein.

Amended JLS 4/13/92 by Pet.

F. On or about May 17, 1984, Patient D, a 72 year-old woman, was admitted to ~~St. Barnabas~~ Montefiore Hospital for the treatment of chronic pancreatitis and pain. On or about June 19, 1984, Respondent performed a distal pancreatectomy and splenectomy.

amended by Pet. 5/26/92

1. The June 19, 1984 operation was contraindicated given the patient's condition at the time.

2. Respondent performed the June 19th operation without a clear plan of what he was trying to accomplish.

3. Respondent failed to properly diagnose and treat Patient F's psuedo-cyst of the pancreas.

4. Respondent failed to terminate the procedure and control the hemorrhage which occurred upon

Amended 5/26/92 JLS → Respondent encounter ing Patient F's psuedo-cyst.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law section 6530 (McKinney Supp. 1992), Petitioner charges:

1. The facts in paragraph A, A 1 through A 3.

2. The facts in paragraph B, B 1.

3. The facts in paragraph C, C 1.

4. The facts in paragraph D, D 1 through D 3.

5. The facts in paragraph E, E 1 through E 3.

6. The facts in paragraph F, F 1 through F 4.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCASSION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligen on more than one occasion within the meaning of N.Y. Educ. La section 6530 (3) (McKinney Supp. 1992), in that Petitioner cha that Respondent committed two or more of the following:

7. The facts in paragraphs A, A 1 thorugh A 3, B, B 1, C, C1, D, D1 through D 3, E, E 1 through E 3 and/ or F, F 1 through F 4.

EIGHTH THROUGH THIRTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law section 6530 (McKinney Supp. 1992), in that Petitioner charges:

8. The facts in paragraph A, A 1 through A 3.

9. The facts in paragraph B, B 1.

10. The facts in paragraph C, C 1.

11. The facts in paragraph D, D 1 through D 3.

12. The facts in paragraph E, E 1 through E 3.

13. The facts in paragraph F, F 1 through F 4.

FOURTEENTH SPECIFICATION

PRACTICING WITH INCOMEPTENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompete on more than occasion within the meaning of N.Y. Educ. Law sec 6530 (5) (McKinney Supp. 1992), in that Petitioner charges tha Respondent committed two or more of the following:

14. The facts in paragraphs A, A 1 thorugh A 3, B, B 1, C, C1, D, D1 through D 3, E, E 1 through E 3 and/ or F, F 1 through F 4.

DATED: New York, New York
March 17, 1992

Chris Stern Hyman

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct

APPENDIX II
TERMS OF PROBATION

1. Dr. Wapnick shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Dr. Wapnick shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. Wapnick shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Wapnick leaves New York to reside or practice outside the State, Dr. Wapnick shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Wapnick shall have quarterly meetings with an employee or designee of the Office of Professional Medical Conduct during the period of probation. During these quarterly meetings Dr. Wapnick's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

6. Dr. Wapnick shall be monitored and supervised by a licensed physician, acceptable to the Office of Professional Medical Conduct, at each hospital at which Respondent maintains surgical privileges. The monitoring physician, or physicians, shall be required to render second opinions on all cases scheduled for surgery by Respondent. In addition, the monitoring physician, or physicians, shall supervise Respondent during surgery. Dr. Wapnick shall not practice medicine until an acceptable monitoring physician is approved by the Office of Professional Medical Conduct.

7. Respondent shall submit the name of a successor monitoring physician to the Office of Professional Medical Conduct for approval within seven (7) days of Respondent's becoming aware that the current monitoring physician is no longer able to perform that function.

8. Dr. Wapnick shall have quarterly meetings with the monitoring physician, or physicians, to review Dr. Wapnick's

practice. The monitoring physician, or physicians, shall randomly review selected medical records and evaluate whether Dr. Wapnick's medical care comports with generally accepted standards of medical practice.

9. The monitoring physician, or physicians, shall submit quarterly reports to the Office of Professional Medical Conduct certifying compliance with each of the terms of probation by Dr. Wapnick or describing in detail any failure to comply.

10. Dr. Wapnick shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not the specifics of such non-compliance. These declarations shall be sent to the Director of the Office of Professional medical Conduct at the address indicated above.

11. Dr. Wapnick shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If Dr. Wapnick elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

12. If there is full compliance with every term set forth herein, Dr. Wapnick may practice as a physician in New York in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, the stay of revocation shall terminate. In addition, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. Wapnick pursuant to New York Public Health Law §230(19) or any other applicable laws.