STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 3, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Frederick Zimmer, Esq.
NYS Department of Health
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237

Arthur W. Hill, Esq.
16 Court Street, Suite 2403
Brooklyn, New York 11241

Jacob Addes, M.D.
5123 14th Avenue
Brooklyn, New York 11219

RE: In the Matter of Jacob Addes, M.D.

Dear Mr. Zimmer, Mr. Hill and Dr. Addes:

Enclosed please find the Determination and Order (No. 97-32) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 then 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), "the 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 penalties **other than suspension or revocation** 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

JACOB ADDES, M.D.

DETERMINATION

AND

ORDER

BPMC-97-32

ANTHONY SANTIAGO, Chairperson, **DONNA B. O'HARE, M.D.** and **FLORENCE KAVALER, M.D.,** duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law **JEFFREY ARMON, ESQ.,** served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	October 4, 1996
Date of Hearing:	December 3, 1996
Department of Health appeared by:	Henry M. Greenberg, General Counsel NYS Department of Health BY: Frederick Zimmer Assistant Counsel NYS Department of Health Corning Tower Albany, New York 12237
Respondent appeared by:	Arthur W. Hill, Esq. 16 Court Street, Suite 2403 Brooklyn, New York 11241

Witnesses for the Department of Health:	James Terravecchio Alan LaFlore Maury J. Greenberg, M.D.
Witnesses for the Respondent:	Jacob Addes (Respondent)
Deliberations held:	January 17, 1997

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T = Transcript

A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on July 10, 1946 by the issuance of license number 45013 by the New York State Education Department.

2. By 1995, Respondent had been treating Patient A, a 93 year old female, for approximately twenty-five years. She lived across the street from the Respondent with her son, who was about 60 years old at that time. (Ex. 5; T. 87, 91)

3. On the afternoon of October 25, 1995, Respondent received a telephone call from the son. He informed Respondent that Patient A was complaining of chest pains and shortness of breath. (Ex. 7; T. 88)

4. Respondent thereafter went to the home of Patient A and conducted a physical examination of her. He determined that her heartbeat was mildly irregular and that her blood pressure was slightly elevated. (T. 88)

5 Respondent administered a 30 mg. injection of Demerol to Patient A at approximately 2:15 p.m. He telephoned 911 and left a note written on his prescription paper stating, "pt. can't breath. Has chest pains. Has dizziness and nausea. Has Parkinson's. Advise immediate hosp. for cardiac workup. Demerol inj. 30 mg. at 2:15 p.m.". He directed Patient A's son to give the note to the paramedics when they arrived. (Ex. 7; T. 26, 89)

6. Demerol is an artificial narcotic which is used to treat chest pain in a person suspected of having a myocardial infarction as well as to treat certain symptoms not related to a heart attack. It can cause a decrease in blood pressure and can decrease respiration and consciousness. (T. 61-2, 77)

7 Respondent's administration of Demerol, based on the presenting symptoms of Patient A, was appropriate and met accepted standards of medical care. (T. 66-7)

8 Respondent thereafter left Patient A's residence and returned to his office across the street. He left the patient in the care of her mildly retarded son. The son routinely provided care to Patient A and assisted her in her daily activities. (T. 89-91, 95)

9. The Lutheran Medical Center emergency medical services received a call from a dispatcher at approximately 2:25 p.m. on October 25, 1995 which directed a paramedic team to Patient A's address. It is approximately a one to three minute period between the time a telephone call for emergency medical services is initially received by a dispatcher and the dispatcher thereafter contacts a paramedic team. (Ex. 5, p. 2; T. 20-2)

10. The paramedics arrived at Patient A's residence at about 2:36 p.m. A police officer had arrived prior to the paramedics in response to the request for emergency services. (Ex. 5; T. 22-4, 39-40)

11. Patient A was found by the paramedics seated in a chair complaining of shortness of breath, chest pain, dizziness and nausea. Her vital signs were within normal limits. She was not in cardiac arrest. A spent syringe with a bent needle was found with Respondent's note on the table next to the patient. (Ex. 5, pp. 2-4; T. 24-5, 27, 34-5)

12. Proper infection control standards require that used syringes be disposed of in a safe puncture proof container and not on a patient's table. This type of medical waste should then be disposed of by a biomedical waste company or other similar service. (T. 64)

13. The paramedics immediately administered oxygen to Patient A. An EKG was performed at about 2:41 p.m., the results of which indicated that the patient was in atrial fibrillation, which is an irregular heartbeat. (Ex. 5, pp. 2, 5; T. 25, 29)

14. Patient A was transported by ambulance to the hospital at approximately 3:05 p.m. She was diagnosed as suffering from a peptic ulcer and was treated and released from the hospital to her home on that evening. (Exs. 5, 6, pp. 4-5; T. 29-30)

15 Respondent provided an explanation of his care of Patient A on October 25, 1995 by submitting a letter dated April 17, 1996 to the Office of Professional Medical Conduct. In that letter, he indicated that the patient's complaints were of chest pain and shortness of breath, that the results of a physical examination demonstrated a blood pressure of 160/80, mildly irregular cardiac rhythm, fairly good sounds, systolic 2/6 at apex and that the patient could not cooperate as to breathing. His impressions were noted as angina pectorus and an irregular heartbeat with a question of myocardial infarction. (Ex. 7, 43-4, 49, 58-9)

16. Respondent is 78 years of age and maintains a small private practice wherein he treats about 12 to 15 patients per week. His patients are primarily elderly persons who live in his neighborhood. Respondent has no hospital privileges. (T. 86-7, 93, 95-6)

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.

The Hearing Committee concluded that the following Factual Allegations should be sustained. the citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A.	(2-4);
Paragraph A.1.	(5, 8);
Paragraph A.2	(11-12).

The Hearing Committee concluded that the following Specifications of Charges should be sustained:

Third Specification;

Fourth Specification.

The Committee concluded that all other Specifications of Charges should **NOT** be sustained.

DISCUSSION AND CONCLUSIONS

Respondent was charged with multiple 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 the General Counsel for the Department of Health. the document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence and incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

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.

Using the above definitions as a framework for its deliberations, the Hearing Committee determined that the Department had not established, by a preponderance of the evidence, those Specifications of Charges alleging that Respondent had practiced the profession with gross negligence and gross incompetence.

The facts as alleged in the Statement of Charges were not disputed by Respondent. The Committee's responsibility was to determine whether those facts constituted professional medical misconduct. The Hearing Committee concluded that Respondent's treatment of Patient A clearly did not constitute either gross negligence or gross incompetence. The record demonstrated that the Respondent did not leave the patient alone, in that her son remained with her. While the son's mental capabilities may have been somewhat limited, he was able to assist Patient A in her daily activities and he had demonstrated that he was able to telephone the Respondent to request medical assistance. The Respondent testified that his impression of the patient at the time he left her was that she was calmer and not in immediate cardiac distress. For these reasons, the Committee believed that, even if the failure to remain with the patient until the paramedics arrived was not within acceptable standards of practice, such a failure was not so egregious or conspicuously bad so as to constitute gross negligence.

There was similar agreement that Patient A's treatment did not demonstrate that Respondent had an unmitigated lack of the necessary medical skill and knowledge. The Department's expert agreed that the administration of the Demerol was appropriate based upon the patient's condition. Respondent testified that he left the patient because he believed her condition had improved, that there was nothing further he could do and because her son remained present. The Committee did not find that Respondent's treatment constituted gross incompetence in the practice of medicine.

The Committee concluded that Respondent did abandon Patient A while she was under professional care without making reasonable arrangements for the continuation of such care. The Department's expert testified that, following administration of the Demerol, the patient could have experienced decreased respiration and blood pressure that may have required some treatment before the paramedics arrived. He further testified that the treatment that could have been provided under

the circumstances would have been first aid or CPR, if necessary, and that Respondent could have monitored the patient to ensure that an airway was maintained. There was no evidence presented which indicated that the son was advised to monitor the patient's respiration after the Respondent left her home, even assuming that the son may have been capable of undertaking such action. The Committee reasoned that Respondent should have remained with the patient to ensure that she remained stable until the ambulance arrived. Therefore, the Third Specification was sustained.

The Respondent did not dispute the allegation that he left a spent syringe and bent needle behind when he left the patient. Accepted infection control practices require that used syringes be safely disposed. The Fourth Specification was sustained by the Hearing Committee.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent should receive a Censure and Reprimand. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee believed that a number of mitigating factors supported a determination that a more severe penalty not be imposed in this case. The Respondent was considered to have appropriately treated the patient by administering what the Department's expert conceded was not a large dose of Demerol. This medication relieved her symptoms as Respondent testified that she appeared to be calmer and less restless when he left her residence. The patient was left with her son, who was her normal caregiver, and returned to his office which was across the street from where Patient A lived. The period of time during which she was without professional medical attention was approximately fifteen minutes and Respondent reasonably believed the paramedics would quickly

arrive when he called 911 for emergency services. The record indicates that a policeman arrived at the residence before the ambulance which reduced the time during which Patient A was left alone with her son.

The Committee viewed Respondent's abandonment of Patient A as an isolated error in judgment and believed that he was actually to be commended for making a house call when such an action has become increasingly rare. Respondent testified that he had treated the 93 year old patient for many years and was familiar with her circumstances. He believed he could do nothing else for her until the paramedics arrived. The Committee felt it irrelevant as to whether Respondent believed the patient may have been experiencing a heart attack as he had no equipment with him to do anything other than monitor her respiration during the few minutes at issue. Finally, the failure to properly dispose of the syringe was considered to be an isolated oversight that did not merit a more significant penalty.

The Committee took strong exception to the Department's assertion that Respondent's demeanor and affectation at this proceeding supported the contention that he should no longer be practicing medicine. On the contrary, the personal observations made while he testified led the Committee to determine that such demeanor and affectation were completely appropriate. Respondent's testimony was clear and direct and his recollection of the events of October, 1995 was detailed. The Committee found his testimony to be most credible and concluded that a Censure and Reprimand was the most appropriate penalty to impose in this instance.

ORDER

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

1. The Following Specifications of Charges, as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED:**

   THIRD SPECIFICATION; and

   FOURTH SPECIFICATION.

2. Respondent is hereby issued a **CENSURE AND REPRIMAND.**

3. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York

1/30 **1997**

ANTHONY SANTIAGO, (Chairperson)

DONNA B. O'HARE, M.D.
FLORENCE KAVALER, M.D.

TO: Frederick Zimmer, Esq.
NYS Department of Health
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STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JACOB ADDES, M.D.,	:	CHARGES
Respondent	:	

----------X

JACOB ADDES, M.D., the Respondent, was authorized to practice medicine in New York State on July 10, 1946 by the issuance of license number 45013 by the New York State Educatior Department.

FACTUAL ALLEGATIONS

A. Respondent, on or about October 25, 1995, provided medical care to Patient A, a 93 year old female with a history c Parkinson's disease (Patient A is identified in the attached Appendix), at Patient A's residence in Brooklyn, New York for complaints of chest pains, dizziness, nausea and shortness of breath, and a possible myocardial infarction. Respondent's care failed to meet acceptable standards of medical care, in that:

1. Respondent, after administering a Demerol 30 mg. intramuscular injection, called 911, requested an ambulance and left written instructions that the patient should be taken immediately to the hospital for a cardiac workup. Respondent

then left Patient A's residence leaving Patient A in the care of her 40 year-old son, who is mildly retarded.

2. Respondent, upon departing, left a spent syringe and needle on Patient A's table.

SPECIFICATIONS

FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(4)(McKinney's Supp. 1996) by reason of his having practiced the profession with gross negligence on a particular occasion, in that the Petitioner charges:

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

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(6)(McKinney's Supp. 1996 by reason of his having practiced the profession with gross incompetence, in that the Petitioner charges:

2. The facts in paragraphs A and A.1.

THIRD SPECIFICATION

PATIENT ABANDONMENT

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(30)(McKinney's Supp. 1996) by reason of his having abandoned or neglected a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, in that the Petitioner charges:

3. The facts in paragraphs A and A.1.

FOURTH SPECIFICATION

INFECTION CONTROL

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(47) (McKinney Supp. 1996) by reason of his having failed to use scientifically accepted infection control practices, in that the Petitioner charges:

1. The facts in Paragraphs A and A.2.

DATED: Oct. 4, 1996

Albany, New York

Peter D. Van Buren

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