STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

September 11, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Maureen S. Bonanni, Esq.
Thorn, Gershon, Tymann & Bonanni, LLP
5 Wembley Court, New Karner Road
P.O. Box 15054
Albany, New York 12212-5054

Alan S. Levin, M.D.
395 Saratoga Road
Glenville, New York 12302

RE: In the Matter of Alan S. Levin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-238) 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.

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.

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,

James F. Horan/cah

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

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

COPY

IN THE MATTER

OF

ALAN S. LEVIN, M.D.

FINAL DETERMINATION

AND

ORDER

BPMC #03-238

Michael R. Golding, M.D., Chairperson, and **John W. Choate, M.D.**[1] and **James P. Milstein, Esq.**, 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 Sections 230(1)(e) and 230(12) of the Public Health Law. **Susan F. Weber, Attorney at Law,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee. The Department of Health was represented by **Donald P. Berens, Jr., General Counsel, Timothy J. Mahar, Assistant Counsel.** Respondent **Alan S. Levin, M.D.** was represented by **Richard M. Gershon, Esq.**[2] and **Maureen S. Bonanni, Attorney at Law**, of **Thorn Gershon Tymann and Bonanni, LLP**.

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

STATEMENT OF THE CASE

This matter came to the Hearing Committee by Notice of Hearing dated December 31, 2002, which charged Alan S. Levin, M.D., ("Respondent") with fifteen specifications of professional misconduct involving the care and treatment of seven patients from approximately

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[1] Teresa S. Briggs, MD, served on the Hearing Committee for the first four hearing days. Immediately prior to the March 10th hearing date, Dr. Briggs required emergency back surgery, and was unable to continue as a member of the Panel. Dr. John W. Choate agreed to take her place. Dr. Choate's statement and affirmation is annexed as Appendix 2.

[2] At the January 28th Pre-Hearing Conference, Attorney Richard M. Gershon represented Dr. Levin, and explained that he had an extended vacation in Florida planned, commencing in early February. His request for an adjournment of several months was denied.

1985 through 2001. The specifications allege negligence on more than one occasion, gross negligence, and incompetence on more than one occasion, gross incompetence, and failure to maintain adequate records for each patient. The Statement of Charges is annexed hereto as Appendix 1.

The Hearing Committee sustains one specification of gross negligence, one specification of negligence on more than one occasion, and seven specifications of misconduct by failing to maintain adequate records. Specifications of incompetence and gross incompetence are not sustained.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges	December 31, 2002
Respondent's Answer	January 6, 2003
Pre-hearing Conference	January 28, 2003
Hearing Days	February 5, 12, 20, and 21, 2003 March 10 and 11, 2003 May 1 and 2, 2003
Place of Hearing	New York State Dept.of Health Hedley Building 5th Floor Hearing Room 433 River St., Troy, NY
and	
	Riverfront Professional Tower 4th Floor Hearing Room 500 Federal St., Troy, NY
Post-Hearing Briefs Received	June 12, 2003
Deliberations	July 9, 2003 Sept 10, 2003

Petitioner Appeared by	Donald P. Berens, Jr. General Counsel NYS Department of Health By: Timothy J. Mahar, Associate Counsel Bureau of Professional Medical Conduct Corning Tower Room 2512 Empire State Plaza Albany, NY 12237
Respondent Appeared by	Thorn, Gershon, Tymann and Bonanni, LLP By: Maureen S. Bonanni, Attorney at Law 5 Wembley Court, New Karner Rd. PO Box 15054 Albany, NY 12212-5054

WITNESSES

For the Petitioner	Lorne A. Becker, M.D., Expert Sharon Seaman, Nurse Practitioner, PA
For the Respondent	Anthony Marinello, M.D., Expert Alan S. Levin, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages (T. 25, e.g.) or exhibit pages (Ex. 4, p.6) that the Hearing Committee found persuasive in determining a particular finding. Having heard testimony and considered evidence presented by both the Department of Health and the Respondent, the Hearing Committee makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings in this case were unanimous, unless otherwise stated. All findings of fact were established by at least a preponderance of the evidence.

Patient A

The Respondent provided medical care to Patient A from January 2, 1985 to January 11, 1995, for hypertension and diabetes. The following Findings relate to allegations that Respondent, on various occasions, failed to take an adequate history, failed to perform an adequate physical examination and/or to order indicated diagnostic tests, and failed to evaluate Patient A adequately for hypertension.

1. Respondent diagnosed severe hypertension in 52 year old male Patient A on January 2, 1985. Patient A's blood pressure on that date was 160/120 (Ex. 3, pp. 2, 270; T., p. 25, 1194).
2. In 1985, the standard of care for hypertensive patients included an evaluation of secondary causes for high blood pressure. The patient history, physical examination and diagnostic testing should evaluate the patient for symptoms of Cushing Syndrome, abnormalities of blood vessels, narrowing of the aorta, narrowing of the arteries to the kidneys, and hormonal abnormalities relating to sodium and potassium (T., pp. 26-29, 30).
3. In 1985, the standard of care included evaluation of hypertensive patients for target organ damage, particularly to the heart and kidney. This evaluation would include a history, physical examination and laboratory tests (T., p. 31).
4. The standard evaluation of a hypertensive patient such as Patient A for secondary hypertension and target organ damage was required within the first three visits following the diagnosis of hypertension, even absent complaints or symptoms (T., pp. 30, 31, 35-36). Repeat evaluations of target organ damage were required yearly (T., p. 31).
5. Respondent testified that he did not evaluate Patient A for secondary hypertension because Patient A was over 30 (T., pp. 1252-1253). Respondent testified that evaluation for target organ damage was not the standard of care until 1993. Respondent testified that Patient A had blood work and a stress test in 1993; however, they were not repeated in 1994 and 1995; Respondent did not evaluate Patient A for target organ damage in 1994 and 1995 (T. 1253-1257). Respondent's failure to perform these evaluations deviated from accepted standards of medical care (T., p. 31-33, 36).
6. The standard of care required the documentation of abnormalities and significant negative findings (T., p. 34-35)

The following Findings of Fact relate to allegations that the Respondent failed to evaluate Patient A adequately for diabetes, failed to take an adequate history, and failed to perform an adequate physical examination and/or order or perform indicated diagnostic testing.

7. Patient A exhibited symptoms of diabetes on at his visit to Respondent on November 18, 1987: blood sugar of 427, glucose in the urine, and frequent urination, as well as a penile fungal infection (T., pp. 37-38, 1201; Ex. 3, p. 12).

8. Diabetes is a condition in which the patient's insulin does not effectively transport glucose into cells (T., pp. 38-39).

9. In 1987, Type II Diabetes was treated by a diet limiting refined sugars, oral agents and where required, insulin (T., pp. 39-40).

10. Diabetic patients are at increased risk to develop neurological disease, peripheral vascular disease, cardiovascular disease, retinopathy, and renal disease, as well as blindness and loss of limbs (T., p. 42). In 1987, the standard of care was to evaluate diabetic patients annually for such complications. (T., pp. 45-46).

11. The standard of care in 1987 required evaluation of a diabetic by history, including a family history and dietary history, and the presence of symptoms such as thirst, frequent urination and excessive hunger, as well as the known complications (T., p. 42). This annual evaluation was required regardless of patient complaints. (T., p. 51).

12. As there may have been a delay in the diagnosis of diabetes, a patient may have had an elevated blood sugar for a significant period of time (T., p. 42). Therefore, the physician should perform the initial evaluation for complications of diabetes immediately (T., p. 42).

13. The physical examination for diabetic complications includes examining the fundi of the eyes through dilated pupils; obtaining a creatinine level; a cardiovascular examination; and a careful examination of the legs and feet for vascular or neurological disease (T., pp. 42-43). The vascular examination checks for poor or absent pulses, temperature to touch, and color. (T., p. 43). Positive findings would indicate a problem with blood supply. The neurological exam assesses for numbness in the feet on palpation or by use of a monofilament (T., p. 43). The loss of vibration sense is tested by using a tuning fork. A decrease in reflexes may be attributed to a neuropathy (T., pp. 43-44).

14. Respondent acknowledged that a yearly evaluation of the creatinine level or urine was the standard, but that he did not obtain them (T., pp. 1266-1267).

15. Respondent testified that he regularly checked Patient A's blood sugar and blood pressure. He auscultated the patient's heart and lungs. He checked the patient's ankles, but not his feet, for edema and pulses (T., pp. 1214-1215). Further, Respondent "encouraged" yearly ophthalmology and podiatric examinations (T., pp. 1215, 1217, 1289). Respondent did not record the evaluation of the ankles (T., p. 1263) and does not believe that Patient A went to a podiatrist (T., p. 1217).

16. Respondent did not document any neurological examinations of Patient A, including tests for reflexes or vibratory sensation, in Patient A's chart. Respondent did not test Patient A for neuropathy by physical examination, but only by history (T., pp. 1263-1264). Respondent testified that if a patient was not going to a podiatrist, it was Respondent's duty to examine his feet for neurological or vascular disease (T., p. 1265).

17. In the four and a half years from Patient A's diagnosis of diabetes in November, 1987, to May, 1992, Respondent did not perform any evaluation of Patient A for the complications of diabetes (T., pp. 46, 50-51, 56, 60-62, Ex. 3, pp. 12-24).

18. Although Patient A had fundoscopic evaluations by an ophthalmologist in 1987, 1988, 1991, 1992, 1993 and 1994 (T., pp. 62-63; Ex. 5, pp. 3-5), he did not have them in 1989 and 1990. It was the Respondent's responsibility to inquire whether Patient A had been to the ophthalmologist, and to perform the fundosopic exam himself if the patient had not. (T., pp. 65-66).

19. The fundoscopic evaluation must be performed every year, and it is the responsibility of the primary care physician to determine that it has been, by inquiring of the patient as to whether he has seen the ophthalmologist (T., pp. 65-66).

20. Respondent's failure to evaluate Patient A for the complications of diabetes during the period from November, 1987 to May, 1992, deviated from accepted standards of medical care (T., p. 67). A physician is taught in medical school to perform these evaluations as diabetes is a common disease with complications which occur frequently (T., p. 68).

21. An evaluation for cardiovascular risks should be performed annually. (T., p. 94). In May and June of 1993, Patient A was evaluated for ischemic heart disease by means of a Holter monitor and a stress test, part of an appropriate evaluation of possible

cardiovascular complications in a diabetic patient. However, the chart entries indicate that these tests followed patient complaints of vertigo, and were not part of Respondent's evaluation of Patient A's diabetes. An electrocardiogram would have also been indicated, but was not ordered or performed. (Ex. 3, p. 27; T., pp. 93-94)

22. The standard of care would be to obtain a patient's creatinine level each year after the diagnosis of diabetes, to evaluate renal complications. Patient A's diabetes was diagnosed in 1987 (T., p. 95). In February, 1993, the patient had a laboratory study which included a creatinine level. (Ex. 3, p. 261; T., pp. 94-95). There was no creatinine level measured prior to 1993.

23. Respondent's failure to adequately evaluate Patient A for the complications of diabetes from 1987 to 1995 was a serious deviation from the standards of medical care (T., pp. 67, 96-98)

The following Findings of Fact relate to allegations that the Respondent did not evaluate and/or treat Patient A's legs and feet adequately.

24. Respondent's chart entry for June 10, 1992, notes that Patient A had some swelling in the lower third of the left leg, with an open scab on the inside of the leg (Ex. 3, p. 25). Respondent diagnosed cellulitis and treated with an antibiotic (Duricef) and Trental, a drug designed to improve blood flow (T., p. 68).

25. These findings represent an infection in the lower leg, a potential emergency for a diabetic. Decreased blood flow to the legs makes diabetics susceptible to leg and foot infections, and also undermines the normal healing process.(T., p. 69) In diabetics, foot or lower leg infections can progress very rapidly to serious or uncontrollable infection, which might require amputation. (T., pp. 69-71).

26. Respondent's evaluation of Patient A's leg symptoms on June 10, 1992 by history and physical examination for vascular disease or neuropathy deviated from accepted standards of medical care (T., p. 73). The accepted standards of care required a history of symptoms of neuropathy and of vascular changes to the legs and feet. (T., pp.70- 71).

27. Respondent did not perform and document the standard history or physical examination (T., p. 73). The physical examination should include and document the size and area of

the cellulitis, and the presence or absence of inflammation or infection. This allows the physician to evaluate the progress on follow-up exams. On June 10, 1992, Respondent failed to describe the size and area of the wound, or make any note about condition of the legs on Patient A's next visit, nine days later (Ex. 3, p. 25). The physician should also evaluate the rest of the effected limb and the other limb for vascular disease or neuropathy (T., pp. 71-72).

28. The prescription of Trental suggests that Respondent was treating Patient A for peripheral vascular disease, although there was no evaluation for vascular disease (T., p. 72). Trental does not treat the narrowing of the arteries associated with vascular disease; but improves the symptoms by permitting red blood cells to pass easier (T., p. 72).

29. During the next two and one-half years, other symptoms of difficulties with his extremities were noted in Patient A's chart:

-On October 4, 1993, Patient A complained of foot cramps at night. (Ex. 3, p. 30) Such cramps can be symptomatic of neurological or vascular changes. Respondent's note indicates a diagnosis of diabetic neuropathy with "r/o vascular". However, no basis for such diagnosis is recorded (T., pp. 74-75). Respondent deviated from accepted standards of medical care in failing to rule out either neurological or vascular complications of diabetes on this occasion (T., p. 75).

-On November 17, 1993, Respondent noted that Patient A's foot pain persisted, but no evaluation of this condition is recorded (Ex. 3, p. 33; T., p. 77). Respondent refers to a podiatrist ("Consider podiatrist"), the first time in the six years since the diagnosis of diabetes.

-On May 4, 1994, Respondent noted that Patient A had foot pain, but did not perform an evaluation (Ex. 3, p. 35, T., P. 80).

-On May 13, 1994, Respondent noted that Patient A's foot pain persists, again, without an evaluation (Ex. 3, p. 35; T., p. 80).

30. There was no evaluation for neuropathy or vascular disease by history or physical examination at any of these visits other than a reference to a Doppler study at the May 13, 1994 visit (T., pp. 81-82). There is no description as to the character, intensity or location of the foot pain (T., p. 77). The failure to perform such an evaluation deviated

from accepted standards of medical care (T., pp. 81-82). The risk to Patient A was that the pain was due to an infection which was undiagnosed (T., p. 77).

31. On March 22, 1995, Respondent noted in Patient A's chart, " [right] foot distal, cool bluish, no swelling, pulse ok" (Ex. 3, p. 38). There is a reference to a Doppler evaluation performed in May, 1994 which was noted to be negative.

32. The references to temperature, pulses and color are all part of a vascular examination of the foot. Respondent failed to perform a neurological evaluation as well, which would be the standard of care (T. 83; Ex. 3, p. 38). Respondent stated that he only examined the symptomatic right foot, but not the left (T., p. 1287). The standard for evaluating a patient's legs and feet would be to compare the symptomatic extremity with the other side (T., pp. 85-86, 155-156).

33. A Doppler evaluation of the venous system was ordered on March 22, 1995. The findings indicate that there was no evidence of deep vein thrombosis (DVT) in veins of either the right or left leg. (Ex. 3, p. 242; T., p. 84). Respondent failed to order an arterial Doppler study on March 22, 1995 and testified that he did not know why he did not order an arterial study (T., p. 84, 1225, 1283). An arterial Doppler study measures blood flow through the arteries, as opposed to a venous Doppler study which measures blood flow through the veins. A venous Doppler is used to evaluate a possible blood clot or thrombophlebitis. An arterial Doppler study assesses vascular disease due to diabetes (T., p. 81). The failure to evaluate Patient A's lower extremities with an arterial Doppler study on March 22, 1995, was a deviation from accepted standards of medical care (T., pp. 85, 87).

34. The Doppler study indicates that Patient A had pain in his right calf which Respondent acknowledged that he did not record during the office evaluation (T., p. 1288). Respondent testified that he probably did not do an adequate evaluation of Patient A's feet on March 22, 1995 (T., pp. 1314-1315).

35. Respondent's failure to appropriately evaluate Patient A's lower extremities was a significant deviation from accepted standards of care, placing the patient at risk for undiagnosed neuropathy or vascular disease, which can result in amputation. (T., pp. 87-88).

The following Findings of Fact concern Respondent's evaluation of Patient A for cardiovascular risk factors, and his monitoring and treatment of Patient A's elevated cholesterol.

36. Before February of 1993, Patient A's risk factors for cardiovascular disease included diabetes and hypertension (T., pp. 98-99). In 1990, he weighed was 305 pounds, despite being instructed in proper diet by Respondent in connection with diabetes. (T., pp. 1207-1208).

37. On February 19, 1993, Patient A's cholesterol was 295 and his LDL cholesterol was 205 (Ex. 3, p. 261). These elevations in the patient's total cholesterol and LDL cholesterol also constituted cardiovascular risk factors. The normal total cholesterol was 240 and normal LDL cholesterol would be 160 or below (T., p. 100).

38. The standard of care in 1993 would require repeating the lipids test to confirm the level, and then advise the patient on a low cholesterol diet to decrease saturated fat. The lipid studies should be repeated after several months of low cholesterol diet. Drug therapy would then be tried if necessary to bring cholesterol levels into an acceptable range (T., pp. 100-101). When he diagnosed Patient A's hyperlipidemia, Respondent should have documented in the chart his dietary instructions to Patient A. (T., p. 147).

39. Further, Respondent should have repeated the lipid studies annually thereafter to monitor Patient A's cholesterol levels, which Respondent's expert acknowledged. (T., p. 1624-1625).

40. Following the February, 1993 lipid test, Respondent did not order another lipid profile until February, 1996 (Ex. 3, p. 239). Respondent's failure to repeat the test annually deviated from the standards of care for evaluating Patient A's cardiovascular risk factors (T., pp. 101-103)

41. If he were not going to monitor Patient A's lipid profiles, the standard of care would have been to order lipid-lowering drugs for Patient A in 1993 (T., p. 104). The failure to order lipid lowering drugs for Patient A was a deviation from accepted standards of care (T., p. 104).

42. Patient A's hypertension (diagnosed in 1985) and diabetes (diagnosed in 1987), in addition to his sex and age, required that he be monitored for elevated lipids prior to 1993 (T., pp. 104-105). However, the first indication of a lipid profile for Patient A was in

February, 1993. (Ex. 3, p. 85; T., p. 1212). Respondent acknowledged that it probably was the standard in 1987 to monitor hypertensive diabetic's lipid levels (T., p. 1268). Respondent's failure to do so deviated from accepted standards of care (T., p. 105).

The following Findings of Fact relate to the allegation that the Respondent, on various occasions, failed to adequately evaluate Patient A's hypertension.

43. Respondent recorded Patient A's blood pressure on nearly every office visit from the time he diagnosed hypertension in January, 1985 to May of 1990, (Ex. 3, pp. 2-16; T., pp. 107-108). In 1990 the standard of care was to repeat blood pressures at regular intervals and at least every six months for hypertensive patients whose blood pressure was under good control (T., pp. 108-109). For patients with other complicating factors, blood pressure should have been repeated every three months.

44. There were no blood pressures recorded for Patient A from November 28, 1990 through May 14, 1993, during which time Patient A was seen 11 times. (Ex. 3, pp. 19-27; T., p. 109). From March of 1991 to April of 1993, there is no record of anti-hypertensive medication having been prescribed (Ex. 3, pp. 21-26; T., pp. 1261-1262). Patient A had been prescribed diuretics and/or anti-hypertensive medications since his diagnosis in 1985.

45. The failure to obtain blood pressure measurements from the patient during that 29 month period was a deviation from accepted standards of care (T., pp. 109-110).

The following Findings of Fact relate to the allegation that the Respondent on more than one occasion failed to perform adequate physical examinations and/or order indicated diagnostic testing for Patient A.

46. On November 17, 1988, Respondent ordered Zestril for Patient A (Ex. 3, p. 15). Zestril is an ACE inhibitor used to treat elevated blood pressure (T., p. 114). Respondent's prescription of an ACE inhibitor for Patient A was appropriate (T., p. 115). Respondent prescribed Zestril for Patient A regularly between November, 1988 and August, 1993 (Ex. 3, pp. 15-29).

47. However, it was well known within the medical community that Zestril can cause elevations in a patient's serum potassium and serum creatinine levels, particularly in a patient with hypertension due to renal vascular disease (T., pp. 115, 117). An elevated

creatinine level indicates a risk of kidney disease, while potassium changes can cause an irregular heart rate (arrhythmias), which can be fatal (T., p. 115)

48. The standard of care would be to monitor the patient's potassium level within three to four weeks of starting the ACE inhibitor. (T., p. 116). For Patient A, who was also on diuretic medication, there was a further reason to check his potassium level (T., p. 116).

49. There is no record of Respondent having checked Patient A's potassium level during the period of time he was taking Zestril (T., p. 116). Respondent's failure to monitor Patient A's potassium level during this period was a deviation from accepted standards of care.

The following Findings of Fact relate to the allegation that the Respondent failed to perform adequate follow up evaluations of Patient A's solar keratosis.

50. On April 9, 1997, Respondent noted a lesion on Patient A's scalp which he identified as solar keratosis (Ex. 3, p. 58), which might have been either pre-cancerous or malignant. The standard of care would be to remove the lesion (T., p. 118).

51. On April 28, 1997, Respondent performed a shave biopsy of the lesion in which the top portion of the lesion was removed and submitted to pathology, and the remainder of the lesion was removed by freezing and cautery (T., p. 119).

52.. The pathology report diagnosed solar keratosis, a pre-cancerous condition that, according to the biopsy report, extended to the margins of the specimen. (T., pp. 118-119; Ex. 3, p. 59, 183).

53. The standard of care requires education of the solar keratosis patient about the risks of sun damage and how to avoid it. (T., p. 120). There is no record of such counseling.

54. Respondent evaluated Patient A's solar keratosis, which had been clearly visible on the forehead of this bald gentleman, and which Respondent evaluated each time he came to the office, although these subsequent evaluations are not recorded. Respondent testified that he would have sent Patient A to a plastic surgeon had the lesion been present upon reevaluation. (T., pp. 1236-1239)

55. Respondent failed to document his follow up evaluation of the site from which the lesion had been removed. His failure to do so was a deviation from accepted standards of care (T., pp. 120-121).

The following Findings of Fact relate to the allegation that the Respondent failed to timely diagnose Patient A's grade II/VI heart murmur.

56. Respondent had auscultated Patient A's heart on a regular basis between January, 1985 and March, 1996. Respondent never recorded anything other than a regular sinus rhythm for these examinations (Ex. 3, pp. 2-46).

57. On March 4, 1996, a nurse practitioner in Respondent's office noted that Patient A had a grade II/VI systolic murmur (Ex. 3, p. 46). Respondent immediately ordered an echocardiogram which confirmed the grade II murmur. (Ex. 3, p. 236).

58. A grade II out of VI systolic murmur in the aortic area is an abnormal heart sound in the upper part of the chest that indicates the probability of some type of heart disease, most likely aortic valve disease (T., pp. 122-123). Among the possible causes of aortic valve disease is rheumatic fever during childhood or the consequences of congenital abnormalities of the valve during childhood which causes scarring of the valve over time (T., p. 123).

59. A grade II heart murmur, which is very faint, can be heard on some occasions and not others. It can also be intermittent. When one ausculates the heart a lot, he or she may not appreciate a faint murmur. (T., p.15, 1619)

60. The failure to diagnose the grade II/IV heart murmur prior to March, 1996, was not a deviation from the standard of care. (T. p 1620)

DISCUSSION OF PATIENT A

Patient A was a 52 year old white male, considerably overweight, when he first consulted Respondent in 1985. Among his medical conditions were hypertension and diabetes, which conditions carried with them the risk of several often serious complications. The Respondent's care and treatment of Patient A was generally sub-standard, creating the risk that his conditions would worsen and complications would arise.

The Respondent was straightforward and candid in admitting that his record keeping was seriously deficient for all the patients in this case during the period in question. Unfortunately, the failure to document performing examinations or the findings from those examinations, the taking of pertinent patient history, and other relevant factors, calls into question whether these examinations or evaluations were indeed performed. But beyond that, the failure to document

findings on physical examination and history could adversely impact future care of the patient, which may in part be based on findings made at prior evaluations. A family practitioner cannot be expected to remember every important detail of an evaluation which weren't recorded. Another physician dealing with the patient would be unable to utilize the results of unrecorded evaluations, treatment considerations, and historical data. If the physician doesn't record positive findings or significant negative findings, the patient's present condition cannot be compared with those past evaluations. Patient care will be adversely impacted.

Dr. Levin's failure to adequately document his treatment and maintain adequate records for Patient A and his other patients in this case, goes beyond what he described as his medical training in the 60's to record only pertinent positives. His charting on all seven patients in this case was truly sloppy.

With regard to Patient A's diabetes, the Respondent's failure to evaluate possible complications was a major deviation from the standard of care. Risks to diabetics include blindness, heart disease, stroke and limb loss. Hypertensive patients should be evaluated for secondary causes of their hypertension, and for target organ damage, particularly of the heart and kidneys. Sometimes secondary causes can be corrected or resolved, thus controlling or resolving the hypertension. Annual cardiovascular exams and blood work are required to rule out cardiovascular and renal difficulties.

An example of the laxity with which the Respondent dealt with these possible complications is his failure to regularly examine and evaluate the condition of Patient A's lower legs and feet. Diabetics are prone to loss of blood flow and sensory perception in the extremities. Thus, serious infections may develop and the patient could remain unaware until the condition became severe. The Respondent testified that he examined the patient's ankles but generally did not have Patient A remove his socks and palpate or otherwise examine the patient's feet. When Patient A developed a lesion on his leg, a potentially serious situation in a diabetic, the Respondent still did not perform a standard examination of his extremities. Although the Respondent testified that he routinely recommended a podiatrist to his diabetic patients, he knew that Patient A, who was apparently often non-compliant, did not follow this recommendation. It was therefore even more important that the Respondent perform neurological and vascular examinations himself, and properly evaluate Patient A's extremities when no podiatrist was doing so.

There was a 29 month period from November, 1990 through May of 1993, when the Respondent recorded no blood pressure readings for Patient A. It is unlikely that this is explained by a failure to record such readings, since the Respondent recorded them on nearly every visit prior to November, 1990. Failure to take Patient A's blood pressure risked an undiagnosed blood pressure elevation, which can lead to heart attack and stroke, especially in a patient with high cholesterol and diabetes.

Patient A's cardiovascular risk factors increased in 1993 when his cholesterol levels increased beyond the normal range, despite dietary instruction. Respondent failed to follow up on the cholesterol issue by prescribing either lipid-lowering drugs or a special diet, together with repeat lipid testing. Similarly, although Respondent appropriately prescribed Zestril to treat Patient A's high blood pressure, he neglected to monitor serum creatinine and potassium levels as required.

The Hearing Committee determined that the Respondent's treatment of Patient A's solar keratosis was appropriate. The pathology report indicated the lesion was pre-cancerous, but did not recommend further excision at the site. Because of its location at the very front of the patient's bald scalp, it would be clearly visible to the Respondent each time the patient came in, which was fairly regularly. Consequently, freezing and cautery, obtaining the biopsy, and evaluating the site upon the patient's regular visits thereafter, as the Respondent testified he did, met the standard of care.

Patient B

The Respondent provided medical care to Patient B from March 19, 1996 to September 19, 1999, for, as is relevant here, diarrhea and rectal bleeding. The following Findings of Fact relate to the allegations that, on various occasions, the Respondent failed to take an adequate medical history from Patient B, failed to perform an adequate physical exam on Patient B, failed to order or perform appropriate diagnostic tests to evaluate Patient B's rectal bleeding, and failed to follow up appropriately on Patient B's complaints of rectal bleeding.

61. On March 19, 1996, Patient B, then a 76 year old male, was first evaluated by Respondent. Patient B's past medical history included transient ischemic attacks, hypertension, emphysema and chronic lung disease (Ex. 7, pp. 5-6). Patient B was on Coumadin, a blood thinner which decreases blood clotting, and was prescribed to reduce

the risk of strokes (T., pp. 166-167).

62. During the period from March of 1996 through April of 1999, Respondent periodically monitored Patient B's prothrombin time to assess the risks of bleeding from the current Coumadin dosage (T., pp. 167-168).

63. On April 26, 1999, Respondent documented that Patient B, then 79 years of age, complained of diarrhea on and off for the previous few weeks (Ex. 7, p. 34). Between 1996 and April of 1999, there were no significant gastrointestinal complaints recorded in Patient B's chart (T., pp. 169, 1026).

64. The diarrhea noted in April, 1999, could have had many causes including a viral infection, parasites, inflammatory bowel disease and colon cancer (T., pp. 169-170).

65. The standard of care in 1999 for taking a history of a patient with Patient B's complaints would include a detailed description of the diarrhea episodes, their frequency, and any associated symptoms such as stomach cramps, blood, mucous, change in appetite and loss of weight (T., p. 172).

66. The standard of care for performing a physical examination with Patient B's presentation in April, 1999 would include an assessment of hydration, and an abdominal examination to evaluate bowel sounds and detect any distention of the abdomen, enlargement of organs or presence of masses (T., pp. 172-173).

67. Respondent's evaluation of Patient B's diarrhea failed to meet accepted standards of care for either history or physical examination (T., p. 173).

68. Respondent prescribed Imodium AD, which would treat the symptoms of Patient B's diarrhea, but not the underlying conditions that may have caused the diarrhea (T., p. 174).

69. Two days later on April 28, 1999, the office record notes that Patient B called complaining of rectal bleeding for one day. Patient B's INR at that time was 2.8, which was within normal limits (T., pp. 174-176; Ex. 7, pp. 35, 50).

70. On the following day, April 29, 1999, Respondent evaluated Patient B. His office chart indicates that there had been blood in the stool three times the previous day (April 28) and that the patient had had one bowel movement that day (April 29) with a question as to whether there was blood in the stool. Patient B had no constipation (Ex. 7, p. 35). A rectal examination was performed which showed a +2 prostate. A hemacult study showed blood in the stool.

71. The standard of care in evaluating rectal bleeding in a patient in his seventies requires that the source of the bleeding be determined (T., pp. 176, 1029). While there could be a number of innocent causes for Patient B's bleeding, colon cancer must be ruled out with this patient's presentation and age (T., pp. 176-177). Respondent agreed that this was the standard (T., p. 1060). It is unlikely that Patient B's bleeding was caused by the Coumadin, as Respondent suspected, insofar as the patient's INR on April 28, 1999 was within normal range at 2.8 (T., p.175-177).

72. On April 29, 1999, the standard of care for a history would require eliciting information regarding the character of the bleeding, history of bleeding, the volume of bleeding and the possible effects of bleeding, including anemia, dizziness, light headedness (T., pp. 177-178).

73. The standard of care for a physical examination would include a rectal examination, which was performed, an abdominal examination, which was not recorded in the chart, as well as evaluating the patient for signs of excessive bleeding, such as rapid heart rate, and changes in blood pressure while lying down and standing (T., pp. 178-179).

74. The history Respondent took on April 29, 1999 did not meet accepted standards of care. The physical examination Respondent performed on April 29, 1999 did not meet accepted standards of care in that an abdominal examination was apparently not performed (Ex. 7, p.35, T., pp. 178-179).

75. In addition to the appropriate history and physical examination, Patient B should have been ordered for a bowel study to determine the source of the bleeding. A colonoscopy would have provided an evaluation of the entire bowel. If the bleeding was due to a lesion, its discovery at any early state would permit treatment (T., pp. 179-180).

76. Respondent noted in the chart on April 29, 1999, that the patient "may need flex sig", referring to a flexible sigmoidoscopy (Ex. 7, p. 35). Respondent and his expert both testified that Patient B should have had a colonoscopy (T., pp. 1035, 1060, 1069, 1530-1532).

77. Respondent did not order a flexible sigmoidoscopy or any other bowel study for Patient B. There was no indication for delaying a bowel examination by colonoscopy or other means as of April 29, 1999. Respondent's failure to order a bowel study was a significant deviation from acceptable standards of medical care (T., p. 183).

78. Colon cancer is curable if detected early. Rectal bleeding is a well-known sign of colon cancer. In failing to determine the source of the patient's bleeding, Respondent delayed the diagnosis and any indicated treatment (T., p. 183).

79. Given Patient B's age of 79 years, his several serious medical problems, and his rectal bleeding of unknown source, amount and duration, the standard of care would have required follow up with the patient within days of the April 29 office exam. Respondent did not revaluate Patient B until May 24, 1999, nearly one month after the rectal bleeding was noted. Respondent's failure to revaluate Patient B within days of April 29, 1999, was a deviation from accepted standards of care (T., p. 185).

80. During Patient B's next appointments on May 24, June 21, and July 16, 1999, the Respondent should have repeated the standard history, specifically inquiring about any further episodes of diarrhea and rectal bleeding (T., p. 187). None of this history is recorded in these follow-up evaluations (Ex. 7, pp. 36-37).

81. On August 13, 1999, Respondent recorded that Patient B had had bowel movements three or four a day with spasms, for three or four months. He also recorded that the patient had had no weight loss, had a good appetite, with no abdominal pain, and "never constipated!" (Ex. 7, p. 38). The history of three or four months of abdominal spasms was significant as it could indicate irritable bowel syndrome. Any type of abdominal pain, regardless of how it is characterized, in a patient with unexplained diarrhea and rectal bleeding would be considered significant and should have been part of the earlier histories (T., pp. 193 -195).

82. On September 8, 1999, Respondent evaluated Patient B and noted the patient was passing a lot of gas. It was further noted that the patient had no nausea, pain or weight loss. The abdomen was noted to be soft (Ex. 7, p. 39).

83. The fact the patient had no weight loss would only be slightly reassuring as to the issue of colon cancer insofar as weight loss frequently occurs only after the disease has progressed to a stage where it can no longer be cured by surgery . A soft abdomen is somewhat reassuring, but does not eliminate the possibility of a small cancer (T., p. 197).

84. As colon cancer had not yet been ruled out in September of 1999, a bowel imaging study was still medically indicated (T., p. 198). Even if Respondent thought that Patient B's rectal bleeding was a result of a hemorrhoid and Coumadin therapy, he still should have

ruled out colon cancer (T., pp. 209-210).

85. On September 19, 1999, Patient B was seen in the emergency room for rectal bleeding and diarrhea for two months. He had grossly bloody stool that morning (Ex. 10, p. 2). On rectal examination, the patient was noted to have a mass and mahogany stool, which suggests that there was moderately large amount of blood mixed with the stool (Ex. 10, p. 3; T., p. 200).

86. On September 21, 1999, the patient underwent a colonoscopy, which identified a 4x5 cm ulcerated mass on the lateral wall of the rectum, 2 cm from the anus (Ex. 9, p. 18-19; T., p. 202). A colonoscopist recorded an impression that the mass biopsied in the rectum was a carcinoma with probable metastasis to the liver (Ex. 9, p. 18; T., p. 203). The biopsy of the rectal mass (specimen D) was diagnosed as an infiltrating adenocarcinoma (Ex. 7, pp. 40-+41; T., p. 203-204). An infiltrating adenocarcinoma in the rectum is a cancer in the lining of the rectal mucosa which has penetrated into the bowel wall. The biggest health risk is that the cancer would spread to other organs which would result in the patient's death (T., p. 204-205).

The following Findings of Fact relate to the allegation that the Respondent failed to perform an adequate rectal examination on Patient B.

87. The adenocarcinoma was described as 4 x 5 cm ulcerated mass, 2 cm into the rectum, on the report of September 21, 1999. Respondent's expert testified that as colorectal cancers are slow growing, Patient B's tumor at the time of Respondent's rectal exam in April, 1999, would have been greater than one-half the size reported at the time of the September colonoscopy (T., p. 1541).

88. The adenocarcinoma noted to be 2 cm from the anus would have been within reach of Respondent's examining finger at the time of the rectal exam he performed on April 29, 1999 (T., pp. 206, 238). The examining finger can usually reach 8 cm into the rectum and find lesions within that range (T., p. 206).

89. Respondent's failure to detect the mass at the time of the rectal exam on April 29, 1999 was a deviation from accepted standards of care (T., p. 453).

The following Findings of Fact relate to the allegation that the Respondent failed to evaluate Patient B adequately for complications attendant upon the concurrent use of Indomethacin and Coumadin.

90. Respondent prescribed Coumadin for Patient B in March, 1996, which was indicated by the patient's history of transient ischemic attacks (T., p. 211).

91. On May 10, 1996, Respondent prescribed Coumadin for Patient B (Ex. 7, p. 9).

92. On May 30, 1996, Patient B, who had a history of gout, complained of a sore toe on his left foot for six months. Respondent did either ordered Indocin for Patient B, or was aware that Patient B was using Indocin from a prescription written by another physician. Thus Respondent knew that Patient B was using Coumadin and Indocin (T. p.1047, 212; Ex. 7, p. 10)

93. The bleeding complications caused by Indocin, an anti-inflammatory drug, are well known (T., pp. 212-213, 1052). It is also well known that Indocin interacts with Coumadin to create increased risk of a bleeding ulcer (T., p. 213).

94. Coumadin and Indocin could be used in combination in 1996; however, the physician would be required to instruct the patient about the risks of using the two drugs in combination, and monitor the patient for gastrointestinal symptoms indicative of bleeding. Frequent INR's would be required to determine whether there was an increased bleeding time (T., pp. 213-214).

95. In 1996 the standard of care would be to repeat an INR within approximately one week of the patient's taking the combination of Coumadin and Indocin, and to discontinue Indocin as soon as the patient's gout had improved, so as to avoid complications (T. p. 214). Respondent's May 30, 1996 progress note indicated that Patient B was to return to the office within four weeks. This deviated from accepted standards of care and increased the risk of a bleeding gastrointestinal ulcer (T., pp. 215-216). There is no record of Respondent having warned Patient B about the risks of the Indocin/Coumadin combination, or ordering him to return in one week for an INR test.

96. On October 27, 1997, Respondent ordered Indocin for Patient B for gout (Ex. 7, p. 23; T., p. 1040).

97. Respondent did not evaluate Patient B again until three weeks later, on November 17, 1997, to perform a prothrombin time. Waiting three weeks to recheck the patient's

prothrombin time deviated from the standards of care for monitoring the combined use of Coumadin and Indocin (T., p. 241-242).

DISCUSSION OF PATIENT B

The Hearing Committee found Respondent's care and treatment of Patient B seriously deficient in many respects. At the outset, it is necessary to note that, generally, if an examination or a treatment or an issue is not recorded in the patient's chart, the reviewer must conclude that it was not performed. Giving the Respondent the benefit of the doubt in some instances, there is ample evidence in the record to conclude that Patient B's gastrointestinal symptoms were largely ignored. Dr. Levin explained that this patient came in frequently and always had a different complaint, which generally resolved by the next visit. Thus, Respondent was probably lulled into thinking of Patient B as a bit of a hypochondriac. However, in failing to perform the standard history and physical when the patient reported bouts of diarrhea, for example, there was a risk that a significant condition such as an infection or tumor would go undetected. Similarly, when the patient reported rectal bleeding and bloody stool, Respondent clearly should have performed an abdominal exam and a bowel study. The Respondent testified that he assumed the cause of the rectal bleeding was a hemorrhoid.

Respondent's records in this instance, as throughout the patients' charts in this case, are sketchy and sloppy. Respondent testified that he believes he performed an abdominal exam and would have recorded pertinent positives, as he had learned in medical school. But in diagnosing and treating this elderly man with several other serious health conditions, the Respondent should have noted down negative findings, as well, and actively pursued these symptoms until a cause was determined.

Respondent failed to reevaluate Patient B in a timely manner following his complaints of blood in the stool on April 29, 1999. A prudent physician, given the patient's history and present complaint, would have had the patient return for a follow-up exam within a few days. Even though the Respondent felt he knew this patient well and believed he could trust him to return should the symptoms reappear, it is a physician's responsibility to be more pro-active managing a patient with this presentation.

The Respondent's somewhat lackadaisical approach to Patient B's gastrointestinal symptoms continued. On August 13, 1999, Respondent recorded that Patient B had been having three or four bowel movements a day, "with spasms", for three or four months. He also recorded that the patient was "never constipated!" (Ex. 7, p. 38, emphasis in the original). This history of frequent bowel movements with spasms for three or four months, combined with previous recent complaints of diarrhea, rectal bleeding, and bloody stool, was significant. It is notable that the Respondent had seen the patient several times during the preceding three to four month period while, according to the patient, these bouts of diarrhea were occurring, but the Respondent did not elicit this information from the patient or the Respondent did not record it. In either case, it is clear that the Respondent did not take an adequate history of this patient's abdominal symptoms.

By now, a prudent physician would have heard hoof beats and thought of horses, not zebras. While the Respondent may have thought of hemorrhoids or the patient's Coumadin as the culprit, this elderly gentleman required bowel studies to determine the actual cause of his symptoms and to rule out cancer. Both experts agreed on this point. A colonoscopy here would not have been a screening tool, it would have been diagnostic. The Respondent admitted that, in retrospect, he should have ordered either a colonoscopy or a flexible sigmoidoscopy, but did not. The greatest risk to the patient, of course, was that the cause was cancer, and that the undetected cancer would spread to other organs and cause the patient's death.

On September 21, 1999, the patient underwent a colonoscopy, which identified a 4x5 cm ulcerated mass on the lateral wall of the rectum, 2 cm from the anus. The colonoscopist's recorded impression was that the mass was a carcinoma with probable metastasis to the liver. The mass was diagnosed as an infiltrating adenocarcinoma, a cancer in the lining of the rectal mucosa which has penetrated into the bowel wall.

By April 29, 1999, when the patient first presented with symptoms suggestive of bowel cancer, and the Respondent, on rectal exam, did not detect the lesion which was found five months later 2 cm from the anus, the cancer had probably already metastasized. Both experts agreed on this. Still, patient harm is not at issue. The Hearing Committee did not find it credible that a competently performed rectal exam would fail to detect the mass, Dr. Marinello's excessively generous opinion to the contrary. The failure to follow up proactively to determine

the cause of Patient B's symptoms and rule out colon cancer through a bowel study was a gross deviation from the standards of care.

This patient had apparently been taking Indocin, prescribed by another physician, for gout on occasion. Respondent was aware of this. Respondent had Patient B on daily Coumadin therapy due to a history of transient ischemic attacks. On October 27, 1987, the Respondent prescribed Indocin for a recurrence of gout, giving the patient 30 pills to take twice per day. Dr. Marinello and Dr. Becker both testified that concurrent use of these two drugs for over a week would expose the patient to the risk of a bleeding gastrointestinal ulcer. So the standard would have been to educate the patient about the dangers of combining the drugs, and repeat the INRs within a week. While the Respondent properly advised the patient to try Tylenol for the foot pain next time, there is no evidence that the risks of adding Indocin were discussed with the patient, and the INRs were not repeated for three weeks

Patient C

The Respondent provided medical care to patient C from October 24, 1990 to June 21, 2001 for diabetes and ketoacidosis, among other conditions. The following Findings of Fact relate to the allegations that the Respondent failed to adequately and/or timely monitor Patient C's diabetes during the period from 1990 through 1992, and failed to evaluate Patient C adequately for complications of diabetes.

98. On October 24, 1990, Respondent evaluated Patient C, a 47 year-old male, for complaints of frequent urination and excessive thirst for the previous few months. A finger stick blood sugar measured 247, which was clearly elevated Respondent started the patient on a 1500 calorie diet and gave him samples of an oral agent to treat diabetes, Diabeta, 2.5 mgs. (Ex. 11, p. 6; T., p. 248).

99. At that time, the standard of care in the evaluation of a patient for diabetes was to order additional blood tests to confirm an elevated blood glucose. Two elevated blood sugars were necessary to make the diagnosis, and in some cases a confirmatory test, such as a glucose tolerance test, would be indicated. (T., p. 249)

100. The history required from the patient with diabetes would include whether the patient had been treated for diabetes in the past, had similar symptoms previously, and had a family history of diabetes or cardiovascular disease. Respondent elicited an appropriate history from Patient C. (T., p. 394)

101. At the initial visit or soon after, the physician should perform a physical examination for complications of diabetes, including retinopathy, neuropathy, nephropathy, and cardiovascular conditions (T., p. 250). The evaluation for complications of diabetes should be repeated annually (T., p. 258).

102. The patient's chart does not include notes of a physical examination having been performed on October 24, 1990 (Ex. 11, p. 6). Respondent's failure to perform or record an adequate physical examination of Patient C was a deviation from accepted standards of medical care (T., pp. 251-252).

103. Given the patient's presentation on October 24, 1990, it was the standard of care to schedule a follow-up visit within four to six weeks to confirm the initial diagnosis, educate the patient concerning the disease, and evaluate the drug prescribed. (T., p. 252).

104. The next recorded office visit for the patient was on February 11, 1991 (Ex. 11, p. 6). The failure to follow-up with Patient C within four to six weeks of the visit on October 24, 1990, was a deviation from accepted standards of care (T., p. 253). On February 11, 1991, the office note documented a problem the patient was having with Diabeta 2.5 and indicated the patient was on diet only (T., p. 253). This would indicate that the patient had discontinued the medication on his own (T., p. 253).

105. Following the February 11, 1991 visit, the standards of care would have required office visits every three months, which in the instance of a stable patient could be extended to four to six months (T., pp. 254-255). Patients are to be assessed on a quarterly basis, to review their diabetic education, monitor their diet, determine the appropriateness of their medication, and determine the level of their blood sugar control (T., p. 255).

106. Respondent treated Patient C for diabetes from April 17, 1992 through September 11, 2000 (Ex. 11, pp. 7-36). Except for the evaluation performed in connection with Patient C's admission to an outpatient alcohol and drug abuse treatment program on September 4, 1997 (Ex. 11, pp. 56-57), Respondent failed to meet the accepted standards of care for annually evaluating Patient C for the complications of diabetes (T., pp. 261-262, 265,

276, 280, 283). On multiple occasions, Respondent auscultated Patient C's heart, which would be one part of a cardiac examination for diabetic complications (1/13/94, 5/6/94, 10/31/94, 4/27/95, 10/3/95, 2/26/97, 6/3/98, 11/4/98, 11/22/99, 4/3/00) (T., pp. 262, 264, 265, 270, 277, 278, 282). On February 11, 1999 and on October 22, 1999, Respondent reported the absence of chest pain and shortness of breath which would be two additional elements of an evaluation for cardiovascular risk factors. However, this represents only a portion of the evaluation required by accepted standards.

107. Respondent failed to evaluate the Patient C for peripheral vascular symptoms to any degree (T., pp. 278- 279). There is no neurological examination of the extremities (T., p. 852).

108. The evaluation of Patient C's renal function by obtaining BUN and creatinine levels was performed only on January 13, 1994, and February 25, 1997 (T., pp. 262-263, 271). A urinalysis was also performed in February of 1997 which would be part of an evaluation for renal functions (T., p. 273). These evaluations were required annually by standards of care, as Respondent acknowledged (T., p. 845). Respondent admitted that he was not evaluating Patient C annually for renal disease (T., p. 845).

109. Evaluation of the patient's lipid levels, required annually, was tested only in January 13, 1994 and February 25, 1997 (T., pp. 262-263, 272-273).

110. There were no fundoscopic examination performed and no record of Patient C having been referred to an ophthalmologist.

The following Findings of Fact relate to the allegation that the Respondent failed to adequately and/or timely monitor Patient C's liver enzymes while on Rezulin.

111. On September 4, 1997, Respondent prescribed Rezulin, an oral diabetic agent, for Patient C (Ex. 11, p. 25; T., p. 284). Rezulin was commonly added to other oral agents where a patient's blood sugar was not adequately controlled (T., p. 284). The indication for its use for Patient C on September 4, 1997, is unclear as it appeared the patient was hypoglycemic and his insulin dose was being decreased at that time (T., p. 284).

112. Rezulin was started on September 4, 1997 (T., p. 285). The Respondent's progress note for that date indicates a change in Rezulin dosage, suggesting that Respondent prescribed

Rezulin to Patient C prior to September 4, 1997. However, Respondent did not document these earlier prescriptions (T., pp. 285-286).

113. In 1997, there were known complications involving the use of Rezulin including reports of liver damage which were sometimes fatal. Instructions for Rezulin use included monitoring the patients carefully for liver disease (T., p. 286).

114. Patient C's records include correspondence from an HMO drug administration plan dated December 29, 1997, which reports on cases of liver damage in patients using Rezulin. It reports recommendations from Parke-Davis, the manufacturer of Rezulin, that liver enzymes be measured every month for six months, then bi-monthly for the next six months, and periodically thereafter (Ex. 11, p. 58; T., pp. 287, 883). A date stamp at the bottom of this letter indicates that it was received in Respondent's office on January 6, 1998 (the stamp actually indicates the year 1997, but given that the letter is dated 12/97, it is assumed that it was received in 1998) (T., p. 287-288).

115. Respondent ordered Rezulin for Patient C again on January 27, 1998, and increased the dose of Rezulin. This was three weeks after Respondent received the letter with monitoring recommendations. He again prescribed Rezulin to Patient C on June 3, 1998, November 2, 1998, May 3, 1999 and on January 6, 2000 (T., pp. 289-290; Ex. 11, pp. 26, 28, 29, 31, 33).

116. The standard of care for patients using Rezulin as of January 1, 1998, was to measure their liver enzymes every month for six months, then every two months for the next six months and periodically thereafter (T., p. 290).

117. Respondent did not perform any liver function tests for Patient C in 1998 (see, T., pp. 882-883). During the period in which Rezulin was prescribed for Patient C, Respondent ordered liver function tests on February 12, 1999 and June 30, 2000 (Ex. 11, pp. 290-291; T., pp. 290-291). Respondent's failure to monitor Patient C's liver functions monthly for six months and then bimonthly for six months after January 1, 1998, deviated from accepted standards of medical care (T., pp. 291-292). Respondent's failure to monitor Patient C's liver function, as recommended, exposed the patient to the risk of liver damage, which could have been fatal (T., p. 292).

The following Findings of Fact address the allegation that the Respondent failed to adequately monitor and/or treat Patient C's diabetic ketoacidosis.

118. On August 26, 2000, Patient C was admitted to Ellis Hospital with a diagnosis of diabetic ketoacidosis (Ex. 12, p. 9). Diabetic ketoacidosis[3] is a severe and significant complication of diabetes. Even with appropriate care, there is a one to two percent risk of mortality. Incompetent care increases the mortality risk (T., p. 297

119. On the day of admission, Patient C had an abnormally high glucose level of 641, a low sodium level of 132, which could be related to the high blood sugar. Further, Patient C had a high potassium of 6.9 and a very low bicarbonate, $C0_2$, measured at 5. The normal bicarbonate level is between 22 and 30. Patient C had a markedly elevated acetone at 24 (Ex. 12, p. 79; T., pp. 296-297). At the time Patient C was evaluated in the emergency room, he had nausea, vomiting and dizziness (T., p. 31). On physical examination the patient was noted to have dry mucous membranes suggesting dehydration (T., p. 302).

120. Diabetes ketoacidosis is treated with intravenous insulin and intravenous hydration. Patients receive intensive monitoring by the nursing staff and physicians, including frequent metabolic panels. The objective is to monitor and treat the patient's hyperglycemia, dehydration, acidosis and ketosis (T., p. 300).

121. Respondent's admitting orders for Patient C included intravenous fluids running at a rate of 150 cc's and hour, additional potassium, and continuous IV insulin. The patient's blood glucose level was to be measured every two hours. A metabolic panel was ordered for 10:00 p.m. (Ex. 12, p.13; T., pp.302- 303).

122. One treatment objective for diabetic ketoacidosis is to lower the blood sugar to the 150 to 200 range and to maintain it at that level. The insulin therapy is closely monitored, with blood sugars every two hours and the insulin rate is then adjusted as indicated (T., p. 303).

123. Metabolic panels are repeated regularly to determine the progress in correcting the patient's dehydration, acidosis and ketosis (T., p. 304).

124. Following the initial metabolic panel at 2:33 p.m. on August 26, 2000, the metabolic panel was repeated at 8:52 p.m. and 10:21 p.m. (Ex. 12, p. 79). At 10:21 p.m., the

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[3] Diabetic ketoacidocis results from the inability of the body's insulin to transport glucose from the blood stream into the cells. When the cells get insufficient glucose, fat and protein are burned to create glucose. Some of the breakdown products from the burning of fat and protein are acids and ketones which accumulate in the blood (T., pp. 297 - 299).

patient's sodium and potassium were in the normal range. While the blood sugar measured at 317 at 10:21 p.m. remained abnormal, it was lower than it was measured at admission. The $C0_2$, which represents acidosis, was improved, but at 10, was far below the target of 18, indicating that the patient still had some acidosis (T., pp. 306-307). The ketosis was not measured in the 8:52 and 10:21 p.m. lab studies by an acetone level. It can be represented by the anion gap (T., p. 307). The anion gap is measured by taking the sodium number and subtracting the chloride level and the $C0_2$ level (T., p. 307). The objective is to achieve an anion gap level of under 12 (T., p. 307). Patient C's anion gap was 25 at 8:53 p.m. and 23 and 10:21 p.m. (T., p. 311). These levels show improvement in anion gap from the initial level of 35, but it remained well above target level of 12. Patient C was still in diabetic ketoacidosis but was improving, having gone from a condition of severe diabetic ketoacidosis to an improved condition (T., pp. 311-312).

125. Respondent evaluated Patient C the following day, August 27, 2000, at approximately 9:00 a.m. (Ex. 12, p. 28). Prior to the Respondent's evaluation of the patient, comprehensive metabolic panels were performed at 3:00 a.m. and 6:18 a.m. on August 27, 2000 (Ex. 12, p. 77). At 6:18, the patient's glucose was down to 275. Patient C's bicarbonate was up to 12 but still below the normal level of 18 (T., p. 313). The anion gap improved to 18 at 3:35 and 13 at 6:18 (T., p. 313).

126. At 6:18 AM August 27, 2000, Patient C continued to show improvement; however, he remained in diabetic ketoacidosis, since he was acidotic and his blood sugar remained above 200 (T., p. 313).

127. Later that morning, Patient C's blood sugars fell to 173 (Ex. 12, pp. 28, 138; T., p. 314).

128. In his progress note at 9:00 AM, Respondent noted that Patient C was more alert and orientated and had no further nausea, and wanted to eat. His hydration appeared to be improved. (Ex. 12, p. 28; T., p. 315).

129. Respondent's plan was to change the insulin administration from an intravenous drip to insulin injections four times a day based on blood sugars, to decrease the I.V. hydration rate, to transfer the patient to the floor, and to obtain a chest x-ray, among other things (T., pp. 316-317). Respondent's orders for Patient C indicated that the insulin drip was to be discontinued and the patient placed on a sliding scale of insulin injections, with blood sugars being measured at fasting, 11:00 a.m., 4:00 p.m. and 9:00 p.m. The units of

insulin to be administered subcutaneously, would be determined based on the blood sugar measurement. (T., p. 319).

130. Respondent's discontinuance of the insulin drip at 9:00 a.m. on August 27, 2000, did not meet accepted standards of medical care. While Patient C's blood glucose level had reached normal range, he remained acidotic and slightly ketotic (T., pp. 319 - 320). After Respondent's assessment of Patient C at 9:00 a.m. on August 27, the next metabolic panel was ordered for 4:00 p.m., seven hours later. Waiting seven hours to repeat this panel was too long, and the study should have been repeated in two to four hours (T., p.320 -321, 1578).

131. As written, the orders for sliding scale insulin administration posed a risk of Patient C rebounding into ketoacidosis. A patient transferred too abruptly from an insulin drip to subcutaneous insulin can suffer a recurrence or rebound of the ketoacidosis. Patient C should have remained on an insulin drip for another twelve hours, since he was not totally out of DKA when Respondent discontinued the insulin drip and switched to subcutaneous insulin. (T., p. 1577, pp. 1559-1560).

132. To avoid rebounding, the first subcutaneous insulin should be given before the drip is stopped to insure there is no abrupt drop in the insulin level. Transferring to a sliding scale after ketoacidosis requires that the patient's blood sugar be monitored every two hours and subcutaneous insulin be administered every four hours, more frequently than Respondent ordered for Patient C on August 27, 2000 (T., pp. 320-321)

133. It would be the standard of care to continue monitoring Patient C's blood sugar every two hours until there were repeated values under 200 (T., p. 321). In the case of Patient C, the two hour monitoring of the blood sugars was stopped after only a single value under 200. (T., p. 321). Respondent's expert testified that a metabolic panel every two to four hours would assist the physician in guarding against the patient rebounding (T., pp. 1577-1578).

134. Respondent's order at 9:00 a.m. on August 27, 2000 for a sliding scale also failed to meet accepted standards in that it did not identify an abnormal glucose level at which the nursing staff was to contact Respondent. Further, there is no order to contact Respondent with the results of the metabolic panel ordered for 4:00 p.m. If for example, Patient C's blood sugar was at 499, the Respondent's instruction to the nursing staff was to give 12

units of insulin, but there was no instruction to contact the doctor about the abnormal level. The order should have required the nursing staff to contact Respondent if Patient C's blood glucose went above 200 (T., p. 322-323).

135. Further, if the hospital did not contact Respondent with the metabolic panel results, he should have contacted the floor and obtained the results so he could evaluate the patient's progress and risk of rebounding (T., pp. 346-347, 1578-1579). Between 9:00 a.m. on August 27 and 7:15 p.m., Patient C was slowly moving back to acidosis. The insulin drip should have been reinstituted at this point (T., pp. 1579 - 1581). Respondent did not contact the hospital for the results of the 7:15 p.m. metabolic panel. He did not reinstitute the insulin drip.

136. Following the change to sliding scale insulin administration, and despite receiving subcutaneous insulin injections consistent with Respondent's order, Patient C's blood glucose measured 232 at 11:00 a.m., 299 at 4:00 p.m. and 259 at 9:00 p.m. (T., pp. 327-328; Ex. 12, p. 139). The treatment was inadequate for a patient who had not met the criteria for recovery from diabetic ketoacidosis (T., p. 328).

137. At approximately 7:00 a.m.on August 28, 2000, the patient's fasting blood glucose was 339. (Ex. 12, p. 139; T., pp. 329, 1877). At 8:00 a.m. on August 28, there is a voice order from Respondent for Humulin N, 10 units to be administered subcutaneously (T., pp. 329-330; Ex. 12, p. 15). Humulin N is a longer acting form of insulin which will last all day and assist in bringing the blood sugar into better control (T., p. 330). It is appropriate in the treatment of a diabetic who is not in ketoacidosis, but whose blood sugar is too high.

138. Before changing the insulin dose or ordering the Humulin N at 8:00 a.m. on August 28, 2000, Respondent should have determined the patient's blood sugar levels before changing the dose of insulin. Upon learning the patient's blood sugar was 339, Respondent should have appreciated the fact that the blood sugar was too high and that Patient C could be returning to ketoacidosis. Respondent should have checked Patient C's other relevant laboratory values, including the most recent metabolic panel (T., pp. 332-333). Respondent does not believe that he had inquired as to these results (T., p. 878).

139. Patient C's most recent metabolic panel prior to 8:00 a.m. on August 28, 2000 was at

7:15 p.m. on August 27, 2000 (Ex. 12, p. 77). Patient C's blood glucose then measured 388, which is significantly elevated and would further suggest that ketoacidosis was not completely resolved. The bicarbonate was 13, still in the acidotic range, suggesting the patient continued to be in diabetic ketoacidosis. The anion gap which measures ketosis had deteriorated from a level of 13 at 6:18 a.m. on August 27, to 18 at 7:15 p.m. These laboratory values demonstrate a worsening of the patient's diabetic ketoacidosis. (T., p. 334).

140. The standards of care in treating diabetic ketoacidosis require frequent monitoring by the physician (T., p. 346). If a physician has office hours when the patient requires in-person evaluation, the physician could see that patient before office hours, cancel office hours and see the patient, or obtain a critical care consultation. Respondent did order a critical care consultant on August 28, but not until 2:30 p.m. Respondent's failure to either see the patient earlier that day or promptly order the critical care consultation is a deviation from accepted standards of care (T., pp. 348-349, 1586-1587).

141. Patient C had a metabolic panel at 11:02 on August 28, in which the blood sugar remained high at 375, the $C0_2$ at 13 still showed acidosis, and an anion gap remained (T., p. 337; Ex. 12, p. 77).

142. The nurse practitioner assessed Patient C at in the late morning or early afternoon on August 28, and noted the recent metabolic panel findings, as well as Patient C's shortness of breath and bilateral rales in the lungs. She noted the possibility of the patient's developing congestive heart failure. The nurse practitioner discussed the lab values and clinical findings with Respondent by telephone. The plan was to obtain a critical care medicine (CCM) consultation (T., pp. 337-338).

143. At 2:30 p.m. on August 28, there is a note that the patient was discussed with Dr. Wineberg, who is a CMM (T., pp. 338-339). There is a request to transfer Patient C to the ICU.

144. At 5:30 p.m. on August 28, Respondent saw Patient C for the first time in 36 hours. He noted elevated blood sugars and an abnormal chest x-ray. Respondent's note stated, "Nausea persists". However, he had not documented nausea in his prior progress notes (T., p. 339).

145. At approximately 5:40 p.m. on August 28, the CCM consultant concluded from the metabolic panels and blood count that Patient C's diabetic ketoacidosis had not resolved on the floor, and that Patient C had significant acidosis with an acetone of near 80. The CCM consultant ordered Patient C transferred to ICU, where an insulin infusion and IV fluids were restarted. He set out to determine the etiology of the diabetic ketoacidosis, such as heart attack or sepsis (T., pp. 340-341).

146. The standards of care for managing diabetic ketoacidosis require the physician to regularly and frequently monitor the patient and the laboratory parameters (T., p. 346). It is the physician's responsibility to reevaluate the patient periodically, even if only by orders to the nurse to contact him whenever laboratory values are available. Respondent's failure to monitor Patient C more closely demonstrated a lack of understanding of the seriousness of diabetic ketoacidosis and its potentially grave effects for Patient C (T., pp. 341-342).

DISCUSSION OF PATIENT C

The physician's ability to meet the standards of care for timely monitoring the diabetic patient, or any patient, depends to a large degree upon cooperation of the patient her or himself. Despite the best treatment plan and the scheduling of follow up appointments, if the patient fails to keep the appointments, does not take the prescribed medication, fails to follow the low cholesterol and low calorie diet the physician provides, and indeed lives a lifestyle which contributes to the progression of the disease, then the physician cannot be faulted. The burden is on the patient to make a timely visit, rather than on the physician, as Dr. Becker testified.

We cannot tell from the notes whether Dr. Levin discussed with Patient C the risks he was taking by not complying with the treatment plan, including diet, weight loss and refraining from alcohol consumption, and by not keeping regular appointments. However, Respondent appropriately sent the patient to the Ellis Hospital Diabetes Center's educational program where these issues were covered.

Respondent testified that he suggested the patient consult an ophthalmologist annually for a fundascopic examination. Similarly, he testified that he would check the patient for vascular changes, for edema, and for skin and hair changes on the legs and ankles. Unfortunately, the records kept were sketchy. Full neurological and vascular evaluations, as described by Dr. Becker, were pretty clearly not done, according to the Respondent's description of his evaluations. In the case of a patient as non-compliant as Patient C, Respondent's thorough evaluation of all potential risk factors was vital to the patient's long-term health. Respondent did not do this.

On September 4, 1997, Respondent prescribed the oral diabetic agent Rezulin for Patient C. At that time, known complications involving Rezulin included sometimes fatal liver damage. Instructions for the use of Rezulin required careful patient monitoring for liver disease. By letter dated December 29, 1997, Respondent was notified by Patient C's HMO that Rezulin's manufacturer, Parke-Davis, recommended that liver enzymes be measured every month for six months, then bi-monthly for the next six months, and periodically thereafter, in response to reports of cases of liver damage in patients using Rezulin. Respondent prescribed Rezulin for Patient C about every six months after receiving the cautionary letter, until January 6, 2000, but did not see that the patient's liver function was monitored, as the letter recommended. Dr. Becker testified that the manufacturer's recommendation became, in effect, the standard of care. Dr. Marinello did not agree that the drug manufacturer could set the standard for the treating physician, but opined that such testing should be performed every three to six months for the first year, and then every six months to a year thereafter. After receiving such a warning, a prudent physician would at least check the liver function immediately, and then on a fairly frequent periodic basis to protect against potentially fatal liver damage. The Hearing Committee found that waiting from 1998 to 2000 to perform the test deviated from the standard of care.

Patient C's Diabetic Ketoacidocis

Patient C was admitted to Ellis Hospital emergency room on August 26, 2002 with a diagnosis of diabetic ketoacidosis, a severe complication of diabetes with a risk of mortality. It is treated with IV insulin and IV hydration, and the patient must be monitored for hyperglycemia, dehydration, acidosis, and ketosis. Metabolic panels are done frequently to assess the patient's progress.

Patient C responded to treatment. Respondent's note the next morning reported that Patient C was more alert and oriented, and his hydration was better. His blood sugars had fallen to 173 by 8:00 am, but the metabolic panel done at 6:18 showed that he remained in ketoacidosis. Respondent's plan was to change the insulin administration from an intravenous drip to insulin injections four times a day based on a sliding scale; fasting blood sugars to be taken at 11:00 a.m., 4:00 p.m. and 9:00 p.m.; to decrease the I.V. hydration rate; to transfer the patient from ICU to the floor; and to obtain a chest x-ray, among other things. The subcutaneous insulin given would be based on the blood sugar measurement.

Respondent's discontinuance of the insulin drip at 9:00 a.m. on August 27, 2000, did not meet accepted standards of medical care. Even though Patient C's blood glucose level had reached normal range, he remained acidotic and slightly ketotic. After Respondent changed the orders at 9:00 a.m. on August 27, he did not order the next metabolic panel until 4:00 p.m., seven hours later. Failure to monitor Patient C for so long after abruptly discontinuing the insulin drip, together with the sketchy orders Respondent gave for sliding scale insulin administration, created a significant risk that the patient could rebound into ketoacidosis. This in fact occurred.

Respondent's own expert stated that Patient C should have remained on an insulin drip for another twelve hours, as Patient C was not totally out of DKA at the time Respondent switched from IV to subcutaneous administration of insulin. The State's expert testified that to avoid rebounding, the first subcutaneous insulin is given before the drip is stopped to insure there is no abrupt drop in the insulin level. Then the patient transferring from IV insulin to a sliding scale after ketoacidosis must have his or her blood sugar monitored every two hours and subcutaneous insulin administered every four hours. A metabolic panel should be ordered every two to six hours until all abnormal lab values have been corrected.

Respondent's care and treatment of this patient hospitalized for diabetic ketoacidosis failed to meet accepted standards of care. Respondent did not give the level of attention and oversight the patient's condition clearly required. Respondent's order at 9:00 a.m. on August 27, 2000 did not identify an abnormal glucose level at which the nursing staff was to contact him. Nor does the order require that Respondent be called with the results 4:00 pm metabolic panel. Both experts testified that if the hospital did not contact Respondent with the results of the subsequent metabolic panel, Respondent should have contacted the nurses for the results to evaluate the patient's progress and risk of rebounding.

The next day, after Patient C's condition had deteriorated, Respondent finally brought in a Critical Care Medical Consultant, who evaluated Patient C at approximately 5:40 p.m. on August 28. The CCM consultant concluded from the metabolic panels and blood count that Patient C had significant acidosis with an acetone of near 80 and ordered Patient C transferred back to the ICU, where an insulin infusion and IV fluids were restarted. He set out to determine the etiology of the diabetic ketoacidosis, such as heart attack or sepsis.

Respondent's failure to more closely monitor Patient C in diabetic ketoacidosis was a significant and serious deviation from accepted standards of medical care. The standards of care for managing diabetic ketoacidosis require the physician to regularly and frequently monitor the patient and the laboratory parameters, and periodically to reevaluate the patient's condition and treatment plan, based upon the available laboratory results. Respondent's failure to monitor Patient C's condition more carefully could only have resulted from a lack of understanding of the seriousness of diabetic ketoacidosis or failure to appreciate the seriousness of Patient C's condition.

Patient D

The Respondent provided medical care to Patient D from October 21, 1991 to June 1, 2001 for diabetes and hyperlipidemia, among other conditions. The following Findings of Fact relate to the allegations that the Respondent failed to adequately evaluate Patient D for diabetes and/or for the complications of diabetes, and failed to adequately monitor Patient C's diabetes.

147. On October 19, 1992, Patient D was referred to Respondent's office[4] with an elevated blood glucose level of 297. He was then 62 years old, with a history of coronary disease: a bypass graft in 1989, a myocardial infarction in 1984, and a cholecystectomy, among other things. Patient D had a strong family history of heart disease (Ex. 13, T. pp.402-403).

[4] He was seen by Dr. Schnachtenberg, who at that time was working in Respondent's office.

148. Two days later, on October 22, 1992, Patient D's glucose was measured at 109, which would be within the normal range. A fasting glucose performed on October 26, 1992 was 137, which would not have been considered elevated in 1992 (Ex. 13, p. 9; T., pp.404-405).

149. The diagnosis was glucose intolerance, with a recommendation of diet and repeating the fasting glucose in six months. While Patient D did not meet the criteria for diabetes, his ability to manage glucose was impaired. If glucose intolerant, a patient treated with diet and exercise is less likely to develop diabetes. If not successfully treated in this manner, the patient is at increased risk to develop diabetes (T., p. 405).

150. Following the initial workup and evaluation in October, 1992, the standard of care would be to follow Patient D for the symptoms of diabetes, including repeating the blood glucose level, within one year (T., pp. 406-408).

151. After October, 1992, Respondent saw Patient D in April, July, October and November of 1993, but did not order blood glucose levels on any of these visits (T., pp. 986-987).

152. Respondent's failure to obtain a blood glucose level for Patient D within one year of October, 1992 was a deviation from accepted standards of care (T., pp. 407-408).

153. Patient D's first blood glucose test after October, 1992 was on April 26, 1994, ordered by Patient D's surgeon. His fasting glucose was 176 (Ex. 13, p. 91; T., pp. 408-409). A copy of the April 26, 1994, abnormal blood glucose level was sent to Respondent and the report bears Respondent's mark as having reviewed these results (T., pp. 409, 988). A fasting blood glucose of 176 would be considered high and abnormal (T., p. 409).

154. Given Patient D's history of glucose intolerance and the elevated fasting blood glucose of 176, Respondent should have repeated Patient D's blood glucose level immediately. Respondent did not evaluate Patient G's blood glucose until May 10, 1995 (Ex. 13, p. 22; T., p. 410). Patient D had seen Respondent at least nine times between April 26, 1994 and May 10, 1995 (Ex. 13, pp. 15-22). Respondent's failure to monitor Patient D's blood glucose during this period was a deviation from accepted standards of care.

155. On May 10, 1995, Patient D's blood glucose was measured at 159. Blood glucose at this level, whether fasting or finger stick, would require follow-up (T., pp. 411-412).

156. Patient D's blood glucose was next measured on May 28, 1997 at 388 and recorded a repeat evaluation by Respondent measured at 276 (T., p. 412). The blood glucose obtained May 28, 1997 was ordered by Patient D's gastroenterologist, Dr. Moriere, not by Respondent (Ex. 13, p. 62; T., p. 412).

157. A blood glucose of 388 is extremely high; Patient D would have been considered diabetic with that reading (T., p. 413).

158. Patient D required immediate evaluation for the complications of diabetes and, thereafter, annual evaluations (T., p. 413). The evaluation for complications of diabetes would be the same as those required in the cases of Patients A and C (T., pp. 413-414). However, by 1997, it was possible to test for small amounts of protein in the urine, a more sensitive and early indicator of renal disease (T., p. 414).

159. Patient D was seeing a cardiologist at this time, so the Respondent could assume that the cardiologist would be evaluating the patient for cardiovascular and peripheral vascular risks of diabetes. However, Respondent was still required to evaluate Patient D for kidney disease, retinopathy, neurological signs and symptoms in the extremities, and to work towards tight control of sugars. Respondent did not adequately evaluate Patient D for the complications of diabetes, which was a deviation from accepted standards of care (T., pp. 415-417). While parts of the evaluation were performed at different times, the complete evaluation was not performed on an annual basis.

160. Other than the noted recommendation, on October 22, 1997, that Patient D should consult an ophthalmologist, there is no record of Patient D having seen an ophthalmologist. Nor is there a record of Respondent's performing a fundoscopic examination. (T., p. 417).

161. On June 8, 1998, there is a reference to a stress test which would screen for angina, a condition that can be associated with diabetes (T., p. 418).

162. At the evaluation on March 11, 2000, Respondent noted that Patient D did not have chest pain, shortness of breath, or ankle edema. This was a partial, but incomplete, evaluation for the complications of diabetes (T., p. 419).

163. On June 13, 2001, Patient D's cardiologist ordered an arterial Doppler evaluation. Patient D complained of cramps in both calves, relieved by standing still for a few minutes. At times, these symptoms occurred with exertion. Abnormalities were also reported in the pulses of the feet. The patient received relief for his calf numbness at night by quinine. (Ex. 13, p. 43; T., pp. 419-420).

164. Patient D's leg and foot symptoms could have been related to diabetic and vascular complications or could have been symptoms of neuropathy (T., pp 420-. 421).

165. Because of Patient D's significant leg and foot symptoms, this patient required a physical examination of both legs and feet to determine the cause of the symptoms. If related to neuropathy, Patient D's ability to detect symptoms might have been impaired. (T., p. 421).

166. There is a date stamp appearing at the bottom of the arterial report indicating that the report was received in Respondent's office on June 18, 2001. Patient D's next office evaluation was June 26, 2001. No neurological examination is noted for that date. Respondent's failure to perform a neurological evaluation on June 26, 2001, was a deviation from accepted standards of care (T., p. 422). Moreover, the fact that the arterial examination did not find any significant vascular disease would have made it more imperative for Respondent to evaluate Patient D's feet and legs for neuropathy (T., pp.421- 423).

167. From the time diabetes was diagnosed in May of 1997, until 2001, Respondent performed partial evaluations for complications of diabetes but failed to meet the standard of care by not performing thorough and regular evaluations for such complications (T., pp. 423-424).

168. On July 20, 1999, Patient D was started on insulin (Ex. 13, p. 28; T., p. 424).

169. In July, 1999, blood glucose could be measured by hemoglobin A1c testing, which measures the level of control of a patient's diabetes for the proceeding two months. Daily blood sugars fluctuate up and down, and minute by minute with meals. A hemoglobin A1c evaluation is more reliable as a measure of diabetic control than random blood sugars (T., pp. 425-426).

170. In 1999, it was the standard to base decisions regarding changes in diabetic treatment upon hemoglobin A1c levels, rather than upon simple blood sugars (T., p. 425). In 1999, it was understood by physicians that tight control of blood sugars for Type 2 diabetics led to fewer complications (T., p. 426).

171. Respondent acknowledged that in 1999, the standard was to do hemoglobin A1c measurements on diabetics at least every six months, and to repeat the test more frequently with changes in medications where there was uncertainty concerning changes in blood sugar (T., pp. 426-427, 997 [lines 18-19]).

172. On July 30, 1999, Respondent should have performed a hemoglobin A1c test as the patient reported a blood sugar of 128, which was near normal. On August 9, the patient's evening dose of Glucophage was discontinued. The decision to decrease the patient's oral medication should have been based upon a hemoglobin A1c measurement rather than on blood sugars (T., p. 429). In 1999, failure to use a hemoglobin A1c measurement was a deviation from accepted standards of care (T., pp. 429-430).

173. In October 7, 1999, three months after Patient D's evening dose of Glucophage was discontinued, Respondent should have performed a hemoglobin A1c to determine the status of blood sugar flowing this change in dosage. (T., p. 432). The failure to do a hemoglobin A1c in October, 1999 was a deviation from accepted standards of care (T., p. 433).

174. Seven months later, On May 11, 2000, the patient's blood glucose was in the near normal range of 115 to125, and the patient had lost twenty pounds (Ex. 13, p. 31; T., p. 433). Fasting glucose levels were done, but it would have been the standard of care to perform a hemoglobin A1c. The failure to do so was a deviation from accepted standards of care (T., pp. 433-434).

175. On November 30, 2000, Patient D's blood glucose was 127, which is slightly elevated. Given this finding, a hemoglobin A1c would have been indicated, but was not performed (T., p. 434).

The following Findings of Fact relate to the allegation that the Respondent, on various occasions, failed to adequately evaluate Patient D's liver function.

176. On May 30, 1997, Patient D's cardiologist measured his cholesterol at 240 and discussed in his report the benefits of lipid-lowering medications. This report was copied to Respondent. The cardiologist intended to discuss Patient D with Patient D's gastroenterologist, given his previous history of biliary track disease. Prescribing Lipitor for this patient, with his history of hepatic disease, would raise concerns, since Lipitor is known to cause liver problems in some patients (Ex. 13, p. 61; T., pp. 435-437).

177. Respondent acknowledged starting Patient D on Lipitor in September, 1997, having initially provided Patient D with samples and then issuing a pharmacy prescription (Ex. 13, pp. 23-24; T., pp. 998-999).

178. Both experts agreed that the standard of care would have been to perform a liver function test prior to starting Patient D on Lipitor to determine if there was any evidence of pre-existing liver damage. (T., p. 437). If Patient D already liver function abnormality, precautions could be instituted before Patient D started on the Lipitor (T., pp. 437-439).

179. After starting the patient on Lipitor, liver function tests should have been repeated after three months, and periodically thereafter, to make sure that the patient's liver function remained unchanged.

180. Respondent's failure to perform a liver function test for Patient D prior to starting Lipitor was a deviation from accepted standards of care (T., p. 439). Patient D did have a liver function test on December 4, 1997, which would be within three months of the start of this medication (T., p. 440). On June 4, 1998, the report of Patient D's cardiologist, copied to Respondent, indicated that Respondent was prescribing Lipitor to Patient D (T., pp. 442-443). The cardiologist further noted that Patient D had not had blood studies in quite some time and suggested that liver function tests (AST and ALT) be obtained (Ex. 13, p. 56).

181. On May 19, 1998, Patient D's gastroenterologist wrote to Respondent stating that he would see the patient in one year, but that Patient D should have blood work every six months, including liver function tests (Ex. 13, p. 54; T., p. 443).

182. On December 2, 1998, Patient D's cardiologist again reports, indicating the Respondent had increased the patient's Lipitor from 10 to 20 mg in May, 1998. The cardiologist suggests that the patient have his liver function tests repeated. (Ex. 13, p. 53; T., pp. 443-444)

183. The gastroenterologist's May 1998 letter indicates that the Respondent was expected to order the blood tests, since he was regularly following Patient D for diabetes and other chronic conditions, while the gastroenterologist would not be seeing the patient again for one year (Ex 13, p.53; T., p. 467).

184. The Respondent did not repeat the liver function tests until August 21, 2000 (T., pp. 440-441). Liver function tests were performed by the cardiologist in December, 1998. Failure to perform liver function testing between December, 1997 and December, 1998, deviated from accepted standards of care (T. p. 441).

185. The risk to Patient D was undiagnosed liver disease as a consequence of using Lipitor, or the combination of Lipitor and the patient's biliary tract disease. Liver disease could require a liver transplant, or could be fatal (T., p. 441).

186. As the prescribing physician, it was the Respondent's responsibility either to order liver function tests or, if he assumed another physician were ordering these tests, to obtain the liver function test values and to ensure that they were normal (T., pp. 468-469, 1610-1611). If the values were abnormally high, the Respondent as prescribing physician would need to make a decision as to whether to continue the drug (T., p. 468).

DISCUSSION OF PATIENT D

Following the initial workup in October of 1992, the standard of care would be to follow Patient D both for the symptoms of diabetes and the complications of diabetes, including repeating blood glucose levels within one year. Respondent acknowledged that it would have been appropriate to recheck Patient D's blood glucose in six months, or by April of 1993.

Patient D was seeing a cardiologist, so the Respondent could assume that the cardiologist would be evaluating the patient for cardiovascular and peripheral vascular risks. However, Respondent was following the patient for diabetes, and was required to evaluate Patient D for kidney disease, retinopathy, neurological signs and symptoms in the extremities, and to work towards tight control of sugars. While the Respondent performed physicals, measured blood pressure, and performed blood glucose tests, he did not perform these tests regularly. The Respondent did not properly deal with potential ophthalmologic risks by making sure that the patient was seen by an ophthalmologist or performing his own fundoscopic examination.

Although parts of an appropriate evaluation for diabetes and the complications of diabetes were performed at various times, the complete evaluation was not performed annually, as the standard of care requires.

On June 13, 2001, Patient D's cardiologist ordered an arterial Doppler evaluation, after Patient D complained of foot and leg symptoms which could indicate vascular or neurological complications of diabetes. The report was received in Respondent's office. Clearly, such a report should have triggered action on Respondent's part to nail down the cause. Patient D's chart contains no notation regarding a neurological exam on June 26, 2001, the first examination of Patient D following receipt of the arterial report.

Regarding his evaluation of Patient D's liver function, both experts agreed that the standard of care would have been to perform a liver function test prior to starting Patient D on Lipitor to determine if there was any evidence of pre-existing liver damage. If Patient D already experienced liver function abnormality, precautions could be instituted before Patient D started on the Lipitor. In addition, such a test would provide a baseline for following the patient's liver function in future. Liver function tests should then be repeated after three months and regularly thereafter to make sure that the patient's liver function remained unchanged by the medication. Respondent's expert agreed that the standard of care was to obtain a base line measurement prior to starting Lipitor, repeating the study at three months, then at six months and one year (T., pp. 1609-1610).

Respondent did not order liver function tests before Patient D started taking Lipitor. Patient D did have a liver function test on December 4, 1997, within three months of the start of this medication. On May 19, 1998, Patient D's gastroenterologist wrote to Respondent stating that he would see the patient in one year, but that Patient D should have blood work every six months to include liver function tests, clearly indicating that Respondent should order them. On June 4, 1998, the report of Patient D's cardiologist noted that Respondent was prescribing Lipitor to Patient D and that Patient D had not had blood studies in quite some time. He suggested that liver function tests (AST and ALT) be obtained. On December 2, 1998, there is another report from Patient D's cardiologist noting that the Respondent had increased the patient's Lipitor dose and suggesting that his liver function tests be repeated.[5] Respondent did not repeat these tests until August 21, 2000.

[5] Liver function tests were performed by the cardiologist in December, 1998.

The risk to Patient D was undiagnosed liver disease resulting from the use of Lipitor, or from the combination of Lipitor and the patient's biliary tract disease. A patient's reaction to Lipitor is idiosyncratic, and can occur with a large or small dose, according to the State's expert. Lipitor and other statins are routinely prescribed by family practitioners. Liver disease is potentially fatal. In a complicated patient such as Patient D, frequent liver function tests would be required, and a prudent practitioner would err on the side of over-caution in monitoring the diabetic patient for complications from the Lipitor he was prescribing.

Both Dr. Becker and Dr. Marinello agreed that, as the prescribing physician, Respondent was required to obtain the liver function values, if he thought that another doctor was ordering the tests, and to ensure that they were normal. If the values were abnormally high, the Respondent would need to make a decision as to whether to continue the drug.

Patient E

The Respondent provided medical care to Patient E from March 3, 2000 to July 24, 2001 primarily for hypertension, urinary frequency, and osteoporosis. The following Findings of Fact relate to the allegation that the Respondent failed to adequately evaluate Patient E's renal function.

187. On March 30, 2000, Patient E was 91 years of age, with a history of hypertension. Her blood pressure at that first visit to Respondent was 196/86 and she complained of nocturia three or four times per night, and frequent urination for two years, among other things (T., pp. 479-480; Ex. 15, p. 6). Patient E's blood glucose was subsequently measured at 105, which was normal (T., pp. 480-481).

188. Respondent appropriately treated Patient E's hypertension with Inderal. The symptoms of frequent urination, urination at night and a rash under the breast suggest the possibility of diabetes. Respondent appropriately ordered a fasting glucose test.

189. Patient E should have been evaluated for renal disease because: renal function declines with age, her elevated blood pressure, and her urinary symptoms (T., p. 481). Patients with elevated blood pressure can have renal disease as the result of those elevations, and Patient E had been without her medications for ten months (T., pp. 481-482). Patient E's frequent urination and urination during the night suggested urinary tract involvement, which could be due to renal insufficiency as a consequence of an obstruction or a partial obstruction (T., p. 482). Patient E required a creatinine level to determine renal functioning, a urine culture to rule out infection, and a physical examination to determine presence of an enlarged bladder (T., p. 482). Respondent's expert testified that a urinalysis would have been "a good idea" for Patient E (T., p. 1415).

190. A more detailed medical history regarding urinary symptoms, particularly the presence or absence of burning or pain with urination, as well as the patient's history of urinary infections was the standard of care (T., pp. 482-483).

191. A urinary tract infection is potentially a serious condition for a woman of Patient E's age, and can lead to sepsis if not timely detected and treated (T., p. 483).

192. Respondent failed to investigate the cause of Patient E's urinary symptoms. His failure to do so was a deviation from accepted standards of care (T., p. 484).

193. The evaluation of Patient E's renal function should have been performed within a few weeks of her initial visit on March 30, 2000. The standard would have been to order laboratory tests at the first visit and to reschedule the patient for an office visit within two or three weeks of the initial office visit (T., p. 485).

194. If the testing had been done but not recorded, Respondent's failure to record the values and results of such testing violated accepted standards (T., p. 488).

195. Given the patient's prior urinary symptoms and her urinary infection in October, 2000, Patient E required follow-up, including a repeat urine culture after treatment to determine whether the urinary infection had completely resolved (T., p. 488).

196. On May 2, 2001, Patient E had a urinalysis which suggested blood in the urine (Ex. 15, p. 14). This could be the result of a number of conditions including right sided back pain, tumor of the kidney, a kidney stone, or a urinary tract infection (T., pp. 492-493). There is no record of Respondent having treated the abnormal urinalysis on May 2, 2001 (T., pp. 519, 530-531). A urinalysis was repeated twelve days later on May 14, at which time

the findings were normal (Ex. 15, p. 12; T., p. 493). While a normal urinalysis for Patient E would have been somewhat reassuring, it did not rule out a renal tumor, which could bleed intermittently. If the patient had a stone, it may have passed to a different area, where it was not irritating or causing bleeding. If the patient had a urinary tract infection, the bleeding phase may have passed without the infection having been resolved. Negative urinalysis does not rule out any of the potentially serious conditions which could have caused the hematuria (T. pp. 493-494).

197. At Patient E's next office visit on July 24, 2001, the medical record indicates a negative history for genital urinary disease. However, a negative history did not rule out any of the significant conditions, and a laboratory investigation, including urine culture and serum creatinine, would have been indicated (T., p. 495).

198. While Patient E's urinary symptoms may have been due to a dropped bladder, it did not obviate the need to rule out other possible conditions, presenting greater health risks. If Patient E refused such testing, her refusal should have been documented in the medical record (T. pp.513-514).

199. A prolapsed bladder can result in frequent urination and sometimes retention of urine in the bladder. Retention of urine can cause recurrent urinary infections, which can lead to chronic renal infections (T., p. 524).

200. Patient E required evaluation not only due to her prolapse, but due to her age, her hypertensive state, and eighteen year history of renal symptoms. Any of those conditions would provide an indication for evaluation of the patient's renal function (T., pp. 524-525).

201. Respondent records no past medical history of prolapse. It would be the standard to inquire as to such a history as a possible explanation for the patient's frequent urination. The history would also be important to determine whether recent symptoms represented a change, which might suggest that the patient's current symptoms relate to a condition in addition to prolapse (T., pp.528-529).

202. On June 24, 2001, Respondent examined Patient E and noted "GU negative", suggesting that symptoms relating to prolapse or urinary tract were not present at that time. However, a prolapsed bladder and the symptoms associated with it are consistently present; they do not come and go. (T., p. 530)

The following Findings of Fact relate to the allegation that the Respondent failed to adequately evaluate, treat and/or manage Patient E's osteoporosis.

203. Patient E was admitted to the hospital on March 29, 2001, with a complaint of low back pain. She had fallen at home after shopping (Ex. 16, p. 18).

204. Patient E's past medical history included fractures of the right wrist and right ankle in the last five years (Ex. 16, pp. 18, 49).

205. Patient E had an x-ray of the lumbar spine during the admission which demonstrated a compression fracture of L-1, which the radiologist indicated was likely osteoporotic and of uncertain age (Ex. 16, p. 23; T., pp. 497-498). X-rays can suggest the presence of osteoporosis, but are not considered definitive. Patient E's x-ray suggested that she may have osteoporosis causing a weakening of her lumbar spine resulting in a fracture (T., p. 498).

206. A hip x-ray indicated that Patient D's bones were osteopenic, suggesting a thinning of the bones consistent with osteoporosis. Further, Patient D's history of fractures of two other bones in the last five years was consistent with osteoporosis (T., pp. 498-499).

207. The standard of care for evaluating a patient for osteoporosis was to perform or order a bone densitometry exam, or DEXA scan (T., p. 500). This test measures the density of bones and would indicate if the patient had osteoporosis or osteopenia, which is a stage prior to osteoporosis (T., pp. 500-501).

208. Patients with osteoporosis are at increased risk for bone fractures. A very common fracture is a hip fracture, which in patients of Patient E's age can be fatal as a result of post-surgical infections, pulmonary embolus, or other complications. Patients who survive hip fractures have significant physical impairment, and often cannot live on their own. (T., p. 501).

209. Patient E should have been evaluated for osteoporosis at the time of discharge or as soon as the DEXA scan could have been performed. This should have been done following the patient's discharge from her rehabilitation admission (T., p. 501).

210. Respondent failed to evaluate Patient E for osteoporosis. The failure to do so was a deviation from accepted standards of care (T., p. 502).

211. Patient E required treatment for osteoporosis regardless of whether the condition was further evaluated. Dietary supplements of calcium and vitamin D decrease the progression of osteoporosis. Drugs such as Fosamax impede the progression of osteoporosis, and could also reverse it to some degree (T., pp. 503-504).

212. It was the standard of care to order Fosamax for Patient E even without further evaluation for osteoporosis because of the clear evidence on x-ray of potentially osteoporotic fractures and osteopenia of the bones (T., p. 504).

213. Respondent did not order calcium, vitamin D or Fosamax for Patient E. The failure to treat the patient's osteoporosis was a deviation from accepted standards of care (T., p. 504)

214. It is the standard of care to treat osteoporosis regardless of the patient's age (T., pp. 521, 531). Prior to her hospitalization following a fall at home, Patient E was living independently and was quite active for 90 years of age. Following her fall, Patient E's physical therapy discharge summary indicated that she was capable of living independently using a walker. The only limitation was getting in and out of a bathtub (T., pp.532- 533).

215. Fosamax does have serious side effects. There are specific instructions as to how the drug is to be taken. If a physician were not going to prescribe Fosamax where indicated, due to the drugs side effects, the inability of the patient to follow the specific instructions regarding taking Fosamax, or the patient's refusal to use the drug, the physician is required to document the decision. (T., pp.521-523). Respondent failed to document any reason for not prescribing Fosamax for Patient E.

216. Regardless of whether the patient was given Fosamax, it would be the standard of care to prescribe Vitamin D and calcium for Patient E (T., p. 533). Respondent did not prescribe Vitamin D or calcium for Patient E.

DISCUSSION OF PATIENT E

When Patient E first consulted Respondent in March, 2000, she was 91 years old and living independently. She had a history of high blood pressure and, not unusually in a woman of her age, complaints of urinary frequency and nocturia three or four times per night. While Respondent appropriately treated Patient E's hypertension and ordered tests to rule out diabetes, his apparent failure to do a full evaluation of Patient E's gynecological and urinary health, including taking and recording a detailed medical history and performing a gynecological exam and urinalysis on the first visit, was clearly substandard. The Respondent did not elicit the information that Patient E had had a prolapsed bladder for many years, information which came out at the time of a subsequent hospitalization. Respondent did not evaluate the patient for renal disease, another age-related condition her symptoms might indicate. He did not investigate her complaints of nocturia. He did not evaluate Patient E for osteoporosis.

The Respondent indicated that he did not perform a pelvic exam on this patient out of delicacy for her age and feelings. Such considerations do not override the patient's right to appropriate medical care.

On March 29, 2001, Patient E was admitted to the hospital complaining of low back pain. She had fallen at home after shopping. She had fractured her right wrist and right ankle in the previous five years. A lumbar spine x-ray demonstrated a compression fracture at L-1, which the radiologist indicated was likely osteoporotic and of uncertain age. Patient E's x-ray suggested that she may have osteoporosis, causing a weakening of her lumbar spine and resulting in a fracture. A hip x-ray indicated that Patient D's bones were osteopenic, consistent with osteoporosis.

The standard of care for evaluating a patient for osteoporosis was order a bone densitometry exam, or DEXA scan, to measure bone density and determine whether the patient had osteoporosis. Osteoporosis is especially common in post-menopausal women. People with osteoporosis are at increased risk for bone fractures. Fracture of the hip is very common and, in patients of Patient E's age, can be fatal because of common post-surgical infections, pulmonary embolus, or other complications. Patients who survive hip fractures may have significant physical impairment and a decline in quality of life. They often can no longer live on their own.

By the time Patient E was discharged from the hospital, there was sufficient x-ray and historical evidence to conclude that she was suffering from osteoporosis and required treatment. She should have been evaluated by a DEXA scan to determine her baseline, and started on calcium and vitamin D which slow the progression of osteoporosis. Drugs such as Fosamax, although not always well tolerated, can sometimes even reverse the disease somewhat, and should have been seriously considered as part of the treatment regimen.

The Respondent's explanation, that Patient E was too old to start dietary supplements since they can take a year or more to show results, and that she probably could not tolerate the complicated instructions for taking Fosamax, did not persuade the panel. There was nothing in the record to indicate the likelihood the patient would have problems with Fosamax, but clearly calcium and vitamin D therapy could have no downside. It was the standard of care in 2001 to treat osteoporosis, regardless of the patient's age. The failure to begin such treatment for Patient E, an independent and active individual, still able to live on her own, was a serious deviation from accepted standards of care.

Patient F

The Respondent provided medical care to Patient F from April 14, 1989 to September 21, 2001, for anxiety, attention deficit disorder, and hyperlipidemia, among other conditions. The following Findings of Fact relate to the allegation that the Respondent failed to adequately follow-up on complaints and/or findings made at an April 14, 1989 evaluation of Patient F, and that the Respondent, on various occasions, failed to adequately evaluate Patient F for psychiatric conditions, including, but not limited to performing inadequate histories or physical examinations.

217. Respondent examined Patient F, a 68 year-old woman, on April 14, 1989. Two to three weeks earlier, she had an episode of weakness and tiredness. Her past medical history was significant for pulmonary emboli on two occasions and for smoking two packs of cigarettes per day for many years. She had quit smoking six months earlier. She reported

insomnia at times, sleepiness after meals, and a lot of stress. She had taken Valium from a friend and was asking for a prescription for Valium from Respondent (Ex. 17, p. 12; T., pp. 534-535).

218. Patient F's symptoms of weakness, tiredness, and insomnia could be consistent with depression. Insomnia can be aggravated in times of stress. The patient's weakness and tiredness could also be the result of physical conditions, including endocrine problems, cardiovascular problems or electrolyte imbalances (T., p.536).

219. Respondent ordered an EKG and was considering a stress test to test for ischemic heart disease. The EKG was negative for ischemic disease. A urinalysis was performed on April 26, 1989 and was negative. A chest x-ray showed some hyperinflation, suggesting chronic obstructive pulmonary disease (COPD), which would be consistent with the patient's history of smoking. Although blood panel was part of the treatment plan, no results of any such testing were reported in the record (Ex. 12, p. 9; T., pp. 537-538).

220. The history of the patient's complaints of weakness and tiredness was not well developed from the cardiovascular perspective. Patient F was at high risk for coronary disease. Other than reporting the weakness and tiredness, the Respondent failed to provide any indication for the EKG or his consideration of a stress test (T., p. 539).

221. Patient F required a more extensive history of physical problems such as intolerance to cold, or changes in bowel movements that might have indicated a thyroid problem. Further questioning of psychological symptoms was also indicated to determine the presence of a depression or major depressive disorder. The history at the first visit should have included information regarding difficulties with concentration, loss of interest in usual activities, and fatigue. Where depression is possible, the patient should be questioned immediately concerning ideas of suicide and plans for suicide in order to prevent death (T., pp. 540-541). None of this history appears in Respondent's records.

222. The failure to take such a history from Patient F or to record such history, if taken, deviated from accepted standards of medical care (T., p. 541).

223. Patient F had tried Valium provided by a friend and requested Valium at the time of her initial office visit. Valium is a tranquilizer which is used in the treatment of insomnia, acute anxiety or general anxiety disorder. However, Valium is not used for the treatment of depression. There are other drugs more effective than Valium in treating depression (T., p. 542).

224. Respondent's progress note for the April 14, 1989 evaluation indicates that the patient "wants Valium" (Ex. 17, p. 12). Providing Valium to new patients at their request, in the absence of a diagnosis, presents risks. The drug can be abused and patients can become habituated. Physicians are often more cautious when such drugs are requested by the patient. Further, in a 68 year old patient, Valium can accumulate in the system and lead to symptoms of fatigue and excessive tiredness. Valium is appropriate for short-lived stresses. It is not the recommended drug for chronic stress (T., pp. 543-544).

225. Respondent's evaluation of Patient F on April 14, 1989 did not meet the standard of care for evaluating a patient with anxiety. There is insufficient documentation about the causes of anxiety, the duration of reported symptoms, and the existence of any anxiety symptoms other than insomnia. There is no history, either positive or negative, for physical symptoms associated with anxiety such as rapid heartbeat, or whether her anxiety keeps Patient F from going places or participating in customary activities. There is no past history relating to anxiety (T., pp. 544-545).

226. Past history is important in making a diagnosis. It was noted in October of 2000 that Patient F had a history of schizophrenia "years ago" (Ex. 17, p. 78). Schizophrenia can lead to anxiety-like symptoms for which Valium would not be the appropriate treatment. It would have assisted the present therapy if Respondent had known what conditions of anxiety the patient had experienced in the past and how that anxiety was managed (T., pp. 545-546).

The following Findings of Fact relate to the allegation that the Respondent failed to perform a follow-up chest x-ray on Patient F after May 25, 1990.

227. On May 25, 1990, Respondent examined Patient F and noted that the patient had been treated in the emergency room at St. Clare's Hospital for chest pain. Respondent listed the diagnosis as pleurisy, and there is a note that the x-ray showed a possible or questionable right lower lobe pneumonia. Included in the plan for the patient was to repeat the chest x-ray in a week (Ex. 17, p. 13; T., p. 547).

228. The standard of care is to repeat a chest x-ray showing possible pneumonia, as the patient's pneumonia may have been caused by another condition or the pneumonia seen on x-ray may mask or obscure another condition, such as lung cancer. Patient F had smoked two packs of cigarettes for many years, so she was at risk for certain forms of cancer. The chest x-ray would be repeated to determine whether the pneumonia had completely resolved and to be certain that cancer was not present. Respondent failed to repeat the chest x-ray. His failure to do so was a deviation from accepted standards of care. The risk is that patient had an undiagnosed lung cancer which, if detected early and treated, could prolong the patient's life (T., p. 548-549).

229. When Respondent examined Patient F on August 22, 1990, he should have realized that the repeat chest x-ray had not been performed. It was Respondent's responsibility to continue ordering chest x-rays until the x-ray was clear or an underlying condition was noted (T., p. 549).

The following Findings of Fact relate to the allegation that the Respondent, on various occasions, inappropriately prescribed Valium to Patient F.

230. On May 25, 1990, Respondent again prescribed Valium for Patient F. Respondent made no evaluation as to the effectiveness of the Valium the patient had been taking, nor did he evaluate her for anxiety or depression. The patient was taking 5 mg. of Valium a day, the standard dose for a person older than 65 (T. pp. 550 551).

231. At the July 9, 1991 examination of Patient F, Respondent noted that her husband was in Hospice for prostate cancer and that the patient had a lot of anxiety (Ex. 17, p. 14; T., p. 551). Patient F again requested tranquilizers and felt that Valium had helped in the past. A prescription for 5 mg of Valium, 60 tablets to be taken twice or three times a day as necessary was noted in the chart (T., p. 552). Respondent did not evaluate Patient F for

anxiety or depression.

232. Between August, 1991 and November, 1991, Respondent continued to prescribe Valium for Patient F. In November of 1991, Respondent noted that the patient "denies depression". (Ex. 17, pp. 15-16) While this is part of the evaluation for depression, numerous other components of the evaluation are not recorded. Respondent's evaluation did not meet the standard of care for evaluating a patient for depression (T., pp. 553-554).

233. On November 6, 1991, Respondent's entry in Patient F's chart states "anxiety/depression continues". This seems to indicate that Respondent believed the patient had a combination of anxiety and depression at that time. There is no documented evaluation for depression. It was a violation of the standards of care to treat a patient with Valium for a condition which had anxiety and depressive components. Such patients respond best to anti-depressant medications, which will also improve their anxiety symptoms. With the diagnosis of anxiety and depression, the Respondent failed to treat the depression component (T. pp. 554-555).

234. On March 3, 1992, Respondent evaluated Patient F and listed insomnia and anxiety as her symptoms. The note further indicates that patient needs Valium to function and 90 tablets are prescribed, to be taken three times a day (Ex. 17, p. 18; T., p. 556).

235. There was a risk of Patient F becoming both psychologically and physiologically dependent on Valium. Psychologically dependent patients feel they need to take drugs such as Valium because it decreases anxiety symptoms and they feel that they cannot get through their day without using it. Patients who use the drug over long periods of time can develop withdrawal symptoms if they stop using the drug. These patients gradually escalate the dose they require. Patient F had started with 5 mg dose once a day and as of March, 1992 was using 5 mg three times a day (T., pp. 556-557).

236. When the physician increases the dosage of a medication such as Valium, the standard is to document the effectiveness of the drug and the reasons for increasing the dosage. The physician should document the discussion with the patient as to possible adverse effects of drowsiness, difficulty concentrating, and difficulty functioning. There is no indication that Respondent did an evaluation of Valium's effectiveness and any adverse effects. The failure to do these evaluations was a deviation from accepted standards of care (T. pp. 557-558).

237. In September, 1992, Respondent diagnosed Patient F with chronic insomnia and panic attacks (Ex. 17, p. 21). There is no evaluation of Patient F for panic disorder in the patient's chart (T., pp. 559-560).

238. On October 11, 1993, Respondent examined Patient F and noted that she "admits to being depressed", and that he was considering Zoloft to be included in Patient F's therapy (Ex. 17, p. 25). Zoloft is an anti-depressant and would be an appropriate treatment for a major depressive disorder. Patient F required a more thorough evaluation to assess suicide risk, other features of the depressive disorder, and the indications for anti-depressive therapy (T., pp.560-561).

239. Respondent continued to prescribe Valium for Patient F from October, 1993 through April 24, 1996, at which time the patient was given samples of Zoloft 50 mgs. To be taken for one week. (Ex. 17, p. 40; T., p. 562)

240. The Respondent did not evaluate Patient F for depressive disorder before prescribing Zoloft. This deviated from accepted standards of care. The patient had in the past years displayed symptoms of major depressive disorder warranting an evaluation (T., p. 563).

241. At the patient's next visit, on July 9, 1996, the progress note makes no reference to Zoloft but Valium is again prescribed. Patient F continued to receive Valium between April, 1996 and June, 2000, except for brief periods when she went off Valium (T., pp. 562-564).

242. On June 22, 2000, Respondent prescribed Prozac to Patient F. Prozac is an anti-depressant medication in the same class as Zoloft (T., p. 564). There is no indication in Patient F's chart as to why Valium was discontinued and Prozac was prescribed. The failure to perform an evaluation was a deviation from the standards of care. Respondent continued to prescribe Valium to Patient F up to and including August 9, 2001 (T., pp. 564-565).

243. Between her first visit in April, 1989 and her visit on August 9, 2001, there is no recorded evaluation of Patient F for depression which met the accepted standards of care. Portions of an evaluation appear at times; however, there was no assessment of suicide potential, or of other symptoms of depression. The greatest risk to Patient F in neglecting this evaluation was the failure to disclose any immediate suicidal thoughts or ideas, and thereby preventing the act. A second risk to Patient F was an inadequate evaluation for

other depressive symptoms and as a result, incorrect or inadequate therapy may have been prescribed. The failure to evaluate Patient F for depression deviated from accepted standards of care (T., pp. 566-567).

244. If Respondent gave Patient F a referral to a psychiatrist and she refused to go for evaluation, it was the standard of care for Respondent to document the patient's refusal. His failure to record any such refusal was a deviation from accepted standards of care (T., p. 567).

245. Respondent's prescription of Valium to Patient F during the period from 1989 to 2001, did not meet the accepted standards of care because Respondent failed to do the appropriate evaluation for either depression or anxiety, and arrive at a diagnosis. There was no assessment of the effectiveness of the drug and no notations regarding side effects or problems (T., pp. 567-568).

246. If a benzodiazepine such as Valium was indicated because Respondent diagnosed anxiety, there were choices other than Valium. For elderly patients, shorter-acting benzodiazepines are preferred, such as Oxazepam, which are less likely than Valium to accumulate and cause side effects in elderly patients (T., pp. 618-619).

The following Findings of Fact concern the allegation that the Respondent prescribed Ritalin to Patient F without appropriate medical indications.

247. On October 31, 1995, Respondent evaluated Patient F for complaints of lack of focus, anxiety, and difficulty concentrating. Patient F requested a prescription for Ritalin, having seen a TV talk show regarding the drug. Ritalin is a stimulant used in the treatment of attention deficit disorder (ADD) (Ex. 17, pp. 36-37; T., p. 619).

248. Respondent deviated from accepted standards of care by prescribing Ritalin to Patient F without a clear diagnosis of ADD (T., pp. 620-621). It is the standard of care in adult patients to perform a psychological profile before diagnosing ADD (T., p. 675). Respondent prescribed 30 tablets of Ritalin, 5 mg with instructions to take one daily (T., pp. 621-622).

249. In prescribing Ritalin without making a diagnosis, Respondent created a risk of not treating appropriately the cause of Patient F's lack of concentration and focus. These could have been symptoms of depression (T., p. 690). ADD is a life-long condition

dating back to childhood. It does not come and go (T., pp. 687-688). Patient F had no such history. Ritalin can also make anxiety and insomnia worse. Patient F had chronic anxiety and insomnia from time to time (T., pp. 622-623, 689). Patient F took Ritalin once, but she discontinued it when it kept her awake (Ex. 17, p. 38; T., p. 623).

The following Findings of Fact relate to the allegation that the Respondent failed to adequately evaluate and/or treat Patient F for the risk of pulmonary embolus.

250. Patient F had pulmonary emboli in 1973 and 1983. A pulmonary embolus is a blood clot in the lungs. The clot usually develops at a remote location, such as in the large veins of the pelvis or legs. A piece of the clot breaks off and travels through the blood stream where it becomes lodged in the lungs, interfering with the lungs' ability to oxygenate the blood. The condition is often fatal. Symptoms of a pulmonary embolus include chest pain, difficulty breathing, shortness of breath, and cough with bloody sputum. In the legs, symptoms include sudden painful swelling of one leg (T., pp.624-625).

251. On February 13, 1995, Respondent evaluated Patient F and noted that she had had heart pain a few weeks earlier, which had resolved. Patient F complained of numbness in her feet for the past few days. The history of pulmonary emboli was noted, along with the fact that Patient F was now smoking sometimes. A lung examination was clear. There is no documentation that Respondent examined Patient F's legs, but a Doppler study to rule out clots was planned (Ex. 17, p. 31; T., pp. 627-628).

252. The fact that Patient F's chest pain had resolved weeks earlier would not be consistent with pulmonary embolus as the cause of that pain. Numbness in the feet is not a typical symptom of thrombophlebitis. However, in ordering the Doppler "r/o clots", Respondent wanted to rule out deep vein thrombosis, and therefore was considering a pulmonary embolus (T., pp. 628-629).

253. Respondent should have obtained a more detailed history from Patient F, including information regarding pain and swelling in the legs. A physical examination that included the legs for signs of tenderness, difference in size and the presence of swelling should have been performed. If Respondent had obtained such history and performed such physical examination, the standard of care required that they be documented. Respondent deviated from the standards of care in ordering a Doppler to rule out clots without

obtaining a history and physical assessing the patient for thrombophlebitis (T., pp. 629-630).

254. If Respondent suspected blood clots in Patient F's legs, she required an immediate Doppler exam and anti-coagulant treatment to prevent those clots from moving and causing a pulmonary embolus (T., pp. 630-631). The Doppler examination Respondent ordered was not scheduled until February 15, 1995, two days later. It was dangerous and a deviation from accepted standards of care to delay the Doppler examination in a patient with a history of pulmonary emboli. (T., p. 632).

255. There is no report of the February 15, 1995 Doppler examination. The February 15 examination is referred to in the report of a subsequent Doppler examination, performed on March 20, 1995 (Ex. 17, p. 150; T., p. 632). On February 15, 1995, deep vein thrombosis of the left lower extremity was noted. The clot found on February 15, 1995 was resolved by the time of the March 20, 1995 evaluation. A deep vein thrombosis poses the risk of a portion of the clot breaking off and traveling to the lungs, which could be fatal (T., pp.632- 633).

256. The standard treatment of deep vein thrombosis in 1995 was to admit the patient to the hospital and begin intravenous and oral anti-coagulants. Patient F refused to go to the hospital, but was started on the anti-coagulant Coumadin by Respondent. (Ex. 17, p. 32). Coumadin is used in the treatment of blood clots and to prevent future clots in patients with repeat pulmonary emboli (T., p. 636).

257. Patient F was continued on Coumadin by Respondent from February, 1995 to October, 2000 (Ex. 17, p. 78; T., pp. 635-636).

258. Coumadin treatment must be monitored by regular international normalized ratios for anticoagulant monitoring (INR). If excessive Coumadin is given, patients are at risk of having serious bleeding, usually from the bowel or stomach. If patients are not receiving sufficient Coumadin, they are at risk of having another blood clot. Target range for an INR in the treatment of thrombophlebitis and pulmonary embolus is between two and three. With an INR under two, the Coumadin should be increased. If the INR is over three, the Coumadin is decreased. Because patients' INR's tend to go up and down unpredictably, the standard is to measure INR frequently. In stable patients, INR's are to be measured every two to four weeks. If there are abnormalities in the INR, patients

must be monitored more frequently with adjustments to the Coumadin dose and repeat a INR soon after (T., p. 637). Respondent's expert testified that INR's should be repeated monthly (T., p. 1491).

259. During the five and a half year period Patient F was prescribed Coumadin, only five INR's were performed: INR's were performed on April 19, 1996, April 8, 1997, October 31, 1997, October 13, 1998, and March 14, 2000 (Ex. 17, pp. 144, 137, 134, 118, 175; T., pp. 639 - 642).

260. The INR measured on April 8, 1997 was 1.1, which is below the therapeutic range. The standard of care requires instruction to the patient to increase Coumadin and follow-up immediately with an INR to determine whether the INR is within the therapeutic range. The repeat INR should have been performed within two weeks. There were no instructions in Patient F's chart to increase her Coumadin dose, nor was there a repeat INR within two weeks (Ex. 17, pp. 39-40).

261. The failure to increase the Coumadin dose and to repeat the INR in April, 1997 was a deviation from accepted standards of care. The failure to perform INR's at least each month during the period Coumadin was prescribed was a deviation from accepted standards of care (T., pp. 641-642). Respondent acknowledged that it was the standard of care to order monthly INR's in this situation and that he failed to do so (T., p. 1166). Patient F was placed at risk of either receiving too much Coumadin which could potentially cause bleeding complications, or not receiving sufficient anti-coagulation, creating the risk of pulmonary embolus (T., p. 643).

262. The risks of deficient or excessive Coumadin therapy are taught in medical school and residency training (T., p. 643).

The following Findings of Fact relate to the allegation that the Respondent failed to adequately monitor Patient F's anticoagulant therapy during her hospital admission on February 21, 2001.

263. During an office examination by Respondent on February 19, 2001, Patient F complained of swelling of the left leg for four days with no pain, no chest pain, and no history of injury. A physical exam notes swelling at the left calf, when compared to the right, with

some tenderness of the left calf. A Homans sign (a test for deep vein thrombophlebitis) was reported as positive. These findings are suggestive of new onset deep vein thrombosis in the left calf. (Ex. 17, p. 82; T., pp. 643-644) Respondent's plan was to rule out deep vein thrombosis (DVT) on the left side, and testing was performed the same day at Ellis Hospital (Ex. 18, p. 9; T., p. 644).

264. A physical exam Respondent performed in the hospital indicated, among other things, that the patient's lungs were clear, with swelling of the left leg and calf tenderness, and a positive Homan's sign, and a normal right leg. The Doppler examination was positive and Respondent's plan was to administer Heparin and Coumadin (T., p. 645).

265. Heparin and Coumadin are the appropriate treatment for a patient with new onset of deep vein thrombophlebitis . Heparin is an intravenous anti-coagulant that acts immediately, and Coumadin is an oral anti-coagulant that will start acting within a couple of days and would be continued as the treatment regimen following discharge (T., p. 645-646).

266. With any anti-coagulant therapy, including Heparin/Coumadin therapy as administered to Patient F, there is a risk of bleeding. The standard of care is for the attending physician to personally evaluate the patient each day of the admission. The focus of this evaluation is to identify signs or symptoms of bleeding complications from the anti-coagulant therapy, and to re-evaluate the patient for further compromise caused by the clots, particularly signs or symptoms that would suggest a pulmonary embolus (T., p. 646).

267. In addition, laboratory testing to monitor both the INR and the partial thromboplastin time (PTT) should be done regularly. The PTT monitors the Heparin dose in a similar fashion to which the INR monitors the Coumadin dose (T., p. 647).

268. Respondent personally evaluated Patient F on the first day of admission, February 20, 2001 (Ex. 18, pp. 9-10; T., p. 647). Respondent next evaluated the patient on February 22, two days later. There is no evaluation recorded in the hospital record for February 21, 2001. Respondent acknowledged that he probably did not see Patient F on February 21, 2001 (T., pp. 647, 1170).

269. Respondent's failure to examine Patient F on February 21, 2001 to determine whether there had been further compromise from the blood clots or complications from the anti-coagulant therapy was a deviation from accepted standards of medical care (T., p. 648).

270. The physician's orders indicate that Respondent followed Patient F by telephone on February 21, 2001(Ex. 18, p. 7; T., p. 649) and, on February 21 and 22, Respondent made adjustments to the Coumadin dose, probably based upon the INR's that were reported to him. This would represent only part of the appropriate assessment. Respondent was still required to personally evaluate Patient F, and to obtain his own history and physical examination (T., pp. 649-650).

271.. Respondent apparently never diagnosed pulmonary embolus in Patient F. To assess a patient for a pulmonary embolus, a VQ scan evaluates the blood and air going to the lungs. A CT scan of the lungs also assists in the diagnosis. The most effective test would be a pulmonary angiogram. Patients can have chronic small pulmonary emboli that are symptom free (T., pp.692-693, 699).

DISCUSSION OF PATIENT F

Anxiety and Depression

The Hearing Committee found it disturbing that the Respondent treated Patient F with Valium for "anxiety" for twelve years without once performing an evaluation for that or any other psychological condition. While Valium may have been an appropriate therapy for short-term anxiety, it was inappropriate for depression and inappropriate for long-term therapy in an older individual such as Patient F. The chart reflects inadequate social or psychological history upon which to base a diagnosis. Little note is made of indications for prescribing this drug or its effectiveness.

Both the State's expert and Respondent's expert testified that there is a risk of dependence on Valium with long term use. This patient continued on Valium for the large part of twelve years. From time to time she increased her daily dose up to 15 mg. and once or twice "went off it", and the Respondent all the while relied upon her evaluation of her condition and her judgment when prescribing for her. At one point, she requested Zoloft, an anti-depressant, and he prescribed that. Despite Respondent's respect for his patient's intellect and judgment as to her own condition, as her physician he should have applied his own medical judgment. If he was uncertain as to the appropriate diagnosis, he should have referred this patient to a psychologist or psychiatrist for evaluation. However, he neither diagnosed Patient F's condition

nor referred the patient elsewhere, but merely prescribed what the patient requested. This is inappropriate.

Respondent's expert testified that Patient F should have been evaluated for depression at the time of her first office visit, including an inquiry as to sleeping patterns, stress level, lifestyle and family issues, her interest or lack thereof in pleasurable activities, any suicidal ideation, and prior psychiatric history. Information concerning these subjects is not in the record. In April, 1996, Respondent gave Patient F a one week supply of Zoloft, an anti-depressant, without explanation in the chart. However, at least a four-week course of anti-depressant is needed to obtain any therapeutic benefit. Respondent testified that the patient diagnosed herself, "So I think between April 18th and April 24th she must have thought to herself, maybe I'm depressed. We had a pretty good relationship. So she probably called and said...maybe I'm depressed. I would like to try the Zoloft." In view of her history of not taking medication, Respondent said he did not want to give her enough for four weeks, instead hoping the one week treatment would alleviate some of her symptoms.

The Respondent knew the appropriate dose, knew that three or four weeks' treatment was needed to get the full benefit, and yet he again allowed the patient to control her own case to an excessive degree. Similarly, Respondent later prescribed Ritalin after Patient F saw a television program about Adult Attention Deficit Disorder and diagnosed her problem as ADD. Again, there was no documented medical indication to prescribe Ritalin. Ritalin is a stimulant which can aggravate insomnia and anxiety, symptoms Patient F frequently complained of, just as long-term Valium use can cause depressive symptoms. Respondent erred in allowing the patient to dictate her own treatment.

Pulmonary Embolus

Patient F's history of two previous pulmonary emboli placed her at risk of future emboli. She consulted the Respondent on February 13, 1995, complaining of numbness in her feet for the previous few days. She was scheduled for a Doppler study to rule out deep vein thrombosis, but not for two days. The Doppler showed that Patient F did indeed have a DVT, and Respondent appropriately started her on Coumadin, an anti-coagulant used to treat blood clots and to prevent future clots in patients with repeat pulmonary emboli. He should have performed, and recorded the results of, a physical examination of the legs for signs of tenderness, any difference in size, and the presence or absence of swelling.

Respondent rightly suspected blood clots in Patient F's leg. She required an immediate Doppler exam and anti-coagulant treatment to prevent those clots from moving and causing a repeat pulmonary embolus. Respondent testified that the only way to get an immediate Doppler for Patient F would have been through the emergency room. This was the appropriate course of action for a symptomatic patient with a history of pulmonary emboli. Both the State's and Respondent's experts agreed that it was inappropriate to wait two days to schedule a Doppler study to rule out clots.

Respondent continued Patient F on Coumadin from February, 1995 to October, 2000. Patients on Coumadin treatment must be regularly monitored by international normalized ratios (INR) for anticoagulant. If given excessive Coumadin, patients are at risk of serious bleeding, usually from the bowel or stomach. If patients are not given sufficient Coumadin, they are at risk of having another blood clot. Because patients' INR's tend to go up and down unpredictably, the standard is to measure INR frequently. In stable patients, INR's are to be measured every two to four weeks. If there are abnormalities in the INR, patients must be monitored more frequently, adjustments to the Coumadin dose made, and INRs repeated. During the five and a half year period Patient F was prescribed Coumadin, only five INR's were performed. Respondent acknowledged that it was the standard of care to order monthly INR's in this situation and that he failed to do so. Again, the Respondent knew the appropriate care but, unaccountably, failed to provide it.

On February 20, 2001, Patient F was hospitalized with DVT. Respondent placed her on Coumadin and Heparin. Although he medicated her appropriately and followed her condition by phone with nursing staff after seeing her that first day, he did not examine her himself in the hospital on February 21. He may have been a busy solo practitioner, but he needed to see this patient either before his office hours or by canceling patients to make the time. The risks to this patient were such that Respondent should have examined her personally to evaluate her condition and the appropriate level of treatment.

Repeating the Chest X-Ray

Patient F's office record for May 25, 1990, noted that she had recently been treated for pneumonia, having had a chest x-ray showing a questionable right lower lobe pneumonia. Respondent's plan included repeating the chest x-ray, a standard follow-up under these circumstances. First, it would be important to determine whether the pneumonia had resolved,

and second, the suspected pneumonia could mask another more serious condition. A repeat X-ray would help settle these issues.

There is no evidence in the record that this planned repeat x-ray was ever ordered or performed. Respondent's explanation, that the hospital must have advised his office that the original x-ray had been read as negative, is not persuasive. If that had been the case, note of it should have been made in the chart. This episode is another example of the Respondent's rather slip-shod management of patients' treatment.

Patient G

The Respondent provided medical care to Patient G from August 1, 1995 to May 25, 2001 for osteoporosis and edema, among other conditions. The following Findings of Fact relate to the allegations that the Respondent, on various occasions, failed to take an adequate medical history from Patient G, failed to perform an adequate physical examination on Patient G, and failed to adequately evaluate Patient G's complaints of back pain.

272. On August 1, 1995, Respondent evaluated Patient G, then a 75 year old woman, for complaints of back pain on and off for one year. There is no back examination recorded other than that Patient G had curvature of the spine and that her pain was usually in the right side muscles of her back (she had no pain at the time of the examination). The plan was to rule out osteoporosis, to obtain an x-ray of the thoracic spine, to consider calcium, and to give her Darvocet N100 (Ex. 19, p. 8; T., pp.700- 701).

273. Back pain can have a number of causes, including musculoskeletal. Patients older than 55 can have much more serious conditions associated with back pain, such as osteoporosis, primary cancer of the bones, or secondary cancer metastasized from another location, aneurysms, and abdominal or lung conditions. It is required that those more serious conditions be ruled out before diagnosing a musculoskeletal cause (T., pp. 701-702).

274. The standard evaluation for a 75 year old patient with relatively new onset back pain includes a history regarding the onset of the pain, any precipitating causes, maneuvers which make the condition better or worse, and a review of the systems. A limited review

of some systems was done, including weight and appetite. The exam should have also evaluated the heart, lungs, abdomen, and should have included a neurological exam of the lower extremities, rectal exam, a review of the gastrointestinal system, and a thorough examination of the back, including the areas of tenderness, areas of deformity and range of motion. As Patient G's back pain appeared to be in the thoracic region, as indicated by the chest x-ray that was ordered, a pelvic exam was not required. However, a breast examination would have been indicated, since breast cancer can lead to metastasis in the spine (T., pp.702-703).

275. As Patient G's symptoms had continued, on and off, for a year, this evaluation should have been performed within the first several weeks of Patient G's initial visit. There is no adequate history or findings from a physical examination of Patient G's back pain anywhere in Respondent's office record (T., pp. 703-705). The failure to evaluate Patient G's back pain by history and physical, as described above, was a deviation from accepted standards of medical care (T., p. 705)

The following Findings of Fact relate to the allegation that the Respondent failed to adequately evaluate Patient G for osteoporosis.

276. Despite the fact that Patient G's thoracic spine x-ray was negative (Ex. 19, p. 48), neither cancer nor osteoporosis can be ruled out on that basis. An x-ray does not show loss of bone until approximately half of the bone is missing, so a patient can have a significant cancer with a negative x-ray. Similarly, an osteoporotic patient can have small fractures, causing significant back pain, that do not appear on an x-ray. Moreover, if the pain were caused by a condition not related to the spine, the x-ray would not detect that condition. (T., pp. 706-707)

277. The standard of care required Respondent to rule out osteoporosis in Patient G by a bone density study (DEXA scan) for osteoporosis (T., pp. 707, 1435). The failure of Respondent to order a bone density study for Patient G was a deviation from accepted standards of care (T., p. 708).

The following Findings of Fact relate to the allegation that the Respondent failed to adequately monitor Patient G while treating her with Darvocet.

278. Respondent ordered Darvocet N100, a narcotic painkiller, for Patient G. There are risks of addiction with Darvocet, and it can be very sedating. Darvocet should be used with caution in elderly patients and in patients with liver or kidney disease, as Darvocet can build up in the blood stream. (T., pp. 708-709).

279. On subsequent visits, Respondent prescribed Lortab and Ultram, which are different forms of pain killers (T., pp. 710-711). On examination on May 5, 1997, it is reported Patient G's back pain was on and off (Ex. 19, p. 10; T., p. 711). There is an indication of localized muscle spasm, and a muscle relaxant, Flexeril, was ordered for Patient G. A muscle spasm is a non-specific finding, as muscles tend to tighten whenever there is pain. A complete evaluation was indicated to determine the cause of this long-standing back pain. (T., p. 713).

280. On examination October 28, 1997, Respondent noted the condition of kyphoscoliosis in the medical record (Ex. 19, p. 11; T., pp. 713-714). Kyphoscoliosis is an abnormal curvature of the spine usually found in thoracic area. Respondent's impression of kyphoscoliosis in Patient G, was inconsistent with the thoracic spine x-ray which showed no abnormality (T., p. 714).

281. Respondent prescribed Darvocet to Patient G regularly from May 5, 1997 through February 12, 2001 without adequately evaluating her back pain (Ex. 19, pp. 10-17). During the period from January 27, 1998 to November 12, 1998, Respondent ordered Darvocet N for Patient G on seven occasions without seeing her (Ex. 19, pp. 11-13; T., pp. 714-715).

282. Given Patient G's more frequent use of Darvocet in 1998, and the fact that Darvocet was being prescribed on a long-term basis, the standard would be to evaluate her regularly for the presence or absence of side affects from the medication, as well as the ongoing progression or improvement in the pain (T., pp. 715-716). Respondent failed to adequately evaluate Patient G during this period. If Patient G refused to come to the office for the indicated evaluation Respondent had the option of not prescribing Darvocet until Patient G came in (T., p. 748).

283. Because Darvocet is a narcotic, patients can become dependent, experience withdrawal symptoms, and may possibly need detoxification programs to get off the drug (T., p. 718). The prescription of Darvocet to Patient G did not meet accepted standards of care insofar as she did not have frequent monitoring for side affects of the drug, there is no documented education about possible addiction, and alternatives to Darvocet, including Tylenol and non-steroidal anti-inflammatory drugs, were not sufficiently attempted (T., pp. 718-719).

284. While Patient G was using Darvocet, her renal and hepatic functions should have been monitored, since Darvocet can cause liver disease (T., p. 719). Darvocet can accumulate in a patient, resulting in increased risk of side affects. Blood tests of liver enzymes and serum creatinine should be performed at the beginning of Darvocet treatment and, if normal, need not be repeated. Respondent did not evaluate Patient G's liver or kidney function prior to starting Darvocet. This was a deviation from accepted standards of medical care (T.,pp. 719-20).

The following Findings of Fact concern the allegation that the Respondent failed to adequately monitor Patient G while treating her with Hydrochlorothiazide.[6]

285. On December 21, 2000, a duplex ultrasound was performed of the veins in Patient G's legs due to swelling in the right and left lower extremities, to rule out deep vein thrombosis. The ultrasound findings showed no evidence of deep vein thrombosis in either leg, but a moderate amount of interstitial fluid was suggestive of some edema. Leg edema in an 80 year old patient can be benign or the result of more serious conditions, such as kidney disease, heart failure and heart disease. The indicated evaluation would include a review of symptoms that addressed heart problems and renal problems, a cardiovascular examination, an examination of the lungs, and laboratory evaluation to assess renal function and electrolytes (T., pp. 721-724).

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[6] Petitioner withdrew allegation G.6, which alleged that Respondent failed to adequately evaluate Patient G's edema. Respondent produced a progress note dated December 21, 2000 after Dr. Becker had completed his testimony.

286. For the leg edema, the Respondent prescribed Hydrochlorothiazide, a diuretic, which causes the kidneys to excrete potassium as well as extra water. Respondent ordered a relatively high dose, 50 mg. of Hydrochlorothiazide per day until the edema went down, and then 25 mg. a day. (Ex. 19, p. 16). The standard follow-up while on this treatment regimen would be to perform serum potassium studies to be sure that the patient was not becoming hypokalemic. Respondent did not evaluate Patient G's potassium. His failure to do so was a deviation from accepted standards of care (T., p. 725).

The following Findings of Fact concern the allegation that the Respondent failed to adequately evaluate Patient G and/or rule out various pathologies during Patient G's May 8, 2001 hospital admission.

287. On May 8, 2001, Patient G was admitted to Ellis Hospital, having fallen at 11:00 p.m. the previous evening due to severe back pain. She was discovered on the floor the following morning by her son and was brought to the hospital. Patient G had not lost consciousness, and had no chest pain or shortness of breath (Ex. 20, p. 4). On physical examination, Patient G had some tenderness in her neck, her back was found to be non-tender, she had full range of motion, her cardiac examination was regular, but she had a 2 over 6 systolic murmur (T., pp.725-727). She was noted to have bruising on the left hip and left shoulder.

288. Her admission diagnosis by the emergency room physician was rhabdomyolysis (breakdown of muscle cells from a large bruise) and dehydration (T., p. 727).

289. Patient G's lab studies showed several abnormalities. She had low potassium at 3.3, her BUN was elevated to 38, consistent with dehydration, her creatinine was normal; her bilirubin was elevated, indicative of possible liver disease. Her AST and ALT were elevated, again indicating the possibility of liver disease. Her CPK, an enzyme that is found in muscle, was very high at 8377. However, a high CPK can be anticipated where there has been a lot of bruising. Patient G's CK-MB was elevated at 35.9. CK-MB measures the heart muscle primarily (Ex. 20, p. 22; T., pp. 728-729). Patient G's Troponin level was abnormal at 3.8. The lab guidelines provided that a Troponin level greater than 2 may indicate significant myocardial injury and that clinical correlation was required (Ex. 20, pp. 22 and 23).

290. Patient G also had an electrocardiogram, which indicated that a inferior infarct of an undetermined age could not be ruled out (Ex. 19, p. 20). This would be considered an abnormal EKG; however, it is possible that it was a normal variant.

291. While the results of Patient G's electrocardiogram neither confirmed nor ruled out a recent heart attack, the abnormal EKG results, together with the elevated Troponin, may indicate cardiac damage. It may also have been related to other bruising. (T., p. 730).

292. Patient G should have been admitted to a hospital bed to monitor her heart rate and rhythm in case she developed any arrhythmias. An electrocardiogram should have been repeated in the first twelve to twenty-four hours. The cardiac enzymes were repeated. Patient G should have been questioned regarding chest tightness or pain. Patients can have silent heart attacks with no pain whatsoever, so an adequate history must be elicited regarding such symptoms (T., p. 731).

293. While Respondent's exam documents many aspects of an appropriate evaluation – history of her fall, review of systems including "cardiac negative" , ""RSR" (regular sinus rhythm) and "respiratory negative," Respondent did not document heart sounds, the presence or absence of murmurs, or the point of maximal impulses of the heart (indicating enlargement) (Ex. 19, p. 17; T., p. 732).

294. This evaluation, including repeat EKG in the first 12 to 24 hours, should have been performed immediately on admission. If Patient G had had a heart attack, it would have required immediate assessment (T., p. 733-734).

295. Respondent's failure to perform this evaluation was deviation from the accepted standards of care (T., p. 734).

296. Subsequent testing of the muscle enzyme does not rule out a heart attack, since these values tend to decrease over hours to days following a heart attack. The fact that the Troponin was lower after two days does not rule out a heart attack (T., p. 734). It was not acceptable for Respondent to discharge Patient G from the hospital without ruling out cardiac disease (T., p. 735).

297. Patient G was readmitted to Ellis Hospital one week later, unable to walk and complaining of weakness (Ex. 21, p. 10). It was then noted that Patient G had lost significant weight over the previous year, and had developed severe neuropathy in the last few months (Ex. 21, pp. 26, 28). Neither of these findings had been recorded in

Respondent's progress notes for Patient G during the same period. The failure to obtain this history from the patient while she was hospitalized the week before deviated from the standards of care (T., p. 745). On May 26, 2001, Respondent signed an order admitting Patient G to a hospice program under the diagnosis of end stage liver disease (Ex. 19, p. 28).

DISCUSSION OF PATIENT G

Back Pain

Respondent prescribed Darvocet regularly to Patient G for back pain for four years without arriving at a diagnosis as to the cause of the pain, described in the record as back spasms or muscle pain. Apparently, the Respondent believed the source to be musculoskeletal. Early on, the Respondent's plan was to rule out osteoporosis, an appropriate plan for a woman of 75. However, no DEXA scan was ordered or documented. Respondent should also have ruled out other more significant pathologies for patients of Patient G's age, including cancer. Details of Patient G's symptoms are not charted. There was apparently no neurological exam or range of motion study. Respondent's failure to adequately evaluate Patient G's back pain follows the pattern evident with his care of the diabetic patients, of his treatment of Patient B's rectal bleeding, and in dealing with Patient F's psychological complaints. Symptoms are treated without tracking down the cause of the symptoms, without making a diagnosis, and more significantly, without ruling out critical and/or treatable pathologies.

The Respondent prescribed Darvocet and, occasionally, other painkillers for Patient G from August 1995 through February 12, 2001, without adequately evaluating or diagnosing the cause of Patient G's significant and persistent back pain. Nor did the Respondent properly monitor the patient for effects of the medication. January 27, 1998 through November 12, 1998, Respondent gave the patient Darvocet without seeing her. Despite his patient's apparent reluctance to submit to an examination, Respondent's course of action should have been to discontinue prescribing Darvocet unless she agreed to be seen. Darvocet is a narcotic painkiller which can accumulate in the system, causing confusion especially in older patients such as Patient G. There is also a risk of dependence. In addition, without an evaluation the physician cannot know whether the patient has developed some other pathology that the analgesic effect of the Darvocet may be masking. Again, the Respondent took the path of least resistance and kept

on providing the medication on the patient's terms, instead of following accepted medical standards.

Hydrochorothiazide

Patient G had leg swelling in December of 2000. A Doppler study ruled out DVT; however, fluid was noted below the knee. Respondent prescribed 100 tablets of the diuretic HCTL, 25 mg to be taken two a day until the swelling went down and then one a day (Ex. 19, p. 16). Dr. Marinello agreed with Dr. Becker that the patient's potassium should be monitored when taking a diuretic, but only if she was taking 50 mg a day for one month. With the 100 tablet supply provided by Respondent's prescription, Patient G could have taken 50 mg a day for more than one month, requiring an assessment of her potassium level, which Respondent failed to perform.

Evaluating Elevated Cardiac Enzymes

Patient G was admitted to the hospital following a fall at home. Her son discovered her on the floor the following morning. Respondent attributed the fall to back pain. Patient G's cardiac enzymes were significantly elevated, possibly "indicat[ing] a significant myocardial injury. Clinical correlation is required" (Ex. 20, p. 23). An EKG was read electronically as abnormal.

Respondent discounted the possibility of a cardiac condition, attributing the abnormal lab levels to extensive bruising caused by Patient G's fall. He further stated that Patient G's frail state would preclude stress testing and other forms of cardiac evaluation, with the exception of an echocardiogram. The Respondent did not order a monitored bed or repeat serial EKGs, which Dr. Marinello and Dr. Becker agreed were indicated.

This case is yet another example of Respondent's failure to rule out more serious pathologies in favor of the more simplistic, mundane, and more easily handled. While Patient G did have extensive bruising, and this could have been responsible for the high Troponin levels, that possibility did not preclude the existence of cardiac disease. It was Respondent's responsibility to rule out cardiac disease.

CONCLUDING DISCUSSION

The Hearing Committee found Lorne A. Becker, MD, the State's expert, to be extremely credible, straight-forward, and knowledgeable. Dr. Becker is a board certified family practitioner, Chief of the Family Practice service at SUNY Upstate and Chair of the Family Practice Department at the SUNY Upstate Medical School. Dr. Becker also has a clinical practice in which he treats a similar cross-section of cases as the Respondent. He fairly and impartially assessed the Respondent's treatment of his patients in this case from the records he had before him. The Committee generally judged his assessments to be well-founded.

Respondent's expert, Anthony Marinello, MD, is Board Certified in family practice, and has been practicing locally since 1989. He is also the Chief School Physician for the Schenendehowa Central School District, and serves as local team physician for SUNY at Albany Division I program and summer training physician for the New York Giants. Dr. Marinello explained the varied nature of family practice in the local region. His practice is also similar to that of Dr. Levin. Dr. Marinello was also straight-forward and credible in his opinions, if at times more generous to the Respondent, particularly on direct examination. When challenged on cross-examination regarding specifics of standards of care, Dr. Marinello sometimes acknowledged that Respondent did not meet the applicable standard. Often, the two experts were in general agreement.

Also testifying for the Petitioner was Nurse Practitioner and Physician's Assistant Sharon Seaman, regarding the Respondent's care of Patient C while hospitalized with diabetic ketoacidosis. Ms. Seaman was entirely believable and appeared most competent as she described intervening to contact the Respondent when she had determined the patient had apparently rebounded into ketoacidosis. It was then that the Respondent ordered another metabolic panel and critical care consult.

The Hearing Committee also credited the Respondent's testimony in some respects. He acknowledged that his record-keeping practices were sloppy, and stated that he has taken steps to improve them and to regularize certain examination procedures. He frequently testified that he thought certain examinations had been performed, certain matters discussed with the patient, or certain analyses made, despite the lack of mention of these things in the patients' charts. The Hearing Committee most often had to conclude that, if it wasn't recorded it wasn't done. Even giving the Respondent the benefit of the doubt on many such occasions and assuming

Respondent did as he described, he still did not, for example, order or perform the necessary test panels or evaluate the patient appropriately for complications. It was clear to the Committee that Respondent frequently did not provide the appropriate level of care.

In September of 2001, after a nine-month review of his admissions, Respondent was offered a choice by Ellis Hospital of either reforming his practices with in-patients or accepting the services of a hospitalist for his admitted patients. Respondent's description of this choice he was given was less than forthcoming. Nevertheless, on cross-examination he admitted that the "choice" he was offered was not voluntary. He accepted having another physician, the hospitalist, take charge of his patients who were admitted to Ellis rather than to "tighten up" on his charting, make himself available during lunch hour, evaluate his admissions on a daily basis, and the like. The shortcomings that concerned the hospital are consistent with the behaviors this Committee found disturbing.

The Hearing Committee found Respondent's testimony concerning many aspects of family practice encountered in these cases showed sufficient medical knowledge and skill. However, it appeared that the Respondent's approach was lackadaisical, sloppy, and careless. Generally, this Respondent failed to exercise reasonable care under the circumstances, as opposed to not knowing the care that should have been exercised. Respondent did not strike the Hearing Committee as incompetent. Failing to screen symptomatic elderly female patients for osteoporosis, for example; providing requested medications without medical indications; failing to evaluate diabetic patients for complications of their disease; neglecting to follow up on indicated tests, procedures, or evaluations are just a few of many instances where Respondent appeared to take the easy, less complicated treatment route. It seemed that he knew the appropriate care, but just didn't provide it. It is understandable that mistakes may sometimes happen in a busy practice, and tests are not followed up or patients who miss appointments are not chased down. But the pattern easily discernable in the Respondent's care of these seven patients is inappropriately deficient. None of these patients received the appropriate care. Some were luckier than others but all would have benefited substantially from his greater attention to their cases.

The Hearing Committee determined that Respondent's care of Patient B went beyond simple negligence. The patient's persistent gastrointestinal symptoms, clearly requiring bowel studies, were largely ignored. It was not credible to the Panel that Respondent was unable to detect a mass within 2cm of this patient's anus if he had in fact performed a rectal exam. The Panel found that Respondent's management of this patient's gastrointestinal complaints was egregious. In this patient, a colonoscopy would not have been a screening tool, it would have been diagnostic. There is no excuse for failing to routinely perform a sigmoidoscopy or colonoscopy in symptomatic patients even younger than Patient B. Making no effort to track down the cause of this patient's persistent symptoms was gross negligence.

That being said, the Hearing Committee believes it important to note that Respondent has good relationships with many of these patients, patients who relied and continue to rely upon him for medical care and for a consistent and caring presence in their lives. It is clear that this Respondent has medical skills of value to the community in which he practices. It would be unfortunate to have to remove this caring physician from the community.

SPECIFICATIONS AND CHARGES

The Hearing Committee voted unanimously as follows:

1. The Respondent committed professional misconduct as defined in NY Education Law Section 6530(4), Gross Negligence, based upon the facts set forth in paragraphs B and B.3. The Second Specification is sustained.
2. The Respondent committed professional misconduct as defined in NY Education Law Section 6530(3) by practicing the profession of medicine with negligence on more than one occasion, based upon the facts set forth in:

   Paragraphs A and A1, A and A2, A and A3, A and A5, A and A6, A and A8, A and A9, and A and A10, Paragraphs B and B1, B and B2, B and B4, B and B5; Paragraphs C and C1, C and C2, C and C3, C and C4; Paragraphs D and D1, D and D3, and D and D4; Paragraphs E and E1, E and E2; Paragraphs F and F1, F and F2, F and F3, F and F4, F and F5, F and F6, F and F7; Paragraphs G and G1, G and G2, G and G3, G and G4, G and G5, G and G7, and G and G8.

   The Fourth Specification is sustained.

3. Specifications 9 through 15 charging medical misconduct by failure to maintain an accurate patient record are sustained, based on the facts set forth in paragraphs A and A11, B and B7, C and C5, D and D5, E and E3, F and F8, and G and G9 of the Statement of Charges.

4. Paragraph D2 was withdrawn; Paragraph A4 was withdrawn; Paragraph G 6 was withdrawn.

5. Specifications 5, 6, 7, and 8 charging Gross Incompetence and Incompetence on more than one occasion are not sustained.

PENALTY

The Hearing Committee, taking into consideration and carefully weighing all the evidence presented in this case, has concluded unanimously that a punishment consistent with Respondent's misconduct must include suspension of his license to practice medicine in New York State for a meaningful period. However, the Committee believes that the Respondent would benefit greatly from a period of probation, to include participation in an appropriate educational program, as specified in the Terms of Probation document annexed to this ORDER. Further, during the three-year probationary period, Respondent's practice shall be overseen by a practice monitor.

ORDER

Based upon the foregoing, it **is hereby ORDERED THAT:**

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for three (3) years from the date of this **ORDER.**

2. The **SUSPENSION SHALL BE STAYED,** commencing six months from the date of this **ORDER.**

3. Upon expiration of the **SUSPENSION,** concurrent with the **STAY,** the Respondent shall serve **a three (3) year period of PROBATION.** The terms of this probation are annexed to this **ORDER.**

4. This **ORDER** shall be effective immediately upon service upon Respondent.

DATED: New York, New York
September 10, 2003

MICHAEL R. GOLDING, M.D., CHAIR
JOHN W. CHOATE, M.D.
JAMES P. MILSTEIN, ESQ.

Terms of Probation

1. Respondent shall submit written notification to the New York state Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC) Hedley Park Place, 433 River St., Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions, or disciplinary actions by any local, state or federal agency, institution, or facility, within thirty days of each such action.
2. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC, as requested by the Director.
3. The period of probation shall be tolled during periods in which the Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC in writing if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon the Respondent's return to practice in New York State.
4. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records, and/or hospital charts, interviews with or periodic visits with the Respondent and his staff at practice locations or OPMC offices.
5. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.
6. Respondent shall enroll in and complete continuing education programs including but not limited to hypertension, diabetes management, use of anti-coagulants, and the management of osteoporosis, to be equivalent to at least 25 credit hours of Continuing Medical Education, over and above the recommended minimum standards set by the American Academy of Family Practice. Said continuing education program shall be subject to the

prior written approval of the Director of OPMC and be completed within the period of probation.

7. Respondent shall practice medicine during the three-year probationary period only when monitored by a licensed physician, board certified in family practice, proposed by the Respondent and subject to the written approval of the Director of OPMC.

   A. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice on a random unannounced basis at least monthly and shall examine a selection of records maintained by the Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with generally accepted standards of professional medical care. Any perceived deviation from accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

   B. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   C. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   D. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy years, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice, after the six-month suspension provided in the Order.

8. Respondent shall comply with all terms, conditions, restrictions, limitations, and penalties to which he is subject pursuant to the Order, and shall assume and bear all costs related to compliance. Upon receipt of evidence of non-compliance with, or any violation of these terms, the Director of OPMC and/or the Board of Professional Medical Conduct may initiate a violation of probation proceeding and/or any other such proceeding against Respondent as may be authorized pursuant to law.

APPENDIX I

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

IN THE MATTER

OF

ALAN S. LEVIN, M.D.

STATEMENT

OF

CHARGES

ALAN S. LEVIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 16, 1977, by the issuance of license number 132312 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified by name in Appendix A hereto) during the period including January 2, 1985 to January 11, 1995 at his office located in Glenville, New York for hypertension and diabetes, among other conditions. Respondent's care of Patient A deviated from accepted standards of medical care in the following respects.

1. Respondent failed to adequately evaluate Patient A for complications of diabetes.
2. Respondent failed on various occasions to adequately evaluate Patient A for cardiovascular risk factors.
3. Respondent failed to adequately evaluate and/or treat Patient A's legs and/or feet.
4. Respondent failed to adequately treat Patient A's diabetes.
5. Respondent, on various occasions, failed to take an adequate history from Patient A.

6. Respondent, on various occasions, failed to perform an adequate physical examination and/or order indicated diagnostic testing for Patient A.

7. Respondent failed to timely diagnose Patient A's grade II/VI heart murmur.

8. Respondent failed to adequately treat and/or monitor Patient A's elevated cholesterol.

9. Respondent failed to perform adequate follow-up evaluations of Patient A's solar keratosis.

10. Respondent, on various occasions, failed to adequately evaluate Patient A's hypertension.

11. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B during the period of March 19, 1996 to September 19, 1999 at his office and Ellis Hospital, Schenectady, New York for diarrhea and rectal bleeding, among other medical conditions. Respondent's medical care of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate medical history from Patient B.

2. Respondent, on various occasions, failed to perform an adequate physical examination on Patient B.

3. Respondent, on various occasions, failed to order appropriate diagnostic tests to evaluate Patient B's rectal bleeding.

4. Respondent failed to timely re-evaluate Patient B following his complaints of blood in stool on April 29, 1999.

5. Respondent failed to perform an adequate rectal examination on Patient B.
6. Respondent failed to adequately evaluate Patient B for complications attendant to the concurrent use of Indomethacin and Coumadin.
7. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C during the period of October 24, 1990 to June 21, 2001 at his office and at Ellis Hospital for diabetes and diabetic ketoacidosis, among other conditions. Respondent's care of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately and/or timely monitor Patient C's diabetes during the period from 1990 through 1992.
2. Respondent failed to adequately evaluate Patient C for complications of diabetes.
3. Respondent failed to adequately and/or timely monitor Patient C's liver enzymes during treatment with Rezulin.
4. Respondent failed to adequately monitor and/or treat Patient C's diabetic ketoacidosis.
5. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent provided medical care to Patient D during the period of October 21, 1991 to June 1, 2001 at his office and Ellis Hospital for diabetes and hyperlipidemia, among other conditions. Respondent's care of Patient D failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient D for diabetes and/or for the complications of diabetes.
2. Respondent failed to timely diagnose Patient D's diabetes.

3. Respondent failed to adequately monitor Patient D's diabetes.

4. Respondent, on various occasions, failed to adequately evaluate Patient D's liver function.

5. Respondent failed to maintain an accurate medical record for Patient D.

E. Respondent provided medical care to Patient E during the period of March 3, 2000 to July 24, 2001 at his office and Ellis Hospital for hypertension, urinary frequency and osteoporosis, among other conditions. Respondent's medical care of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient E's renal function.

2. Respondent failed to adequately evaluate, treat and/or manage Patient E's osteoporosis.

3. Respondent failed to maintain an adequate medical record for Patient E.

F. Respondent provided medical care to Patient F during the period of April 14, 1989 to September 21, 2001 at his office and at Ellis Hospital for anxiety, attention deficit disorder, and hyperlipidemia, among other conditions. Respondent's medical care of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately follow-up on complaints and/or findings made at an April 14, 1989 evaluation of Patient F.

2. Respondent failed to adequately evaluate and/or treat Patient F for the risk of pulmonary embolus. Patient F had a history of pulmonary emboli, as revealed in a history given by the patient in April, 1989.

3. Respondent failed to perform a follow-up chest x-ray after May 25, 1990.

4. Respondent, on various occasions, failed to adequately evaluate Patient F for psychiatric conditions, including, but not limited to, performing inadequate histories and/or physical examinations.
5. Respondent, on various occasions, inappropriately prescribed Valium to Patient F.
6. Respondent prescribed Ritalin to Patient F without appropriate medical indications.
7. Respondent failed to adequately monitor Patient F's anticoagulant therapy on February 21, 2001, during a hospital admission.
8. Respondent failed to maintain an adequate medical record for Patient F.

G. Respondent provided medical care to Patient G during the period of August 1, 1995 to May 25, 2001 at his office and at Ellis Hospital for osteoporosis and edema, among other conditions. Respondent's medical care of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent, on various occasions, failed to take an adequate medical history from Patient G.
2. Respondent, on various occasions, failed to perform an adequate physical examination on Patient G.
3. Respondent failed to adequately evaluate Patient G for osteoporosis.
4. Respondent, on various occasions, failed to adequately evaluate Patient G's complaints of back pain.
5. Respondent failed to adequately monitor Patient G while treating her with Darvocet.
6. Respondent failed to adequately evaluate Patient G's edema.
7. Respondent failed to adequately monitor Patient G while treating her with Hydrochlorothiazide.

8. Respondent failed to adequately evaluate Patient G and/or rule out various pathologies during Patient G's May 8, 2001 hospital admission.

9. Respondent failed to maintain an adequate medical record for Patient G.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts set forth in paragraphs A and A.1, and/or A and A.3.
2. The facts set forth in paragraphs B and B.3.
3. The facts set forth in paragraphs C and C.4.

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

4. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, and/or G and G.8.

FIFTH THROUGH SEVENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

5. The facts set forth in paragraphs A and A.1, and/or A and A.3.

6. The facts set forth in paragraphs B and B.3.

7. The facts set forth in paragraphs C and C.4.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

8. The facts set forth in two or more of the following paragraphs: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, A and A.10, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, F and F.7, G and G.1, G and G.2, G and G.3, G and G.4, G and G.5, G and G.6, G and G.7, and/or G and G.8.

NINTH THROUGH FIFTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

9. The facts set forth in paragraphs A and A.11.

10. The facts set forth in paragraphs B and B.7.

11. The facts set forth in paragraphs C and C.5.

12. The facts set forth in paragraphs D and D.5.

13. The facts set forth in paragraphs E and E.3.

14. The facts set forth in paragraphs F and F.8.

15. The facts set forth in paragraphs G and G.9.

DATED: December 31, 2002
Albany, New York

Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

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

IN THE MATTER

OF

ALAN S. LEVIN, M.D.

----------X

STATEMENT OF REPLACEMENT PANEL MEMBER

I, John W. Choate, M.D., affirm under penalty of perjury, that I have read and considered the evidence and transcripts of all the proceedings prior to my service on the panel in this matter, and that consequently I am fully qualified and prepared to serve on the hearing committee in place of Theresa Briggs, M.D.

John W. Choate, M.D.

Dated: 7/09/03