Public

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

IN THE MATTER

OF

HARVEY PHILIP INSLER, M.D.

COPY

DETERMINATION

AND

ORDER

BPMC #05-176

A Notice of hearing, dated January 13, 2005, and an Amended Statement of Charges, dated January 24, 2005, were served upon the Respondent, **HARVEY PHILIP INSLER, M.D.** **STEPHEN W. HORNYAK, MD.**, Chairperson, **ROY M. SCHOEN, M.D.** and **RUTH HOROWITZ, Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee ("the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **FREDERICK ZIMMER, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The **NEW YORK STATE DEPARTMENT OF HEALTH** ("the Department" or "the Petitioner") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **ANN GAYLE, ESQ.**, of Counsel. The Respondent appeared by **WOOD & SCHER, ANTHONY Z. SCHER, ESQ.**, of Counsel.

Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Answer Filed	January 26, 2005
Pre-Hearing Conference	February 9, 2005
Witnesses for Petitioner	Joseph Anthony Bosco III, M.D., Frank Butera, M.D.
Witnesses for Respondent	Paul Goldiner, M.D., Harvey Philip Insler, M.D., Joseph Fetto, M.D.
Hearing Dates	February 9 and April 8 and 15, 2005
Deliberation Date(s)	June 17, 2005

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Harvey Philip Insler, M.D. ("Respondent") is charged with five specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). Specifically, Respondent is charged with

practicing the profession of medicine with negligence on more than one occasion,

and with failing to maintain a record which accurately reflected his care and treatment of a patient.

These charges concern allegations regarding Respondent's treatment of Patient A during Patient A's hospitalization of September 14, 2001 through October 14, 2001 at Lincoln Medical and Mental Health Center. Factual Allegations A.2 and A.3 were withdrawn by the Department during the course of the hearing. A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix I.

Respondent admitted in his Answer that he treated Patient A at Lincoln Medical & Mental Health Center but otherwise denied the Factual Allegations and Specifications contained in the Amended Statement of Charges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These

citations refer to evidence found persuasive by the Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Department and Respondent, respectively, the Committee hereby makes the following Findings of Fact:

1. **HARVEY PHILIP INSLER**, the Respondent, was authorized to practice medicine in New York State on April 10, 1981 by the issuance of license number 145724 by the New York State Education Department, and has a current registration address of 99 Quentin Roosevelt Boulevard, Garden City, New York 11530-4818 (Dept's Ex. 2).
2. On September 14, 2001, Patient A, a male born on September 13, 1954, was admitted to Lincoln Medical and Mental Health Center through the emergency room with a diagnosis of a fractured right tibial plateau. Patient A's overall health status was poor. He was suffering from end stage cirrhosis of the liver (Dept's Ex. 3, pgs. 183, 302-306; Bosco, T. 28-31; Butera, T. 167).
3. To meet the minimum standard of care, a record must be kept for patients seen by physicians. Findings must be documented so that the physician who wrote the notes and other physicians can read the chart and see what the physician's thoughts and opinions were. The pertinent facts, findings, opinion, and plan must be noted for each visit (Bosco, T. 51-52).

4. "Attending of record" means the attending physician who is in charge of the patient. (Bosco, T. 125-126).

5. At the time of Patient A's hospitalization, Respondent's company, Signature Health Care, provided every aspect of orthopedic care for all orthopedic patients in Lincoln Hospital. Only orthopedists who worked for Signature provided orthopedic care at Lincoln Hospital. Physician assistant/specialist assistants who were employed by Lincoln Hospital, and physician's assistants who were employed by Signature, also provided orthopedic care at Lincoln Hospital (Butera, T. 161-165; Insler, T. 275-278).

6. The orthopedic service at Lincoln Hospital was called to address Patient A's orthopedic injuries. The duties and responsibilities of the physician assistants/ specialist assistants involved in the care and treatment of Patient A were to provide daily care and assistance for his surgical and non-surgical care. The duties of Respondent and his employee, Dr. Butera, were to provide surgical and non-surgical daily care for the patient, sign the physician assistant/specialist assistants' notes, and supervise the pool of physician assistants/specialist assistants (Butera, T. 167-171).

7. Dr. Butera was the attending physician for Patient A from the time of his admission to the orthopedic service until Patient A underwent surgery on October 4, 2001. Dr. Butera countersigned virtually every physician assistant/specialist assistant note beginning on Patient A's admission to the orthopedic service until October 4th, 2001. Because physician assistant/specialist assistant notes were to be countersigned every 48 hours, Dr. Butera would commonly flip backwards in the chart to see if there were notes that had not been countersigned during the days when neither he nor Respondent had seen the patient, and countersign any such notes. Therefore, some

notes countersigned by Dr. Butera were written on a daily basis but were not countersigned by him on a daily basis (Dept's Ex. 3, pgs. 34-95; Butera, T. 201-212, 242-243; Insler, T. 279-284, 296-298, 378-381).

8.

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11. Respondent did not countersign the physician assistant/specialist assistant notes for Patient A and did not share joint responsibility for Patient A prior to October 5, 2001 (Insler, T. 279-284, 296-298, 378-381).

12. On October 4, 2001, Dr. Butera performed an irrigation and debridement ("I&D") of an ulcer on Patient A's right lower extremity. I&D is a procedure in which the wound is opened, necrotic tissue is removed, and the wound is irrigated. A post-operative note described diagnoses of "Right venous stasis ulcer with purulent drainage, proximal fascial plane tracking of infection with abcess, necrosis, and destruction of posterior tibial tendon and posterior tibialis muscle belly." (Dept's Ex. 3, p. 208-212; Butera, T. 58-59).

13. Respondent expressed, in a verbal agreement with Dr. Butera, that he would handle the next procedure (Butera, T. 179-182, 190, 228).

14. After countersigning a post-operative note of Friday, October 4 and writing a note on October 5, Dr. Butera did not countersign Patient A's notes which was contrary to Dr. Butera's practice prior to October 5th of countersigning the physician assistant/specialist assistant notes for Patient A (Dept's Ex. 3, pgs. 34-95 particularly pgs. 93 and 95; Butera, T. 182-186, 222-224).

15. On the weekend of October 6th, Respondent was the on-call physician responsible for the care of Patient A (Butera, T. 183-184, 224).

16. Standard guidelines of orthopedic surgery required prompt additional I&D and exploration procedure(s) following the October 4th surgery. The minimum standard of care for infected wounds requires serial debridement procedures every two days until the wound is clean because it is impossible at the initial surgery to ascertain with certainty which tissue is alive, which is dead, and which tissue that looks alive will subsequently die. For a patient like Patient A, whose ability to fight infection was compromised by his liver disease, the need for serial debridement procedures was heightened because his infection could not be cured with one I & D. Therefore, to meet the minimum standard of care, subsequent to the surgery of October 4th, Patient A, who was now Respondent's patient, should have received serial debridement procedures every two days until the wound was clean. If the additional I&D and exploration procedure(s) were not done every 48 hours, there should have been a complete inspection charted so that subsequent physician observers could determine why the I & D did not occur (Dept's Ex. 3; Bosco, T. 48-51; Butera, T. 181).

17. Respondent failed to meet the minimum standard of care in that he did not perform the required serial debridement procedures or otherwise document acceptable medical reasons for not performing the serial debridement procedures (Dept's Ex. 3; Bosco, T. 48-52).

18. Respondent's next contact with Patient A was on October 10, 2001 when Respondent performed an I&D upon Patient A with repair of iatrogenic vein injury. The I&D was performed on October 10, 2001 because Patient A was septic and had persistent wound drainage and systemic infection. This surgery was originally scheduled for October 9th, but was cancelled because the patient ate. This was an urgent procedure;

i.e., falling between an elective procedure and an orthopedic emergency (Dept's Ex. 3 p. 114, 222-223; Bosco,T. 58-59, 105-106; Butera, T. 186-187).

19. To meet the minimum standard of care, a physician must evaluate a patient prior tc performing surgery upon the patient. It is impossible to do an adequate job surgicall without first examining the patient. The evaluation must include the patient's medica history and a physical examination. To meet the minimum standard of care, the evaluation that was done must be noted in the patient's chart. Even patients who are already under anesthesia, prepped and draped, can be examined when they are asleep. When unusual circumstances prevent the physician from writing a preoperative note, to meet the minimum standard of care, the physician must note the extenuating circumstances in the chart (Bosco, T. 54-56, 131-132, 142-145; Insler, T. 362-363; Fetto, T. 446-447).

20. Respondent did not evaluate Patient A prior to performing the surgery of October 10th upon him. The consent form, dated October 9, 2001, on pages 9 and 10 of the chart (see Patient A's medical record, Dept's Ex. 3) listed Respondent and Dr. Butera as the physicians given permission to perform the surgery. Respondent signed the consent form on page 10 and included the last four digits of his social security number. The consent form on pages 9-10 did not constitute a preoperative evaluation of Patient A. Nor did the consent forms on pages 17 and 18. The lack of a preoperative evaluation in Patient A's chart is not strictly a charting issue; it also reflects the standard of care for the care and treatment of this patient because there is no preoperative history and physical, no documentation thereof, and no notes for several days either written or countersigned by Respondent who had assumed the care of Patient A (Dept's Ex. 3, p. 9-10, 17, 18, 222-223; Bosco, T. 56-58, 131-133; Insler, T. 311-316, 362-363).

21.

22.

23.

24. Respondent had not examined Patient A's knee prior to the surgery which was a deviation from the standard of care ((Dept's Ex. 3; Bosco, T. 56-58, 131-133; Insler, T. 311-316, 362-363).

25. An October 10, 2001 note on page 119 of Patient A's medical record which reads, in part, "general surgery ICU team will manage the patient while in ICU" was in effect a note transferring Patient A to the intensive care unit (Dept's Ex. 3, p. 118-119; Insler, T. 334-337, 375, 403-404).

26. Respondent then wrote an October 11th 2001 note which read "Events of chart reviewed w/thanks. Pt under surg/trauma care for the moment. Agree w/ need for AK in view of sepsis". It was not beneath the standard of care for Respondent not to write further notes after October 11th when Patient A had been transferred to the surgical ICU. This was particularly so in light of the impending amputation of Patient A's right lower extremity ("AK" referred to amputation of knee) (Dept's Ex. 3, p. 127; Bosco, T. 113-117, 128-131; Insler, T. 334-337, 375, 403-404).

27. On October 11, 2001, Patient A had a through-knee transarticular amptutation in the Surgical Intensive Care Unit, and he expired on October 14, 2001 (Dept's Ex. 3, pg. 147, Bosco, T. 74).

DISCUSSION

Respondent is charged with specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. This memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law ", sets forth suggested definitions for, among other things, negligence,

The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It

involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding (Id.).

The Committee first considered the credibility of the various witnesses presented by the parties. Joseph Bosco, M.D., testified as an expert witness for the Department. Dr. Bosco was credible, knowledgeable and conversant with his field of medicine. He answered most questions directly although the Committee believed he was slightly evasive in his efforts to establish the Department's points. Respondent's expert, Joseph Fetto, M.D., was, also, slightly evasive when making Respondent's key points. Dr. Fetto was generally knowledgeable, however, and the Committee found both experts credible while recognizing that they interpreted the same facts differently.

Frank Butera, M.D., who worked for Respondent testified as to his involvement with this case. Two members of the Committee believed Dr. Butera to be less than credible. They found that he did not give clear answers to direct questions and that his credibility was compromised because he was compelled to testify. One Committee member viewed Dr. Butera as a more credible witness than Respondent, due to Respondent's interest in the case. This Committee member viewed Dr. Butera as having done penance as a result of having been previously sanctioned by the Department in connection with the Patient A case. Therefore, this Committee member found Dr. Butera somewhat believable and not as evasive a witness as Respondent.

With regard to Respondent's testimony, the Committee concluded that while he was credible in the medical sphere, he phrased his answers in a way to benefit his position and, at times, seemed to lack a sense of truthfulness when asked direct questions. In non-medical areas, his testimony was self-serving and dismissive of his responsibility.

The Committee found Dr. Goldiner who testified on behalf of Respondent, to be credible but concluded that the points he made were not critical to the Committee's conclusions.

GENERAL CONCLUSIONS

FACTUAL ALLEGATION A

The Committee sustains Allegation A that Respondent treated Patient A, a male born on September 13, 1954, during Patient A's hospitalization at Lincoln Medical & Mental Health Center, Bronx, New York, and that during the patient's hospital stay, Respondent failed to render appropriate care and treatment to Patient A, who had necrotizing fascitis of the lower extremity.

Two Committee members believed that Respondent assumed responsibility for Patient A's care only following the October 4, 2001 surgery in which Respondent agreed to assume responsibility for the next procedure upon Patient A and after Dr. Butera wrote the October 5th, 2001 note. Factual Allegation A is, therefore, sustained only to the extent that it relates to the care Respondent provided to Patient A after October 5, 2001. The Committee did not conclude that Respondent's evaluation of Patient A on September 24, 2001 was indicative that he was Patient A's attending physician at that time but rather that Respondent was called in for an evaluation on the specific issue of Patient A's swollen calf on that date. One Committee member concluded that Respondent was Patient A's attending physician prior to October 4, 2001 relying on pages 292-293 of Patient A's medical record (Dept's Ex. 3).

FACTUAL ALLEGATION A.4

Factual Allegation A.4 alleges that following the October 4, 2001 surgery, Respondent failed to adequately perform serial debridement procedures upon Patient A. The Committee unanimously sustains this allegation.

The Committee sought to determine which physician was responsible for Patient A's care following the October 4th surgery and notes that there is nothing in Patient A's medical

record which indicates that he was transferred to Respondent's care prior to October 10, 2005. In fact, Dr. Butera countersigned a note in Patient A's chart on October 4 and wrote his own note on October 5. However, he did not countersign any notes for Patient A after October 5, 2005 or write any more notes. After considering all the circumstances, the Committee did not view Dr. Butera's countersignature of the October 4th note and his October 5th note as convincing evidence that he continued to be responsible for Patient A's care following the October 5th note.

Respondent held primary responsibility for Patient A at least during the forty eight hour weekend period of October 6-7, 2001. The Committee found Dr. Butera to be credible when he testified that Respondent and the physician assistants would have been responsible for Patient A's care that weekend. Dr. Butera's habit was to countersign the physician assistant notes and the Committee believed it was logical that he would have continued to do so had he still been responsible for Patient A's care. Additionally, the Committee notes that Dr. Butera's testimony that Respondent was responsible for rounds during the weekend of the 6th and 7th was not addressed by Respondent. It was difficult for the Committee to believe that under all of the above circumstances, Respondent was not responsible for Patient A's care during the weekend.

The Committee concluded that Respondent was accountable for Patient A's care following Dr. Butera's note on the 5th of October. Respondent needed to supervise the physician assistants/specialist assistants and countersign their notes during periods he was responsible for Patient A and at least during the October 6th and 7th period. However, there were no countersignatures to the physician assistant/specialist assistant notes by Respondent during the entire October 6th through October 9th period, and Respondent, himself, did not write any notes pertaining to Patient A during the entire October 6th through

October 9th period. In fact, Respondent basically conceded that he had little contact with Patient A until the October 10th surgery.

At very minimum the standard of care required that Patient A be evaluated every forty eight hours to determine if he needed serial debridement. The Committee concludes based on the medical record and all of the above circumstances, that no debridement procedures were performed by Respondent or by the physician assistant/specialist assistants under his supervision. In the absence of debridements, there should have been at least, some documentation that an evaluation had been performed and a determination made that no debridement was necessary.

Respondent's failure to perform the debridements, in the absence of any documented medical justification for dispensing with the debridements, represented a significant and serious deviation from acceptable medical standards which presented the risk of potentially grave consequences to Patient A. In this regard, the Committee noted Dr. Bosco's testimony that Patient A was in liver failure and would, therefore, have problems eradicating infections. Respondent should have been aware of the risk that Patient A's infection could not be cured with one debridement, and that Patient A should have been brought back serially because of his inability to fight infection due to his liver disease. The Committee concludes that Respondent's omissions placed Patient A at risk for potentially grave consequences

FACTUAL ALLEGATION A.5

Factual Allegation A.5 alleges that Respondent inappropriately failed to evaluate Patient A prior to performing the surgery of October 10, 2001 upon him, or to note such

evaluation in the chart if he did evaluate Patient A prior to the surgery. The Committee unanimously sustains this allegation.

In sustaining this allegation, the Committee accepted the testimony of the Department's expert, Dr. Bosco, that the minimum standard of care requires that a physician evaluate a patient prior to performing surgery upon that patient. Even Respondent's expert, Dr. Fetto conceded that the "standard of care is that you would like to have examined the patient before an operation" (T. 447). The Committee discounted Respondent's testimony that he felt it inappropriate to examine Patient A while the patient was asleep.

Respondent conceded that he had not examined Patient A prior to the October 10, 2005 surgery (T. 363). The Committee believed that by not examining Patient A pre-operatively, Respondent could not visualize the patient's whole leg prior to the surgical procedure. Had Respondent visualized the entire leg, findings could potentially have been elicited which could have affected the course of the surgery. While the Committee is cognizant that Respondent received Patient A for surgery after the patient was already asleep, it, also, doubts Respondent's testimony that he was unaware prior to October 10th that he would be operating. The Committee concluded that Respondent knew he would be operating on Patient A by the day before the surgery, October 9th. In this regard, the Committee gave great weight to the Informed Consent Progress Note, dated October 9, 2001, signed by Respondent along with the last four digits of his social security number (Dept's Ex. 3, pg. 10, Insler, T. 159-160).

The Committee does not sustain that part of Factual Allegation A.5 which charges that Respondent failed to note the evaluation in the chart if he did indeed evaluate Patient A prior to the surgery. Because Respondent acknowledged that he did not examine Patient

A prior to the surgery, he could not have noted the particulars of that evaluation in Patient A's record. However, as noted in A.7 below, the Committee does find that if Respondent determined that he could not do a pre-operative evaluation, he should have noted in the record.the reasons why he was not evaluating the patient.

The Committee, therefore, concludes that the facts alleged in A.5 constitute negligence only with regard to the failure to perform an evaluation.

FACTUAL ALLEGATION A.7

Factual Allegation A.7 alleges that Respondent failed to maintain a record which accurately reflects the care and treatment provided to Patient A. The Committee sustains this allegation as both negligence and as a record keeping violation.

The Committee accepted Dr. Bosco's testimony that the lack of a pre-operative evaluation in Patient A's chart was not strictly a charting issue but reflected upon the standard of care, and that findings must be documented by a physician so that other reviewing physicians can ascertain what the evaluating physician was thinking (Bosco, T. 51-52, 57-58). Even patients who are sleeping can be evaluated and if unusual circumstances arise which prevent the evaluating physician from writing a pre-operative note, the physician should note what happened in the chart and the extenuating circumstances. Respondent's explanation that he wanted to avoid compromising the hospital, and Dr. Butera who was reluctant to perform the surgery, was not found tenable by the Committee.

The Committee, therefore, sustains this allegation as both negligence and as record keeping. As noted previously, the Committee concluded that Respondent failed to conduct a pre-operative evaluation prior to the October 10th surgery. If in Respondent's judgment, a pre-operative evaluation was not feasible because Patient A was asleep or for other reasons, Respondent should have noted that judgment and the reasons therefore.

With regard to the October 6-9 period, the Committee concluded that Respondent did not provide any care for Patient A during the October 6-9 period (see above). With regard to the question of whether the lack of documentation by Respondent during that period constituted a failure to maintain a record of his evaluation and treatment of the patient, the Committee was instructed by the Administrative Law Judge that the record did indeed reflect Respondent's evaluation and treatment of the patient, since the record accurately reflected that no care and treatment were provided.

CONCLUSIONS AS TO SPECIFICATIONS

Based upon the above Findings and Conclusions, the Committee sustains the following Specifications, as follows;

First Specification (negligence on more than one occasion) – based upon sustained Factual Allegations A, A.4, A.5 and A.7.

Fifth Specification (failure to maintain records) – based upon sustained Factual Allegations A and A.7.

DETERMINATION AS TO PENALTY

The Committee unanimously concludes that imposition of a censure and reprimand along with a five year period of probation during which a practice monitor will perform a quarterly review of Respondent's medical records, is an appropriate penalty.

The Committee's determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L §230-a, including:

> (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license to a specified area or type of practice; (4) Revocation of the license; (5) Annulment of the license or registration; (6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service, and (10) Probation.

The Committee believes that Respondent may have been careless with regard to his care of Patient A but that he is not incompetent. Consequently, remedial measures would not be of help in his case. Nor was a monetary penalty deemed appropriate. The Committee also noted that Respondent's care was questioned only with regard to one patient and that the events occurred in 2001. Consequently, more severe penalties such as revocation, limitation of Respondent's license, suspension or a stayed suspension were not imposed.

ORDER

IT IS HEREBY ORDERED THAT:

1. The **FIRST, THIRD AND FIFTH SPECIFICATIONS** are hereby **SUSTAINED;**

3. Respondent is hereby **CENSURED AND REPRIMANDED**; and
4. Respondent is hereby placed on **PROBATION** for a period of **FIVE YEARS** subject to the Terms of Probation, attached to this Determination and Order, as Appendix A; and
5. This **DETERMINATION AND ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law section 230(10)(h).

DATED: Staten Island, New York
August 15 **, 2005**

STEPHEN W. HORNYAK, M.D.
Chairperson
ROY M. SCHOEN, M.D.
RUTH HOROWITZ, Ph.D.

EXHIBIT 1

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

IN THE MATTER

OF

HARVEY PHILIP INSLER, M.D.

AMENDED STATEMENT OF CHARGES

HARVEY PHILIP INSLER, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 10, 1981, by the issuance of license number 145724 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a male, d.o.b. 9/13/54, during his hospitalization of 9/14/01 to 10/14/01 at Lincoln Medical & Mental Health Center, Bronx, New York. During his hospitalization, Respondent failed to render appropriate care and treatment to Patient A, who had necrotizing fascitis of the lower extremity as follows:

4. Following the surgery of October 4, 2001, Respondent failed to adequately perform serial debridement procedures upon Patient A.

5. Respondent inappropriately failed to evaluate Patient A prior to

performing the surgery of October 10, 2001 upon him, or to note such evaluation in the chart if he did evaluate Patient A prior to the surgery.

7. Respondent failed to maintain a record for Patient A which accurately reflects the care and treatment provided to Patient A.

SPECIFICATION OF CHARGES

FIRST 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:

1. Paragraphs A A4, A5, and/or A7.

FOURTH AND FIFTH 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:

5. Paragraphs A and A7.

DATED: January 24, 2005
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Appendix A
Standard Terms of Probation
All Orders

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

2. Respondent shall submit written notification to the New York State Department o Health, addressed to the Director, Office of Professional Medical Conduct (OPMC) Hedley Park Place, 433 River Street Suite 303, 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 action.

3. 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.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal o permits or licenses [Tax Law Section 171(27); State Finance Law Section 18; CPLR Section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is no 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 Respondent's return to practice in New York State.

6. 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 Respondent and his staff at practice locations or OPMC offices.

7. 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.

8. Within thirty (30) days of the effective date of the Order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by 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 at each and every location, on a random unannounced basis at least quarterly and shall examine a selection (no less than twenty five) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of 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 year, 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 effective date of this Order.

   e. 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 noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

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