STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

June 24, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jerry Bush, P.A.
R.D. 1 Box 115a
Hornell, New York 14843

Chauncey J. Watches, Esq.
13 West Main Street
Canisteo, New York 14823

Kevin P. Donovan, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2438
Albany, New York 12237

Effective Date: 7/1/94

RE: In the Matter of Jerry C. Bush, P.A.

Dear Mr. Bush, Mr. Watches and Mr. Donovan:

Enclosed please find the Determination and Order (No. 94-90) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the

Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER

OF

JERRY C. BUSH, P.A.

Respondent

DETERMINATION

AND

ORDER

OF THE

HEARING COMMITTEE

NO. BPMC-94-90

This matter was commenced by a Notice of Hearing and Statement of Charges, both dated March 1, 1994, which were served upon **JERRY C. BUSH, P. A.** (hereinafter referred to as "Respondent"). **STANLEY D. LESLIE, M.D., Chairperson, DONALD F. BRAUTIGAM, M.D., and TRENA DeFRANCO**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JONATHAN M. BRANDES, ESQ.**, Administrative Law Judge, served as the Administrative Officer. A hearing was held on April 20, 1994 at the offices of the New York State Department of Health, Corning Tower, Albany , New York. The State Board For Professional Medical Conduct appeared by **KEVIN P. DONOVAN, Esq.**, Associate Counsel. Respondent appeared in person and by **CHAUNCEY J. WATCHES, ESQ.** Evidence was received and witnesses sworn and heard. A transcript of these proceedings was made.

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

STATEMENT OF CASE

This case was brought pursuant to Public Health Law Section 230(10)(p). This statute provides for an expedited hearing where a licensee is charged solely with a violation of Education Law Section 6530(9) In such cases, a licensee is charged with misconduct based upon a prior criminal conviction in New York or another jurisdiction, or upon a prior administrative adjudication regarding conduct which would amount to professional misconduct, if committed in New York. The scope of an expedited hearing is limited to a determination of the nature and severity of the penalty to be imposed upon the licensee.

In the instant case, Respondent is charged with professional misconduct pursuant to Education Law Section 6530 (2), practicing the profession beyond its authorized scope; 6530 (4) practicing the profession with gross negligence and 6530 (3) practicing the profession with negligence on more than one occasion. A Copy of the Notice of Referral Proceeding and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The Committee adopts the factual statement set forth on pages one and two of the Statement of Charges (Appendix I) as its findings of fact and incorporates them herein.

CONCLUSIONS

The State has satisfied its burden of proof with regard to the factual allegations herein. Indeed, Respondent admits he wrote an order for an excessive amount of insulin, that he did not contact and review the order with the attending physician and that he did not adjust the order when questioned by other staff members about it. Furthermore, Respondent was found to have commited these acts in a prior proceeding before the Department of Health. The question presented then is whether any of the acts established constitute medical misconduct. Respondent is charged with acting beyond his license, gross negligence, and simple negligence on more than one occassion. After reviewing the evidence, the Committee sustains two acts of simple

negligence. In so finding, the Committee considered the following facts significant.

This patient had been receiving Humulin N 48 units and Humulin R, 60 units at the hospital, prior to her admission to Respondent's care. Later, the patient's dose had been adjusted to 16 units of insulin, again, prior to her transfer to Respondent's care. It is this last amount, 16 units, which Respondent should have written his orders for. The Committee further finds Respondent thought he had written the order for 16 units of insulin (a sizable but safe amount) when in fact he had written his order for 60 units (an excessive amount). When other staff members mentioned that the insulin order was high, Respondent understood them to be referring to the 16 units rather than the 60 units. The Committee is convinced that had Respondent been informed that the amount was 60 and not 16, the Committee is confident Respondent would have corrected the order.

Nevertheless, Respondent had a duty to review the order when questioned by his colleagues. Part of the checks and balances in medical facilities is the review of patient orders when other staff members question a dose. When this paradigm is followed, it ensures that the kind of error which occurred here is caught. Respondent's failure to review the order when questioned by others is one act of negligence. Writing the order in error is also an act of negligence.

With regard to the other charges, the Committee finds that while a serious lapse in care, the error made by Respondent was not without extenuating circumstances and cirtainly did not rise to the level of eggregious conduct. Hence, no gross negligence is found. With regard to the allegations Respondent acted beyond the scope of his license, the Committee finds that under the protocols of the facility, Respondent had no duty to contact the patient's physician at the time he wrote the orders. Respondent had no questions as to the correct dose, he simply mis-wrote it. Therefore, the Committee finds no evidence that Respondent acted outside the scope of his license.

Under all the facts and circumstances the Committee finds two clear acts of simple negligence on the part of Respondent: He had a duty to write the order correctly and review same when a possible error was brought to his attention. He failed in both these regards. Nevertheless, the Committee believes that other staff members must share some of the blame for the plight of this patient. Certainly, the nurses working with Respondent noticed the very large amount of insulin.

Any one of them could have called the error to Respondent's attention by refusing to give such a large dose or by contacting the physician on call or simp;y recitint the numbers to Respondent and hence bringing them to the attention of Respondent. This failure by others, while not exonerating Respondent, contributes to a picture which would have been quite different had not part of the system of checks and balances failed.

In addition to the above, the Committee was favorably impressed by Respondent's forthright acceptance of full responsibility for the entire event. The Committee believes that Respondent has learned from this event and will be disposed to greater care in the future. Given the nature of the offense, the punishment suffered by Respondent and his forthright manner, the Committee believes that no further punishment is warranted. Still, the two acts of negligence cannot be overlooked. Accordingly, the Committee believes that Censure and Reprimand will serve the best interests of Respondent and the public.

ORDER

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

1. The Factual allegations in the Statement of Charges is **SUSTAINED.**

Furthermore, it is hereby ordered that;

2. With regard to a finding of negligence on more than one occassion, the Specification of Misconduct contained within the Statement of Charges (Petitioner's Exhibit #1) is **SUSTAINED**;
3. Respondent be subject to a **CENSURE AND REPRIMAND.**

Dated: Fayetteville, New York:

14 June, **1994**

STANLEY D. LESLIE, M.D., chairperson

DONALD F. BRAUTIGAM, M.D.
TRENA DeFRANCO

TO:

kevin P. Donovan, Esq.
Associate Counsel
N.Y.S. Department of Health
Corning Tower,
Albany, New York 12237

Chauncey J. Watches, Esq.
13 West Main St.
Canisteo N.Y. 14823

Jerry Bush, .P.A.
R. D. 1 Box 115 a
Hornell, N.Y. 14843

APPENDIX I

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
JERRY C. BUSH, P.A.	:	CHARGES

----------X

JERRY C. BUSH, P.A., the Respondent, was authorized to practice as a physician's assistant in New York State on November 18, 1974, by the issuance of registration number 239 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice as a physician's assistant for the period from January 1, 1993, through December 31, 1995, with a registered address of RD #1, Box 115A, Hornell, New York 14843.

FACTUAL ALLEGATIONS

A. By Order of the Commissioner of New York State Department of Health dated May 5, 1993, Respondent was found to have written an order for a patient for an excessive amount of insulin; to have failed to contact and review the order with the patient's attending physician as required by the facility's policy and procedures; and to have failed to adjust the amount of insulin ordered for the patient after being notified by various members of the nursing staff of the high amount of

insulin ordered and of the patient's low blood sugar level resulting in the patient being required to be hospitalized after becoming hypoglycemic, all in violation of New York Public Health Law Section 2803-d, and there being no appeal pending in this matter.

B. The above violations would constitute professional misconduct pursuant to New York Education Law Section 6530, namely practicing the profession beyond its authorized scope as defined in New York Education Law Section 6530(2) (McKinney Supp. 1994), practicing the profession with gross negligence as defined in New York Education Law Section 6530(4) (McKinney Supp. 1994), and practicing the profession of negligence on more than one occasion as defined in New York Education Law Section 6530(3) (McKinney Supp. 1994).

SPECIFICATION OF MISCONDUCT

The Respondent is charged with misconduct as defined in New York Education Law 6530(9)(c) (McKinney Supp. 1994) of having been found guilty in an adjudicatory proceeding of violating a state statute pursuant to a final decision or determination and when no appeal is pending, or after resolution of the proceeding by stipulation in agreement, and when the violation would constitute professional misconduct pursuant to New York Education Law Section 6530, as defined in New York

Education Law 6530(9)(c) (McKinney Supp. 1994) in that Petitioner charges:

1. The facts of Paragraphs A and B.

DATED: Albany, New York
March 1, 1994

Peter D. Van Buren

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