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

August 15, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Evangelos A. Catsoulis, M.D.
REDACTED

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5 Penn Plaza, 6th Floor
New York, New York 10001

RE: In the Matter of Evangelos A. Catsoulis, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. #02-250) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has

been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above. As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:djh

Enclosure

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

COPY

IN THE MATTER

OF

EVANGELOS A. CATSOULIS, M.D.

DETERMINATION
AND
ORDER
BPMC 02 - 250

ELEANOR KANE, M.D., (Chairperson), NAOMI GOLDSTEIN, M.D., and JAMES DUCEY duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by CLAUDIA MORALES BLOCH, ESQ., Associate Counsel.

Respondent, EVANGELOS A. CATSOULIS, M.D., appeared personally and was represented by LA BARBERA & LAMBERT, P.C. by ALAN LAMBERT, M.D., ESQ., of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	January 15, 2002
Date of Statement of Charges:	January 15, 2002
Date of Answer to Charges:	February 13, 2002
Date of Amended Statement of Charges:	February, 2002
Date of Amended Answer to Amended Charges:	February 19, 2002
Pre-Hearing Conference Held:	February 26, 2002
Hearings Held: - (First Hearing day):	March 05, 2002 April 15, 2002 April 23, 2002 May 06, 2002 May 30, 2002
Intra-Hearing Conference Held:	May 06, 2002
Department's Proposed Findings of Fact, Proposed Conclusions of Law and Proposed Sanction:	Received June 26, 2002
Respondent's Brief:	Received June 26, 2002
Witness called by the Petitioner, Department of Health (in the order they testified):	Joseph A. Markenson, M.D. Carole Leavey, R.N.
Witnesses called by the Respondent, Evangelos A. Catsoulis, M.D.	Evangelos A. Catsoulis, M.D. Ariel Distenfeld, M.D. John Hosnedl, R.N. John L. Xethalis, M.D. Robert Holtzman, M.D.
Deliberations Held: (last day of Hearing)	July 23, 2002

STATEMENT OF CASE

The State Board for Professional Medical Conduct 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 ["P.H.L."]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" or "**Department**") pursuant to §230 of the P.H.L.

Evangelos A. Catsoulis, M.D., ("**Respondent**") is charged with six (6) specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: (1) practicing the profession with gross negligence[1]; practicing the profession with gross incompetence[2]; (3) practicing the profession of medicine fraudulently[3]; and (4) failing to maintain a record for a patient which accurately reflected the evaluation and treatment of the patient[4].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct towards one patient[5] and responses to an application for reappointment to the medical staff of Cabrini Medical Center.

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[1] Education Law §6530(4) - (see also the First Specification of the Amended Statement of Charges [Department's Exhibit # 2]).

[2] Education Law §6530(6) - (see also the Second Specification of the Amended Statement of Charges [Department's Exhibit # 2]).

[3] Education Law §6530(2) - (see also the Third through Fifth Specifications of the Amended Statement of Charges [Department's Exhibit # 2]).

[4] Education Law §6530(32) - (see also the Sixth Specification of the Amended Statement of Charges [Department's Exhibit # 2]).

[5] Patient A is identified in the Appendix annexed to the Amended Statement of Charges (Department's Exhibit # 2).

Respondent denies all factual allegations contained in the Amended Statement of Charges and all Specifications of Misconduct.

A copy of the Amended Statement of Charges and a copy of the Amended Answer are attached to this Determination and Order as Appendix I and II respectively.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

General Findings

1. Respondent was licensed to practice medicine in New York State on October 7, 1968 by the issuance of license number 102576 by the New York State Education Department (Department's Exhibits # 2 and # 3)[6].

[6] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Evangelos A. Catsoulis (Respondent's Exhibit #).

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent accepted service and had no objection regarding personal jurisdiction); (P.H.L. §230[10][d]); [P.H.T-11-14][7].

Patient A

3. Patient A was admitted to Lenox Hill Hospital on June 6, 1999 under the care and treatment of Respondent. Respondent was the attending physician for Patient A on admission and throughout the patient's hospitalization (Department's Exhibits # 6 & # 7); [T-41-42, 423].

4. Respondent claims that Patient A was a long standing friend as well as an intermittent patient of Respondent. Respondent claims a significant amount of care was given to Patient A by a V.A. Hospital [T-422].

5. Patient A complained of knee pain to Respondent and he was referred by Respondent for surgery to Dr. John Xethalis, an orthopedic surgeon. Dr. Xethalis found that Patient A had peripheral vascular disease complicated by skin which was not intact. Dr. Xethalis could not undertake a big operation like a total knee replacement in the presence of peripheral vascular disease complicated by skin which was not intact; thus he told Respondent that the ulcers had to heal first [T-859-860, 872-873].

6. Respondent, as Patient A's attending physician, had the ultimate responsibility for the management of the patient's care [T-55, 650].

7. Patient A was admitted to Lenox Hill Hospital for treatment of peripheral vascular disease, osteoarthritis of both knees, swollen leg, draining fistula, bilateral leg edema, questionable cellulitis and an open ulcer over his leg (Department's Exhibit # 6); [T-41-42, 423, 754-755].

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[7] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

8. Following Doppler studies and an Ultrasound of Patient A's lower extremities, a diagnosis of non-occlusive thrombus in the right sural vein was made (Department's Exhibit # 6); [T- 42-44].

9. On admission, Patient A gave a history of taking the following medications: Ecotrin (aspirin), Allopurinal, Cardura and Lasix. This medication history is in Patient A's Lenox Hill Hospital medical record, ("**medical record**") both on the intern's admission note, co-signed by Respondent, and on the patient information data form. Respondent claims he read the admission note (Department's Exhibit # 6); [T-42-46, 273-277, 427, 491-493].

10. The admitting medication orders included an order for Ecotrin, 325 milligrams. Patient A was started on Ecotrin on June 6, 1999[8], the day of admission, and continued on a daily dose through June 22, 1999 without ever being discontinued by Respondent. Ecotrin, 325 milligrams was renewed for Patient A on June 18, 1999 (Department's Exhibit # 6 @ pages 16, 23, 193. 195 & 198); [T-46-49, 68, 273-277].

11. Respondent claims he did not know that Patient A was on Ecotrin, which was continued on admission to Lenox Hill Hospital [T-429-431].

12. If Respondent had reviewed the admitting orders when he first saw the patient, as is required of an attending physician, he would have know that Patient A was receiving Ecotrin and should have taken him off the Ecotrin (Department's Exhibit # 6); [T-497].

13. Respondent should have been aware that Patient A was taking Ecotrin and its effect on anticoagulation therapy. However Respondent testified that he did not know this (Department's Exhibit # 6); [T-271-272, 486-490, 656].

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[8] First dose given June 7, 1999.

14. Standard practice dictates that the attending physician know the medication his patient is on. Minimally accepted standard of practice requires that the attending physician admitting a patient to a hospital review the medication that the patient is on and determine whether or not any of the medications should be continued given the patient's condition [T-293, 655].

15. Respondent's expert, Dr. Distenfeld, agreed that the attending physician has the responsibility to be aware on a daily basis of the care and treatment being rendered his patient and to assure that the patient is getting the correct medication [T-652].

16. An attending has a responsibility to review order sheets and medication sheets. Had Respondent done so in this case, he would have noted exactly what medications the patient was receiving (Department's Exhibit # 6); [T-652-653].

17. From the fact that Respondent did not at any time discontinue the Ecotrin, and that the Ecotrin was renewed on June 18, 1999, it can be concluded that Respondent either did not understand the use of Ecotrin or never looked at the record (Department's Exhibit # 6); [T-658].

18. Respondent had the responsibility to discontinue the Ecotrin [T-658-659].

19. On June 18, 1999, another order for Ecotrin, 325mg was given. Respondent did not counter this order and allowed Patient A to remain on Ecotrin through June 22, 1999. It was a gross departure from minimally accepted standards of care for Patient A to remain on Ecotrin and for Respondent to allow the continuation of said medication (Department's Exhibit # 6); [T-68-69, 79].

20. Once a diagnosis of a non-occlusive thrombus in the right sural vein was made, the appropriate treatment was to start the patient on anti-coagulation therapy, typically with a form of Heparin and Coumadin, and to discontinue the Ecotrin. Patient A was started on Subcutaneous ("Sub Q") Heparin and continued on Ecotrin (Department's Exhibit # 6); [T-48-49, 65].

21. Both the physician order sheets and the medication sheets document that Sub Q Heparin, 5000 units Q12, was ordered on the day of admission, June 6, 1999, and discontinued the next day, June 7, 1999, at or about 3:50 p.m. Patient A was given only two (2) doses of Sub Q Heparin (June 6th at 10:00 p.m. and June 7th at 10:00 a.m.) (Department's Exhibit # 6); [T-50-51].

22. When the Sub Q Heparin was discontinued on June 7, 1999, Lovenox, 135 milligrams ("mg.") Sub Q was ordered, but never administered since on that same date the order was changed to Lovenox, 80mg. Sub Q, Q12. According to the medication sheets, Lovenox 80mg. was given for the first time at 10:00 p.m. of June 7, 1999. Patient A was continued on two (2) doses daily of Lovenox, 80mg. Sub Q, from June 7, 1999 through and including June 22, 1999 (Department's Exhibit # 6); [T-50-53, 272].

23. Lovenox is a low molecular weight form of Heparin. Lovenox is a preferred anti-coagulant to Heparin when needed over a long-term period because it requires less monitoring then Sub Q Heparin. Lovenox is a safe, effective medication for the treatment of deep vein thrombosis [T-53-54].

24. Minimally acceptable practice requires that an attending physician, seeing a patient for the first time in the hospital, obtain a history from the patient, conduct a physical examination of the patient and note his findings in the medical record of the patient. The attending physician has an obligation to review the hospital record completely at the time he first sees the patient [T-56-57, 76-77, 267-268].

25. Other than co-signing the admission note, in Patient A's medical record, written by a resident, the patient's medical record is void of information from Respondent that he personally obtained an adequate history from the patient. The record is also void of information from

Respondent that he personally conducted an appropriate physical examination, either prior to or subsequent to admission (Department's Exhibit # 6); [T-76-78, 269-270,278-280].

26. Maintaining an accurate medical record, including progress notes, orders and medication administration records, is essential to patient care in that it provides for communication among physicians and other health care providers, documents thought process, and provides up to date information for anyone caring for a patient at any given time as to what has been ordered for the patient, what has been given the patient, the time medication is administered and the overall status of the patient. This standard of care applies in the hospital setting to attending physicians as well as residents, interns and nurses [T-57-59, 659].

27. In addition to the order sheets, the fact that the patient was being given Lovenox was noted in the progress notes of the chart by a nurse on June 7, 1999 ("Lovenox given as ordered") and by an intern on June 8th, 9th, 10th and 11th. After each and every one of the entries by the intern, Respondent also made a note in the chart (Department's Exhibit # 6); [T-61-63, 297-299, 661-662].

28. On June 9, 1999, Patient A was started on Coumadin; however, neither the Lovenox nor the Ecotrin was discontinued. In fact, the patient was maintained on all three medications: Coumadin, Lovenox and Ecotrin, from June 9, 1999 through June 22, 1999. Minimally acceptable standards of care require that, when starting a patient on Coumadin, a complete review of medications should be made, especially with respect to other anticoagulation therapy the patient is receiving (Department's Exhibit #6); [T-63-64, 296-297, 660].

29. Respondent failed to review the medications Patient A was being given prior to starting Coumadin [T-296-297].

30. It was a gross departure from minimally accepted standards of care for Respondent to have maintained Patient A on Coumadin, Lovenox and Ecotrin simultaneously and for such a long period of time. The appropriate treatment should have been to discontinue the Ecotrin and maintain the patient on Coumadin and Lovenox until the Coumadin was found to reach therapeutic levels in the patient, at which time the Lovenox should have also been discontinued [T- 64-66, 133, 265-267, 650].

31. Respondent did not agree that maintaining the patient on Aspirin, Coumadin and some form of Heparin, be it Heparin or Lovenox, was inappropriate [T519-520].

32. Therapeutic levels of Coumadin in a patient are reached when the patient's INR level reaches between 2 and 3. An INR level is only affected by Coumadin and is not an indicator of levels of anticoagulation by other medications, such as Lovenox or aspirin (Ecotrin) [T-72-75, 150-151].

33. On June 14, 1999, Respondent personally wrote an order to discontinue the subcutaneous Heparin. At the time Respondent wrote this order, the patient was not receiving subcutaneous Heparin, since it had already been discontinued by an order of June 7th. The fact that the patient was no longer on Heparin as of June 14th and was receiving Lovenox, was clearly documented in Patient A's medical record (Department's Exhibit # 6); [T-66-68, 294-296].

34. Contrary to Respondent's testimony, an order to start or discontinue subcutaneous Heparin is not interchangeable with an order to start or discontinue Lovenox. The two drugs are distinctly different. An assumption otherwise is incorrect [T-439-440, 522-528, 662-663].

35. Between June 14th and June 22nd, 1999, Respondent was unaware that Patient A was continued on and being given Lovenox in addition to Coumadin and Ecotrin [T-440].

36. Regardless of whether house staff is available in a hospital setting, the attending physician has an obligation to review the complete chart for a patient, including drug history for the patient and medication sheets documenting the medication the patient is currently receiving [T-261-263, 325-326].

37. It is the attending physician's responsibility to supervise the house staff and assure that the care received by the patient is appropriate and that the information contained in an intern's note is accurate [T-485-486, 650, 652-653].

38. On June 19, 1999, an order was written to renew Lovenox 80mg Q12. Respondent did not at any time counter this order and allowed Patient A to remain on Lovenox through June 23, 1999 (Department's Exhibit # 6); [T-69, 78, 667-668].

39. If Respondent had appropriately reviewed Patient A's medical record, he would have noted that the Lovenox was renewed and should have then discontinued it. It was a departure from minimally accepted standard of care for Respondent to have failed to discontinue the Lovenox once that order to renew it had been written [T-668-669].

40. Maintaining Patient A on three anticoagulation medications, as was done by Respondent, dramatically and dangerously increased the risk of the patient bleeding. The failure to discontinue the Lovenox and the Ecotrin after the INR had reached a therapeutic level was a gross departure from minimally accepted standards of care [T-73-74].

41. Patient A died on June 24, 1999 at 8:30 a.m. from a retro peritoneal hemorrhage directly caused by an inappropriate anticoagulation regimen (Department's Exhibit # 6); [T-79-82].

42. Respondent practiced at Lenox Hill Hospital for approximately 27 years. During that time period, Lenox Hill Hospital was his primary affiliation. Respondent was familiar with the

organization of the Lenox Hill Hospital medical records, including knowing where nurses maintained a record of the medications given a patient [T-481-484].

43. Regardless of the organization of a chart, the minimally accepted standard of care requires a comprehensive review of a patient's medical record by the attending physician, including a daily look at the medication record, especially in a case involving anticoagulation therapy [T-181-183, 261-262, 306-307, 421, 669-670].

44. An intern's note made on June 23, 1999, at 6:30 a.m. states, "Multiple attempts made to contact Dr. Catsoulis via his service since 4:50 a.m. No call back. Will continue to attempt to contact him and will sign out to day intern." (Department's Exhibit # 6); [T-329-335].

45. Respondent failed to maintain a record for Patient A in accordance with minimally accepted standards and in a manner which accurately reflected the care and treatment of the patient (Department's Exhibit # 6); [T-337-339].

46. Ms. Carole Leavey, an associate risk manager, first became aware of Patient A, in the afternoon of June 23, 1999. Ms. Leavey received a call in the risk management department of Lenox Hill Hospital, from the head nurse on the floor that Patient A had been on anti-coagulant therapy and was being transferred to ICU to rule out a retroperitoneal bleed. The morning of June 24, 1999, Ms. Leavey received a call from a resident that Patient A had died of a retroperitoneal bleed. At that point, she went to the ICU, retrieved Patient A's medical record and made a copy of it. She then had the original patient record hand delivered to the bed control unit in the admitting department of Lenox Hill Hospital [T-354-357].

47. Later in the afternoon of June 24, 1999, Ms. Leavey went to the bed control unit where she saw Respondent sitting at a desk provided for physicians to work at, writing in Patient A's medical record [T-361].

48. At the time Respondent modified Patient A's medical record, he did not know that Ms. Leavey had already made a copy of the medical record [T-571-572].

49. When Ms. Leavey saw Respondent writing in Patient A's medical record, she specifically noted that he was writing on a note that was dated June 14, 1999; which was not the current date, but rather about 10 days prior [T-361].

50. Ms. Leavey advised Respondent that he could not write on an existing note, but rather, if he needed to add anything, write an addendum at the end of the progress notes with the current date on it. Respondent declined Ms. Leavey's offer to discuss the matter in the risk management department and left the bed control unit [T-361-362, 394-395].

51. Ms. Leavey made a copy of the June 14, 1999 note that she saw Respondent writing on, and compared it with the copy of the original medical record she had made earlier in the day. She discovered that Respondent had added to the original note (Department's Exhibits # 6, # 7 and # 10); [T-363-365].

52. On receipt of the original medical record, around July 7, 1999, Ms. Leavey compared it with the copy she had made on the morning of June 24, 1999, just after Patient A's death. On review, she noted that there were additional alterations made to Patient A's medical record. These alterations are admitted to by Respondent and highlighted in Department's Exhibit # 10 (Department's Exhibit # 10); [T-368-372, 452-453, 564-565].

53. The accepted standard of practice for making additions to a medical record is to date the additional entry with the current date and write it as an addendum at the end of the progress notes. To correct an error made in an existing note, the accepted practice is to draw a line through the error, write the correction, sign and note the date the correction was made [T-83-84, 395-396, 690-691, 852-853].

54. The modifications and additions to entries in Patient A's medical record made by Respondent were made by him in notes where there was space enough to fit an addition before his signature line, or add a new note in an available space sequentially, as if the note was written contemporaneously (Department's Exhibit # 10); [T-566-568, 691].

55. The modification to the June 14, 1999 order wherein Respondent added the word "Lovenox" to his order to discontinue subcutaneous heparin, was an attempt by Respondent to convince others who would review the medical record that Respondent was active and knowledgeable about the care that had been provided to Patient A. Respondent modified the medical record in places where Respondent knew the medical record was deficient. The impact of the modifications was an attempt to shift the blame for Patient A's death from over anti-coagulation therapy away from Respondent and on to the nursing and resident staff (Department's Exhibits # 6, # 7 and # 10) [T-689-690, 856-867].

Applications to Cabrini Medical Center

56. On April 14, 1997, Respondent was found guilty, after a Jury Trial, of "Assault 3rd degree in violation of Section 120.1 of the Penal Law of the State of New York" (should be §120.00[1]). On June 9, 1997, Respondent was sentenced to 30 days incarceration, 3 years probation, 3 year Order of Protection for wife, daughter & grandson, and restitution of $1,700 + 5% surcharge (Department's Exhibit # 4).

57. Respondent admitted that he had been found guilty and that he understood this to be a criminal conviction [T-469].

58. On August 20, 1997 Respondent signed an application for 1998-1999 reappointment to the Medical staff of Cabrini Medical Center ("Cabrini"). In this 1997 application, Respondent

checked the box "No" to question # 13: "Except for violations, have you been convicted of committing an act constituting a crime under New York State Law ..." (Department's Exhibit # 5); [T-470-472, 581-582].

59. On August 5, 1999 Respondent signed a reappointment application for years 2000-2001 to the Medical staff of Cabrini. In this 1999 application, Respondent checked the box "No" to question # 13: "Except for violations, have you been convicted of committing an act constituting a crime under New York State Law ..." (Department's Exhibit # 5); [T-473-474].

60. On April 8, 1998 Respondent was served with disciplinary charges from the State Board for Professional Medical Conduct ("SBPMC"). The disciplinary charges involved the 1997 criminal conviction. After a Hearing, the SBPMC dismissed the disciplinary charges in the interest of justice. This dismissal was affirmed by the Administrative Review Board of the SBPMC. The SBPMC Determination and Order did not change or alter Respondent's criminal conviction of 1997 (Respondent's Exhibit # G).

61. On August 20, 1998 Respondent signed an application for reappointment to the Medical staff of Lenox Hill Hospital for 1999-2000. In this 1998 application, Respondent wrote "yes appeal pending see attach letter ..." to question # 1: "Have you ever been convicted of a crime or have criminal charges been brought against you in New York State or any other jurisdiction?" (Respondent's Exhibit # K); [T-475-477, 581-583].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Amended Statement of Charges were by a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that all of the Factual Allegations, except for paragraph A.4., contained in the February, 2002 Amended Statement of Charges are **SUSTAINED.**

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee unanimously concludes that the FIRST through SIXTH SPECIFICATIONS[9] contained in the Amended Statement of Charges are **SUSTAINED.**

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with six (6) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct, which constitute professional misconduct. However, §6530 of the Education Law does not provide definitions or explanations of some of the types of misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were mostly obtained from the memoranda submitted by the Department, entitled: Definitions of Professional Misconduct under the New York Education Law [10]. Respondent's legal arguments contained in Respondent's Brief were considered as well. During the course of its deliberations on these charges, the Hearing Committee entertained the following instructions from the ALJ:

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must

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[9] The third through fifth specifications are incorrectly labeled as third and fifth specifications in the Amended Statement of Charges.

[10] A copy of this Memorandum was made available to both parties at the Pre-Hearing Conference [P.H.T-8-10].

establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits you find worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to you as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

Gross Negligence

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

Gross Incompetence

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

Practicing the Profession Fraudulently

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly

be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Catsoulis made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; (2) Dr. Catsoulis knew that the representation was false; and (3) Dr. Catsoulis intended to mislead through the false representation. The opinion of the medical experts of the occurrence of or non occurrence of fraud should be disregarded in total. The Hearing Committee is the sole arbiter of whether fraud occurred and must base its determination on the credible facts (including Respondent's testimony) and not on whether others believe that fraud occurred or did not occur.

For all other terms the Hearing Committee used ordinary English usage and their general understanding of those terms. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony.

With regard to the testimony presented, including Respondent's, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence The Hearing Committee understood that as the trier of fact we may accept so much of a witnesses' testimony as is deemed true and disregard what we find and determine to be false.

The Hearing Committee found Nurse Carole Leavey to be very credible, direct and believable. We found Dr. John Xethalis to be credible. As a friend of Respondent he was in an uncomfortable position. Dr. Xethalis clarified how and why Patient A was in the hospital. Respondent had sent Patient A to Dr. Xethalis in consultation for a knee replacement prior to

admission to Lenox Hill Hospital. Dr. Xethalis declined to perform surgery since Patient A's leg ulcers were too severe. This detail reinforced our conclusion that Respondent didn't even examine Patient A prior to sending him to Dr. Xethalis. Dr. Xethalis also reinforced both experts' opinions regarding the standards of practice for medical records and the distinction between Heparin and Lovenox.

The Hearing Committee found Dr. Joseph A. Markenson[11] to be credible in the medical information he provided. Dr. Markenson tried to "lean over backwards" to be fair to Respondent. He did some edging (in favor of Respondent's position) in what appeared to be clear cut situations. Dr. Markenson's initial conclusions, regarding the additions to the medical record by Respondent (Respondent's Exhibit # H), were given based on insufficient information. In any event those conclusions are not binding on the Hearing Committee. We found Dr. Markenson's expertise and experience to be more than sufficient for the medical allegations presented. The Hearing Committee also found Respondent's expert, Dr. Ariel Distenfeld[12], to be credible and straightforward. Dr. Distenfeld often sustained or bolstered the expert medical opinions provided by Dr. Markenson.

Respondent testified on his own behalf and clearly has an interest in the outcome of the case. We found some of the testimony presented by Respondent to be evasive, non-responsive at times, not credible at times and not supported by common sense or by Patient A's medical record.

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[11] Department's expert witness testified on 03/05/02 and 04/15/02 [T-29-192, 219-348].

[12] Respondent's expert witness testified on 05/06/02 [T-597-746].

Factual Allegations A.1. and A.2. - Sustained.

Patient A's medical record indicate that Respondent failed to appropriately perform and note a full and complete medical evaluation and review of Patient A's condition when Respondent first saw Patient A as well as throughout Patient A's hospitalization. Respondent also failed to review Patient A's medical record and medication sheets during Patient A's hospitalization.

Respondent acknowledged that he was responsible for the care and treatment of Patient A and for the medication to be provided to Patient A. However, Respondent then attempted to pass the blame or responsibility to others in the hospital, including the nurses, the interns, the residents, and/or the pharmacy. Respondent even altered the medical record of Patient A to specifically cast blame on the nursing staff. Respondent's words of acceptance of responsibility do not match his deeds or actions, both prior to the Hearing and at the Hearing.

The Hearing Committee has also inferred that Respondent never did a physical of Patient A before sending him to Dr. Xethalis. Even though Respondent testified that he examined Patient A just before referring him to Dr. Xethalis. If Respondent had done an examination, he would have seen Patient A's leg ulcers and sent him to the hospital rather than for an orthopedic consultation. Respondent also did not produce his own office records to show that he had performed a physical or clinical examination prior to Patient A's hospital admission. The failure by Respondent to perform a full and complete medical evaluation and clinical examination of Patient A at the first opportunity after admission was egregious conduct and a gross departure from minimally accepted standard of care.

Factual Allegations A.3. - Sustained.

Respondent failed to appropriately, and with the requisite medical knowledge, administer, monitor and manage the patient on anticoagulation therapy, and/or to note same, to wit: the use of Ecotrin 325mg, Heparin, Sodium Heparin, Lovenox and Coumadin.

Patient A should have been continued on Lovenox until therapeutic levels of Coumadin had been reached. Once that occurred, or within two or three days Lovenox should be discontinued. To do otherwise is to raise the risk of the patient bleeding. When Ecotrin is added to this formula the risk of bleeding is tripled and there is danger because a large percentage of the patient's platelets become inactive. Also Ecotrin takes longer to get out of the body's system so that the platelets can work again [T-70-74].

There is no question that Respondent failed to monitor or manage the care of Patient A. The fact that the intern's notes subsequent to admission, do not contain a reference to Ecotrin does not diminish Respondent's responsibility to have been aware that the patient was being given this medication from admission through June 22, 1999. The Hearing Committee was deeply concerned by Respondent's apparent total inattention to the care and treatment of Patient A. Respondent did not review or read Patient A's medical record during Patient A's hospital stay. The management of this patient was not esoteric medicine. The interactions of these drugs is well within common everyday medical practice. Although members of the hospital staff should also be held accountable, it is Respondent who bears the main burden. Respondent was supposed to be in charge and it is clear that he was not. Respondent was sloppy and inattentive.

In addition we believe that Respondent is grossly incompetent in his knowledge and administration of the drugs involved. Respondent still does not agree that maintaining the patient

on Aspirin, Coumadin and some form of Heparin, be it Heparin or Lovenox, was inappropriate. The medical record of a patient does not consist of only progress notes. In addition to being a gross departure from accepted standards of care, we finds that Respondent's admitted failure to realize that Ecotrin was ordered for Patient A and continued through June 22nd, evidences his failure to have reviewed the medical record. We found Respondent's testimony that, notwithstanding the fact that he admitted not seeing the patient on June 7th, he asked the intern to discontinue "normal molecular Heparin and to start on low molecular Heparin," not credible. If Respondent had issued such an order it would have been on the order sheets of Patient A's medical record. We find that Respondent did not review the hospital record for Patient A as he was obligated to do, since, if he had, he would have known that the patient was being given Lovenox and not Heparin. Respondent also failed to review the medications the patient was on prior to starting Coumadin. This failure by Respondent is further evidence of gross incompetence and gross negligence.

Factual Allegations A.4. - Not Sustained.

It is alleged that on or about June 23, 1999, Respondent did not timely respond to the house staff's attempts to reach him when Patient A's condition began to rapidly deteriorate. The Hearing Committee finds that the Department failed to prove this allegation by a preponderance of the evidence. The Department did not provide phone records or live testimony regarding this allegation. We do not sustain Factual Allegation A.4.

Factual Allegations A.5. - Sustained.

Respondent knowingly falsely altered the hospital medical record subsequent to Patient A's death, in that he made additional entries on pre-dated progress notes and order sheets.

When Respondent altered Patient A's medical record, subsequent to the patient's death, Respondent added the word, "Lovenox" to an order. This addition was done knowingly and was false. Respondent knew it to be false and Respondent made the alteration to mislead others who would be reviewing Patient A's medical record. We find that, in making additional entries on predated progress notes and order sheets, Respondent knowingly falsely altered Patient A's hospital medical chart subsequent to the patient's death. We find that Respondent made the alterations, especially the alteration to the June14,1999 order wherein he added the word "Lovenox" to his order to discontinue subcutaneous heparin, in an attempt to shift the blame for the patient's death from over anti-coagulation therapy away from him and to the nursing and resident staff. We determine that Respondent's actions in altering Patient A's medical record was fraudulent and evidenced gross incompetence and gross negligence.

Factual Allegations A.6. - Sustained.

Respondent failed to maintain a hospital record for Patient A in accordance with accepted medical standards and in a manner which accurately reflected his care and treatment of the patient.

A physician must record meaningful and accurate information in a patient's medical records, which accurately reflects the care and treatment of the patient, for a number of reasons. These reasons include: (1) for the physician's own use; (2) for the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient. The medical record of Patient

A is incomplete and inaccurate. The alterations made by Respondent alone are sufficient to sustain this charge. The medical record of Patient A are incomplete in that they fail to convey, to other health care professionals a treatment plan for the patient. Respondent did commit professional misconduct by failing to maintain records for Patient A which accurately reflected the care and treatment that he provided to Patient A.

Factual Allegations B.1. - Sustained.

In an application for 1998-1999 Reappointment to the Medical Staff of Cabrini Medical Center, completed and signed by Respondent on August 20, 1997, Respondent knowingly and falsely answered "No" to question # 13 on the application which asked, " Except for violations, have you been convicted of committing an act constituting a crime under New York State Law ... ".

Respondent was found guilty of committing a crime on April 14, 1997. On June 9, 1997 Respondent was sentenced to 30 days incarceration for the crime he committed. Respondent signed the 1997 application a little more than 3 months after he was sentenced for the crime he committed. Respondent's attempted explanations of the reasons for his negative answer are contrived and not believable. Respondent's answer to the 1997 application was false. Respondent knew his answer was false. Respondent intended to assure his reappointment and intended to mislead Cabrini when he answered "No" to question # 13.

Factual Allegations B.2. - Sustained.

In an application for 2000-2001 Reappointment to the Medical Staff of Cabrini Medical Center, completed and signed by Respondent on August 5, 1999, Respondent knowingly and falsely

answered "No" to question # 13 on the application which asked, " Except for violations, have you been convicted of committing an act constituting a crime under New York State Law ... ". See discussion directly above. Respondent's attempted explanations of the reasons for his negative answer are contrived and not believable. Respondent's answer to the 1999 application was false. Respondent knew his answer was false. Respondent intended to assure his reappointment and intended to mislead Cabrini when he answered "No" to question # 13.

Respondent is guilty of committing professional misconduct by practicing the profession of medicine with gross negligence. Respondent is guilty of committing professional misconduct by practicing the profession of medicine with gross incompetence. Respondent is guilty of committing professional misconduct by practicing the profession of medicine fraudulently. Respondent is guilty of committing professional misconduct by failing to maintain records for a patient which accurately reflected the care and treatment of that patient.

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above unanimously determines that Respondent license to practice medicine in New York State should be REVOKED.

This 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; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service; (10) Probation and (11) Dismissal in the interest of justice.

The Hearing Committee considered Respondent's actions and misconduct to be very serious. One of the foundations of the medical profession is " first do no harm". Respondent ignored this principle, as well as some of the basic premises of medicine (conducting a proper history and physical and reviewing medications being taken by the patient). Respondent's behavior towards Patient A from June 6, 1999 through June 23, 1999 demonstrated a reckless disregard for the welfare of Patient A.

We reviewed and considered the possibility of not revoking Respondent's license but believe any other penalty to be insufficient under the specific circumstances and total presentation of this case.

Respondent was not paying attention to the care and treatment he should have been providing to his friend and patient. On June 14, 1999, Respondent personally wrote an order to discontinue subcutaneous Heparin. However, at the time Respondent wrote this order, Patient A was not receiving subcutaneous Heparin, since it had already been discontinued by an order of June 7th, 1999. Respondent tried to convince the Hearing Committee that to "discontinue Heparin" was synonymous with "discontinue Lovenox" and that was what he meant when he wrote discontinue Heparin. As indicated by both experts, Lovenox and Heparin are two distinctly different drugs, albeit both are forms of Heparin. Respondent did not convince us, especially in light of the fact that one of the fraudulent alterations that Respondent made to the medical record was adding the word Lovenox after his order to discontinue Heparin. The fact that the patient was no longer on Heparin as of June 14th and was receiving Lovenox, was clearly documented in Patient A's medical record.

Between June 14th and June 22nd, 1999, Respondent was unaware that Patient A was continued on and being given Lovenox. Until June 23, 1999 Respondent did not know that Patient A was on Ecotrin which had been prescribed on the first day of admission and re-prescribed one

week later. We find Respondent's admission of his lack of knowledge about Patient A's medication status to be clear and compelling evidence of Respondent's blatant failure to review the medical record for his patient during this period of time. Respondent's failure to appropriately follow his patient, review the record and know the medications his patient was on represents a gross departure from accepted standards of care.

Respondent intentionally and deliberately altered Patient A's medical record. Respondent's actions would have never been noticed if a prior copy of the patient's medical record had not been obtained by risk management. Particularly egregious is Respondent's attempt, when he altered the medical record, to shift the blame of Patient A's death to others within the hospital - anyone but him. The alterations of the medical record, which is always a serious offense, is even more serious here because of Respondent's attempts to shift the blame to others, as he did throughout the Hearing.

We are convinced that Respondent is a danger to the public and should not be practicing medicine. Respondent does not currently have the skills necessary to practice minimally acceptable medicine. Patient A's death was avoidable and unnecessary. The Hearing Committee believes that the condition that Patient A presented on June 6, 1999 through his death on June 24, 1999 did not require an unusually high level of expertise or any particularly challenging medical knowledge. This was basic medicine. Therefore the Hearing Committee does not believe that suspension or retraining will be sufficient to protect the public.

We have reviewed the transcript, Patient A's medical record and all the exhibits and can find no evidence that Respondent is presently competent to do an adequate history and physical or to correctly manage the care and treatment of a patient under a similar situation.

The Hearing Committee concludes and determines that the findings of gross negligence, gross incompetence, failure to maintain a record of his care and treatment, Respondent's fraudulent acts on his reappointment application and his intentional acts of altering Patient A's medical record are more than enough justification to revoke Respondent's license to practice medicine in New York State. Respondent's fraudulent conduct not only evidences lack of veracity, but demonstrates his lack of integrity which is necessary for the practice of medicine.

Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. No other available sanction is deemed sufficient to address Respondent's acts of professional misconduct, to deter future misconduct, to protect the public and to adequately punish Respondent.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The FIRST through SIXTH SPECIFICATIONS contained in the Amended Statement of Charges (Department's Exhibit # 2) are **SUSTAINED**; and

2. Respondent's license to practice medicine in the State of New York is **REVOKED**; and

3. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
August, 14 **2002**

REDACTED

ELEANOR KANE, M.D., (Chairperson)
NAOMI GOLDSTEIN, M.D.
JAMES DUCEY

Evangelos A. Catsoulis, M.D.

REDACTED

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APPENDIX I

Evangelos A. Catsoulis, M.D.

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

IN THE MATTER

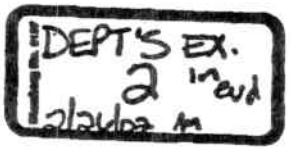
OF

EVANGELOS A. CATSOULIS, M.D.

AMENDED STATEMENT OF CHARGES

EVANGELOS A. CATSOULIS, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 7, 1968, by the issuance of license number 102576 by the New York State Education Department.

FACTUAL ALLEGATIONS



A. On or about June 6, 1999, Patient A (the identity of Patient A is set forth in the Appendix annexed hereto) was admitted to Lenox Hill Hospital, 100 East 77th Street, New York, N.Y., under the care and treatment of Respondent with a chief complaint of, inter alia, leg edema and cellulitis. On admission, a diagnosis of a deep vein thrombosis was made and the patient was started on anticoagulation therapy and I.V. antibiotics. Additionally, Patient A was continued on Ecotrin 325mg daily, which he had been taking prior to admission. Patient A died on or about June 24, 1999 from massive retroperitoneal bleeding plus bilateral hemorrhagic pleural effusions. In his care and treatment of Patient A, Respondent:

1. Failed to appropriately perform and/or note a full and complete medical evaluation and review of Patient A's condition and progress throughout the hospital course, including a review of the medical record and medication sheets.
2. Failed to perform and/or note his performance of a complete

physical/clinical examination and evaluation of Patient A.

3. Failed to appropriately, and with the requisite medical knowledge, administer, monitor and manage the patient on anticoagulation therapy, and/or to note same, to wit: the use of Ecotrin 325mg, Heparin, Sodium Heparin, Lovenox and Coumadin.
4. On or about June 23, 1999, failed to appropriately and timely respond to the house staff's attempts to reach him when Patient A's condition began to rapidly deteriorate.
5. Knowingly falsely altered the hospital medical chart subsequent to Patient A's death, in that he made additional entries on pre-dated progress notes and order sheets.
6. Failed to maintain a hospital record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Respondent knowingly falsely answered "No" to an application question which asked, "[H]ave you been convicted of committing an act constituting a crime under New York State Law," to wit:

1. In an application for 1998-1999 Reappointment to the Medical Staff of Cabrini Medical Center, completed and signed by Respondent on or about August 20, 1997.
2. In an application for 2000-2001 Reappointment to the Medical Staff of Cabrini Medical Center, completed and signed by Respondent on or about August 5, 1999.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

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 as alleged in the facts of the following:

1. Paragraphs A and A(1) through A(6).

SECOND SPECIFICATION

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:

2. Paragraphs A and A(1) through A(6).

THIRD AND FIFTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A(5) and A(6).
4. Paragraphs B and B(1).
5. Paragraphs B and B(2).

SIXTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2002) 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:

6. Paragraphs A(1), A(2), A(3), A(5) and A(6).

DATED: February , 2002
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Evangelos A. Catsoulis, M.D.

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

IN THE MATTER

OF

Evangelos A. Catsoulis, M.D.

RESPONDENT'S AMENDED ANSWER TO STATEMENT OF CHARGES

Respondent, Evangelos A. Catsoulis, M.D., by his attorneys, LaBarbera & Lambert, P.C., hereby responds to the Petitioner's factual allegations and specifications as follows:

FACTUAL ALLEGATIONS

A. Respondent respectfully refers the Hearing Committee to the Lenox Hill Hospital record for Patient A and denies any allegations in Paragraph A that the Petitioner alleges in support of the Specification of Charges.

A.1. Respondent denies factual allegation A.1.

A.2. Respondent denies factual allegation A.2.

A.3. Respondent denies factual allegation A.3

A.4. Respondent denies factual allegation A.4.

A.5. Respondent denies factual allegation A.5.

A.6. Respondent denies factual allegation A.6.

B. Respondent denies factual allegation B.

B.1. Respondent denies factual allegation B.1.

B.2. Respondent denies factual allegation B.2.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

Respondent denies committing gross negligence.

SECOND SPECIFICATION

Respondent denies committing gross incompetence.

THIRD THROUGH FIFTH SPECIFICATIONS

Respondent denies fraudulent practice.

SIXTH SPECIFICATION

Respondent denies a failure to maintain medical records.

Respectfully submitted,

Dated: February 19, 2002
New York, NY

Alan Lambert, Esq.
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