NEW YORK
STATE OF
OPPORTUNITY.
Department
of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 30, 2016

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Quist, Esq,
NYS Department of Health
ESP-Corning Tower-Room 2511
Albany, New York 12237

James D. Lantier, Esq,
Smith, Sovik, Kendrick & Sugnet, P.D.
250 S. Clinton Street – Suite 600
Syracuse, New York 13202

RE: In the Matter of David Adelson

Dear Parties:

Enclosed please find the Determination and Order (No.15-222) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah

Enclosure

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

In the matter of	
	Determination and Order
Mark David Adelson, M.D.	
	BPMC #16-222
regarding charges of violations of NYS Ed.L 6530	

Before a committee on professional conduct:

Gail Homick Herrling, Chair
John D. Thomas, II, M.D.
Edmund A. Egan, II, M.D.

John Harris Terepka, Administrative Law Judge

Held at: New York State Department of Health
217 South Salina Street
Syracuse, New York 13202
November 18, December 21, 2015; January 20, 27, February 15, 2016
Deliberations: April 19, 2016

Parties: New York State Department of Health
Bureau of Professional Medical Conduct
2511 Corning Tower
Empire State Plaza
Albany, New York 12237
By: David W. Quist, Esq.

Mark David Adelson, M.D.
By: James D. Lantier, Esq.
Smith Sovik Kendrick & Sugnet, P.C.
250 S. Clinton Street, Suite 600
Syracuse, New York 13202

JURISDICTION

As is set forth in Public Health Law 230(1)&(7) and Education Law 6530, the legislature created the State Board for Professional Medical Conduct (the Petitioner) in the Department of Health, and authorized it to conduct disciplinary proceedings in matters of professional medical conduct.

A notice of hearing dated October 9, 2015 (Exhibit 1), and an amended statement of charges dated November 16, 2015 (Exhibit 27), were served on Mark David Adelson, M.D. (The Respondent). A hearing before a committee on professional conduct (the hearing committee) was scheduled pursuant to PHL 230(10) and hearing procedures set forth in Department of Health regulations at 10 NYCRR Part 51. The burden of proof is on the Petitioner. 10 NYCRR 51.11(d)(6).

SUMMARY

Respondent Mark David Adelson, M.D. was authorized to practice medicine by the New York State Education Department on February 11, 1985 under license number 161388. (Exhibit 2.) The Respondent practiced in obstetrics and gynecology in the Syracuse, New York area.

The charges arise from medical care the Respondent provided to six patients in the Syracuse area between 2009 and 2013. The amended statement of charges made twenty-five "factual allegations" in support of six charges of misconduct. (Exhibit 27.) The Petitioner charged gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and failure to maintain records with regard to all six patients (Patients A-F). The Petitioner charged unwarranted tests/treatment with regard to three patients (Patients A, C, F).

The Petitioner essentially alleges the Respondent performed surgical procedures for which medical need was not established or documented, failed to adequately evaluate and treat patients, used inappropriate procedures, performed multiple procedures without first attempting more conservative measures, failed to perform appropriate testing, and failed to maintain adequate patient records. The Respondent denies any inappropriate care or recordkeeping.

The Petitioner withdrew factual allegations F4 and F5. The hearing committee unanimously sustains factual allegations D2 and D3, and finds that the Petitioner failed to meet its burden of proving the remaining twenty one factual allegations. The two sustained factual allegations, which criticize one medical decision, are insufficient to establish gross negligence or gross incompetence, or negligence or incompetence on more than one occasion, and so are insufficient to establish misconduct. The charges are accordingly dismissed. All findings were made by unanimous vote of the hearing committee.

HEARING RECORD

Witnesses for the Petitioner:	Daniel Kredentser, M.D. (1-411) Rachel Elder, M.D. (419-470)
Petitioner exhibits:	Exhibits 1-18, 18a-27, 30
Witnesses for the Respondent:	Mark David Adelson, M.D. (471-868) Brent DuBeshter, M.D. (2/15/16, 1-213)
Respondent exhibits:	Exhibits A-B
ALJ exhibits:	I

A transcript of the proceedings was made. (Transcript, pages 1-868; 2/15/16 pages 1-220.) Each side submitted one post hearing brief.

DISCUSSION

Credibility of witnesses

Dr. Krendentser, who testified for the Petitioner in support of the charges, was well qualified in the area of practice pertinent to this case, with significant and extensive surgical experience. (Transcript, pages 30-31; Exhibit 3.) The hearing committee did not reject his opinions about patient care. To the contrary, it found them to be credible and worthy of respect. To the extent the committee disagreed with Dr. Kredentser, it was on the grounds that Dr. Kredenster did not entirely distinguish between "best practices" and the minimum acceptable standard of care, having a tendency to view his opinion as being the same as the standard of care. This view taken by the committee is to some extent consistent with Dr. DuBeshter's comment that some of the concerns raised in this case would be more appropriately addressed as issues of quality assurance, as was done at Crouse Hospital with regard to other matters in 2013. (Transcript 2/15/16, pages 153-54; Exhibit 30.)

Dr. DuBeshter, testifying for the Respondent, was also well qualified. (Transcript, 2/15/16 pages 10-17; Exhibit B.) He gave greater deference to the treating physician's exercise of medical judgment and the recognition that tests that will not change treatment decisions are not always necessary and can sometimes give false results. The committee found Dr. Rachel Elder to be highly credible but her evidence had little impact on the committee's findings.

The committee concluded that Dr. Adelson was knowledgeable but had difficulty being objective about his patients, and difficulty in admitting error. He falsely claimed, for example, that a suspension and investigation of his surgical practices at Crouse Hospital was improperly motivated, and that it completely vindicated him. He claimed the motive was:

> a big push to get me to become a robotic doctor [that is, use robotic surgery techniques].... So this went on for a couple of years, that pressure... the University Department and Crouse were trying to move in that direction. So I was suspended for various claims that on review were all dropped. (Transcript, pages 505-506.)

The record of that suspension clearly establishes that the criticisms were not "dropped." The investigation concluded, to the contrary, that Crouse' concerns about the Respondent's inappropriate communication with other staff and its impact on patient care needed to be addressed by additional supervision and training. (Exhibit 30.) Characteristic of the Respondent's attitude was his testimony, immediately after claiming he was well-educated and well-trained in the practice of medicine:

> Q. Is it possible for a person well-educated in the practice of medicine to provide substandard care?
>
> A. I'm not sure what you mean. They're educated and they learn what they are supposed to learn, I don't think so.
>
> Q. You don't think it's possible for a well-educated person to provide substandard medical care?
>
> A. No.
>
> Q. Is it possible for a person well-trained in the practice of medicine to provide substandard care?
>
> A. So well-trained means properly trained?
>
> Q. Well-trained. Is it possible that they could still provide substandard care?
>
> A. Somebody is properly trained, learns what they are supposed to and does it, no. (Transcript, pages 575-76.)

The hearing committee gave greater weight to Dr. DuBeshter than to the Respondent, but gave equal weight to the opinions of Dr. DuBeshter and Dr. Kredentser. Giving equal weight to these two witnesses, the committee concluded that the Petitioner, having the burden of proof by a preponderance of the evidence, failed to meet it.

The factual allegations

The hearing committee concluded that the Petitioner did not meet its burden of proving the Respondent failed to maintain an adequate medical record, as was alleged for all six patients. (Allegations A3, B5, C3, D4, E3, F7.) Dr. DuBeshter's differences of opinion from Dr. Kredentser's were not based upon assumptions that care was provided that was not documented, but were instead based on the information he found in the charts. He said "the records were sufficient for us to collect all of this information." (Transcript 2/15/16, page 43.) These six factual allegations were not sustained. The other factual allegations are as follows:

Patient A (Exhibits 4-6.)

The Respondent provided medical care for Patient A, a 50 year old female, in November and December, 2012. He performed surgery, which included an omentectomy and right pelvic lymphadenectomy, on December 3, 2012. The Petitioner charges that the Respondent performed these procedures without first adequately evaluating the patient and documenting such an evaluation. (Allegation A1.) The Petitioner further charges that the procedures were performed without adequate medical indications. (Allegation A2.)

Dr. DuBeshter testified "I don't see where the medical record was insufficient." (Transcript, pages 30, 43.) The hearing committee agreed that the Petitioner has failed to meet its burden of proving that it was not adequate. The committee also agreed with Dr. DuBeshter that the decision to proceed with the surgery was a reasonable exercise of discretion in this case, and that the patient's documented anxiety about cancer in general, and specific requests for the procedures (Exhibit 5, page 80) were legitimate factors to take into account. While the committee agreed it would have been advisable to do a frozen section,

which was not done, it also agreed that since it was reasonable to proceed in this case without it, failure to do the frozen section was not negligence or incompetence.

The committee unanimously agreed that the Petitioner failed to meet its burden of proving failure or inadequate evaluation of the patient or to document an adequate evaluation and medical indication for the omentectomy and right pelvic lymphadenectomy, or to maintain an adequate medical record. Factual allegations A1, A2 & A3 were not sustained.

Patient B (Exhibits 7-9, 26.)

The Respondent treated Patient B from April 2010 until May 2013. He performed surgeries on March 15 and March 18, 2013, when the patient was age 49. The day after the March 15, 2013 hysterectomy performed by the Respondent, the patient complained of pain and vomiting. (Transcript, pages 125, 161; Exhibit 26, page 3.) She came to the hospital emergency room three days later, on March 18, 2013, with an infection. (Exhibit 26.) The Respondent performed surgery on March 19, and repaired a perforation of the colon. (Exhibit 8, pages 12-16; Transcript, page 129, 163.) In April, 2013, she required further surgery to repair the repair. (Transcript, page 131; Exhibit 7, pages 118, 1193-94.)

The March 15 surgery is not criticized. (Transcript, page 134.) The Petitioner's criticism is of the Respondent's care on March 18, when the patient returned with severe pain and indications suggesting a bowel injury. Dr. Kredentser said she should have been taken directly to the operating room when she first complained of pain, on the evening of March 18. (Transcript, pages 137.) The decision to do the surgery was not made until March 19, at 9:15 a.m. (Exhibit 7, page 1048.)

The Respondent evaluated the patient at 8 p.m. on March 18th and decided to wait until the next morning. This was not just the evaluation of Respondent: Dr. DuBeshter

pointed out that the patient was also seen and evaluated by emergency room personnel. (Transcript 2/15/16, page 75.) He said:

> Well, this all happened the same evening that she came to emergency. So I don't understand – I mean, he saw her, he had a plan of action developed so I don't see where he failed to inadequately treat her for what he was worried about... There wasn't any delay once there was sufficient concern. (Transcript, pages 77-79.)

The hearing committee agreed that the Petitioner failed to prove allegations B1and B2 and also concluded that the failure to go immediately to surgery on March 18 did not constitute negligence or incompetence.

The Petitioner also charges that when the Respondent did the bowel repair on March 19, he should have performed a laparotomy, or "open" surgery, not laparoscopy. (Transcript, pages 163, 172.) The hearing committee agreed with Dr. DuBeshter, who said the Respondent's decision was a reasonable approach that the doctor was comfortable with:

> You want to do the procedure that you think is going to take care of the problem the best way that you know how. For some doctors, that's going to be with an open surgery. For other doctors, it may be with a laparoscopic approach. (Transcript 2/25/16, pages 80-81.)

The Petitioner failed to establish the Respondent's approach violated the standard of care. Factual allegation B3 was not sustained.

The hearing committee also accepted Dr. DuBeshter's testimony that there was no failure to adequately inspect the bowel for other defects. (Transcript, page 82.) Dr. Kredenster's criticism was based upon his preference for open surgery. (Transcript, pages 142-43.) Factual allegation B4 was not sustained.

Factual allegation B5, regarding record keeping, was not sustained.

Patient C (Exhibits 10-12.)

The Respondent treated Patient C from January 2008 until April 2013. He performed surgeries on April 26, November 26, 2010, December 3, 2012, and March 22, 2013. She was 32 years old at the first surgery in April 2010.

Patient C began complaining of bleeding and abdominal pain in early 2009. (Transcript, page 177; Exhibit 11, page 158.) The Respondent first performed surgery on April 26, 2010. (Exhibit 11, page 196.) She continued to have pain. On November 9, 2010, after telling the Respondent "I don't want to live with pain anymore" she underwent a laparoscopic hysterectomy on November 26, 2010. (Exhibit 11, page 201; Transcript, pages 178-79.) She continued to complain of pain, and another procedure, laparoscopy with bilateral salpingectomy, was done on December 3, 2012. (Transcript, pages 181; Exhibit 11, page 255.) The Petitioner criticizes the surgery as being not indicated.

The Respondent pointed out that this patient was placed on medication in early 2009, continued to complain of pain over the next year, and that she expressed a desire to keep her ovaries. (Transcript, pages 200-206, 208-10.) Dr. DuBeshter also emphasized that this 31 year old patient wanted to retain her ovaries. (Transcript 2/15/16, page 107.) In response to the criticism that more conservative measures than surgery were not attempted, he pointed out:

> ... this patient had been – had birth control pills; progesterone therapy, which is a form of hormonal therapy; as well as another type of therapy that's frequently used in patients with chronic pelvic pain because they think a fair percentage of them can have a psychological component to the depressive symptoms, so Prozac was used also. So I take exception to the State's expert. (Transcript 2/15/16, page 108.)
>
> For patients that want to preserve childbearing or don't want to have an extricative procedure, you're frequently going to try some sort of medical therapy. This patient had already had birth control treatment, which would have been probably the first line

> for that type of therapy. Progestin treatment is another common type of therapy to be used for that.
>
> When those things fail, then surgical management becomes, you know, a frequent method of trying to deal with the problem, and it doesn't always involve taking everything out all at once. That's up – that's a decision that ends up being with the patient, what they want to preserve, whether they're willing to take the risk of subsequent surgeries.
>
> This patient's course over the course of, you know, a number – probably three or four years, is not at all uncommon for patients with chronic pain and they just – they don't come to have almost everything taken out until they're tired of having the pain. (Transcript 2/15/16, pages 110-11.)

Dr. Dubeshter also pointed out that these matters were fully discussed with the patient. (Transcript 2/15/16, page 115; Exhibit 11, page 253.)

The hearing committee agreed that the Petitioner failed to prove that treatment approaches short of surgery were not taken, and failed to prove that the procedures performed, including the December 3 laparoscopy, were done in violation of the appropriate standard of care and were not a reasonable continuation of a reasonable approach to treatment undertaken with appropriate attention to the patient's concerns. Allegations C1, C2 and C3 were not sustained.

Patient D (Exhibits 13-17.)

The Respondent treated Patient D, a 54 year old female, in July and August 2009. Dr. Kredentser agreed that the July 9, 2009 evaluation indicated a need for surgery. (Transcript, page 225.) The surgery, which included a hysterectomy and bilateral salpingo-oophorectomy, was done August 3, 2009. (Exhibit 14, page 33.)

A mass was noted on the right ovary, and Dr. Kredentser testified that the management of the surgery in this case failed to meet the standard of care "because a prudent

GYN oncologist would have obtained a frozen section and done the staging." (Transcript, pages 228-30, 243.) Dr. DuBeshter testified:

> Q. Would you say it should have been performed?
>
> A. I think it depends on the person so—
>
> Q. In this case?
>
> A. Well, yeah. It turned out to be a malignancy. So it's easy looking back, yeah, it should have been -- but, you know, it's hard when you have ---... So he did an intraoperative evaluation and didn't think it was cancer and he was wrong. (Transcript, pages 149-50.)

Dr. DuBeshter finally agreed that the failure to do a frozen section "was a mistake" and "would have been a prudent thing to do." (Transcript, page 158.) Even the Respondent agreed "I wish I had done" it. (Transcript, page 760.)

Dr. DuBeshter and Dr. Kredenster agreed that the medical record documents the August 3 surgery was indicated. Factual allegations D1 and D4 were not sustained. Dr. DuBeshter and Dr. Kredenster agreed that the failure to do a frozen section was a mistake. As a consequence of the failure to do a frozen section, appropriate staging was not done. (Transcript, pages 231-32.) Factual allegations D3 and D4 were sustained. The committee agreed, however, that the failure to do the more extensive evaluation did not constitute gross negligence or incompetence. As this is the only instance of alleged incompetence or negligence that has been sustained, it is not sufficient to establish misconduct by negligence or incompetence on more than one occasion.

Patient E (Exhibits 18-20.)

The Respondent treated Patient E, a 41 year old female, between October and July, 2013. The Respondent performed surgery on November 14, 2012 that included removal of a

portion of the patient's colon. (Exhibit 19, page 115.) An entire section was not removed, only a section, leaving the posterior wall. (Transcript, pages 286-87.)

The closure did not hold and the surgery had to be redone on November 22, 2012 to repair the colon, which had become infected. (Transcript, pages 299, 304-305; Exhibit 18, page 3605; Exhibit 19, page 95.) Subsequent procedures were also required because of the failure of the original suture done by the Respondent on November 14. (Transcript, page 308.)

According to Dr. Kredentser, the "usual approach to this type of tumor in the pelvis is what we call an on-block [sic] resection." (Transcript, page 294.) He first said "That would be the standard [of care], yes." (Transcript, page 295.) He then immediately conceded on cross examination, however, that there were other ways to do it:

> Q. I believe what you are saying is that there are different ways of addressing the presentation that this patient had at her surgery of November 14, 2012; is that correct?
>
> A. Yes.
>
> Q. You're not saying that there is a failure of standard of care or a violation of the standard of care by reason of the fact that an on-block [sic] resection was not performed; is that correct?
>
> A. No. That the surgery itself – that the surgery that was performed did not meet the standard of care. (Transcript, page 312.)

After agreeing that the standard of care did not require en-bloc resection, he then immediately reverted to that criticism:

> Q. ... you are saying that he should have done that repair using a double layer of suturing as opposed to a single layer of suturing?
>
> A. No, my main objection is that it shouldn't have been repaired; it should have been resected. (Transcript, page 313.)

Dr. DuBeshter testified that the approach taken by the Respondent in this case was an appropriate exercise of his discretion. He pointed out:

> The reviewer made a lot of that issue, but there's nothing to say that it's mandated or mandatory to take out the posterior wall, because if you start getting into a full resection, then you also are interfering with the blood supply. If you don't do that, you're not bothering any of the blood supply. So you might even make the argument that if you can get away with it, you're better off leaving whatever portion is normal there and leaving the blood supply intact.... So I think that, there again, that this is something that's a matter of judgment or personal style or a matter of training. It's not something that's a standard of care issue. (Transcript 2/15/16, pages 171-72.)

The hearing committee concluded that the Petitioner failed to meet its burden of proving that the Respondent's conduct in performing a partial resection rather than removing an entire section of the colon violated the standard of care.

Dr. Kredenster also criticized the Respondent for performing the colon repair with a "single-layer" rather than "two-layer" closure, but, as with Allegation B4, this criticism was inextricable from his opinion that the procedure should have been done an entirely different way, by an en-bloc resection: Asked to comment on the use of a single-layer closure he reverted to the criticism that the "repair" should have been a "resection" of the colon:

Q. What is your understanding of the term "repair" in this context?

A. Well, a segment of the anterior wall was removed, so we're talking about a tube, and you take out a center segment and you have to sew the walls back together. So that's what was done in this case.

Q. ... how did Dr. Adelson repair the remaining colon section during the 11/14 surgery?

A. With a single-layer closure...

Q. Based on your education, training and experience, do you have an opinion as to whether Dr. Adelson's resection was in accordance with what a reasonably prudent physician would have done under the circumstances?

A. Yes.

Q. What is that opinion?

A. The opinion is that a reasonably prudent GYN oncologist would have removed that segment of colon and done and end-to-end anastomosis rather than trying to repair the anterior abdominal wall in one layer. (Transcript, pages 296-97.)

Dr. Dubeshter testified that the single layer closure was appropriate in this case:

Because I don't agree with the statement that it had to be done in a – that the standard of care is the two-layer closure. It's not. That was news to me and lot of other people who do bowel surgery. I think that may be Dr. Kredentser's personal preference, but it's certainly not a standard of care. And it is also not born out by any literature that I'm aware of. As a matter of fact, it's just the opposite. (Transcript 2/15/16, pages 174-75.)

In view of this difference of medical opinion between two well qualified witnesses, the hearing committee concluded that the Petitioner failed to meet its burden of proving the Petitioner deviated from accepted standards of care in the colon resection and repair he performed on November 14. Allegations E1, E2 and E3 were not sustained.

Patient F (Exhibits 21-23.)

The Respondent treated Patient F, a 79 year old female, between October 2012 and January 2013. He performed surgery on October 31 and December 21, 2012. (Transcript, page 358; Exhibit 21, page 513.)

Factual allegations F1 through F5 criticize five procedures all performed on October 31, 2012. The Petitioner charges that the five procedures were performed "without medical indication." While in Dr. Kredentser's view these procedures should not have been performed (Transcript, pages 364-69), his criticism was not that the decision was made to begin surgery. His objection was that the procedures proved not to be indicated once the surgery was commenced and the Respondent saw the situation:

Q. In that particular moment in surgery, you get the interoperative result, he had plans to do a hysterectomy, bilateral salpingo-oophorectomy, pelvic washings, cytology washings, lymphectomy and cystoscopy. During the surgery, however, he got these interoperative diagnoses.

A. Yes.

Q. What would the standard of care have required him to do on receiving these interoperative diagnoses?

A. Based on all the information that was probably a melanoma?

Q. Correct.

A. Wake the patient up.

Q. So basically just stop?

A. Stop. (Transcript, page 364.)

At the hearing, Dr. Kredentser then agreed that once the surgery was commenced, the cystoscopy was reasonable. (Transcript, page 367.) Regarding the pelvic lymphadenectomy, he also said that once the surgery was commenced "[t]aking out a few lymph nodes, as long as you don't put a hole in a major blood vessel, you're probably not going to hurt anybody." (Transcript, page 369.) The Petitioner subsequently withdrew factual allegations F4 and F5. (Petitioner brief, page 47.)

Dr. DuBeshter agreed with Dr. Kredentser that, as it turned out, the patient had a malignant melanoma in the vaginal wall, "and that all other pathology was negative." (Transcript 2/15/16, pages 182, 199.) Dr. DuBeshter also did not dispute Dr. Kredentser's testimony that "[t]he treatment for a malignant melanoma is not a hysterectomy." (Transcript, page 371.)

Dr. DuBeshter did not agree, however, that as of the date of surgery, October 31, 2012, the diagnosis should have been melanoma as opposed to endometrial carcinoma. He said "[t]here's no way to have known that at the time." (Transcript 2/15/16, page 189.)

> So my plan would have been – actually my plan would have been to do exactly what ended up getting done in this case.
>
> ... you know, yeah, it ended up, with the retrospectoscope, proving to be what the patient had and it was limited to the vagina, but there was no way to have known that without doing the things that were done. (Transcript 2/15/16, pages 193-95.)

Regarding the vaginectomy on December 21, 2012, Dr. DuBeshter said:

> It was palliative... There aren't very many good treatment options for somebody with a vaginal melanoma. The patient had persistent problems with bleeding and you want to prevent that... I doubt that he thought that it was a curative procedure. (Transcript 2/15/16, pages 200-201.)
>
> Just for bleeding. If that's what's bothering her, you can do a relatively simple procedure and get – eliminate her angst or whatever with bleeding with a procedure that's not that awful to have performed. We'd do that. I mean, we try a lot of different things to alleviate bleeding for patients who are – (Transcript 2/15/16, pages 212-13.)
>
> And it wasn't long after these procedures that she presented in the emergency room with widely metastatic disease and probably died of her cancer shortly thereafter. (Transcript 2/15/16, page 183.)

The hearing committee disagreed with Dr. Kredentser's denial that "going into the surgery of 10/31/12, Dr. Adelson had conflicting information in front of him as to the type of cancer that this patient had." (Transcript, page 386.) The committee agreed that the Petitioner failed to meet its burden of proving the October 31 and December 21, 2012 procedures were performed or documented without indication and in violation of the appropriate standard of care.

Factual allegations F1, F2, F3, F6 and F7 were not sustained. Factual allegations F4 and F5 were withdrawn by the Petitioner.

CONCLUSION

The hearing committee sustains factual allegations D2 and D3. The Petitioner withdrew factual allegations F4 and F5. The Petitioner failed to meet its burden of proving the remaining twenty one factual allegations. Factual allegations D2 and D3 are insufficient to support any of the specifications of misconduct.

ORDER

IT IS HEREBY ORDERED THAT:

1. The charges of misconduct under Ed.L 6530 are not sustained.
2. This order shall be effective upon service on the Respondent by personal service or by registered or certified mail as required under PHL 230(10)(h).

Dated: June 24, 2021

By: [redacted]
Gail Homick Herrling, Chair

John D. Thomas, II, M.D.
Edmund A. Egan, II, M.D.