



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H.
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Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health
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Office of Professional Medical Conduct

PUBLIC

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Chair
Denise M. Bolan, R.P.A.
Vice Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

December 21, 1999

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Robert J. Klinger, M.D.
461 Park Avenue South
11th Floor
New York, NY 10016

RE: License No.: 192123

Dear Dr. Klinger:

Enclosed please find Order #BPMC 99-260 and the Order modifying this determination of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **December 21, 1999**.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, NY 11042

Silvia P. Finkelstein, Esq.

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

IN THE MATTER
OF
ROBERT J. KLINGER, M.D.

ORDER MODIFYING
HEARING COMMITTEE
DETERMINATION
AND
ORDER #
BPMC 99-260

Upon the proposed Stipulation of ROBERT J. KLINGER, M.D. (Respondent) for a consent order modifying the Determination and Order of the Hearing Committee, which Stipulation is made a part hereof, it is agreed to and

ORDERED, that the stipulation and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 12/16/99


WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER
OF
ROBERT J. KLINGER, M.D.

STIPULATION
AND
ORDER

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

ROBERT J. KLINGER, M.D., (Respondent) being duly sworn, deposes and says:

That on or about May 6, 1993, I was licensed to practice as a physician in the State of New York, having been issued License No. 192123 by the New York State Education Department.

My current address is 461 Park Avenue South, 11th Floor; New York, New York 10016 and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I stipulate that the New York State Board for Professional Medical Conduct has charged me with six specifications of professional misconduct, and that after hearing a Hearing Committee has sustained the first specification, and has imposed sanctions, all as more fully set forth in Determination and Order Number BPMC 99-260, annexed hereto, made a part hereof, and marked as Exhibit "A". I further stipulate that Petitioner Department of Health (Petitioner) has filed a Notice of Appeal with the Administrative Review Board of the State Board for Professional Medical Conduct (ARB), seeking review of the sanction imposed by the Hearing Committee.

In consideration of withdrawal by Petitioner of the pending Appeal to the ARB, I stipulate to modification of the sanction imposed by the Determination and Order of the Hearing Committee, which shall in all other respects remain in effect, as follows:

1. The fully stayed two-year suspension imposed by the Hearing Committee shall be modified and I shall be suspended for a period of two years with twenty-two months of said suspension to be stayed. I shall be fully suspended from the practice of medicine for a period of sixty days, said sixty day period to commence at beginning of business, January 22, 2000. As a result of this modification, under the terms of the Order of the Hearing Committee, I shall be subject to terms of probation during the 22 month period of stayed suspension.
2. The sanction of public service imposed by the Hearing Committee shall be modified to require me to serve 500 hours of public service as otherwise specified by the Hearing Committee, during the period of probation.

I further agree that the Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent.

Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order.

Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary

proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

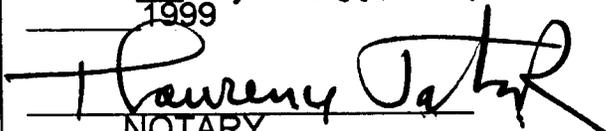
I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same, incorporating Determination and Order Number BPMC 99-260 and Modifying it as set forth herein. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of further litigation on the merits, I knowingly waive any right I may have to contest the Order for which I hereby apply, whether administratively or judicially, ask that the Application be granted, and agree that such final order be issued.

DATED 12/6/99


ROBERT J. KLINGER, M.D.
RESPONDENT

Sworn to before me
on this 6 day of December
1999


NOTARY

Notary Public, State of New York
No. of 4986086
Exp. 12/31/01
2001

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: Dec. 6, 1999


T. LAWRENCE TABAK, ESQ.
Attorney for Respondent

DATE: Dec 7, 1999


SILVIA P. FINKELSTEIN
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: December 9, 1999


ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

COPY

IN THE MATTER
OF
ROBERT J. KLINGER, M.D.

DETERMINATION
AND
ORDER

BPMC-99-260

JOHN W. CHOATE, M.D. Chairperson, PETER B. KANE, M.D. and
MR. JAMES J. DUCEY, duly designated members of the State Board for Professional Medical
Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section
230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to
Section 230(10)(e) of the Public Health Law. JEFFREY ARMON, ESQ., served as
Administrative Officer for the Hearing Committee. After consideration of the entire record, the
Hearing Committee submits this Determination.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	January 26, 1999
Amended Statement of Charges (Ex. 1A):	February 23, 1999
Pre-hearing Conference:	February 25, 1999
Dates of Hearing:	March 30-31,; May 5-6, 10-11, 24; June 1, 22; July 12, 27, 29-30, 1999
Department of Health appeared by:	HENRY M. GREENBERG, ESQ. General Counsel, NYS Department of Health BY: SILVIA P. FINKELSTEIN, ESQ
Respondent appeared by:	T. LAWRENCE TABEK, ESQ.
Witnesses for the Department of Health: ..	Husband of Patient A Sister of Patient A Lillian Cintron, R. N. Stephen Gonzales, R.N. Rita Roberts, R.N.

EXHIBIT "A"

Janice Robbins, R.N.
Winifred Mack, R.N.
Allan Jacobs, M.D.
Richard U. Hausknecht, M.D.

Witnesses for the Respondent:

Ann Walsh, R.N.
Kurt Christopher, M.D.
William Rashbaum, M.D.
Arthur Gross, M.D.
Ruth Tessler, M.D.
Rabbi Yakov Neuberger
Brian Cohen, M.D.
Alan DeCherney, M.D.
Richard J. Traystman, Ph.D.
Anita Shin, R.N.
Robert J. Klinger, M.D. (Respondent)

Receipt of written submissions:

August 26, 1999

Deliberations held:

September 7, 1999

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's exhibits are designated by Letters.

T = Transcript

A copy of the Amended Statement of Charges (Ex. 1A) is attached to this Determination and Order as Appendix II.

FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about May 6, 1993 by the issuance of license number 192123 by the New York State Education Department. (Ex.2)
2. Patient A, a 29 year old female, first saw Respondent in August, 1997 with complaints of heavier and lengthier menstrual periods. Respondent performed a physical examination and noted an impression of menorrhagia and probable fibroid uterus. (Ex. 3, p.5)
3. Respondent diagnosed Patient A as having a submucous myoma, which is a benign fibrous uterine tumor. A hysteroscopic vaginal myomectomy was scheduled to be performed by Respondent at the Phillips Ambulatory Care Center of Beth Israel Medical Center (BIMC) on November 20, 1997. (Ex. 4; T. 1201-2, 1919)
4. A hysteroscopic myomectomy is performed by dialating the cervix to admit a hysteroscope, a telescopic instrument which carries a light and fluid source. An inflow tube introduces a distention medium which distends the uterus to permit visualization of the uterine cavity. The electrocautery element, which resects the myoma, is inserted through the inner shaft of the hysteroscope. An outflow tube is also present to enable the fluid to exit the uterine cavity. The surgeon operating the hysteroscope utilizes two stopcock valves to regulate inflow and outflow of the distention medium. (T. 212-5, 1171, 1203-4, 1208-9)
5. The hysteroscopic procedure performed on Patient A on November 20, 1997 utilized a Johnson & Johnson VersaPoint Bipolar Electrosurgery System (hereinafter referred to as the "VersaPoint"). This was a bipolar instrument that accepted a high voltage electrical current to vaporize tissue. The fact that bipolar current was generated permitted the use of saline as the

distention medium for the surgery instead of the more commonly used glycine. The advantage of saline was that the possibility of hyponatremia, or sodium imbalance, was reduced. (Ex. 6; T. 1017-8, 1203-4, 1215-7, 1600-1, 1861-2)

6. Respondent had performed two diagnostic and three operative hysteroscopic procedures utilizing saline as the distention medium prior to Patient A's surgery on November 20, 1997 and had also previously utilized a monopolar vaporizing system. Respondent had never used the VersaPoint system before the patient's surgery (T. 1678, 1861-2)

7. There is no difference in the technical performance of an operative hysteroscopy or in the monitoring of fluid input and output when utilizing a bipolar, instead of monopolar, system. The mechanical skill necessary to perform the surgery is similar and should be relatively easily transferred from one system to the other. (T. 383-4, 1181-2, 1252-3, 1600-01, 1862)

8. In a memo to the Administrative Director of Surgical Services at BIMC dated October 6, 1997, the Chairman of the Department of Obstetrics and Gynecology initiated the process for obtaining the VersaPoint system for use in the hospital. Facility policy for approving the use of new equipment required that a safety approval be secured from the Engineering Department, and when applicable, the Biomedical Engineering Department. The process for obtaining approval for the use of the equipment was not completed at the time of its use during Patient A's surgery. Two stickers from the hospital's Biomedical Engineering Department were affixed to the equipment on the day of surgery. (Ex. 8, 11; T. 410, 911, 919-21, 1010-12, 1113-4)

9. A sales representative from the Ethicon Division of Johnson & Johnson was present in the operating room during Patient A's surgery. It was not uncommon for a sales representative to be present when new equipment was being used in an operating room at BIMC. (T. 218, 702-5, 1805, 1886-7)

10. During the surgical procedure, the sales representative monitored the VersaPoint system, adjusted one or more settings on the machine on at least one occasion and participated in conversations with the Respondent and others in the operating room related to the performance of the medical equipment. At one point and not acting on a request by Respondent to do so, the salesman moved to squeeze a bag of saline that had been hung. It could not be determined whether or not he actually squeezed the bag. He took no role in the surgery beyond those activities. (T. 683, 882-3, 1461, 1466-8, 1474-5, 1888-90)

11. The surgical procedure began at about 3:00 p.m. and lasted approximately two hours. During the procedure, about 9,000 cc's (9 liters) of saline was infused into the patient's uterus via the hysteroscope and approximately 1,000 cc's were recovered as output from the suction cannisters. About 500 cc's were measured as urine output and spillage was calculated as an additional 500 to 1,000 cc's. At the completion of the surgery, the discrepancy between fluid inflow and outflow was approximately six to seven liters. (Ex. 4)

12. During the surgery, Respondent opened and closed the fluid outflow stopcock. The outflow stopcock must be closed for at least brief periods during such a surgical procedure to enable distention of the uterus. (T. 1332-4, 1592-4)

13. When the surgery was completed, the drapes were removed from around Patient A and abdominal distention and severe edema of her upper body was noted. The patient was catheterized, a diuretic was administered and she was transferred to the hospital's recovery room. Patient A suffered cardio-pulmonary arrest while in the recovery room. She was transferred to BIMC's Emergency Department where she died at approximately 8:25 p.m. (Ex. 4; T. 227-30, 719-21, 1943-6)

14. The responsibilities of the nurses present in the operating room during a hysteroscopic procedure include the measurement and recording of the inflow and outflow of the distension medium and the reporting of such information to the surgeon. It is appropriate for a surgeon to delegate these responsibilities to the nurses. (T. 1217-8, 1262-3, 1270-1, 1620-2, 1624-5)

15. The operating surgeon retains overall responsibility for fluid intake and output even if the responsibility to monitor and record input and output has been delegated to the nurses. While he may delegate activities such as recording and monitoring fluid levels, the surgeon retains ultimate responsibility to be aware of fluid input and output. (T. 1228-9, 1263-4, 1287-8, 1309-10, 1323, 1537-8, 1693-6)

16. During the course of the surgery, Respondent did not specifically ask of the nurses the status of the inflow or outflow of the fluid. He asked the anesthesiologist at the completion of the case whether the patient was stable. (T. 719, 806, 1949)

17. The entire medical record maintained for Patient A by Respondent, including dictated and handwritten reports and notes, accurately reflected the condition of the patient during surgery and the circumstances surrounding the surgery. (T. 1642-3)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A.	(3, 5, 9, 11, 13)
Paragraph A.1. (sustained in part only) :	(11, 13-16);
Paragraph A.3. (sustained in part only):	(11, 13-16).

The Hearing Committee determined that all other Factual Allegations should **NOT BE SUSTAINED.**

The Hearing Committee concluded that the **FIRST** Specification of Charges, as it relates to Paragraphs A. 1. and A. 3. only, should be **SUSTAINED** and that all other Specifications should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for certain types of professional misconduct.

The following definitions were utilized by the Hearing Committee during its deliberations:

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

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.

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

Factual Allegations Not Sustained

The Committee concluded that there was much less substance to the Department's charges than an initial review would indicate and that, as a result, a great amount of time and effort was needlessly expended. A majority of the Factual Allegations were not sustained for reasons set out as follows.

The issues of the allegedly unauthorized presence of the VersaPoint system and the sales representative were seen as matters totally unrelated to the surgical complication of the fluid imbalance. Simply put, *there was no evidence that the presence, authorized or not, of either the equipment and/or the salesperson contributed in any way to the surgical complication.* The VersaPoint, designed to provide a source of electricity to power the hysteroscope, functioned perfectly. The fact that it may not have been fully authorized for use in the operating room was not related to the quality of care provided Patient A. The record demonstrated that the Chair of the Department of Ob/Gyn had requested that the administrative process to obtain the equipment be undertaken. It appeared that such process had not been completed by the date of Patient A's surgery. The equipment was not brought in by the Respondent and appeared in the operating room with the appropriate stickers from the facility's Department of Biomedical Engineering. There was no evidence that Respondent conspired in some manner to sneak the equipment into the operating room. It was being used to verify the purported advantages of performing the surgical procedure with a safer distension medium. The discrepancy between the fluid inflow and outflow was unrelated to the use of the VersaPoint system.

The Committee also concluded that Respondent did not need additional specialized training and that he had adequate experience to use the VersaPoint. He had experience utilizing saline as the distention medium in operative hysteroscopies. The fact that a bipolar, instead of monopolar, system was being used was not considered to be significant. The medical experts for both parties agreed that the technical performance of the procedure would not differ. The Department contended that the resection of a myoma differs from the vaporization of such a fibroid. The Committee viewed that fact as an insignificant technical distinction unrelated to the overall care provided to the patient. That portion of Paragraph A. 3. alleging that Respondent "failed to demonstrate an acceptable level of knowledge in...the use of the instrumentality involved and in the performance of the procedure" was not sustained.

The presence, authorized or not, of the salesperson was also seen as not affecting the care rendered Patient A. It was undisputed that BIMC policy permitted sales representatives to be in an operating room when new equipment was being utilized. The record demonstrated that the salesman took no action while present during Patient A's surgery other than adjusting settings on the VersaPoint and conversing with the surgeons. He functioned as a type of a technician and the fact that he spoke with Respondent during the procedure would be expected and was not unusual. The surgeons did not "avail themselves of the instructional and participatory support" of the sales representative beyond that point. There was absolutely no evidence that he operated, or attempted to operate, the hysteroscope.

There was testimony that at one point the representative moved to squeeze a bag of saline that was hanging. While this would have been inappropriate, it could not be established whether he merely moved toward the saline bag or actually squeezed it. In any event, the Respondent did not ask the sales representative to take such an action. There was no evidence that Respondent in some way sneaked the salesman into the operating room and it was clear to the Committee that, all other facts remaining the same, the surgical complication would have occurred even if the sales representative had been properly authorized to be in the room.

The Committee rejected any suggestion that the Respondent deceived Patient A by utilizing the VersaPoint and by having the sales representative present at the surgery. To reiterate, Respondent was adequately trained in the use of the equipment and the distention medium. The equipment had previously been requested by the Chair of Respondent's Department. Hospital policy permitted sales representatives in the operating room. The sales representative did not participate in Patient A's actual surgical procedure. Respondent had no reason to believe that either the equipment or the salesman was not properly authorized. The Committee did not sustain Factual Allegations B., B.1 and B.2.

A contention of the Department was that the discrepancy in the amount of fluid that entered into and was removed from the patient's uterine cavity was the result of Respondent having closed the outflow stopcock valve during all or much of the procedure. Each party expended great effort to demonstrate whether or not the outflow valve was closed for a significant portion of the surgery. The Committee considered it unnecessary to make a determination on this point based on its interpretation of Factual Allegation A.2. This Paragraph only alleges that Respondent closed and/or caused to be closed the outflow tract *during* the procedure. Both medical experts agreed that the outflow must be closed on occasion during an operative hysteroscopy to permit distention of the uterus. The closing of the outflow valve by Respondent at some point during the surgery was not inappropriate and the Factual Allegation was not sustained.

The Department's allegation that the medical records maintained by Respondent for Patient A were inadequate was based on a review of his dictated Operative Report, which stated that no surgical complications were noted. The Report does make reference to the abdominal distention and facial edema observed at the completion of the procedure. While the dictated Report may have been less than completely accurate, Respondent's handwritten Summary Note was also included in the patient's chart. This Summary Note did describe the surgical complication of the fluid discrepancy. The Committee considered that the entire record maintained by Respondent did, in fact, accurately reflect his care and treatment of Patient A and

that it was unreasonable to rely on one document from the entire medical record to make such an allegation. Factual Allegation A. 4. was not sustained.

Factual Allegations Sustained

Paragraph A was sustained as a generally accurate statement of fact providing background information. The stated start of the surgical procedure and amount of outflow were considered to be inaccurate. The Paragraph, by itself, did not constitute professional misconduct.

The Committee felt that the only significant issue presented by the Department's charges was the question of Respondent's duty to be aware of the inflow and outflow of the distention medium during the surgery. The members wrestled with the extensive testimony of the nurses in an attempt to evaluate the credibility of their contentions that Respondent was repeatedly warned of the discrepancy between inflow and outflow during the procedure. The nurses were subjected to considerable examination of their ability to recall the most minute details of the events surrounding Patient A's surgery. The detailed and repetitive nature of the cross-examination of their recollections led to inconsistencies and contradictions in their testimony. Rather than clarify, the inquiry confused the Committee and made its credibility determination more difficult.

The Committee was concerned about the absence of any documentation in the nursing notes which would have confirmed the contention that Respondent was advised of the fluid discrepancy. Although the notes indicated the amount of input and output, there was no reference such as "M.D. aware" of the discrepancy recorded in those notes. The explanation that such a notation would not have been included because it was not "objective" information was held to be unsatisfactory. It was also observed that no other individual present in the operating room during any portion of the surgery corroborated their testimony. However, the Committee felt that the nurses generally appeared truthful and seemed to have no bias or reason to be less than honest. At the end, the Committee could not establish, to any degree of certainty, whether or not the Respondent was informed by the nurses of the fluid discrepancy and was unable to determine

their credibility. It concluded that the Department failed to carry its burden to demonstrate by a preponderance of the evidence that Respondent ignored repeated warnings from the nursing staff and did not sustain that portion of Factual Allegation A. 1.

The Committee determined to sustain the balance of Paragraphs A. 1. and A. 3. It considered the failures to "appropriately act in response to the dangerous condition created by the discrepancy" of fluid inflow and outflow and to "demonstrate an acceptable level of knowledge in the management of Patient A's condition during surgery" to be similar allegations and sustained both for the same reasons. The Committee believed that it was appropriate for Respondent to delegate the responsibility to monitor the fluids to the nurses, but did not agree with Respondent's contention that he had no obligation to ensure that the delegated activity was properly carried out. It strongly disagreed with the argument that there was no responsibility for Respondent to inquire as to the status of inflow/outflow if he was not made aware of a problem by the nurses. The Committee accepted Dr. Hausknecht's opinion that the surgeon retains ultimate authority to be aware of fluid input and output even if the duty to monitor the fluids is delegated to the nurses. Respondent's failure to inquire, at any time during the surgery, as to the status of the fluid input and output was considered to be an inappropriate response to the fluid discrepancy and a failure to demonstrate an acceptable level of knowledge in the management of the patient's condition.

SPECIFICATION OF CHARGES

The Committee concluded that Respondent's failures, as set out in the sustained portions of Paragraphs A. 1. and A. 3., were so egregious as to constitute gross negligence. This decision was made after the Committee members were instructed that they were not to consider either the fact that Patient A died, that Respondent contributed in any manner to the patient's death or that the death was caused by a fluid overload. The Committee made its determination as to whether Respondent had practiced the profession with gross negligence by considering if Respondent's

conduct would have been an egregious failure to exercise the care that would have been exercised under the circumstances by a reasonably prudent physician had Patient A fully recovered from the surgical complication and been discharged in good health. There was a firm conviction among all members that the failure of Respondent to appropriately act and to manage the patient's condition was a significant and egregious deviation from acceptable standards of care. It was not reasonable for Respondent to assume there was no problem with the amounts of inflow and outflow if, as he repeatedly contended, he was not made aware of the fluid discrepancy until the completion of the surgery. The delegation of the monitoring of fluids did not absolve Respondent from ensuring that adequate care be provided to Patient A. Dr. Hausknecht's question, "who is to be ultimately responsible if not the physician?" was seen as a succinct summation of the opinion of the Committee. The members of the Hearing Committee strongly believed that Respondent should have asked the nurses as to the status of the fluid inflow and outflow if he was not being provided such information and that such an inquiry would have been an appropriate act in the management of the patient's condition during the surgery.

The Committee did not consider Respondent's acts or failures to act to constitute gross incompetence. It felt that he was experienced in the performance of operative hysteroscopies and, as discussed above, that he required no additional training to use the VersaPoint or saline to perform the procedure. The surgical complication that arose was the result of negligent, not incompetent, practices.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's license to practice medicine in New York should be suspended for two years, said suspension to be stayed, and that he be placed on probation in accordance with the Terms of Probation as set forth in Appendix I during said period of stayed suspension. Included in the Terms of Probation were requirements that Respondent practice all operative hysteroscopic

cases only when monitored by a licensed physician, board certified in Obstetrics and Gynecology, and that Respondent perform thirty (30) hours of community service per month. In addition, the Committee determined to impose a civil penalty of ten thousand dollars (\$10,000). This decision was made following due consideration of the full spectrum of penalties available pursuant to statute, including license revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee concluded that there was a system-wide failure by a number of parties charged with ensuring that Patient A be provided safe and appropriate medical services. The lack of documentation in the nursing notes of any warnings given to Respondent and the unclear facility policies of approvals of medical equipment, visitors to the operating room and fluid management responsibilities were specific concerns. Committee members believed that Respondent also shared in the blame for the inadequate level of care that was provided which led to the complication of the fluid overload. They were troubled by his refusal to accept any personal responsibility and particularly objected to the position that the nurses were entirely to blame for the complication. The imposition of a monetary penalty was made with the intent of penalizing him for taking such an ill-advised position.

The Committee considered that the treatment of only one patient was at issue and that Respondent had no previous disciplinary history related to his medical practice. It noted the significant number of positive character references and Respondent's achievements during his training and medical practice. Respondent was seen as being well trained and not lacking in skills. He appeared sincerely remorseful as to the events which ultimately resulted in Patient A's death. The Committee was convinced that those circumstances were unlikely to reoccur during the course of Respondent's practice. Consequently, it felt that an actual suspension of Respondent's license, as requested by the Department, would be counter-productive. An inability to practice would only serve to erode skills which were considered to be acceptable. A requirement for community service, delivered to a needy or underserved population, was seen as a more practical alternative in this case.

ORDER

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

1. The First Specification of Charges as set forth in the Amended Statement of Charges (Ex. 1-A) and, as it relates to Paragraphs A. 1. and A. 3. only, are SUSTAINED; and
2. All other Specification of Charges set forth in the Amended Statement of Charges (Ex. 1-A) are NOT SUSTAINED and are hereby DISMISSED; and
3. The license of Respondent to practice medicine in New York State be hereby SUSPENDED for a period of two years, said suspension to be STAYED; and
4. Respondent shall be placed on PROBATION during the period of the stayed suspension of his license, and he shall comply with all terms of probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order.
5. A CIVIL PENALTY of TEN THOUSAND DOLLARS (\$10,000) be imposed upon Respondent, such penalty to be payable in full within sixty (60) days of the effective date of this Order. Payment shall be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1258
Albany, New York 12237.

Any civil penalty not paid by the above prescribed date shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to, the imposition of interest, late payment charges and collection fees, and non renewal of permits or licenses pursuant to Sections 171(27) of the Tax Law, 18 of the State Finance Law, 5001 of the CPLR and 32 of the Executive Law, and;

6. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York

10/13, 1999



JOHN W. CHOATE, M.D. (Chair)

**PETER B. KANE, M.D.
MR. JAMES J. DUCEY**

**TO: Silvia P. Finkelstein, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza-Sixth Floor
New York, New York 10001**

**T. Lawrence Tabek, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, New York 11042**

**Robert Klinger, M.D.
461 Park Avenue South, 11th Floor
New York, New York 10016**

APPENDIX I

Terms of Probation

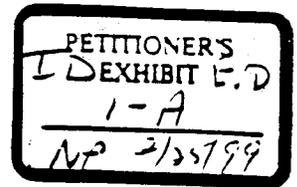
1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.
2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 4th Floor, 433 River Street, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.
3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide periodic written verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.
4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.
5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.
6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients.
7. Respondent shall perform all operative hysteroscopic cases only when monitored by a licensed physician, board certified in Obstetrics/Gynecology, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. An approved practice monitor shall be in place within thirty (30) days of the effective date of this Order.

- a. Respondent shall make available to the monitor any and all records related to operative hysteroscopic cases or access to the practice as requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records related to operative hysteroscopic cases. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
- b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
- c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
- d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

8. Respondent shall perform thirty (30) hours of community service per month for the length of his probation. The service must be medical in nature, and be delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population. A written proposal for community service must be submitted to, and is subject to the written approval of the Director of OPMC. Community service performed prior to written approval shall not be credited toward compliance with this Order.

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

APPENDIX II



IN THE MATTER
OF
ROBERT J. KLINGER, M.D.

AMENDED
STATEMENT
OF
CHARGES

ROBERT J. KLINGER, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 6, 1993, by the issuance of license number 192123 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. On or about November 20, 1997, Respondent, an obstetrician-gynecologist, undertook the care and treatment of Patient A, a 30 year old female, at the Phillips Ambulatory Care Center of Beth Israel Medical Center (BIMC). On that date, Patient A underwent a hysteroscopic vaginal myomectomy because of a demonstrated submucous myoma. (The Patient is identified in the annexed Appendix B). During the hysteroscopic vaginal myomectomy referred to above, a surgical salesman was present in the operating room instructing and/or assisting the surgeons in the use of a new bi-polar cautery unit (Versapoint). During the procedure, which began at 2:00 p.m. and lasted until 5:10 p.m. Patient A

received 9000 cc of normal saline infused into the uterus. Only 1000 cc were measured as output. The patient was noted to be massively swollen. In the recovery room she suffered cardio-pulmonary arrest. Despite various resuscitative efforts the patient expired. The autopsy is consistent with fluid overload. Respondent engaged in conduct as follows:

1. Respondent failed to appropriately act in response to the dangerous condition created by the discrepancy in the amount of fluid infused into the uterus versus the fluid output and ignored repeated warnings from the nursing staff;
2. Respondent inappropriately closed and/or caused to be closed the stopcock of the fluid outflow tract during the procedure;
3. Respondent failed to demonstrate an acceptable level of knowledge in the management of Patient A's condition during surgery, the use of the instrumentality involved and in the performance of the procedure;
4. Respondent failed to maintain a medical record for Patient A which accurately reflects the condition of the Patient during surgery and the circumstances surrounding the surgery.

B. Respondent failed to accurately communicate to Patient A that neither he nor the other participants in the surgery, were adequately trained and/or experienced in the performance of an operative hysteroscopic procedure using an unauthorized electrocautery unit (Versapoint) that utilized saline, instead of glycine, as the fluid distension medium. Respondent also failed to accurately communicate to Patient A that he and the other participants in the surgery would avail themselves of the instructional and participatory support of a medical equipment salesman who was not a licensed health care provider and who was not authorized by the hospital to be present in the operating room and/or to participate in the surgery.

1. Patient A's purported consent to the procedure was induced by Respondent's failure to appropriately disclose the facts set forth in paragraph B, above. The procedure performed was, therefore, not duly authorized by Patient A or her legal representative.
2. Respondent withheld the information set forth in Paragraph B, above, knowingly and with intent to deceive.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A, A.1, A.2, and/or A.3;

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. Paragraphs A, A.1, A.2, and/or A.3;

THIRD SPECIFICATION
FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A, B and/or B.2.

FOURTH SPECIFICATION
PERFORMING PROFESSIONAL SERVICES WHICH
HAVE NOT BEEN DULY AUTHORIZED BY THE PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(26)(McKinney Supp. 1999) by performing professional services which have not been duly authorized by the patient or her legal representative, as alleged in the facts of:

4. Paragraphs A, B, and/or B.1.

FIFTH SPECIFICATION
INAPPROPRIATELY ACCEPTING AND/OR PERFORMING
PROFESSIONAL RESPONSIBILITIES

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(24)(McKinney Supp. 1999) by accepting and performing professional responsibilities which Respondent knew or had reason to know that he is not competent to perform, as alleged in the facts of:

5. Paragraphs A, A.1, A.2, and/or A.3;

SIXTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain a record for the patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

6. Paragraph A.4.

DATED: February 23, 1999
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct