

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 10, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001

Andrew S. Garson, Esq.
Belair & Evans
61 Broadway
New York, New York 10006

Charles M. Lewis, M.D.
141 Avenue P
Brooklyn, New York 11223

RE: In the Matter of Charles M. Lewis, M.D.

Dear Ms. Gayle, Mr. Garson and Dr. Lewis:

Enclosed please find the Determination and Order (No. 97-39) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

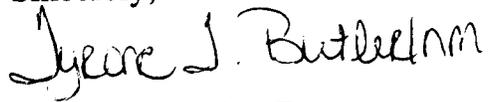
The notice of review served on the Administrative Review Board should be forwarded to:

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,

A handwritten signature in black ink that reads "Tyrone T. Butler". The signature is written in a cursive style with a large initial "T" and a long horizontal stroke at the end.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

COPY

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

IN THE MATTER

-OF-

CHARLES M. LEWIS, M.D.

DECISION
AND
ORDER
OF THE
HEARING
COMMITTEE

ORDER NO.
BPMC-97- 39

The undersigned Hearing Committee consisting of **KENNETH KOWALD, Chairperson, DIANA E. GARNEAU, M.D. RALPH LEVY, D.O.**, was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Esq.**, Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **CHARLES M. LEWIS, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges Dated / Served: May 14, 1996 / May 16, 1996

Notice of Hearing returnable: June 11 and June 12, 1996

Location of Hearing: 5 Penn Plaza, New York

Respondent's answer dated / served:

The State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner" or "The State") appeared by: **HENRY M. GREENBERG, ESQ.**
General Counsel by
ANN HRONCICH GAYLE, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza Room 601
New York, New York 10001

Respondent appeared in person and was represented by: **ANDREW S. GARSON, Esq.**
Belair & Evans
61 Broadway
New York, New York 10006

Respondent's present address: 141 Avenue P Brooklyn NY 11223

License Number / Registration Date: April 4, 1980 141702

Pre-Hearing Conference Held: June 11, 1996

Hearings held on: June 11, 12, July 3, August 13 and August 14, 1996

Conferences held on: May 23, June 11, July 3, August 6, 8 and 13, 1996

Closing briefs received: October 7 & 8 1996

Record closed: October 9, 1996

Deliberations held: October 29, 1996

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges five grounds of misconduct:

1. Respondent has committed **negligence on more than one occasion** as forth in N.Y. Education Law Section 6530 (3)
2. Respondent has committed **gross negligence** as set forth in N.Y. Education Law Section 6530 (4)
3. Respondent has committed **incompetence on more than one occasion** as set forth in N.Y. Education Law Section 6530 (5)
4. Respondent has committed **gross incompetence** as set forth in N.Y. Education Law Section 6530 (6)
5. Respondent **failed to maintain appropriate patient records** as required by N.Y. Education Law Section 6530 (32)

The allegations arise from two patients seen by Respondent from 1986 to 1992 . The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

Respondent entered a verbal denial of each of the charges.

Petitioner called these witnesses:

Steven B. Tamarin, M.D.

Expert Witness

Respondent testified and called these witnesses:

Robert N. Holtzman, M.D.
Morton Davidson, M.D.

Expert Witness
Expert Witness

SIGNIFICANT LEGAL RULINGS
INSTRUCTIONS TO THE TRIER OF FACT

1. The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the panel that negligence as used herein, is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. Likewise, Gross incompetence was defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or severe deviation from standards.

2. With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart or record and be able to understand a practitioner's course of treatment and the basis for same.

3. The standard of proof in this proceeding is a preponderance of the evidence. In assessing whether the proof adduced meets that standard, it was explained to the Committee that the State does not meet its burden of proof, and the charges cannot be sustained against Respondent merely by adducing testimony as to what some other physician would have done in circumstances similar to those found to have existed, at the time of treatment. In order to find that Respondent committed one or more of the Specifications of Charges, the State must demonstrate that Respondent's action, or failure to act, was a departure from accepted standards of medical care as they existed at that time.

4. The Committee was reminded that it has heard testimony that Respondent admitted Patient A to Community Hospital of Brooklyn in March 1992 for treatment of thrombocytopenia. The Committee was instructed that the level of care required of Respondent was to bring to the patient that knowledge, skill, care and diligence which are ordinarily exercised in similar situations by a prudent member of the medical profession practicing within the scope of accepted standards *in his field*.

5. The Committee was instructed that a physician may rely upon other professionals to fulfill their duties according to accepted standards of practice. An attending physician who admits a patient to a hospital may rely upon hospital personnel, as well as other consultants and medical specialists, to follow accepted standards of care.

6. With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according

to his or her training, experience, credentials, demeanor and credibility. The Committee was further instructed that it is not bound to the testimony offered by an expert witness. Notwithstanding the presentation and qualification of a witness as an expert, the Committee was told it is free to reject some or all of the testimony as irrelevant, not probative, not credible or unpersuasive.

7. The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.
8. The Committee was instructed that patient harm need never be shown to establish negligence or incompetence in a proceeding before the State Board For Professional Medical Conduct.
9. The Committee was reminded that it has the advantage of hindsight. The Committee must be mindful that in assessing the acts of Respondent, it must base its conclusions upon what Respondent knew at the time and what he could or should have reasonably ascertained at the time.
10. The Committee was instructed with regard to the legal theory of *negative inference*. It was explained to the Committee that a trier of fact in an administrative hearing may draw a negative inference from the choice of Respondent to remain silent during this proceeding.

This means the Committee may infer that under direct testimony, cross-examination or panel questioning, Respondent may have been forced to testify against his interest in this proceeding, had he chosen to testify about Patient A. It was further explained that any negative inference drawn from Respondent's failure to testify must be based upon the credible evidence presented by the parties. The Committee was free to draw the most negative inference that the evidence will allow. However, no conclusions may be based solely upon Respondent's invocation of his right to remain silent. Moreover, it was explained that while the Committee may draw a negative inference, there is no requirement that it do so.

11. The Committee was told that in drawing any negative inference, it must consider that there is currently pending a lawsuit against Respondent which arises from the care of Patient A. Plaintiffs in the lawsuit are seeking a substantial sum of monetary damages. Under New York State Law, any statements made by Respondent concerning Patient A before this Committee could be obtained and utilized by attorneys for plaintiffs in the prosecution of this lawsuit. Upon advice of counsel, Respondent elected, as is his right, not to offer testimony concerning Patient A at this hearing.

FINDINGS OF FACT

The findings of fact which follow, were made after review of the entire record. Reference to transcript pages (Tr.__) and/or exhibits (Exh.__) denotes evidence that was found persuasive in determining a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

GENERAL FINDINGS

1. Charles Marshall Lewis, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 4, 1980, by the issuance of license number 141702, by the New York State Education Department. (Dept's Exh. 2)
2. To meet the minimum standard of care, physicians must take a history from each patient and note that history in the chart or patient record. This is so even where the patient is being treated by other physicians. When patients are treated by more than one physician, documentation of that fact must appear in the chart. It is also necessary for the physician to record the exchange of data, lab tests, and history with the other physician. (Tr. 39-41, 53, 220-221, 243-250, 472-473)

3. To meet the minimum standard of care, the history must include all the information that is necessary to treat the patient, including chief complaint, history of any present illness, past medical history (including hospitalization), allergies, medications being taken, associated medical conditions, and social history. Other information not listed here may be required if it is necessary to obtain a full and accurate picture of the patient. (Tr. 28-30, 357-358)
4. A full patient history must be taken at the first patient contact. Such histories must be updated at subsequent encounters. The physician must consider any spontaneous history given by the patient. However, in order to obtain the minimally necessary information, the physician must also question the patient about history. The physician must record all pertinent data, even if only to summarize that nothing of note was discovered. (Tr. 30-32, 34-35, 100-101, 268-271, 714, 717-718)
5. To meet the minimum standard of care, physicians must take a history from each person who visits the physician for medical care. This is so even if the physician met or knew the patient previously in a capacity other than as a physician-patient. (Tr. 37-38)
6. In addition to obtaining a patient history, to meet the minimum standard of care, physicians must keep a chart or record for each patient. The patient record must include all pertinent facts involved in any treatment or other action taken by the physician. The chart must contain a sufficient amount of information to enable the physician to structure the treatment plan and record data for future care. The chart must also provide sufficient information to

explain to successor physicians or reviewing bodies what was done, what the practitioner was thinking, the overall treatment plan and the basis for all of the above. (Tr. 32-34, 236-237, 399-400)

7. At a minimum, the chart must include the date, the patient's chief complaint, subjective and objective observations, a history, an assessment, and a treatment plan. (Tr. 32-34, 236-237, 399-400)
8. An attending physician is the physician who is ultimately responsible for the care of a hospitalized patient. The attending physician coordinates care between sub-specialists. He is the contact person for the patient's family, and he often participates directly in the treatment of the patient during the hospitalization. The attending physician should note the patient's history in the patient's hospital chart. (Tr. 50-51, 53)

FINDINGS OF FACT
WITH REGARD TO
PATIENT A

9. Respondent treated Patient A, a male, d.o.b. 3/25/56, from approximately 1986 or 1989 to March 1992, at Community Hospital of Brooklyn, Brooklyn, New York, and at his office, located at 421 Avenue P, Brooklyn, New York. (Dept's Exh. 3, 4, 5)

10. Respondent, on various occasions during the course of treatment of this patient, failed to obtain a medical history sufficient to meet accepted standards of medical care. (Dept's Exh. 3, 4, 5) (Tr. 36-40, 42-45, 51-54, 566, 776-779, 782-783, 785-789)
11. Respondent did not communicate with other physicians regarding Patient A's medical condition. (Dept's Exh. 3, 4, 5) (Tr. 36-40, 42-45, 51-54, 566, 776-779, 782-783, 785-789)
12. Complete blood counts were performed on Patient A. The reports of the counts are dated May 14 and 16, 1991. The reports of these tests showed platelet counts of 23,000 and 30,000, respectively. These are very low values and are consistent with thrombocytopenia. Thrombocytopenia is a low blood count. (Dept's Exh. 3, pp. 20-21) (Tr. 445-6)
13. The primary risk of thrombocytopenia is spontaneous hemorrhage. The bleeding can occur in the urine, behind the kidney, in the G.I. tract, and most commonly, in the brain or central nervous system. Thrombocytopenia is a potentially lethal condition. (Tr. 57-58, 73-75, 118, 445-446)
14. Some of the etiologies of thrombocytopenia are autoimmune thrombocytopenia purpura (called "ITP"), HIV, thrombocytopenia purpura (called "TTP"), anhydremic and abnormal blood cells in the spleen, disorders of megakaryocyte production in the bone marrow, drugs, and leukemia lymphoma. Respondent did not address or rule out any of these etiologies in his record for this patient. (Dept's Exh. 3, 4) (Tr. 211-212)

15. To meet the minimum standard of care for patients with thrombocytopenia a physician must repeat the test and confirm or refute the initial diagnosis. Assuming thrombocytopenia to be confirmed, the practitioner must then:
- a. take what remedial action he can on his own;
 - b. inform the patient of the risks and consequences of not following up on the findings;
 - c. consult a hematologist or refer the patient to a hematologist for a formal review of a peripheral blood smear;
 - d. follow-up with the hematologist, and note the above in the patient's chart.
(Tr. 59-62, 217-218, 243-250)
16. Respondent did not perform any of the steps above in response to the May 1991 findings indicative of thrombocytopenia. (Dept's Exh. 3, 4, 5) (Tr. 56-58, 60-68, 70-73, 217-218, 243-250, 252-257, 272-273, 445-446)
17. On March 11, 1992, Patient A was admitted to Community Hospital of Brooklyn. The admitting diagnoses were hematuria and sepsis. (Exh. 5)
18. On March 16, 1992, at 3 p.m., Patient A complained of numbness and loss of strength in his left hand. At 4:30 p.m., the numbness persisted and the patient's ability to grasp was diminishing. At 5 p.m., Patient A had numbness of the left leg. (Dept's Exh. 5, p. 77, 107, 133) (Tr. 77-78, 79-80, 215, 219-220, 250-252)

19. Respondent was made aware of these symptoms. On March 16, 1992, at approximately 6 P.M., he visited the patient. (Dept's Exh. 5, p. 77, 107, 133) (Tr. 77-78, 79-80, 215, 219-220, 250-252)
20. At this time, Respondent also contacted a neurologist. (Dept's Exh. 5, p. 77, 107, 133) (Tr. 77-78, 79-80, 215, 219-220, 250-252)
21. Respondent treated the patient by providing prescriptions for Xanax, Dalmane and, later, Tylenol 3. (Dept's Exh. 5, p. 77, 107, 133) (Tr. 77-78, 79-80, 215, 219-220, 250-252)
22. None of the medications prescribed by Respondent addresses the possibility of, or has any effect upon, hemorrhaging into the brain. Furthermore, these medications can confuse the clinical symptoms of the patient by reducing the patient's sensorium. (Dept's Exh. 5, p. 77-9, 107, 133) (Tr. 79, 216-217, 539)
23. At 7 p.m., subsequent to Respondent's visit, Patient A complained of terrible headache and right eye ache. Respondent was made aware of these symptoms. Respondent addressed the report by providing a prescription for Tylenol. (Dept's Exh. 5, p. 107, 134) (Tr. 80)
24. Based on the aforesaid symptoms, to meet the minimum standard of care, Respondent's treatment should have included the following elements:
 - a. Patient A's symptoms should have been treated as an emergency
 - b. an effort to rule out brain hemorrhage should have been undertaken;

- c. The low platelet count should have been treated aggressively with platelet transfusion and intravenous immunoglobulin (IVIG);
- d. An immediate CAT scan should have been ordered;
- e. a neurologist and a hematologist should have been consulted.

(Dept's Exh. 5) (Resp's Exh. J, K) (Tr. 80-81, 89-92, 200-205, 250-252, 538)

- 25. Respondent took none of the actions set forth above. Respondent's notes do not reflect any reason for his failure to act as warranted. (Dept's Exh. 5) (Resp's Exh. J, K) (Tr. 80-81, 89-92, 200-205, 250-252, 538)
- 26. At 8:30 p.m., Patient A's headache persisted and was very strong. He requested additional pain medication. He also complained that he could not feel his left leg and his left hand. Such a report indicates that the previously noted numbness had progressed and had now reached the stage of anesthesia. (Dept's Exh. 5, p. 107, 134) (Tr.81-82)
- 27. Respondent was made aware of these symptoms. He ordered Tylenol with codeine in response to the report. (Dept's Exh. 5, p. 107, 134) (Tr.81-82)
- 28. Based on the aforesaid symptoms, to meet the minimum standards of care, Respondent should have addressed the neurologic changes in the setting of a low platelet count. (Dept's Exh. 5, p. 107, 134) (Tr. 81-82, 216-217, 540-541)

29. Patient A's symptoms, displayed the potential for a catastrophe. (Dept's Exh. 5, p. 134) (Tr. 82-87, 189-192, 215)
30. An immediate neurological examination was required at this point. (Dept's Exh. 5, p. 134) (Tr. 82-87, 189-192, 215)
31. If one neurologist was unavailable, another neurologist should have been contacted by Respondent for immediate action. Respondent failed to take these actions. (Dept's Exh. 5, p. 134) (Tr. 82-87, 189-192, 215)
32. On or about March 17, 1992, Patient A suffered a massive right cerebral hemispheric bleed (intracerebral hemorrhage), and he expired on March 22, 1992.
33. The intracerebral hemorrhage was precipitated by the thrombocytopenia. The intracerebral hemorrhage that occurred with Patient A is consistent with Patient A's symptoms on March 16, 1992. This outcome was one of the predictable risks of thrombocytopenia as first detected in May 1991. (Dept's Exh. 3, 4, 5) (Tr. 87-88, 267-268, 276-277)

FINDINGS OF FACT
WITH REGARD TO
PATIENT B

34. Respondent treated Patient B, a female, age 43, on June 6, 1988. Respondent saw Patient B at her home in Brooklyn, New York, at approximately 9:00 p.m. (Dept's Exh. 6) (Resp's Exh. G) (Tr. 593-594, 642)
35. Patient B expired very early in the morning on June 7, 1988, within approximately seven to nine hours after Respondent saw her. (Dept's Exh. 7, 8) (Tr. 416-418, 594-595, 642-644)
36. An autopsy was performed on Patient B. The autopsy report and death certificate state that this patient died of acute purulent peritonitis resulting from a ruptured tubo-ovarian abscess. The report also shows that the perforation was partially sealed by omentum. In addition, a large amount of fibrinous material covered the serosal surfaces. Finally, according to the report, the patient had marked atrophy of the musculature and was in a very poor nutritional state. (Dept's Exh. 7 and 8) (Resp's Exh. G) (Tr. 334-336, 398-399, 637)
37. The symptoms of peritonitis usually include lower abdominal pain, rigidity of the abdomen, decreased bowel sounds, rebound tenderness. The patient would exhibit signs of excruciating pain following hand pressure on the abdomen. There would also be fever, accelerated heart rate, low blood pressure. When there is a ruptured abscess, there would be fluid in the abdominal cavity. The abdomen would be rigid and board-like, as well as

tender. If a patient were unconscious or had an altered sense of pain, she might not respond to painful stimuli. (Resp's Exh. I, p. 51-53) (Tr. 317-318, 326, 350-351, 364-366, 684-685)

38. On June 6, 1988, Respondent did not note in Patient B's chart that she had any of the signs or symptoms of peritonitis. (Dept's Exh. 6) (Resp's Exh. G) (Tr. 334-336, 398-399, 637)
39. At the time Respondent examined this patient, she exhibited some or all of the symptoms of acute purulent peritonitis. (Dept's Exh. 6, and 7, Resp's Exh. G) (Tr. 319-323, 415-420)
40. A perforation of a tubo-ovarian abscess does not become partially sealed by omentum immediately. Rather, such sealing is a biological process which occurs over a period of days. (Dept's Exh. 6, and 7, Resp's Exh. G) (Tr. 319-323, 415-420)
41. In this patient there was a widespread inflammatory process that occurred as a result of pus in the abdomen. Signs and symptoms of peritonitis would have been obvious upon examination seven to nine hours prior to this patient's expiration. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Tr. 321-326, 415-420)
42. When a patient complains of abdominal pain, the reasonably prudent physician would inspect, palpate, percuss and auscultate the patient's abdomen. (Tr. 327, 677-678)

43. Bowel sounds are detected and assessed by placing a stethoscope on the abdominal surface and listening. Minimum accepted standards of medicine would require the examining physician to listen to and assess this patient's bowel sounds. (Tr. 326-327)
44. When a female patient has pelvic inflammatory disease or infection in the pelvis, the infection can cause salpingitis (infection of the fallopian tubes). Salpingitis can form an abscess. When the abscess is at the site of the fallopian tube and ovary, it is called a tubo-ovarian abscess; the abscess can become an extremely large mass, filled with pus. If that mass ruptures, the pus spills into the abdominal cavity. Such an occurrence is called a ruptured tubo-ovarian abscess. When a pus filled mass ruptures in the body cavity, the body responds by attempting to seal the rupture off with omentum. The omentum covers the abscess and attempts to wall it off. (Tr. 327-330, 342-343, 695-696)
45. Patient B's right tubo-ovarian abscess ruptured prior to the examination by Respondent at 9 P.M. on June 6, 1988. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Tr. 330, 415-420)
46. A "very poor nutritional state" is a chronic condition involving wasting of the muscles of the face and extremities. In addition, the eyes could be sunken. Upon even the most minimal examination, the reasonably prudent and competent physician would recognize marked atrophy (wasting) of the musculature and of the extremities. Marked atrophy of the extremities would be obvious, even if the physician were meeting the patient for the first time. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Tr. 332-335, 398)

47. Marked atrophy is a process that takes days, not hours. The condition could not have arisen in the time between Respondent's examination of this patient and her demise. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Tr. 332-335, 398)

48. Respondent reported the abdomen, vital signs, HEENT, and extremities of this patient were normal. It is not possible to reconcile normal findings in an examination followed by the death of a patient from a ruptured tubo-ovarian abscess seven to nine hours after the examination. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Resp's Exh. I, p. 51-53) (Tr. 337-338, 364-366, 415-420, 600-602, 607-610, 612-614, 622-623, 638-640, 697-698)

49. There is no entry in the chart for Patient B on June 6, 1988, recording an adequate medical history. (Dept's Exh. 6) (Resp's Exh. G) (Resp's Exh. I, p. 44-45) (Tr. 313-315, 371-374, 395-399, 423, 598-599, 625-628, 634-637, 738-743, 754)

50. There is no record of a physical examination appropriate to this patient's complaints on June 6, 1988. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Resp's Exh. I, p. 44, 49-50, 51-57,) (Tr. 315-317, 336, 354, 364-369, 375, 382-388, 391-392, 394-396, 398-399, 406-407, 413-420, 600-603, 612-613, 628, 637, 644-648, 651-653, 656, 738-743, 749-750)

51. Based upon the symptoms exhibited by Patient B¹ on June 6, 1988, to meet minimum accepted standards of medicine, a physician exhibiting minimally acceptable levels of competence and attention to the patient's needs, would have immediately referred Patient B to a hospital for diagnosis and treatment. (Dept's Exh. 6, 7, 8) (Resp's Exh. G) (Resp's Exh. I, p. 51-53, 59, 95) (Tr. 336-337, 364-366, 369-370, 379-380, 406-407, 411, 610-611, 730-736)

CONCLUSIONS

CONCLUSIONS WITH REGARD TO WITNESSES AND EVIDENCE

The committee finds the testimony of Stephen B. Tamarin, M.D., to be credible. Dr. Tamarin testified on three separate occasions, and was subject to extensive cross examination as well as questions by the panel members. Dr. Tamarin had the requisite training, knowledge and experience to render an expert opinion. He was forthright in his opinions, and his testimony was consistent. When presented with hypothetical questions on cross examination, he answered honestly. Dr. Tamarin showed the mental discipline necessary to answer hypothetical questions as

¹The Committee refers to the symptoms that the evidence establishes were present when Respondent was there (see Findings of Fact thirty-six and thirty-seven). The Committee finds Respondent's description of this patient false. This conclusion is based upon the findings of disinterested parties and will be developed fully in the conclusions which follow.

posed, notwithstanding a particular answer might have been in contradiction to something he said during direct examination. Rather than undermine Dr. Tamarin's testimony, this level of intellectual honesty bolsters his overall credibility. Moreover, it must be noted that Dr. Tamarin's testimony as to the actual facts set forth in the evidence, while tested, was never refuted either through cross-examination or contradictory evidence.

With regard to Respondent's expert witnesses, Robert N. Holtzman, M.D. and Morton Davidson, M.D., The Committee finds them to be credible. However, the Committee further finds that many of their assertions were made based upon hypothetical questions which were not supported by the facts of this case. The Committee finds the testimony given by Respondent was self-serving, and vague. Respondent was evasive on cross-examination as well as panel questions. His testimony was, at times, contradictory.

CONCLUSIONS
WITH REGARD TO
FACTUAL ALLEGATIONS
ARISING FROM
PATIENT A

NEGATIVE INFERENCE

Respondent chose to remain silent with regard to the charges arising from the care and treatment of this patient. The Committee respects Respondent's right to do so. The Committee is aware of Petitioner's request that it draw a negative inference from Respondent's election. The Committee chooses not to do so.

In so deciding, the Committee notes that the evidence presented by Petitioner was clear, complete and convincing. Therefore the Committee finds no need to draw any inference at all from Respondent's choice to remain silent regarding this patient. The fact is, given the irrefutable portions of the evidence (the hospital record and Respondent's own notes), it is hard for the Committee to imagine anything Respondent could have added to change the basic facts. It is upon those basic facts that the Committee makes all its conclusions regarding the charges associated with Patient A.

ALLEGATION A.1

Petitioner has proven by a preponderance of the evidence that Respondent failed on most occasions to obtain and record histories for Patient A which were consistent with accepted medical standards, as set forth above. While the Statement Of Charges alleges Respondent failed to take an appropriate history "at any time", it is clear to the trier of fact that the essence of the charge is the failure of Respondent, on a regular and routine basis to obtain adequate history. While some of the encounters recorded herein show minimally acceptable historical comments, the vast majority of Respondent's chart entries are unequivocally inadequate. Therefore, in the total context of this proceeding the charge must be sustained.

Therefore, based upon the above conclusions:

Factual Allegation A.1. IS SUSTAINED

ALLEGATION A.2

In this allegation, Respondent is cited for failing to properly follow-up on the low platelet count found for this patient. The facts in this case show that Respondent was confronted by a patient who had a seriously low platelet count. The record is equally clear Respondent took none

of the actions set forth in Finding of fact 15: The physician finding a patient to have a low platelet count must confirm or refute the initial diagnosis by repeating the blood test. Assuming thrombocytopenia to be confirmed, the practitioner must:

- a. take what remedial action he can;
- b. inform the patient of the risks and consequences of not following up on the findings;
- c. consult a hematologist or refer the patient to a hematologist for a formal review of a peripheral blood smear;
- d. follow-up with the hematologist, and note the above in the patient's chart.
(T59-62, 217-218, 243-250)

Respondent failed to take any of the appropriate actions listed. He also failed to refer this patient to a practitioner who would do so. In fact, the record herein shows Respondent ignored a dangerously low platelet count. Such a count cannot be ignored as it is potentially life-threatening. Yet, there is no evidence of treatment or referral by Respondent.

Therefore, based upon the above conclusions:

Factual Allegation A.2 IS SUSTAINED

ALLEGATION A.3

Petitioner has proven by a preponderance of the evidence that Respondent failed to take appropriate action when confronted with Patient A's condition on March 16 and thereafter. While the situation presented in May of 1991 and addressed under Allegation A. 2 was serious, by the time Patient A is in the condition described on March 16, 1991, a crisis of catastrophic proportions should have been recognized by any competent physician exhibiting reasonable care and diligence.

As set forth in Finding of Fact 23, faced with the symptoms presented by Patient A on March 16, to meet the minimum standard of care, Respondent's treatment should have included the following elements:

- a. Patient A's symptoms should have been treated as an emergency
- b. an effort to rule out brain hemorrhage should have been undertaken;
- c. The low platelet count should have been treated aggressively with platelet transfusion and intravenous immunoglobulin (IVIG)
- d. An immediate CAT scan should have been ordered;
- e. a neurologist and a hematologist should have been consulted.

Respondent failed to take any of the steps set forth above. In fact, Respondent's primary reaction to Patient A's malady was the prescribing of Xanax Dalmane and Tylenol 3 (a tranquilizer, a hypnotic, and a narcotic analgesic, respectively). Clearly, such prescriptions are the wrong treatment, in terms of a cure, because they do not address the causes of the patient's condition. Perhaps more important, these prescriptions constituted the wrong treatment in that these particular drugs would make it more difficult for later practitioners, particularly the neurologist, to properly assess and treat the patient. Each of these drugs would cloud the patient's sensorium. In concert, they could be expected to synergize and further complicate appropriate treatment. Hence the Committee finds Respondent not only failed to treat this patient properly, but he also increased the patient's risks and lowered the likelihood of proper assistance.

Therefore, based upon the above conclusions:

Factual Allegation A.3 IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
FACTUAL ALLEGATIONS ARISING FROM
PATIENT B

ALLEGATION B.1

In Allegation B.1, Respondent is charged with the failure to obtain an adequate medical history for this patient. The fact is that not only do Respondent's records lack a basic medical history, his testimony confirms that he obtained an insufficient amount of information. The Committee is mindful of Respondent's assertion that the patient was not communicative and the family present was of little assistance. However, given the severity of the presentation of the patient, Respondent had a greater than usual basis to obtain basic information. If that meant calling someone in to assist with a language problem or referring the patient to a hospital, Respondent had a duty to do so. Clearly, the utter paucity of relevant information obtained by Respondent is unacceptable and inexcusable.

Therefore, based upon the above conclusions:

Factual Allegation B.1 IS SUSTAINED

ALLEGATION B.2

In this charge, Respondent is cited for failing to perform an adequate physical examination of this patient. At this point, the autopsy report, Exhibit 7, becomes very important to the trier of fact. The autopsy was performed by a disinterested third party. While Respondent had a motive to be less than truthful, certainly, no such motive existed for those who performed the autopsy.

Therefore, where contradictions arise, the autopsy report is worthy of greater credibility than the testimony of Respondent.

Respondent alleges he did an appropriate physical examination on Patient B at the time she was seen. Whether or not the notes taken reflect this, it is Respondent's contention that it was done. Furthermore, according to Respondent, there was nothing shown upon examination which appeared extraordinary or threatening to the patient.

However, it is beyond dispute that this patient died some seven to nine hours after Respondent saw her. Furthermore, according to the autopsy, this patient died of a ruptured tubo-ovarian abscess. The autopsy also revealed that there was omentum surrounding the rupture and the patient was in a very poor nutritional state. Knowing what caused the demise of this patient, the amount of time between Respondent's presence and her death, and her physical state upon autopsy, there are certain conclusions that the Committee can draw about the condition of the patient at the time of the examination.

Given the facts presented to this Committee, it can be concluded without reasonable doubt that upon the most rudimentary physical examination, a physician would have noted this patient's emaciation. Respondent made no mention of this in his notes. More important however, this patient would have either been in extreme pain or obtunded from pain and debilitation. Again, a physician using his basic senses would have observed these facts. Knowing without doubt that the examining physician, at the time of Respondent's visit would have observed extreme emaciation and severe pain, it follows that a physician rising to the most basic medical standards would have referred this patient to a hospital immediately. Respondent took no such action.

Respondent's suggestion that the conditions described above were not visible when he visited the patient are belied by scientific fact offered by other parties and hence devoid of credibility. Clearly, Respondent could not have known at the time of his examination that the patient was suffering *specifically* from a tubo-ovarian abscess, that there had been a rupture and the rupture had occurred sufficiently earlier such that omentum had been created. However, it is unquestioned that this patient died some seven to nine hours after she was seen by Respondent. Upon autopsy, omentum was found at the sight of the rupture. The fact is that it takes days, not hours, for a patient to develop the conditions found upon autopsy. Therefore, they had to be present at the time of Respondent's visit. It is equally beyond doubt that a tubo-ovarian abscess and the resulting conditions are extremely painful. Respondent's assertion that he did not consider this patient to be in a state serious enough to warrant hospital care either means that he never examined her or he ignored obvious signs and symptoms. Even if the patient were in an obtunded state and hence could not communicate pain, Respondent, using the most basic medical skills, would have recognized she was in a serious state and had her transported to a hospital.

Therefore, based upon the above conclusions:

Factual Allegation B.2 IS SUSTAINED

ALLEGATION B.3

As explained above, the reliable facts show that when Respondent saw this patient on the night in question, she was in serious condition and that a physician meeting the barest minimum standards of medicine would have noted same. Having so noted, it is clear that Respondent had neither the equipment nor the expertise at hand to treat the patient. The Committee does not expect him to have had such at hand. However, given the facts, Respondent should have immediately

referred this patient to a hospital where treatment could have been engaged on an emergency basis. Respondent failed to take any of the appropriate steps necessary to respond to what would have had to exist on the night in question. Having failed to perceive this emergency case as significant, he engaged in no follow-up whatsoever.

Therefore, based upon the above conclusions:

Factual Allegation B.3 IS SUSTAINED

**CONCLUSIONS
WITH REGARD TO
SPECIFICATIONS**

Having sustained each of the Factual Allegations, the Committee now turns its attention to the Specifications of misconduct to assess whether the facts sustained give rise to findings of medical misconduct.

**CONCLUSIONS
WITH REGARD TO
THE FIRST SPECIFICATION
(PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION)**

This Committee finds that Respondent committed numerous acts of negligence in the treatment of these two patients. Respondent did not examine or treat either of these patients within accepted standards of medicine. He displayed a level of care and diligence that was clearly sub-standard. As will be developed below, Respondent's acts rise to egregious deviations from accepted standards. Hence gross negligence has been found with regard to both patients on numerous

occasions. Based upon the reasoning set forth for the findings of gross negligence, the lesser included offenses of negligence on more than one occasion are also sustained.

Therefore, based upon the above conclusions:

The First Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE SECOND SPECIFICATION
(Gross Negligence Arising From the Care of Patient A)

To sustain this specification, the State must prove that Respondent failed to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state and that he did so as a single act of negligence of egregious proportions or by multiple acts of negligence that cumulatively amount to egregious conduct. This Committee finds that Respondent fulfilled both criteria. As is developed below, the Committee finds that the facts set forth under any of the three Factual Allegations alone would support a finding of gross negligence.

With regard to Allegation A.1 (failure to obtain an adequate history), the Committee finds that while on some occasions Respondent could be said to have included the most basic of medical histories in the patient's record, overall, his general failure to obtain an appropriate medical history constituted a series of negligent acts which in total, arise to gross negligence. It is to be noted that Respondent suggested in his defense that the patient was seeing other physicians who held primary responsibility for obtaining an overall history of this patient. If this were true, a copy of said history should have been in the record or accounted for, as with a note to the effect that it was requested

but not forwarded. Moreover, even if other practitioners had primary responsibility for this patient, the Committee does not find the historical notes contained in this record to be sufficient for even limited treatment. Given the nature of this case, the amount of time over which Respondent saw the patient, and the seriousness of the patient's malady, the Committee finds the overall failure of Respondent to account for the history of this patient to be a profound violation of accepted standards of care and diligence and hence, to constitute gross negligence.

Allegation A.2 refers to Respondent's failure to act appropriately when the patient was found to have a low platelet count. First, let it be said that it was not contested that the platelet count for this patient was dangerously low in 1991 and that Respondent was aware of same. Having so admitted, Respondent had two basic options : take the actions set forth in finding of fact 15 or see to it that another practitioner did so on an urgent basis. Respondent fulfilled neither requirement. While there was some testimony to the effect that Respondent assumed that another practitioner was attending to the low platelet count, the value was sufficiently low and the potential outcome so serious that direct action, at least by consultation was required on the part of Respondent. Respondent's failure to take action, given the unequivocal symptoms combined with the danger of the potential outcome, makes this deviation from accepted standards of care and diligence one of egregious proportions.

With reference to Allegation A.3, (failure to appropriately respond to the symptoms of March 16 1992 and following), here the Committee again finds deviations from accepted standards of medicine of egregious proportions. While the Committee does not expect this or any other practitioner to have expertise beyond his field, given the symptoms displayed at the time in question

Respondent had the duty to treat the patient properly or obtain alternative care immediately. He did neither. As was discussed under the factual allegations, Respondent prescribed drugs that not only did not help the patient but also made it more difficult for others to provide care. While there is some evidence that Respondent made an effort to obtain consultations with other more qualified physicians, his efforts were entirely inadequate. The minimum standards of care were listed in the findings of fact and again in the factual conclusions. The Committee finds the standards enunciated to be basic and obvious to any physician in this state. Therefore Respondent's deviation is so significant that the Committee finds it constitutes gross negligence.

Therefore, based upon the above conclusions:

The Second Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE THIRD SPECIFICATION
(Gross Negligence Arising From the Care of Patient B)

To sustain the Third Specification, the State must again prove that Respondent failed to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state and that he did so as a single act of negligence of egregious proportions or by multiple acts of negligence that cumulatively amount to egregious conduct. This Committee again finds that Respondent fulfilled both criteria. It is the conclusion of this Committee that Respondent's actions under any one of the three charges arising from the care and treatment of Patient B constituted an egregious violation of accepted standards of care and diligence and hence, gross negligence.

Turning now to Allegations B.1 and B.2, the Committee finds Respondent failed to obtain an appropriate history (B.1) and that he failed to examine this patient (B.2). Both these findings, under the circumstances herein constitute gross negligence.

On the night of June 6, 1988, Respondent was called to the home of Patient B. According to Respondent she exhibited symptoms of indigestion. In fact however, she was dying of a ruptured tubo-ovarian abscess. While Respondent could not have known the precise malady this patient was suffering from, the incontrovertible evidence, provided by an autopsy, proves beyond a preponderance of the evidence, that at the time Respondent saw this patient she was urgently ill and warranted emergency care.

The autopsy shows that her condition had been developing over time. One does not become in poor nutritional state and show omentum at the sight of a tubo-ovarian abscess within hours. Rather, both processes take days or longer. Had Respondent obtained a rudimentary history he would have discovered the existence of pain and lack of nutrition over a significant period of time. Had he examined the patient he would have either seen symptoms of severe pain, not to mention emaciation, or the patient would have been in an obtunded state. Either finding upon examination, with a basic history, would have led a physician exhibiting the most fundamental standards of care and diligence to refer this patient to a hospital. Respondent met none of these criteria.

As has been stated earlier, this Committee does not believe that Respondent actually examined this patient. It is important to point out, that the very failure to examine the patient after some sort of history is basic to the practice of medicine. A physician who is called to a patient and

fails *either* to examine the patient or take a basic history has egregiously violated fundamental standards of care and diligence and hence has committed gross negligence. Therefore, Respondent's failure either to obtain an appropriate history or perform an appropriate examination, individually constitute a gross deviation from accepted standards of care and diligence, and hence, gross negligence.

Therefore, based upon the above conclusions:

The Third Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FOURTH SPECIFICATION
(PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION)

This Committee finds that Respondent displayed incompetence in the treatment of these two patients on numerous occasions. Respondent did not examine or treat either of these patients within accepted standards of medicine. As will be developed below, Respondent's acts rise to egregious deviations from accepted standards. Hence gross incompetence has been found with regard to both patients on numerous occasions. Based upon the reasoning set forth for the findings of gross incompetence, the lesser included offenses of incompetence on more than one occasion are also sustained.

Therefore, based upon the above conclusions:

The Fourth Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FIFTH SPECIFICATION
(Gross Incompetence Arising From the Care of Patient A)

The Committee finds Respondent demonstrated gross incompetence in his conduct with regard to Patient A. The bases upon which these findings are made are essentially the same as those set forth in the discussion of gross negligence above. Stated most succinctly, the difference between negligence and incompetence is that a finding of negligence assumes the actor knows proper procedure but was careless. A finding of incompetence means that the physician acts like someone who is lacking in skill and expertise. Respondent's failures with regard to both patients combined both carelessness and an obvious lack of skill.

With regard to Patient A, a physician acting within the requisite bounds of skill and knowledge would have performed and recorded an examination and history (Allegation A.1). Of greater importance, a physician exhibiting basic skill and knowledge would have recognized that this patient had a low platelet count and confirmed that recognition with the action set forth above (Allegation A.2). Finally, as was explained in greater detail earlier, a physician acting within minimal standards of knowledge and expertise would have recognized the emergent nature of the March 1992 hospitalization and confirmed that recognition with appropriate action, as set forth above (Allegation A.3). As was explained previously, not only did Respondent in this case fail to take the actions required to reflect the requisite standards of skill and knowledge, the actions he did take were contrary to basic medical tenets. That is, Respondent reflected incompetence both in what he failed to do for this patient as well as what he actually did.

Just as with the findings of gross negligence, this Committee affirms that each of the factual violations constitutes an egregious deviation from accepted standards of knowledge and expertise. Hence, the failure to keep an ongoing history of this patient, under all the facts and circumstances was an extreme deviation from accepted standards. Likewise the failure to take appropriate action regarding the low platelet count constitutes gross negligence as does Respondent's failure to act appropriately when this patient was hospitalized.

Therefore, based upon the above conclusions:

The Fifth Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE SIXTH SPECIFICATION
(Gross Incompetence Arising From the Care of Patient B)

Moving to Patient B, the Committee again finds Respondent to have demonstrated gross incompetence. As was explained earlier, the incontrovertible facts lead the Committee to conclude that Respondent never examined this patient. This, in and of itself would constitute a severe deviation from standards and hence, gross incompetence. However, if the Committee were to accept Respondent's position, that he examined the patient and concluded she was suffering from indigestion, there would still be a finding of gross incompetence. As was explained earlier, it is beyond the realm of medical possibility that this patient would not have exhibited symptoms of a very serious condition at the time she was seen by Respondent. If Respondent examined this patient and failed to see that she was seriously ill, he demonstrated an egregious departure from the level of skill and knowledge expected of a physician in this state.

Just as with the findings of gross negligence, this Committee affirms that each of the factual violations arising from the care and treatment of Patient B constitutes an egregious deviation from accepted standards of knowledge and expertise. Hence, the failure to obtain and record a medical history of this patient, under all the facts and circumstances was an extreme deviation from accepted standards. Likewise the failure to perform a physical examination of this patient reflects an extreme deviation from accepted standards of knowledge and expertise. Finally, Respondent's failure to take appropriate action based upon this patient's medical condition either shows he could not recognize what would be obvious to the knowledgeable physician or he did not know what action to take upon recognizing the signs and symptoms he saw. Either interpretation constitutes gross incompetence.

Therefore, based upon the above conclusions:

The Sixth Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE SEVENTH AND EIGHTH SPECIFICATIONS
(Failure to keep adequate medical records for Patient A and Patient B)

The Committee finds upon review of both patient records that it would not be possible for a successor caretaker or reviewing body to know what findings Respondent had made for each patient, what treatment he had given and his thinking at the time. Those are the standards which

medical records must fulfill in this state. It follows then, that the patient records kept by Respondent are inadequate.

Therefore, based upon the above conclusions:

The Seventh Specification IS SUSTAINED

and

The Eighth Specification IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
PENALTY

The care rendered by Respondent herein shows that he does not understand the basic fundamentals of the treatment of life-threatening conditions. In the case of Patient A, Respondent showed an inexcusable failure to follow-up on a dangerously low platelet count, a potentially life threatening condition. When the patient was hospitalized, he failed to take necessary affirmative action and the actions he took were inappropriate and incompetent. With regard to Patient B, he failed to note obvious signs and symptoms of an extremely serious condition. The evidence in this case establishes that Respondent failed to appropriately follow up on serious diagnoses and medical findings. Respondent has shown a degree of carelessness, neglect and incompetence that renders him incapable of continuing to provide medical care to patients in New York State with any reasonable degree of safety. Perhaps of most concern, Respondent showed not the slightest sign that he understood his level of practice to need improvement. Hence, this Committee sees no hope of rehabilitation. Finally, the Committee wishes to stress that the facts in either of these cases would be sufficient to show that it is unsafe to permit Respondent to continue practicing medicine

in this State. That there were two incidents established merely serves to affirm that primary conclusion.

For all the above reasons, the Hearing Committee revokes Respondent's license to practice medicine in the State of New York.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

1. The Factual Allegations contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

2. The Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

3. The license of Respondent to practice medicine in the State of New York is hereby **REVOKED**;

Furthermore, it is hereby **ORDERED** that;

4. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail to Respondent or his attorney.

Dated: *February 6, 1997*
Richmond Hill, New York

Kenneth T. Kowald 1997

KENNETH KOWALD, Chairperson,

DIANA E. GARNEAU, M.D.
RALPH LEVY, M.D.

(12)

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APPENDIX ONE

IN THE MATTER
OF
CHARLES MARSHALL LEWIS, M.D.

STATEMENT
OF
CHARGES

Charles Marshall Lewis, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 4, 1980, by the issuance of license number 141702, by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent treated Patient A, d.o.b. 3/25/56, from approximately 1986 or 1989 to March 1992, at Community Hospital of Brooklyn, Brooklyn, New York, and/or at his office, located at 421 Avenue P, Brooklyn, New York. (The identities of Patients A and B are disclosed in the attached Appendix.)
1. Respondent failed, at any time throughout the course of treatment of Patient A, to obtain an adequate medical history, or note in the chart(s) such adequate history, if any.
 2. Although Patient A was found to have a low platelet count in approximately May 1991, Respondent failed to appropriately follow up on said findings.
 3. When Patient A repeatedly complained of numbness, and eventually complained of eye pain, headache, nausea and vomiting, on or about March 16, 1992, Respondent failed to appropriately respond to said complaints. On or about March 17, 1992, Patient A suffered a massive right cerebral hemispheric bleed, and he expired on March 22, 1992.

B. Respondent treated Patient B, age 43, on or about June 6, 1988, at Patient B's home in Brooklyn, New York.

1. On or about June 6, 1988, Respondent failed to obtain an adequate medical history, or note in the chart such history, if any.
2. On or about June 6, 1988, Respondent failed to perform an adequate physical examination.
3. On or about June 6, 1988, Respondent failed to appropriately respond to, and/or follow up on, Patient B's medical condition, and Patient B expired the next day.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1, 2 and/or 3, B and B1, 2 and/or 3.

SECOND AND THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1, 2 and/or 3.
3. Paragraphs B and B1, 2 and/or 3.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

4. Paragraphs A and A1, 2 and/or 3, B and B1, 2 and/or 3.

FIFTH AND SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

5. Paragraphs A and A1, 2 and/or 3.
6. Paragraphs B and B1, 2 and/or 3.

SEVENTH AND EIGHTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1996) by failing to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, as alleged in the facts of:

7. Paragraphs A and A1.
8. Paragraphs B and B1.

DATED: May 14, 1996
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct