STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 15, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
NYS Department of Health
5 Penn Plaza, Suite 601
New York, New York 10001

T. Lawrence Tabak, Esq.
Kern Augustine Conroy Schopmann, P. C.
420 Lakeville Road
Lake Success, New York 11042

Steven Wilkins, M.D.
REDACTED

RE: In the Matter of Steven Wilkins, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-179) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), 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.

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

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

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

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER OF OF STEVEN WILKINS, M.D.	DETERMINATION AND ORDER BPMC #00-179

STEPHEN W. HORNYAK, M.D., Chairperson, **ARTHUR N. TESSLER, M.D.**, and **MR. JAMES DUCEY**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with gross negligence on a particular occasion (five specifications) and gross incompetence (five specifications), and with negligence on more than one occasion (one specification) and incompetence on more than one occasion (one specification).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	October 13, 1999 and August 17, 1999 respectively
Date of Service of Notice of Hearing and Statement of Charges:	November 2, 1999
Answer to Charges Dated:	November 17, 1999
Prehearing Conference Date:	December 2, 1999
Hearing Dates:	December 13, 1999 January 24, 2000 January 31, 2000 February 7, 2000 March 6, 2000
Deliberation Date:	April 24, 2000
Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	David W. Smith, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Kern Augustine Conroy & Schoppmann, P.C. 420 Lakeville Road Lake Success, N.Y. 11042 By: T. Lawrence Tabak, Esq.

WITNESSES

For the Petitioner: Arthur G. Lerner, M.D.

For the Respondent: Steven B. Wilkins, M.D.
David Befeler, M.D.
Louis-Joseph Auguste, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations 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 cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Steven Wilkins, M.D. ["the Respondent"] was authorized to practice medicine in New York State on September 24, 1984 by the issuance of license number 160318 by the New York State Education Department (Ex. 4).
2. The Respondent is Board Certified in General Surgery and holds a special letter of certification for surgical critical care from the American College of Surgeons (Tr. 250; Ex. B).
3. The Respondent maintains a private medical practice limited to general surgery. Most of his patients are emergency room and critical care patients. (Tr. 251 and 256).

4. Since 1994 the Respondent has been affiliated with St. John's Episcopal Hospital ["SJEH"], Smithtown, New York, John T. Mather Memorial Hospital, Port Jefferson, New York and St. Charles' Hospital and Rehabilitation Center, Port Jefferson, New York (Tr. 250-251; Ex. B).

5. The Respondent currently maintains a medical office in Smithtown, New York, which is attached to SJEH (Tr. 251-252; Ex. B).

FINDINGS AS TO PATIENT A

6. Patient A, a 57 year old female, was admitted to SJEH on January 13, 1996 (Tr. 24; Ex. 5, pp. 27, 30-33 and 146). The Respondent was the attending physician covering for Dr. A. d'Alessandro (Tr. 270-271; Ex. 5, p. 146 and Ex. 6, p. 1).

7. The Respondent was aware of Patient A's condition and medical history having treated her previously (Tr. 261 and 269; Ex. 5, p. 509).

8. On admission Patient A was complaining of abdominal pain, vaginal discharge and bloody stool. The Respondent knew at that time that there was an obstruction at the site of a previous anastomosis. (Tr. 25-28 and 267- 273; Ex. 5, p. 146).

9. On January 15, 1996 Patient A underwent a barium enema which demonstrated complete obstruction at the rectosigmoid junction (Tr. 282; Ex. 5, p. 248).

10. On January 16, 1996 the Respondent performed a laparotomy on Patient A after she acutely developed severe abdominal pain and an x-ray demonstrated free air (Tr. 32; Ex. 5, pp. 134, 164-167 and 222).

11. The laparotomy findings included perforation of the cecum and gross contamination of the peritoneal cavity with bowel contents (Tr. 32-33; Ex. 5, pp. 164-167).

12. During the laparotomy repairs were made to the intestine and a colostomy was performed. Following the operation Patient A developed progressive infection and she ultimately expired. (Tr. 32-38; Ex. 5, pp. 30-33 and 164-167).

13. The Respondent did not operate in a timely fashion which resulted in the perforation of the patient's bowel while still under observation (Tr. 36-42; Ex. 5, pp. 164-169).

14. In view of the infection at the time of the operation, cultures should have been obtained but were not (Tr. 38-39; Ex. 5, pp. 164-167).

15. The care the Respondent provided to Patient A did not meet minimum acceptable medical standards (Tr. 37-42).

FINDINGS AS TO PATIENT B

16. Patient B, a 60 year old male, first presented to the Emergency Room of SJEH at approximately 4:00 p.m. on May 27, 1995. He was diaphoretic and complained of abdominal pain and nausea. After being evaluated by the Emergency Room staff, he was sent home. (Tr. 94-95; Ex. 8, pp. 127 and 128).

17. Later that day, at about 11:30 p.m., Patient B returned to the Emergency Room of SJEH with the same symptoms that he had during his earlier visit to the Emergency Room (Tr. 94-96 and 317-318; Ex. 8, pp. 21, 130 and 131).

18. The Respondent admitted Patient B just after midnight, but he did not operate on the patient until approximately 2:30 p.m. of that day (Tr. 101-102 and 113; Ex. 8, pp. 3, 5-6, 21 and 32-33).

19. At about 2:45 a.m. on May 28, 1995 Patient B complained of severe abdominal pain associated with an increased pulse rate of 142. The Respondent ordered, in response to this complaint, increased pain medication and an enema. (Tr. 98 –99, 132, 327-328 and 336-337; Ex. 8, pp. 8-10).

20. At about 10:40 a.m. on May 28, 1995 a CT scan of Patient B's abdomen and pelvis was ordered by the Respondent and performed. This CT scan confirmed the perforation of the patient's intestine. (Tr. 99, 330 and 332; Ex. 8, pp. 9, 12 and 59).

21. The Respondent discussed the results of the CT scan and the need for exploratory surgery with Patient B and his wife (Tr. 101 and 330; Ex. 8, p. 12).

22. At about 2:30 p.m. on May 28, 1995 the Respondent performed an exploratory laparotomy and found a perforated colon and the abdomen filled with feces. The Respondent opened the bladder looking for stones and resected the colon. Despite infection, no cultures were taken. (Tr. 101-104 and 331; Ex. 8, pp. 32-33 and 38-41).

FINDINGS AS TO PATIENT C

23. Patient C, a 45 year old female, was admitted to SJEH by the Respondent on January 4, 1998 with left lower quadrant pain (Tr. 137 and 343-344; Ex. 9, pp. 4, 69 and 307).

24. At the time of admission the Respondent made various differential diagnoses, which included a left inguinal hernia. A CT scan of the abdomen was performed. It showed the presence of diverticula. (Tr. 141, 147-150 and 347-348; Ex. 9, pp. 115 and 140). An abdominal x-ray was read as a normal abdomen (Tr. 346; Ex. 9, p. 113).

25. Later that day the Respondent operated on Patient C, performing an exploratory laparotomy and colon resection. However, there was no emergent need to operate at that time. (Tr. 143, 149-152, 158 and 163; Ex. 9, pp. 13 and 80-81).

26. The Respondent stated that the reason for the surgery was to distinguish between an inflammatory process in the large intestine and abdominal adhesions (Ex. 9, p. 80).

27. The Respondent did not provide Patient C with proper preoperative care since he failed to prescribe antibiotics or have the bowel mechanically prepared prior to the surgery (Tr. 150-152, 164-167, 349-350 and 369-372; Ex.9, pp. 80-81 and 82).

28. The care the Respondent provided to Patient C did not meet minimum acceptable medical standards because of the failure to prepare the patient's bowel prior to the surgery and the performing of an anastomosis in an unprepared bowel in the face of a contaminated field (Tr. 149-152, 166-167 and 369-372).

FINDINGS AS TO PATIENT D

29. Patient D, a 62 year old male, was admitted to SJEH on October 30, 1997 with upper abdominal pain, nausea and vomiting (Tr. 186-187; Ex. 10, pp. 3 and 5-7).

30. On October 31, 1997 the Respondent performed exploratory surgery and repaired an epigastric hernia (Tr. 187-188; Ex. 10, pp. 39-40). However, the Respondent should have known that the hernia was not the cause of the patient's symptoms (Tr. 190-192).

31. On November 1, 1997 Patient D's condition was stable (Tr. 189; Ex. 10, pp. 13-14).

32. On November 2, 1997 Patient D's condition deteriorated. He was hypotensive, his hematocrit had plunged to 30 percent and shortly thereafter he expired. (Tr. 189-190; Ex. 10, pp. 5-7 and 15-25).

33. The Respondent recognized the need for a preoperative endoscopy and planned to have an endoscopy performed by Dr. Zvi Alpern, a gastroenterologist, immediately prior to the surgery (Tr. 404-411).

34. At the time of the proposed endoscopy Dr. Alpern could not be located and Patient D had already been anesthetized. The Respondent did not wake up the patient from the anesthesia and proceeded with the surgery. (Tr. 411-414).

35. An upper endoscopy should have been performed before the surgery. Despite the fact that the Respondent had noted the strong possibility of an ulcer, he did not visualize enough of the patient's anatomy during the surgery to be able to find it. (Tr. 190-192 and 449; Ex. 10, pp. 39-40).

36. The Respondent misjudged the cause of Patient D's falling hematocrit, did not correctly respond to it and the patient died (Tr. 191-192, 432-434; Ex. 10, pp. 5-7).

37. The care the Respondent provided to Patient D did not meet minimum acceptable medical standards (Tr. 190-192).

FINDINGS AS TO PATIENT E

38. Patient E, a 58 year old female who had been losing weight and suffered from cancer of the left breast, was seen by the Respondent in his office on June 14, 1997. Patient E had been referred to the Respondent by Dr. Roger Perrone, her internist, for a needle biopsy, chemotherapy and placement of a port. Patient E was also seeing Dr. Joan V. Dobbs, a hematologist and oncologist. (Tr. 220 and 460-462; Ex. 11, pp. 13-15).

39. The Respondent scheduled Patient E to go to the hospital for a port and a simple mastectomy (Tr. 464; Ex. 11, p. 15).

40. On June 18, 1997 the Respondent admitted Patient E to SJEH and then operated on her later that same day (Tr. 220; Ex. 11, pp. 3, 10-11, 16 and 68-69).

41. Prior to June 18, 1997 the Respondent realized that Patient E had a low platelet count and he even spoke to Dr. Dobbs about it (Tr. 472-473 and 485; Ex. 11, p. 15). Dr. Dobbs had previously noted that the patient also suffered from thrombocytopenia (Ex. 11, pp. 13-14). Thrombocytopenia is a condition of the blood that makes coagulation difficult and surgery on a patient who has it dangerous (Tr. 221).

42. On June 4, 1997, two weeks before the Respondent operated on Patient E, Patient E's platelet count was 86,000 (Tr. 221, 464, 473, 485-487, 489 and 511; Ex. 11, pp. 13-14). Despite the Respondent's awareness of the possibility that Patient E's platelet count was dropping since her cancer had mestasticized to her bone marrow and liver, the Respondent failed to order a complete hematologic work-up prior to the operation (Tr. 224-225, 502, 509-511 and 513-515; Ex. 11).

43. On June 18, 1997 the Respondent operated on Patient E, performing a left breast mastectomy. However, due to bleeding, the Respondent abandoned his plan for the placement of a venous access port during this operation. (Tr. 222 and 474-476; Ex. 11, pp. 10-11 and 68-69).

44. At the time the Respondent stopped the operation, Patient E's platelet count had dropped to 13,000. Patient E had developed coagulation difficulties and died on June 25, 1997. (Tr. 222-223, 225, 475-478 and 489; Ex. 11, pp. 10-11 and 91).

45. The care the Respondent provided to Patient E did not meet minimum acceptable medical standards (Tr. 223-226).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C, D and/or E, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.[1]

[1] The specific conclusion relating to the Respondent's treatment of Patient D was not unanimous. This conclusion, that the Respondent did not practice medicine with gross negligence on a particular occasion while treating Patient

The Respondent did not practice medicine with gross incompetence. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D and/or E.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, C, D and E, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D and/or E.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each

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D, represents the view of a majority of the Hearing Committee.

witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of Arthur G. Lerner, M.D., in its efforts to establish its case against the Respondent. Dr. Lerner, an expert in the field of Surgery, testified to the Respondent's medical care and treatment of Patients A, B, C, D and E.

Dr. Lerner is Board Certified in Surgery and has an impressive medical background. He has been in private practice for more than 25 years and has an office in White Plains, New York. In addition, he is affiliated with White Plains Hospital in White Plains, New York, where he serves as Director of Surgery, a member of the hospital's board of directors as well as the director of the hospital's cancer program. (Tr. 21-23; Ex. 12).

The Hearing Committee found Dr. Lerner to be a very convincing and highly credible witness. He was straightforward, non-evasive, extremely knowledgeable and his testimony was balanced and unbiased. His credentials were quite impressive and he demonstrated a far-reaching command of the field of surgery. The Hearing Committee unanimously agreed that Dr. Lerner was an excellent witness whose testimony was the most persuasive out of all the other medical testimony presented at this hearing.

The Respondent's case rests on the medical testimony of David Befeler, M.D., Louis-Joseph Auguste, M.D. and the Respondent. While the testimony of both Dr. Befeler and the Respondent related to Patients A, B, C, D and E, Dr. Auguste's testimony related only to Patient C.

Dr. Befeler is Board Certified in General Surgery and also has an impressive medical background. He is licensed to practice medicine in both New York and New Jersey. In addition, he is affiliated with Overlook Hospital in Summit, New Jersey, where he previously served as Chief of Surgery, and Morristown Memorial Hospital in Morristown, New Jersey, which is the sister hospital of Overlook Hospital. (Tr. 529-532; Ex. C).

The Hearing Committee found Dr. Befeler to be straightforward, non-evasive and extremely knowledgeable. He has excellent credentials and his testimony was impressive.

Dr. Auguste is Board Certified in General Surgery and also has an impressive medical background. He is licensed to practice medicine in New York and Maine. He is presently in private practice and has an office in New Hyde Park, New York. His practice encompasses general surgery and surgical oncology. He is on the staff of Long Island Jewish Medical Center, where he previously served as Director of Surgery and the Chief of the Section of Surgical Oncology, and North Shore University Hospital. He is also an Associate Clinical Professor of Surgery at Albert Einstein College of Medicine. In addition, he is currently the President of Queens County Medical Society. (Tr. 584-588; Ex. J).

Although Dr. Auguste was an impressive witness with very fine credentials, the Hearing Committee noted that the scope of his testimony was quite limited. He testified about past studies which the Hearing Committee found were arguably applicable to some of the issues relating to the Respondent's treatment of Patient C.

The most important witness to testify in support of the Respondent's case, was the Respondent himself. The Hearing Committee found the Respondent to be a presentable witness with an adequate medical background.

However, the Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. He did not maintain a consistent level of believability throughout his testimony. He was often evasive and he skirted around questions that he preferred not to answer. In addition, he demonstrated a reluctance to accept responsibility for his actions. For example, at different times during his testimony he attempted to transfer responsibility which was rightfully his to others. At other times during his testimony, he made unconvincing attempts to justify or minimize obvious mistakes. He never fully accepted responsibility for his failure to adhere to acceptable medical standards. Consequently, while certain portions of his testimony appeared truthful, other portions of his testimony appeared self-serving and questionable.

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

Patient A

Since the Respondent was aware of the diagnosis of colonic stricture, he should have performed an emergent surgical procedure when the diagnosis of a complete obstruction was made. Under these circumstances a reasonably prudent physician would not delay surgery until an acute perforation developed.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient A. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence.

Patient B

The Hearing Committee believes that even under the best circumstances, wherein a CT scan would have been performed during the night, the diagnosis of free air would not have been made until later in the morning. Therefore, in the best case, the potential delay of getting the patient to the operating room was between four and six hours. That certainly does not constitute an inordinate delay warranting a finding of negligence and/or incompetence. The Hearing Committee also wishes to note that the time in question occurred during a Memorial Day weekend. (Tr. 620-622).

Patient C

The Respondent operated in a non-emergent situation without a complete consideration of the therapeutic options. When the decision was made to operate, adequate preparation of the bowel was not performed which precluded a primary anastomosis of the colon in an infected field.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient C. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence.

Patient D

From the onset of the patient's admission, the Respondent believed that the patient had a peptic ulcer and required an endoscopy. The gastroenterologist was unable to be located at the time of the planned endoscopy. A reasonable and prudent physician would have delayed the surgery until an endoscopy could be performed, since the extent of the anesthesia was regional with sedation. An endoscopy would have confirmed the diagnosis and permitted proper treatment.

After surgery with the lack of significant findings, an endoscopy was still not performed. Three days later the patient sustained a hypotensive episode associated with a 30 percent fall in the hematocrit. Proper medical practice would require more aggressive evaluation and treatment at that time than merely placing the patient under observation.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient D. However, a majority of the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence. On the other hand, the dissenting member of the Hearing Committee believes that the proven allegations relating to the Respondent's medical care of Patient D does constitute gross negligence.

Patient E

In the face of advanced breast cancer with liver and bone involvement, the coagulation status of the patient assumes a substantial importance in the preoperative evaluation of the patient. A full hematologic work-up should have been performed on Patient E within the immediate preoperative period. There is some question as to whether a mastectomy would be appropriate primary therapy prior to chemotherapy. In this patient, the breast tumor had not ulcerated the skin suggesting that the placement of the port for chemotherapy was of primary importance if the hematologic picture had permitted.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient E. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

A Sustained

A1 Not Sustained

A2 Sustained only to the extent that Patient A was admitted to the Hospital on January 13, 1996 and the Respondent delayed operating on Patient A until January 16, 1996.

A3 Not Sustained

Factual Allegations relating to the treatment of Patient B

B Sustained

B1 Not Sustained

Factual Allegations relating to the treatment of Patient C

C Sustained

C1 Not Sustained

C2 Sustained

Factual Allegations relating to the treatment of Patient D

D Sustained

D1 Sustained

D2 Sustained

D3 Sustained

Factual Allegations relating to the treatment of Patient E

E	Sustained
E1	Sustained
E2	Sustained

Specifications

Gross Negligence

First Specification	(Treatment of Patient A)	Not Sustained
Second Specification	(Treatment of Patient B)	Not Sustained
Third Specification	(Treatment of Patient C)	Not Sustained
Fourth Specification	(Treatment of Patient D)	Not Sustained (2-1 vote)
Fifth Specification	(Treatment of Patient E)	Not Sustained

Gross Incompetence

Sixth Specification	(Treatment of Patient A)	Not Sustained
Seventh Specification	(Treatment of Patient B)	Not Sustained
Eighth Specification	(Treatment of Patient C)	Not Sustained
Ninth Specification	(Treatment of Patient D)	Not Sustained
Tenth Specification	(Treatment of Patient E)	Not Sustained

Negligence on More than One Occasion

Eleventh Specification	(Treatment of Patients A, B, C, D and/or E)	Sustained

Sustained Factual Allegations in Support of the Eleventh Specification

Treatment of Patient A:	A and A2
Treatment of Patient C:	C and C2
Treatment of Patient D:	D, D1, D2 and D3

Treatment of Patient E: E, E1 and E2

Incompetence on More than One Occasion

Twelfth Specification (Treatment of Patients A, B, C, D and/or E) Not Sustained

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent should be placed on probation for a period of three years. In addition, the terms of probation shall include requirements for a Practice Supervisor and a Practice Monitor for surgery performed by the Respondent in a hospital setting, including both preoperative and postoperative care provided by the Respondent in connection with any such surgery. The Practice Supervisor shall be required for the first 24 months of the probationary period and the Practice Monitor shall be required for the remaining 12 months of the probationary period. The complete terms of probation are attached to this Determination and Order as Appendix II.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough evaluation of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee recognizes that its primary responsibility is to protect the public and it firmly believes that it is fulfilling this responsibility by imposing probation coupled with a Practice Supervisor and a Practice Monitor. The Hearing Committee notes that all the incidents involving the Respondent's care and treatment of the five patients (Patients A, B, C, D and E) which were the subject of this hearing, occurred in a hospital setting. The common thread running through most of these matters seems to be poor judgment. Therefore, it is important to protect the Respondent's patients from the kinds of errors in judgment which got the Respondent in trouble in the first place.

The Hearing Committee believes that the most effective way to address this problem – poor judgment – is to require some oversight of the Respondent's surgical practice in hospital settings. A Practice Supervisor and a Practice Monitor for surgery performed by the Respondent in hospital settings would provide the necessary oversight, insuring the safety of the public.

Given the totality of the circumstances regarding this matter and the fact that the gross negligence and the ordinary and gross incompetence charges were not proven, the Hearing Committee believes that neither the revocation nor the suspension of the Respondent's medical license is warranted.

The Hearing Committee does not wish to be misunderstood as to in any way condoning the Respondent's conduct. The penalty imposed herein is designed to affirm the Hearing Committee's disapproval of the Respondent's conduct while imposing a fair punishment and offering sufficient protection to the public.

The Hearing Committee believes that by allowing the Respondent to practice medicine under the strict conditions it is imposing, the public is sufficiently protected and the Respondent can continue to provide an important service to the community.

ORDER

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

1. The Eleventh Specification of professional misconduct, as set forth in the Statement of Charges (Appendix I), is **SUSTAINED**; and

2. The First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth and Twelfth Specifications of professional misconduct contained within the Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent shall be placed on **PROBATION** for a period of three years; and

4. The **TERMS OF PROBATION** shall include requirements for a **PRACTICE SUPERVISOR** (for the first 24 months of the probationary period) and a **PRACTICE MONITOR** (for the remaining 12 months of the probationary period) for surgery performed by the Respondent in a hospital setting, including both preoperative and postoperative care provided by the Respondent in connection with any such surgery; and

5. The Respondent shall comply with all **TERMS OF PROBATION** as set forth in Appendix II, which is attached hereto and made a part of this **ORDER**; and

6. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York
June 12, 2000

REDACTED

STEPHEN W. HORNYAK, M.D.
Chairperson

ARTHUR N. TESSLER, M.D.
MR. JAMES DUCEY

TO: DAVID W. SMITH, ESQ.
Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza, Suite 601
New York, N.Y. 10001

T. LAWRENCE TABAK, ESQ.
Kern Augustine Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, N.Y. 11042

STEVEN WILKINS, M.D.

REDACTED

APPENDIX I

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

IN THE MATTER OF STEVEN WILKINS, M.D.	STATEMENT OF CHARGES

STEVEN WILKINS, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 24, 1984, by the issuance of license number 160318 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about January ~~13~~ 16, 1996 Respondent, at St. John's Episcopal Hospital ("Hospital"), operated on Patient A to relieve the complete obstruction of an anastomosis performed previously by another physician.

1. Patient A's prior physician became incapacitated in or about November, 1995. Respondent was filling in for him and he examined Patient A more than once in the Emergency Room of the Hospital during December, 1995. Despite this, Respondent inappropriately delayed proper treatment for Patient A.

2. Upon advice of her internist, Patient A was admitted to the Hospital on January 13, 1996 in critical condition. Nevertheless, Respondent delayed operating on Patient A until January ~~14~~ 16, 1996.

3. On January ~~14~~ 16, 1996 Respondent performed an inappropriate ~~procedure~~ operation on Patient A.

B. In or about May, 1995, Respondent admitted Patient B to the Hospital for abdominal pains.

1. Respondent inappropriately delayed performing a colon resection on Patient B and the creation of a Hartmann's pouch.

C. On or about January 4, 1998, Patient C was admitted to the Hospital by Respondent for the presumptive diagnosis of an inguinal hernia. On or about January 5, 1998, Respondent performed an exploratory laparotomy. Thereafter, on January 10, 1998, Respondent performed a resection of a leaking anastomosis and the creation of a colostomy.

1. Prior to the first operation, Respondent failed to make an appropriate diagnosis and failed to perform an adequate pre-operative work-up.

2. The operation of January 5, 1998, itself, was inappropriately scheduled and inappropriately performed by Respondent.

D. Respondent admitted Patient D to the Hospital on or about October 30, 1997, for abdominal pain. On or about October 31, 1997, he performed an exploratory operation.

1. Respondent failed to perform an adequate pre-operative work-up.

2. The exploratory operation performed by Respondent was both inappropriate and inappropriately performed.

3. Subsequent to the operation the condition of Patient D deteriorated. Respondent failed to appropriately diagnose, evaluate, follow-up or treat such deterioration.

E. Patient E was admitted to the Hospital by Respondent on or about June 18, 1997 for an operation for Advanced Stage IV Breast Cancer.

1. Respondent failed to perform an adequate pre-operative evaluation.

2. Respondent inappropriately operated on Patient E.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH 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 and A1-3.
2. Paragraphs B and B1.
3. Paragraphs C and C1, 2.
4. Paragraphs D and D1-3.
5. Paragraphs E and E1, 2.

SIXTH THROUGH TENTH SPECIFICATIONS

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:

6. Paragraphs A and A1-3.
7. Paragraphs B and B1.
8. Paragraphs C and C1, 2.
9. Paragraphs D and D1-3.
10. Paragraphs E and E1, 2.

ELEVENTH 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. 1999) 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:

11. Paragraph A and A1-3; B and B1; C and C1,2; D and D1-3; and/or E and E1, 2.

TWELFTH 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. 1999) 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:

12. Paragraph A and A1-3; B and B1; C and C1,2; D and D1-3; and/or E and E1, 2.

DATED: August 17, 1999
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

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, 433 River Street, Fourth Floor, Troy, New York 12180; 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 written periodic 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. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. 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.

6. 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 staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. For the first 24 months of the probationary period Respondent shall perform surgery in hospital settings, including both preoperative and postoperative care provided by Respondent in connection with any such surgery, only when supervised by a licensed physician, board certified in general surgery ("the Practice Supervisor"). The Practice Supervisor shall be on-site at all hospital locations, unless determined otherwise by the Director of OPMC. The Practice Supervisor shall be proposed by Respondent and subject to the written approval of the Director. The Practice Supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.

   Respondent shall ensure that the Practice Supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the Practice Supervisor is in a position to regularly observe and assess Respondent's hospital practice. Respondent shall cause the Practice Supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

   Respondent shall authorize the Practice Supervisor to have access to his patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's hospital practice. These narrative reports shall address all aspects of Respondent's hospital practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the Practice Supervisor's assessment of patient records selected for review and other such on-duty conduct as the Practice Supervisor deems appropriate to report.

9. For the remaining 12 months of the probationary period Respondent shall perform surgery in hospital settings, including both preoperative and postoperative care provided by Respondent in connection with any such surgery, only when monitored by a licensed physician, board certified in general surgery ("the Practice Monitor"), proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the Practice 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. The review will determine whether the Respondent's hospital 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 Practice 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.

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he 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.