Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Frank S. Horng, M.D.,	DATE: January 25, 1996
Petitioner,	
- v. -	Docket No. C-94-357 Decision No. CR410
The Inspector General.	

DECISION

This is a case in which the Inspector General (I.G.) determined to exclude Petitioner from participating in the Medicare and Medicaid programs, based on her finding that Petitioner grossly and flagrantly violated his obligation under section 1156 of the Social Security Act (Act) to provide care to Medicare beneficiaries of a quality that meets professionally recognized standards of health care.[1] Although the I.G. determined originally to exclude Petitioner for a period of three years, she now asserts that a 10 - 15 year exclusion is reasonable. Petitioner argues that no exclusion is reasonable. I conclude that it is reasonable to exclude Petitioner for a period of three years.

I. Background

On May 19, 1994, the I.G. notified Petitioner that she had determined to exclude Petitioner from participating in Medicare and Medicaid for three years. The I.G. told Petitioner that the exclusion was authorized by section 1156 of the Act. The I.G. based the determination to exclude Petitioner on a recommendation made by the Medical Society of Virginia Review Organization (MSVRO), the peer review organization for the State of Virginia.

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[1] I use the term "Medicaid" to refer to all State health care programs described in section 1128(h) of the Act.

MSVRO recommended that Petitioner be excluded based on its findings that, in several instances involving two Medicare beneficiaries, Petitioner grossly and flagrantly violated the obligation imposed on him by section 1156(a) of the Act because he did not provide care of a quality that meets professionally recognized standards of health care.[2] The I.G. advised Petitioner that she had reviewed MSVRO's recommendation and that she agreed with it and with the findings on which MSVRO based its recommendation.

Additionally, the I.G. notified Petitioner that she had determined that Petitioner was unwilling and unable to comply with his obligations under section 1156 of the Act. The I.G. told Petitioner that, in part, she based this conclusion on MSVRO's identification of quality of care problems in Petitioner's treatment of five additional patients.[3] The I.G. advised Petitioner also that she concluded that Petitioner's failure to comply with a corrective action plan that was imposed on Petitioner in 1985 by MSVRO was evidence of Petitioner's unwillingness to comply with his obligations under the Act. The I.G. advised Petitioner that his failure to understand the limitations present at the hospital at which Petitioner provided care established his inability to comply with his obligations under the Act.

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[2] The two patients are referred to in the I.G.'s notice to Petitioner as RB and IW. The medical records that pertain to Petitioner's treatment of patient RB are in evidence as I.G. Ex. 2. The medical records that pertain to Petitioner's treatment of patient IW are in evidence as I.G. Ex. 3.

[3] The five additional patients are referred to in the I.G.'s notice to Petitioner as JB, JJ, AM, LO, and BB. The medical records that pertain to Petitioner's treatment of these patients are in evidence as follows: JB -- I.G. Ex. 1, 14; JJ -- I.G. Ex. 4; AM -- I.G. Ex. 5; LO -- I.G. Ex. 6; BB -- I.G. Ex. 7.

The I.G. advised Petitioner that, prior to the effectuation of the exclusion, he was entitled to a preliminary hearing before an administrative law judge concerning whether he posed a serious risk to patients. The I.G. determined that Petitioner was entitled to a preliminary hearing because Petitioner practiced in a county with a population of fewer than 70,000.

Petitioner requested a hearing, both as to the preliminary issue of serious risk, and as to the issues of whether the I.G. was authorized to exclude Petitioner and whether the three-year exclusion determined by the I.G. was reasonable. The case was assigned to me. On August 4 - 5, 1994, I held a preliminary hearing in Washington, D.C., as to the issue of serious risk. On August 18, 1994, I issued a ruling in which I found that Petitioner posed a serious risk to his patients. I permitted the I.G. to effectuate her exclusion of Petitioner pending my decision on the remaining issues.

On July 24 - 27, 1995, I held a hearing in Washington, D.C., on the remaining issues. Prior to the hearing, the I.G. notified Petitioner that she intended to argue that the exclusion imposed against Petitioner should be for a period of 20 years, and not for the three-year period which the I.G. previously had determined to impose. Tr. at 7 - 8. Prior to the hearing, Petitioner advised the I.G. that he was no longer disputing that the I.G. had authority to exclude him pursuant to section 1156 of the Act. Id. At the completion of testimony, I afforded the parties the opportunity to file posthearing briefs. The parties filed posthearing briefs, and Petitioner filed a reply to the I.G.'s posthearing brief.

I base my decision on the law, the evidence that I received at the July 24 - 27, 1995 hearing, and on the parties' arguments. In reaching my decision, I have not relied on my August 18, 1994 ruling on the issue of serious risk, inasmuch as that ruling involved a preliminary issue and did not address the ultimate issue of whether an exclusion of a particular duration is reasonable. In this decision, I am relying on the record created at the July 24 - 27, 1995 hearing, although the record also includes the evidence which I received on August 4 - 5, 1994.[4]

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[4] The evidence which I received at the July 24 - 27, 1995 hearing includes the exhibits which were offered and received at the August 4 - 5, 1994 hearing. Tr. at 11 - 12; 22 - 45. Also, the record of the July 24 - 27,

II. Issue, findings of fact, and conclusions of law

The only issue remaining to be decided in this case is what, if any, exclusion is reasonable. Petitioner acknowledges that the I.G. has the authority to exclude him.[5] I make the following findings of fact and conclusions of law (Findings) which support my conclusion that a three-year exclusion is reasonable. I discuss these Findings in detail below.

1. The purpose of an exclusion under section 1156 of the Act is to protect federally funded health care programs, and the beneficiaries and recipients of those programs, from an individual who is not trustworthy to provide care.

2. Petitioner is a board-certified surgeon who has practiced medicine and surgery in Luray, Virginia, for more than 20 years.

3. Petitioner performed many surgeries at Page Memorial Hospital (Page Memorial), a small rural hospital, which is equipped to handle routine and minor surgeries, but which is not equipped to handle extremely complex surgeries.

4. Petitioner misjudged the risks of performing surgeries at Page Memorial in light of the need for performing surgeries there.

5. Petitioner committed errors in performing surgeries, which caused harm to his patients.

6. Petitioner committed errors in his medical practice, other than surgery, which caused harm to his patients.

1995 hearing includes the transcript of the August 4 - 5, 1994 hearing, which was identified and received into evidence as I.G. Ex. 25.

[5] Petitioner does not acknowledge that he committed a gross and flagrant violation of his obligation to provide care which meets professionally recognized standards of health care. However, by acknowledging that the I.G. has the authority to exclude him, Petitioner has conceded at least that he engaged in conduct which failed to meet the obligations imposed on him by section 1156 of the Act and that he demonstrated an unwillingness or inability to comply with those obligations.

7. Petitioner altered medical records in order to cover up his errors.

8. Petitioner attempted to shift responsibility for his errors to other individuals.

9. Petitioner has acknowledged committing some errors and has made attempts to conform his practice to professionally recognized standards of health care.

10. Petitioner is dedicated to the welfare of his patients and intends to provide them with a good quality of care.

11. Petitioner has not acknowledged fully the extent of his errors or his attempts to cover up past errors.

12. Petitioner continues to attempt to attribute responsibility for some of his errors to other individuals.

13. The preponderance of the evidence establishes that Petitioner remains untrustworthy to provide care to program beneficiaries and recipients.

14. A three-year exclusion is reasonable in this case.

III. Analysis of the law (Finding 1)

Section 1156 of the Act imposes on providers and practitioners who provide care to beneficiaries and recipients of federally funded health care programs duties which include the requirement that they provide care of a quality which meets professionally recognized standards of health care. Act, section 1156(a)(2). The Act authorizes the Secretary, based on the recommendation of a peer review organization, to exclude a provider or practitioner who grossly and flagrantly violates his or her obligation to provide care in accordance with professionally recognized standards of health care. Act, section 1156(b)(1).

Typically, a case brought under section 1156 involves two issues: the authority of the I.G. to impose an exclusion, and whether the exclusion imposed by the I.G. is reasonable. In this case, however, there remains only

one issue for me to decide. That is the issue of what, if any, exclusion is reasonable.

A. The standard for review of exclusions imposed under section 1156

In a case involving the issue of the I.G.'s authority to exclude, the evidence relevant to that issue is that which was obtained and reviewed by the peer review organization recommending the exclusion to the I.G. That is so because the I.G.'s authority to exclude under section 1156 derives from the peer review organization's recommendation. Anthony G. Corkill, M.D., DAB CR289, at 32 - 33 (1993).

A broader test of relevancy applies to the issue of whether an exclusion of a particular duration is reasonable. Exclusion is a remedy and not a punishment. The purpose of an exclusion imposed under section 1156 is to protect the integrity of federally funded health care programs and the beneficiaries and recipients of those programs from untrustworthy individuals. Corkill at 50. An excluded practitioner has a right to a de novo hearing under section 1156 of the Act. In deciding whether it is reasonable to impose an exclusion of a given duration against an individual, I must consider all evidence that relates to that individual's trustworthiness to provide care. The evidence may include evidence that was considered by the peer review organization in its deliberations, but it may also include additional evidence that relates to the provider's trustworthiness. Corkill at 32 - 33, 50.

Evidence which relates to an individual's trustworthiness may consist of evidence showing that, in the past, the individual has violated his or her obligation to provide care that meets professionally recognized standards of health care. Such evidence may predict a propensity by the individual to commit additional misconduct in the future. Also relevant is evidence which relates to the manner in which the individual confronted his or her errors or misconduct. Evidence which shows that the individual attempted to conceal errors or misconduct, or to deflect to others the blame for his or her errors or misconduct, is proof that the individual has attempted to avoid responsibility in the past, suggesting that the individual may be untrustworthy in the future.

Attempts by an individual to identify and correct a tendency to make errors or to avoid repeating misconduct is evidence that the individual may be trusted to provide care. Where conflicting evidence exists of an

individual's conduct and motivation, the conflicting evidence must be reconciled and balanced, in order to determine a remedy that is reasonable. Where the preponderance of the evidence establishes legitimate reasons to doubt the individual's trustworthiness, that individual ought to be excluded for a period of time long enough to assure that programs, beneficiaries, and recipients are protected.

In this case, both the I.G. and Petitioner introduced evidence which related to the remedy issue but which was not considered by MSVRO in its review of Petitioner's current case.[6] The I.G. introduced evidence concerning Petitioner's treatment of seven additional patients specifically referred to in the May 19, 1994 notice letter to Petitioner and in MSVRO's recommendation to the I.G.[7] The evidence concerning these seven additional patients relates to surgery and medical care provided by Petitioner going back to 1984. Petitioner introduced evidence from members of his community concerning the care he had provided to them. He introduced evidence concerning his recent medical practice and the medical

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[6] Petitioner had been involved with MSVRO prior to the present case. In 1985, MSVRO conducted an investigation into the care Petitioner provided to patients. MSVRO proposed that sanctions be imposed against Petitioner. I.G. Ex. 11. Based on the 1985 investigation, Petitioner entered into a corrective action plan with MSVRO.

[7] These seven patients are referred to as FB, MT, H, C, D, A, and P. Petitioner's treatment of some of these patients was the subject of the 1985 MSVRO investigation. Relevant records of the treatment that Petitioner provided to FB and MT are in I.G. Ex. 8. The contemporaneous records of Petitioner's treatment of H, C, D, A, and P are not in evidence. However, the exhibits and transcript of the hearing do contain references to Petitioner's treatment of H, C, D, A, and P. See I.G. Exs. 11, 12. I cite to the relevant exhibits and testimony in my discussion of the evidence.

training and continuing medical education he obtained subsequent to MSVRO's review of cases he had handled.

B. The circumstances under which an administrative law judge may increase the length of an exclusion

In this case, the I.G. determined originally to exclude Petitioner for a period of three years. Shortly prior to the July 24 - 27, 1995 hearing, the I.G. advised Petitioner that she would ask me to find that an exclusion of 20 years is reasonable. In her posthearing brief, the I.G. argues that an exclusion in the range of 10 - 15 years is reasonable. I.G. posthearing brief at 44.

The I.G.'s argument that I should impose an exclusion of more than three years raises the question of whether I have the authority to impose an exclusion which exceeds in length that which the I.G. determined to impose originally. I conclude that I have the authority, in the appropriate case, to impose an exclusion of a duration that is greater than that which is imposed by the I.G. My authority to hear and decide this case is set forth in regulations contained in 42 C.F.R. Part 1005. Under these regulations, an administrative law judge has the authority to decrease or increase the duration of an exclusion imposed by the I.G. 42 C.F.R. § 1005.20.

It is appropriate to increase the duration of an exclusion beyond that which was imposed originally by the I.G. if the preponderance of the evidence proves that the excluded individual is so untrustworthy as to necessitate a lengthier exclusion. Sunil R. Lahiri, M.D., DAB CR348 (1994). As I discuss below, I do not find that an exclusion of more than three years' duration is necessary.

IV. Analysis of the evidence (Findings 2 - 12)

A. Introduction

The evidence of Petitioner's past medical and surgical practice introduced by the I.G. proves that Petitioner made judgment and treatment errors and committed misconduct of such a degree of severity that, if this evidence were considered in isolation, would justify the imposition of a very lengthy exclusion. More than once, Petitioner misjudged the risks to his patient of performing surgery or overestimated the benefits that his patient might obtain from risky and dangerous surgery.

Petitioner committed gross errors in his surgical practice and in the medical care he gave to patients. Petitioner's misjudgments and errors caused needless suffering and even death to some patients. Petitioner attempted to cover up or conceal some of his errors. He attempted to shift responsibility for his judgment errors to other individuals. On some key questions of accountability, Petitioner continues to deny having made errors or committing misconduct. Petitioner's failure to accept full responsibility for all of his past errors and misconduct is strong evidence that he remains untrustworthy.

However, the evidence introduced by Petitioner shows that he is attempting to avoid repeating in the future the errors and misconduct he committed in the past. Petitioner is a dedicated and caring physician. Petitioner now accepts responsibility for some of his past misjudgments and practice errors. He has attempted to rectify his propensity to make judgment errors.

The Findings I make concerning the setting in which Petitioner practices and the errors and misconduct that Petitioner committed (Findings 3 - 8) are in large measure supported by the testimony of the experts who testified on behalf of the I.G. These experts are: Worthington G. Schenk, III, M.D. (I.G. Ex. 25 at 149 - 216); Steven A. Templeton, M.D. (I.G. Ex. 25 at 217 - 256); Quincy A. Ayscue, M.D. (Tr. at 51 - 113); David R. Antonio, M.D. (Tr. at 114 - 192); and Steven A. Schechner, M.D. (Tr. at 298 - 378). I find each of these experts to be well-qualified in his respective field of medicine. I find each of these experts to be unbiased and persuasive.

In some respects, the testimony offered by the I.G.'s experts regarding Petitioner's practice of surgery was contradicted by that offered by an expert witness, Harry LeVeen, M.D. (I.G. Ex. 25 at 336 - 446), who testified on behalf of Petitioner. Dr. LeVeen is a board-certified general surgeon with many years' experience. Id. at 336 -338. I find Dr. LeVeen's opinions to be, in general, less credible than those offered by the I.G.'s experts in surgery. Furthermore, Dr. LeVeen's testimony did not address the expert opinion offered by Dr. Ayscue, who is an anesthesiologist, or the expert opinion offered by Dr. Antonio, who is an orthopedic surgeon. In some respects, Dr. LeVeen's testimony was misleading or evasive. Thus, I do not find Dr. LeVeen's opinions to be persuasive.

It is not necessary for me to discuss all of the testimony that Dr. LeVeen gave which I find to be

unpersuasive, misleading, or evasive. However, one example of the misleading testimony offered by Dr. LeVeen consists of his attempt to cast doubt on the value of an opinion offered by Dr. Schenk. Dr. Schenk opined that it was not safe for Petitioner to have performed hernia surgeries in his office. I.G. Ex. 25 at 210 - 212. Dr. LeVeen testified on direct examination that there existed a "vast literature" that had not been addressed by Dr. Schenk, in Dr. Schenk's testimony, concerning the safety of performing certain surgeries in an outpatient setting. I.G. Ex. 25 at 347. Dr. LeVeen offered this testimony to support his opinion that it is safe for a physician to perform hernia surgery in an office setting and, also, to suggest that Dr. Schenk was either uninformed or not forthcoming in his testimony. Id. In fact, and as became apparent later in the course of Dr. LeVeen's testimony, the "vast literature" that Dr. LeVeen was referring to addressed the safety of surgery in outpatient surgical centers and not in physicians' offices. Id. at 403 - 404.

Petitioner has argued that some of the judgments and decisions he made were vindicated by a study performed by an entity known as Interqual. See P. Exs. 13, 24. I have considered the Interqual study in my evaluation of the evidence, and I find it not to be persuasive. There is no evidence as to the methodology by which the study was performed. The study does not explain its findings in meaningful detail.

Petitioner is himself qualified to testify about his professional specialty. I do not find Petitioner's opinions about the surgeries he performed to be persuasive. His testimony was self-serving, and, on key issues, not credible.

However, I find Petitioner to be credible in his assertions that he is dedicated to the welfare of his patients and is motivated to provide good quality care to his patients. Furthermore, I find credible the testimony of John B. Mansfield, M.D., concerning Petitioner's current office practice and Petitioner's attempts to conform his practice to professionally recognized standards of health care. I.G. Ex. 25 at 447 - 472; Tr. at 689 - 755.[8] Findings 9 and 10, which address Petitioner's motivation and his efforts to conform his

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[8] However, for the reasons that I discuss in this decision, I do not agree with Dr. Mansfield's opinion that Petitioner should not be excluded.

practice to professionally recognized standards of health care, are to a large extent based on the credible parts of Petitioner's testimony and on the testimony of Dr. Mansfield.

B. Petitioner's background and training and his medical practice (Finding 2)

Petitioner is a physician who is board-certified in general surgery. P. Ex. 36. Additionally, Petitioner provides general medical care to many of his patients. Petitioner received his medical education in Taiwan. Tr. at 649. He obtained surgical and medical training in the United States. Id. at 651 - 656. In 1973, Petitioner established a medical and surgical practice in Luray, Virginia. P. Ex. 36; Tr. at 657 - 659. He has practiced there since then.

Petitioner performed numerous surgeries during the course of his practice in Luray. P. Ex. 48; Tr. at 665 - 666. Petitioner performed many of his surgeries at Page Memorial. Tr. at 658, 661. On March 2, 1993, Petitioner resigned as a member of the Page Memorial medical staff. I.G. Ex. 20 at 4 - 5. Petitioner no longer has privileges at Page Memorial. Petitioner continues to maintain an office practice in Luray. He performs outpatient surgeries in his office, which is well equipped to perform minor surgical procedures. Tr. at 696 -697, 711.

C. The setting in which Petitioner practices (Finding 3)

Luray is in Page County, Virginia. Tr. at 382. The county's hospital is Page Memorial. This is a small rural hospital which is licensed for 54 beds. I.G. Ex. 25 at 219. Its average in-patient population is about 15 - 20. Id. The hospital has an emergency room with five patient beds. Id. Page Memorial lacks facilities to provide critical patient care which meets professionally ecognized standards of health care. I.G. Ex. 25 at 175; Tr. at 340 - 343. The hospital does not have an intensive care unit. I.G. Ex. 25 at 219. Anesthesiology services are provided by a nurse anesthetist, and not by an M.D. anesthesiologist. Id. at 175, 191; Tr. at 56, 105, 340. The hospital does not have a blood bank. Tr. at 340. Although Page Memorial is an adequate facility at which to perform relatively routine surgeries such as biopsies and hernia repairs, it is not equipped sufficiently to serve as a facility at which to perform surgeries that are extremely complicated. Tr. at 340 - 343. It is especially ill-equipped to serve as a

facility at which to perform surgeries involving patients who might suffer potentially-life threatening complications, either from the surgeries, or from underlying medical conditions, or from both. Id.

For patients in the Luray area who might require complex surgery, there exist alternatives to having the surgeries performed at Page Memorial. The University of Virginia Hospital at Charlottesville, Virginia is about a one and one-half hour drive from Luray. I.G. Ex. 25 at 190. Luray is located only about 50 miles from the Washington, D.C. Beltway. Id. In emergency cases, patients may be transported to Charlottesville or to another facility by helicopter. In finding that there exist alternatives to having surgery performed at Page Memorial, I am not suggesting such alternatives would exist in every case. Conceivably, there might exist a case where the emergency is so dire, or the time within which to act is so short, that there exists no alternative to performing surgery at Page Memorial. However, I do not find that to have been the case with respect to any of the surgeries that Petitioner performed which I discuss in this decision.

D. Petitioner's errors in judgment in deciding to perform surgery at Page Memorial (Finding 4)

On two occasions, Petitioner erred by electing to perform surgery at Page Memorial when, given the limitations of the facility, the surgeries should have been performed elsewhere. Petitioner may have thought that he was acting in his patients' best interest by electing to perform surgeries at Page Memorial. But, Petitioner failed to measure the benefits that his patients might have obtained from surgery against the risks which were inherent in performing such surgery at Page Memorial. The consequence in each case was that Petitioner placed his patient in jeopardy which far outweighed any benefits that might have been obtained by performing the surgery at Page Memorial.

1. Patient A

The first of the two cases involved surgery which Petitioner performed on Patient A, on December 24, 1985, at Page Memorial. I.G. Ex. 11 at 14. The type of surgery which Petitioner performed on Patient A, repair of an aortic aneurysm, was described by Petitioner's own witness, Dr. Mansfield, as among the most complex surgeries that a general surgeon might be called upon to perform. Tr. at 748. The preponderance of the evidence is that the surgery Petitioner performed was elective, not emergency, surgery. Ample time existed to transport

Patient A to a facility that was better equipped for aneurysm surgery than was Page Memorial. Page Memorial was inadequately equipped as a facility at which to perform aneurysm surgery, and Petitioner unnecessarily placed Patient A at risk of complication or death by performing the surgery there.[9]

Patient A first appeared at the Page Memorial emergency room. I.G. Ex. 12 at 6. Petitioner was notified about the patient by telephone. Id. The patient was transported by automobile to Petitioner's office, where Petitioner performed a sonogram to confirm the presence of an aneurysm. Id. at 7 - 9. Petitioner had Patient A transported back to Page Memorial by automobile. I.G. Ex. 25 at 189. Patient A was admitted and placed in a room. Id. Petitioner performed a physical examination of Patient A and prepared a patient history of the patient. Id. Then, Petitioner performed aneurysm repair surgery on Patient A.

The surgery that Petitioner performed on Patient A was elective, not emergency, surgery. I.G. Ex. 25 at 188 - 189. Although Petitioner asserts that Patient A had possibly experienced a ruptured aneurysm, the clinical evidence does not establish that Patient A's aneurysm had ruptured. I.G. Ex. 12 at 10; I.G. Ex. 24 at 2; see Tr. at 883 - 884. Petitioner admits that he did not determine, even during surgery, that, in fact, Patient A had experienced a ruptured aneurysm. I.G. Ex. 12 at 35. Patient A could have been transferred to any of five hospitals that were better equipped to perform aneurysm surgery than was Page Memorial during the time it took to transport him to Petitioner's office, examine him there, transport him back to Page Memorial, process his admission, examine him again at the hospital, and prepare him for surgery. I.G. Ex. 25 at 189.

Page Memorial was manifestly ill-equipped as a facility at which to perform aneurysm surgery. It lacked adequate anesthesia services. I.G. Ex. 25 at 191. It did not have adequate blood bank facilities. Id. The skills and abilities of its personnel were limited. Id.

In discussing the case of Patient A with MSVRO, Petitioner asserted that Patient A had refused to be

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[9] Patient A died shortly after Petitioner performed the surgery. However, I do not find that the patient's death necessarily resulted from the surgery being performed at Page Memorial.

transferred to a facility other than Page Memorial. Petitioner has introduced a statement by Patient A's son in which the son asserts that Patient A had refused to be treated at any hospital other than Page Memorial. P. Ex. 26. I am not persuaded by this statement that Petitioner was relieved of his obligation to transfer Patient A to a facility which was better equipped for aneurysm surgery than was Page Memorial. I cannot determine from the statement whether Petitioner informed Patient A of the risks of surgery at Page Memorial prior to Patient A expressing a desire not to be transferred. In fact, it is unclear from the statement whether Petitioner ever discussed with Patient A the risks of having surgery at Page Memorial, as opposed to having the surgery performed elsewhere.

Petitioner argues that a report prepared by H.M. Lee, M.D., Chairman of the Division of Vascular Surgery, Medical College of Virginia, supports Petitioner's decision to perform aneurysm repair surgery on Patient A. P. Ex. 25. I do not find this report to be persuasive. It assumes that Patient A experienced a ruptured aneurysm, when, in fact, the evidence does not show that Patient A experienced a ruptured aneurysm. See P. Ex. 25 at 4.

Petitioner argues that it was appropriate for him to have performed the surgery because, prior to performing it, he received a second opinion which supported his decision to perform surgery. It is true that, prior to performing the surgery, Petitioner received a second opinion by telephone that surgery would be appropriate, given the circumstances related by Petitioner in the telephone conversation. However, although there is no evidence that Petitioner attempted to mislead the physician whom he consulted, I am not persuaded that Petitioner accurately described the condition of Patient A in his telephone conversation with that physician. Petitioner may have represented mistakenly that Patient A had suffered a ruptured aneurysm when, in fact, the patient was experiencing a leaking aneurysm.

2. Patient RB

On December 19, 1990, Petitioner performed surgery on Patient RB at Page Memorial. I.G. Ex. 2 at 125 - 127; Tr. at 309 - 313. The operation consisted of a five-hour procedure. Tr. at 309. The surgery that Petitioner performed on Patient RB consisted of removal of an esophageal stricture (a narrowing of the patient's esophagus) at a point just above the patient's stomach. Tr. at 305. The operation involved removing the lower

portion of Patient RB's esophagus, including the stricture, and the upper part of the patient's stomach, and then joining together the remnants of the two organs with staples. Tr. at 307 - 314.

The preponderance of the evidence is that it was inappropriate for Petitioner to have performed the surgery on Patient RB. Tr. at 334 - 335. The operation which Petitioner performed on Patient RB is among the most complex and difficult that a community surgeon might perform. Tr. at 319. The surgery was entirely elective. Although Patient RB was experiencing discomfort and difficulty eating as a consequence of the stricture, she was not in any immediate danger. Tr. at 334. There were ways to provide nutrition to Patient RB and to counteract the problems caused to her by the stricture that were far less drastic and risky than was the surgery performed on Patient RB by Petitioner. Id.

Furthermore, the facilities at Page Memorial were inadequate to meet the demands created by the surgery that Petitioner performed on Patient RB. Tr. at 340 - 344. If the surgery was to have been performed at all, it should have been performed at a facility that was equipped to deal with the contingencies that might arise from the surgery.

Petitioner asserts that Patient RB refused to consider alternative treatment or an alternative location for her surgery. I do not find that Patient RB's expressed desires justified Petitioner's undertaking such drastic and risky elective surgery on Patient RB at Page Memorial. Petitioner should have refused to perform the surgery, in light of its elective nature, and the obvious and unnecessary risks that the surgery entailed. Tr. at 336.

Petitioner avers that he received special privileges from Page Memorial's chief of staff to perform the surgery on Patient RB. However, the fact that Petitioner may have received such privileges does not justify Petitioner's decision to perform the surgery on Patient RB. The surgery was inappropriate despite the concurrence of the

chief of staff of the hospital with Petitioner's decision to perform the surgery.

E. Errors Petitioner committed in his surgical practice (Finding 5)

Petitioner committed egregious errors in his surgical practice, to the detriment of his patients. These errors included failures: to assess accurately the patient's condition and to perform appropriate surgery on the patient; to identify and respond to complications that preexisted surgery or arose during surgery; and to utilize correct surgical and aftercare techniques.

1. Patient RB

Petitioner committed two errors which adversely affected Patient RB and which may have resulted in her decline and eventual death. First, Petitioner failed to suture the staple line which he had used to close an opening he had made in the wall of Patient RB's stomach in order to facilitate surgery. I.G. Ex. 10 at 95; Tr. at 318. Failure to suture the staple line was an error, because, in this type of surgery, there is a risk that the staple line might rupture, and suturing provides reinforcement. Tr. at 318 - 319, 328.

Second, several days after the surgery, Petitioner placed Patient RB on a liquid diet, and then on a diet which included small meals, notwithstanding the fact that tests showed that fluids were not passing through the lower half of Patient RB's stomach. I.G. Ex. 2 at 34 - 37, 198; Tr. at 321 - 322. The decision to place Patient RB on a liquid diet followed by small meals was a major error in judgment by Petitioner. Tr. at 347 - 348. Shortly thereafter, the staple line which Petitioner had used to close the opening in RB's stomach ruptured, as a consequence of the build-up of food in Patient RB's stomach. Tr. at 347. The contents of the patient's stomach spilled into her chest cavity. Petitioner attempted to correct the consequences of his errors by reoperating on Patient RB in order to close the burst staple line and to reinforce it. However, Patient RB developed complications from which she never recovered. I.G. Ex. 2 at 16 - 17; Tr. at 331 - 333.

Petitioner argues that his failure to reinforce the staple line was due to the poor condition of Patient RB's tissue. I find this explanation to be unpersuasive. Petitioner did reinforce the staple line after the second surgery. If, in fact sufficient tissue was present at the second surgery to allow reinforcement, then that

tissue would have been present also at the first surgery. Tr. at 329 - 330.

2. Patient IW

Patient IW was an elderly woman suffering from circulatory impairments and diabetes, who was first seen by Petitioner at Page Memorial for treatment of a gangrenous left big toe. I.G. Ex. 3 at 9 - 10; I.G. Ex. 15 at 13; Tr. at 60. On December 8, 1989, Petitioner amputated the toe, using a local anesthetic agent. I.G. Ex. 3 at 9 - 10; I.G. Ex. 15 at 12, 14. However, in January 1990, Patient IW was readmitted, suffering from additional infection in her left foot. On January 17, 1990, Petitioner performed a transmetatarsal amputation of Patient IW's left foot. I.G. Ex. 3 at 65 - 66; I.G. Ex. 15 at 15 - 18; Tr. at 77, 123 - 124. Shortly prior to this second operation, while anesthetized in the operating room, Patient IW suffered an episode of cardiac arrest. Tr. at 123. The patient was resuscitated, and Petitioner initiated the surgery. Id. During the surgery, Patient IW suffered a second cardiac arrest. Tr. at 123 - 124. Patient IW died shortly after completion of the surgery.

Petitioner committed errors in his evaluation of Patient IW and in his performance of surgery on the patient which may have led to the patient's death. Petitioner failed to evaluate properly Patient IW's peripheral circulation prior to amputating her left big toe. Tr. at 119. It was obligatory for Petitioner to document the degree of impairment of Patient IW's circulation prior to embarking on surgery because of the patient's history of diabetes and severe circulatory disease. Id. Petitioner ran the risk of performing inadequate surgery if, in fact, the patient's circulation was more greatly impaired that Petitioner assumed it to be. There was equipment at Page Memorial that Petitioner could have used, but did not, to map Patient IW's peripheral circulation. I.G. Ex. 25 at 276.

Patient IW's second admission at Page Memorial was a consequence of Petitioner's failure to evaluate adequately the patient's peripheral circulation at the time of the patient's first hospitalization. Tr. at 120, 125. Petitioner failed again to evaluate Patient IW's peripheral circulation at the time of her second hospitalization prior to performing additional surgery on Patient IW. Tr. at 121. Petitioner could not make an informed judgment as to the nature of the treatment or surgery to administer to Patient IW because Petitioner

failed to study adequately the patient's circulation on either of her admissions to Page Memorial.

Petitioner argues that he did not do extensive circulation studies on Patient IW because they were unnecessary and not cost-efficient. This assertion is belied by the evidence I have discussed. I conclude that circulation studies were necessary in this patient, at the very least, to determine the degree of surgery that was necessary to address her infection.

Petitioner made a serious error in judgment in deciding to proceed with the second surgery on patient IW after she experienced an episode of cardiac arrest prior to commencement of the surgery. Although Patient IW needed surgery to address the continuing infection in her foot, Petitioner should not have proceeded with surgery once Patient IW experienced her first episode of cardiac arrest. Tr. at 129.

Petitioner's judgment failures in the case of Patient IW's second surgery were compounded by his failure to properly manage administration of anesthesia to the patient. A nurse anesthetist administered anesthesia to Patient IW at her second surgery. Petitioner, as the surgeon in charge, was responsible, not only for his surgery, but also for the administration and monitoring of anesthesia. Tr. at 130 - 131. However, it is apparent from a review of the record, including Petitioner's testimony, that he failed to monitor closely the performance of the nurse anesthetist. Tr. at 780 - 782.

The preponderance of the evidence establishes further that, once Patient IW experienced the first episode of cardiac arrest, either Petitioner or the nurse anesthetist administered medications to the patient that were inappropriate, and which may have led to her second episode of cardiac arrest. The administration of Atropine and Epinephrine to Patient IW in response to her first episode of cardiac arrest raised her heart rate to a dangerously high level of 140 - 150 beats per minute. I.G. Ex. 3 at 119, 124; Tr. at 84. Petitioner had ordered that this situation be treated by the administration of inappropriate medications. Tr. at 85. Patient IW's heart rate then decreased to a dangerously low level, and she experienced a second episode of cardiac arrest. Tr. at 86.

Petitioner argues that Interqual reviewed his treatment of Patient IW and found it to be without fault. However,

for the reasons I discuss above, I find the Interqual study not to be persuasive. See P. Exs. 13, 24.

3. Patient MT

Patient MT was an elderly woman who suffered a fracture of her left hip. On August 25, 1989, Petitioner operated on Patient MT to repair the fracture. Petitioner inserted an Austin-Moore prosthesis in the patient's femur, in an attempt to replace the fractured hip. I.G. Ex. 8 at 129 - 130. The patient's hip was not x-rayed after the surgery, until September 13, 1989. I.G. Ex. 8 at 209. Nurses treating the patient observed that Patient MT's hip had become swollen and deformed days after the surgery. I.G. Ex. 8 at 129 - 130. The x-ray taken on September 13, 1989 showed that the prosthesis had broken through the shaft of MT's femur and was at a right angle to the femur with its tip close to the surface of the patient's skin. I.G. Ex. 8 at 209; Tr. at 149 - 151. No further attempts were made to repair MT's fractured hip and she was discharged after consultation with her family. I.G. Ex. 8 at 130. Patient MT was discharged from Page Memorial in worse condition than she was in when she entered the hospital. Tr. at 152.

Patient MT suffered from advanced osteoporosis at the time of the surgery and her bones were in extremely fragile condition. I.G. Ex. 8 at 203; Tr. at 145, 147, 854. Petitioner recognized this. During the surgery, he attempted to reinforce the prosthesis by placing three wires and three bands around Patient MT's femur. Tr. at 150. The preponderance of the evidence is that Petitioner erred in attempting to reinforce Patient MT's femur in this manner. The bands did not provide additional support for the prosthesis and may have contributed to the subsequent breakout of the prosthesis. Tr. at 151. There were other techniques available to Petitioner which would have been more likely to reinforce the prosthesis, including the use of a prosthesis with a longer shaft than that used by the Petitioner, and the use of bone cement. Id.

Petitioner cannot justify his failure to use bone cement or a more appropriate prosthesis by arguing that these aids may not have been available at Page Memorial. If that is so, then Petitioner should not have attempted to perform the surgery. Petitioner should have ordered Patient MT transferred to a facility where appropriate aids were available.

The I.G. alleges that Petitioner fractured Patient MT's femur during surgery and his installation of reinforcing bands may have been an effort to compensate for this. Tr. at 150, 152. Petitioner denies fracturing Patient MT's femur. It appears from the patient's hospital records that Petitioner did fracture the patient's femur. I.G. Ex. 8 at 129. However, it is not necessary for me to resolve this issue in order to decide that Petitioner erred in his surgical technique. Whether the fracture occurred during surgery or afterward, the use of reinforcing wires and bands to reinforce the patient's femur, in lieu of other, more appropriate techniques, was wrong. Tr. at 150 - 152, 157 - 161.

The preponderance of the evidence establishes also that Petitioner erred in his management of Patient MT's aftercare. Petitioner should have ordered frequent postsurgical x-rays of the patient's hip in light of the fragile condition of Patient MT's bones. Petitioner's failure to assure that the patient was x-rayed, for approximately 19 days after the surgery, was an obvious error in the care he provided to the patient. Tr. at 148 - 149.

4. Additional errors made by Petitioner during surgery

Petitioner made substantial errors in his performance of surgery in cases in addition to the three cases that I have discussed in detail. These errors contribute to an overall picture of a surgeon who was prone to making grave misjudgments in assessing the problems he treated by performing surgery, in using inappropriate surgical techniques, and in providing inadequate aftercare to his patients. The additional instances of errors include the following.

a. Patient JJ

On August 18, 1991, Petitioner operated on Patient JJ. I.G. Ex. 4 at 5, 33. During this surgery, Petitioner installed an Austin-Moore prosthesis to repair a fracture in the patient's left hip. I.G. Ex. 4 at 5, 33, 65. However, he first initiated surgery on the patient's right hip, assuming erroneously that it was the right hip that had sustained a fracture. Tr. at 934 - 935. Petitioner failed to review x-rays prior to the surgery that would have shown him that the fracture was to Patient JJ's left hip. Id. Petitioner discovered his

error only after he had made an incision on the patient's right hip. Id.

b. Patient H

In October 1984, Petitioner operated on Patient H to remove her entire bowel. I.G. Ex. 11 at 8; I.G. Ex. 25 at 73 - 74. Petitioner performed this operation because he suspected that Patient H had suffered a recurrence of colon cancer. I.G. Ex. 11 at 8 - 9; I.G. Ex. 25 at 73 - 74. In fact, subsequent pathological studies were negative for recurrence of cancer. I.G. Ex. 11 at 8 - 9; I.G. Ex. 25 at 74. Petitioner erred in performing major surgery to remove suspected recurrent cancer without first verifying that, in fact, cancer had recurred. Tr. at 208, 217.

c. Patient C

In October 1984, Petitioner performed a prostatectomy (removal of the prostate gland) on Patient C. I.G. Ex. 11 at 10 - 11; Tr. at 223. His purpose in doing so was to enable the patient to pass urine. I.G. Ex. 11 at 10. Petitioner erred in performing the prostatectomy, because there were far less drastic procedures available which would have accomplished the intended result of enabling the patient to pass urine. Tr. at 221 - 223, 226.

5. Petitioner's misjudgments in deciding whether to perform surgery

Several of the cases which I have discussed so far share a common feature. In more than one instance, Petitioner performed surgery without properly assessing the need for the surgery and without weighing the benefits that his patient might obtain from the surgery as opposed to the risks that the patient might encounter. The I.G. proved that, in one additional case involving Patient JB, Petitioner decided to perform elective surgery under circumstances where such surgery was wholly inappropriate. Fortunately for the patient, that decision was rescinded.

Patient JB was first admitted to Page Memorial on May 14, 1991, suffering from shortness of breath. I.G. Ex. 1 at 8, 15 - 16. Patient JB had a history of several serious conditions, including diabetes, congestive heart failure, and kidney failure. Id. As of the May 14, 1991 admission, Patient JB was experiencing kidney failure. I.G. Ex. 1 at 8; Tr. at 456.

The patient's kidney failure was a hazardous condition. I.G. Ex. 25 at 200 - 202. During the course of the May 14, 1991 hospitalization, Petitioner did not treat Patient JB for his kidney failure. Tr. at 272, 466. However, it was determined during the course of the hospitalization that the patient had gallstones. Tr. at 458 - 459. Petitioner scheduled the patient to be readmitted to Page Memorial for elective gall bladder surgery at a date subsequent to the patient's discharge from the May 14, 1991 hospitalization. I.G. Ex. 1 at 9, 43, 66; Tr. at 430.

Patient JB returned to Page Memorial on May 28, 1991 for gall bladder surgery. I.G. Ex. 1 at 67, 73. As of this second admission, the patient's kidney failure had worsened. I.G. Ex. 1 at 67. Patient JB did not feel up to having gall bladder surgery and was discharged. Id. Petitioner did not treat the patient's kidney failure during this second hospitalization. See id.

Petitioner demonstrated extraordinarily poor judgment in deciding to schedule Patient JB for elective gall bladder surgery, and in ignoring the patient's kidney failure. I.G. Ex. 25 at 199 - 200, 202 - 204. The patient's gallstones were not a life-threatening condition. Id. The patient was suffering from other conditions that were hazardous, especially kidney failure. Id. Patient JB was an extremely poor risk for elective surgery. Surgery might have exacerbated the patient's kidney failure. Id. Page Memorial lacked the facilities to treat critical kidney failure. Tr. at 464 - 465. There is a strong possibility that Patient JB might not have survived gall bladder surgery, in light of his poor health and the absence of critical care facilities at Page Memorial. Tr. at 471.

Petitioner argues that he did not admit Patient JB to Page Memorial for elective gall bladder surgery. He asserts that he had decided not to perform surgery when the patient presented himself for the second admission, but that the documentation of the second admission incorrectly shows the patient being admitted for such surgery. I.G. Ex. 10 at 52 - 56, 61; Tr. at 678 - 679. I do not find this explanation to be persuasive. The documentation of the second admission plainly shows on more than one page that the purpose of the admission was for surgery. I.G. Ex. 1 at 67, 73. Moreover, Petitioner's explanation begs the question. Given the patient's state of health, Petitioner should not even have considered performing elective surgery on the patient, either as of the first hospitalization, or thereafter. Petitioner should have addressed the

patient's life-threatening conditions, especially his kidney failure.

F. Errors Petitioner committed in his medical practice (Finding 6)

Petitioner committed serious errors in his practice of medicine in cases not involving surgery. These errors included incorrect or incomplete diagnoses and administration of improper treatments and medications.

1. Patient LO

Petitioner's mistreatment of Patient LO began at the inception of his treatment of the patient at Page Memorial. Petitioner attended to a minor problem without identifying or investigating a potentially life-threatening neurological problem. Tr. at 442 - 444. That mistreatment continued throughout the patient's hospitalization. Petitioner failed to assess and treat properly the patient's neurological problem as it progressed. Petitioner did not order appropriate tests to establish the cause of the patient's problem until after the patient's condition had deteriorated significantly. See Tr. at 929. He treated the patient's condition without knowing its cause, and without knowing what medications were appropriate to treat the condition. See id. The medications that Petitioner ordered be administered to the patient were contraindicated. The likely result of Petitioner ordering that contraindicated medications be administered to Patient LO was that Petitioner made the patient's condition worse. Tr. at 447 - 448.

Patient LO was seen at Page Memorial's emergency room on June 16, 1991. I.G. Ex. 6 at 11. She was complaining of shortness of breath, numbness in her left arm, and rectal bleeding from hemorrhoids. Id. The patient was experiencing atrial fibrillation (an abnormal quivering of the top chambers of the patient's heart). Tr. at 429. Patient LO's left arm numbness was an indication that the patient might have been experiencing a transient ischemic attack (TIA), a deficiency in the supply of blood to the patient's brain. Tr. at 425 - 426. A TIA can progress into a full-blown stroke, if left untreated, which can cause death to brain tissue. Id.

Petitioner treated the patient's hemorrhoids, and he hospitalized her in order to deal with her atrial fibrillation. However, Petitioner did not perform a neurological examination to evaluate Patient LO's left

arm numbness, nor did he order tests to evaluate the numbness. Tr. at 426 - 427.

On June 21, 1991, while hospitalized, Patient LO showed additional signs of neurological problems. The patient became unresponsive for three to four minutes, and Petitioner recorded in his treatment notes that the patient was showing signs of an additional TIA. I.G. Ex. 6 at 33; Tr. at 434 - 435. Petitioner ordered that the patient be administered anticoagulant medications. I.G. Ex. 6 at 9 - 10, 34; Tr. at 436. The following day, the patient experienced additional neurological signs, including facial palsy and left arm weakness. Tr. at 438. These were signs that the patient was experiencing a stroke. Id. Petitioner addressed these additional neurological signs by ordering that the patient be administered intravenous anticoagulants. Tr. at 438 - 439. The patient's signs of a stroke continued unabated. Tr. at 439. It was not until June 24, 1991, that Petitioner ordered that a CAT scan (also referred to in the transcript of the hearing as a "CT scan") be performed on Patient LO. Tr. at 439 - 440; see Tr. at 448. The CAT scan revealed that the patient had suffered a parietal lobe hematoma on the right side of her brain. Tr. at 441.

Patient LO's neurological signs of facial palsy and left arm weakness were consistent with either a thrombotic stroke (a stroke caused by a blockage of the supply of blood to a portion of a patient's brain) or hemorrhagic stroke (a stroke caused by bleeding within the brain). Tr. at 447. The CAT scan which Petitioner ordered performed on June 24, 1991 showed that Patient LO had suffered a hemorrhagic stroke. Tr. at 447 - 448.

Because anticoagulants exacerbate bleeding, they must not be administered to a patient who is showing signs of having suffered a stroke, until a CAT scan establishes the cause of the stroke. Tr. at 448. In this case, Petitioner ordered a CAT scan of Patient LO several days after his initiation of anticoagulant therapy. Id. The anticoagulants that Petitioner ordered be administered to Patient LO were contraindicated by her condition. Administration of these medications to the patient probably made the patient's condition worse, because they could have increased the bleeding in the patient's brain. Tr. at 447 - 448. Petitioner would have known not to

administer anticoagulants to Patient LO had he ordered a CAT scan of the patient early in her treatment.

2. Patient AM

Petitioner failed to address Patient AM's critical blood sugar and fluid imbalances with available modern techniques, which led to a rapid deterioration of the patient's condition. Although Patient AM was gravely ill on her admission to Page Memorial, she was conscious at that time. She left the hospital in an irreversible coma. See Tr. at 819.

Patient AM was hospitalized at Page Memorial under Petitioner's care from November 20 - 21, 1992. I.G. Ex. 5 at 9 - 10. She was then transferred by helicopter to the University of Virginia Hospital at Charlottesville, Virginia. Id.; Tr. at 819. The patient's condition at the time of her admission to Page Memorial was life threatening. Tr. at 475. When Petitioner admitted the patient to Page Memorial, she was suffering from pneumonia. Tr. at 473. She was a chronically sick, frail, individual whose medical problems, in addition to pneumonia, included diabetes, septicemia (an infection in her bloodstream), and fluid accumulation as a consequence of cirrhosis of the liver. I.G. Ex. 5 at 9 - 10; Tr. at 472 - 474, 482 - 483.

Tests taken at the time of Patient AM's admission to Page Memorial established that the patient was suffering from dangerously low blood sugar. Tr. at 477 - 478. Petitioner treated this problem initially by ordering that the patient be administered glucose intravenously. Tr. at 478 - 479. This initial treatment had the beneficial consequence of raising Patient AM's blood sugar to an acceptable level. Id. Inexplicably, Petitioner then ordered that the treatment be discontinued, although he directed that access to the patient's vein be maintained. Id. In lieu of administering intravenous glucose, Patient AM's daughters administered small quantities of sugar water orally to patient AM. Tr. at 489. This treatment was totally ineffective. Id. The patient's blood sugar dropped dramatically. Tr. at 479 - 480. Eventually, Patient AM's blood sugar became so low that she went into a coma. Id.

Patient AM was suffering from a severe fluid imbalance. Tr. at 481. As a consequence of fluid imbalance and infection, she was in septic shock. Tr. at 482 - 483. It is important to monitor the intake and elimination of fluids to an individual who is in the condition that

Patient AM was in. Id. Petitioner could have monitored Patient AM's elimination of fluids easily with a Foley catheter, a device which is universally available to physicians. Tr. at 484. He could have directed the nurses who were monitoring the patient's condition to record the intake and output of fluids by the patient. Tr. at 485. There were additional monitoring techniques available, as well. Tr. at 485 - 486. Petitioner used none of these techniques. Rather, he asked the patient's daughters to keep count of the number of diapers used by the patient. Tr. at 485. This was an inadequate substitute for the techniques of fluid monitoring that were at Petitioner's disposal, and which were essential, given the state of Patient AM.[10]

Petitioner asserts that Patient AM refused to have her fluid output monitored by Foley catheter. Petitioner reply brief at 8. However, there is nothing in the record to show that Petitioner explained to the patient the risks of not inserting a catheter.

Petitioner asserts that Patient AM had declared that she did not want to be resuscitated. Petitioner reply brief at 8. I do not find anything in the record which supports this assertion. Furthermore, it is contradicted squarely by Petitioner's decision to transfer the patient after she became comatose. Statements in evidence from Patient AM's daughters do not support Petitioner's contention that the patient did not want to be resuscitated. P. Exs. 29, 30. The daughters do not aver that Patient AM had declared that she did not want to be resuscitated. Id. Indeed, there is a suggestion to the contrary in one of the declarations. See P. Ex. 30.

Finally, Petitioner contends that Patient AM did not want to be transferred to another facility. Petitioner reply brief at 8. However, Petitioner's decision to transfer or not to transfer the patient is not at issue here. The errors which Petitioner made in his treatment of Patient

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[10] The nursing progress notes for Patient AM show that a Foley catheter was inserted on the morning of November 21, 1992 at 9:50 a.m. I.G. Ex. 5 at 66. This was done only five hours prior to the patient's transfer to the University of Virginia Hospital and after the patient's condition had deteriorated. I.G. Ex. 5 at 66 - 68.

AM were as avoidable at Page Memorial as they would have been elsewhere.

3. Additional errors made by Petitioner in his medical practice

In other cases, Petitioner made errors of judgment and omission which are similar to those which he made in the cases of Patients LO and AM. These include the following.

a. Patient FB

On January 10, 1993, Patient FB was admitted to Page Memorial under Petitioner's care, suffering from acute respiratory distress and dehydration. I.G. Ex. 8 at 2, 7 - 8. Patient FB had a seriously weakened heart. Tr. at 501 - 502. Petitioner should have avoided administering treatments to the patient that would increase the work that the patient's heart would have to do. However, Petitioner erroneously administered fluids to the patient, and also erroneously administered medication that slowed the patient's heartbeat. Tr. at 509 - 512. As a consequence, Patient FB's condition deteriorated. Petitioner then exacerbated the patient's problems by administering a sedative, Valium, to the patient. Tr. at 510. Fortunately for the patient, a consultative physician identified and properly treated the patient's problems, essentially reversing the treatment that Petitioner had provided to the patient. Tr. at 505 - 507.

b. Patient BB

On February 10, 1993, Patient BB was admitted to Page Memorial under Petitioner's care, suffering from shortness of breath. Petitioner treated this condition, and, by February 15, 1993, the patient was no longer short of breath. I.G. Ex. 13 at 71. On February 16, 1993, Petitioner ordered that a thoracentesis, or chest tap, be administered to the patient. Tr. at 516 - 517. A thoracentesis consists of inserting a needle into a patient's chest cavity, in order to extract fluid. Tr. at 517. A thoracentesis may be appropriate for therapeutic or diagnostic reasons. Tr. at 517. However, it should not be performed unless there is a legitimate need for it. The procedure can be risky. One possible adverse consequence of a thoracentesis is that the patient's lung may be punctured, which can result in the lung collapsing. _See_ Tr. at 518. In this case, Petitioner erroneously performed the procedure without first x-raying Patient BB's chest to determine whether it

was needed. Patient BB experienced a collapsed lung and died in pain a few days later. I.G. Ex. 7 at 16; I.G. Ex. 13 at 71; I.G. Ex. 25 at 259 - 260; Tr. at 518.

Petitioner argues that the I.G. acknowledges that, prior to performing the thoracentesis, a chest x-ray had been made of Patient BB. Petitioner reply brief at 9; see I.G. proposed finding 274. From this, Petitioner suggests that there existed clinical evidence to support his performing the thoracentesis on Patient BB. In fact, the x-ray discussed by the I.G. had been made on February 10, 1993, six days prior to the date when Petitioner performed the thoracentesis. I.G. Ex. 7 at 77. The I.G.'s point, which I find to be supported by the evidence, is that Petitioner failed to do follow up diagnostic studies, including an x-ray, before performing the thoracentesis on Patient BB.

G. Petitioner's altering of records (Findings 7 and 11)

Deliberate altering of a medical record by a physician so as to conceal the truth is misconduct of a high order of magnitude. It puts other physicians at risk, because a physician who relies on an altered record to make a medical judgment about how to treat a patient risks harming the patient. I.G. Ex. 25 at 263. It puts the patient at risk, because that patient may be harmed by incorrect treatments ordered on the basis of the altered record. Id.

Petitioner altered Patient BB's hospital record. Petitioner intended to conceal the fact that he had performed a thoracentesis that contributed to the death of Patient BB, without clinical evidence that would justify performing the procedure. Petitioner offers a dishonest explanation for altering the record.

Petitioner admits altering the record. I.G. Ex. 13 at 70 - 72; Tr. at 966 - 968. Petitioner knew that the alteration would deceive a reviewer. Tr. at 968. In the progress note that Petitioner wrote on February 15, 1993, Petitioner made the following statement: "No S.O.B. - Has good appetite." I.G. Ex. 13 at 71. At some point after Petitioner performed the thoracentesis on Patient BB, Petitioner altered this record to read: "More S.O.B. today - Has good appetite." I.G. Ex. 13 at 72. Petitioner made the alteration by changing the letter "N" in "No" to "M," by adding the letters "re" to the end of the word, and by inserting the word "today" immediately after the acronym "S.O.B." A reviewer would not know

from reading the progress note that Petitioner had altered it.

The plausible explanation for this alteration is that Petitioner was attempting to mislead reviewers into believing that his decision to perform the thoracentesis on Patient BB was medically justified. After Patient BB's lung collapsed, the patient suffered greatly and died in pain. I.G. Ex. 25 at 259. The episode of Patient BB's treatment and death became an issue for investigation by the Page Memorial medical staff. Id.

Petitioner now offers a fanciful and self-serving explanation for altering the record. According to Petitioner, he observed Patient BB twice on February 15, 1993. He claims that, when he first saw the patient, the patient was not short of breath. However, according to Petitioner, at the second encounter Patient BB had become more short of breath. Petitioner asserts that he altered the record in order to depict his observation that Patient BB had become more short of breath at the second observation on February 15, 1993. Tr. at 840 - 842.

If, in fact, Petitioner had wanted to amend his progress note to reflect a change in the patient's condition, he simply could have added a statement to that effect. There are nearly two empty lines in the record between the progress note and Petitioner's signature in which Petitioner could have amended the progress note to show a deterioration in the patient's condition. I.G. Ex. 13 at 71.

Moreover, Petitioner appears not to have offered this explanation at a time when, assuming it to be legitimate, he should have offered it. Petitioner's altering of Patient BB's record is the event which led to Petitioner's resignation from the staff of Page Memorial in March 1993. I.G. Ex. 20. The minutes of the staff meeting at which Petitioner resigned do not suggest that Petitioner offered the explanation for the alteration which he now offers. Id. I am certain that if, in fact, Petitioner altered Patient BB's record in an innocent attempt to document a change in the patient's condition, as he now asserts to be the case, he would have so explained the alteration to Page Memorial medical staff when his privileges were at stake.

Furthermore, Petitioner's purported justification for the way in which he altered this record is belied by the fact that he knew the correct way to amend a record. Petitioner knew that the correct way to amend a record was to draw a line through the words he wished to amend,

to make a change above the line, and to initial that change. Tr. at 961 - 963. In February 1993, Petitioner would have been especially sensitive to the correct way to amend a medical record. There had been problems involving the way Petitioner made records which predate the incident that I describe here. In 1992, Page Memorial medical staff had directed Petitioner to take a course in medical records keeping. Tr. at 955 - 958. The course was taught by Petitioner's attorney, at Petitioner's expense. Tr. at 959. That Petitioner knew the right way to amend a record is underscored also by the fact that Petitioner made an amendment to his progress note of February 16, 1993, using the prescribed form (this change appears at the bottom right-hand corner of the same page which contains the February 15, 1993 progress note). I.G. Ex. 13 at 71.

H. Petitioner's unwillingness to accept full responsibility for all of his errors and misconduct (Finding 11)

As I discuss below, Petitioner has accepted responsibility for some of his errors. But, Petitioner continues to deny responsibility for major errors and misconduct. In this decision, I have discussed several instances where Petitioner continues to deny responsibility for major errors in judgment and misconduct. It is useful to summarize them here because, when Petitioner's denials are considered collectively, they establish a continuing tendency on Petitioner's part to refuse to accept responsibility for misconduct and to learn from this misconduct. These instances include the following.

1. Patient A

In his testimony concerning Patient A, Petitioner asserts that it was necessary to operate on the patient at Page Memorial because of signs that the patient had possibly sustained a ruptured aneurysm. Tr. at 883 - 884. However, as I discuss at Part IV.D.1. of this decision, this contention is not supported by the weight of the evidence. The patient could have been, and should have been, transferred to another facility.

2. Patient RB

Petitioner continues to assert that he was unable to reinforce staple lines in Patient RB during the first surgery he performed on the patient, due to lack of

usable tissue. As I discuss in Part IV.E.1. of this decision, that assertion is not credible.

3. Patient IW

Petitioner continues to argue that he performed adequate studies of Patient IW's peripheral circulation, prior to performing surgery on Patient IW. Tr. at 770 - 772; Petitioner reply brief at 4. However, as I discuss at Part IV.E.2. of this decision, the preponderance of the evidence is that Petitioner failed to perform adequate studies of the patient's circulation. Petitioner's failure to perform these studies may have resulted in his performing inadequate surgery on the patient during her first visit to Page Memorial, and that in turn may have triggered the chain of events leading to her two cardiac arrests and eventual death.

4. Patient JB

Petiioner continues to assert that he did not intend, as of the second hospitalization of this patient, to perform elective gall bladder surgery on the patient. However, as I discuss at Part IV.E.5. of this decision, the evidence shows that Petitioner admitted the patient for the purpose of performing the surgery. Furthermore, Petitioner's assertion evades the point that Petitioner should never have considered performing the surgery.

5. Patient BB

Petitioner continues to deny that he altered the records of Patient BB in order to mislead reviewers into believing that Petitioner had developed adequate clinical evidence for performing a thoracentesis on the patient. As I discuss at Part IV.G., this denial is not credible.

I. Petitioner's efforts to shift responsibility for his errors to other individuals (Findings 8 and 12)

In some instances, Petitioner has attempted to shift responsibility for his errors to other individuals. This tendency is disturbing, because it suggests again that Petitioner has not earned the full lesson taught by his errors. Examples of this tendency to attempt to shift responsibility are as follows.

1. Patient A

In the case of Patient A, Petitioner argues that he received a second opinion over the telephone which

supported his decision to operate on the patient. That is true. But, the physician who supplied that opinion relied on the information communicated by Petitioner. Although I do not find that Petitioner attempted to mislead that individual, it is evident that the opinion Petitioner received was not an independent assessment of the patient's condition which would have justified Petitioner's decision to proceed with aneurysm surgery.

2. Patient RB

In the case of Patient RB, Petitioner asserts that he received special privileges from the Page Memorial chief of staff to perform the stricture removal surgery. However, Petitioner bore responsibility for assessing the patient's condition, the need for surgery, and the suitability of the facilities for such surgery.

J. Petitioner's acknowledgement that he has committed errors (Finding 9)

Petitioner acknowledges committing some errors and accepts responsibility for these errors. This is evidence that Petitioner recognizes judgment failures and errors that he committed in the past and Petitioner shows a capacity on his part to learn from them. Some of the more significant acknowledgements of error by Petitioner are as follows.

1. Patient LO

In the case of Patient LO, which I discuss above, at Part IV.F.1. of this decision, Petitioner admits that he erred in not ordering that a CAT scan be performed, before administering anticoagulants to the patient. Tr. at 929.

2. Patient IW

In the case of IW, which I discuss above, at Part IV.E.2. of this decision, Petitioner now admits that he erred in permitting the nurse anesthetist to administer anesthesia to the patient without Petitioner's supervision. Tr. at 782.

3. Patient JJ

In the case of JJ, which I discuss above, at Part IV.E.4.a. of this decision, Petitioner now admits that he made a "terrible" mistake in commencing surgery on the wrong hip. Tr. at 934. Petitioner admits also that he was responsible for the failure to have x-rays of the patient's hip available in the operating room, prior to

commencement of surgery on the patient. Tr. at 934 - 936.[11]

K. Petitioner's attitude towards his patients and his practice, and his attempts to comply with professionally recognized standards of care (Findings 9 and 10)

Petitioner proved that, notwithstanding the evidence of his errors and misconduct, he is an individual who cares deeply about his patients. Petitioner frequently has made extraordinary and unselfish efforts on his patients' behalf. P. Exs. 49, 55. Petitioner's dedication to the welfare of his patients is reciprocated by the support and loyalty that his patients have shown for him. Tr. at 589 - 646.

While it is reasonable to conclude that a physician who is indifferent to the welfare of his patients is not trustworthy to provide care, it does not necessarily follow that a physician who is a dedicated practitioner is trustworthy to provide care. Nor is the fact that a physician is supported by members of his or her community necessarily a basis for finding that the physician is trustworthy. A physician may be dedicated to his patients, and supported by the members of his or her community, and nonetheless not be trustworthy. A physician may have an excellent rapport with his patients but may not be capable of providing care that meets professionally recognized standards of health care.

The significance of the evidence about Petitioner's attitude and the support for him shown by his patients is that it proves that Petitioner is motivated to provide care that meets professionally recognized standards of

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[11] The I.G. alleges that Petitioner operated on the wrong hip to the extent that he dissected tissue down to the level of the joint capsule and directed the surgical assistant to dislocate the hip. According to the I.G., it was only when the assistant refused this directive that it became apparent to Petitioner that he was operating on the wrong hip. Petitioner vigorously disputes this allegation. He asserts that he discovered his error much earlier in the procedure, after he had penetrated down to the level of the patient's fascia, but before he had reached the joint capsule. The I.G.'s evidence is persuasive. However, Petitioner has at least admitted the seriousness of his error in operating on the wrong hip.

health care. I am satisfied from this evidence that Petitioner is willing to provide such care.

Petitioner has conformed his practice with professionally recognized standards of health care, albeit in an office setting, and not in the context of hospital-based surgery. Petitioner has not performed surgery at Page Memorial since he resigned from its medical staff in March 1993. Tr. at 711. He has continued to provide care to patients at his office. Petitioner's office practice includes performing a number of minor surgeries, such as removals of skin lesions, and routine biopsies. Id.

Petitioner's license to practice medicine in Virginia was placed on probation by order of the Virginia Board of Medicine, effective November 11, 1993. I.G. Ex. 17. In determining to put Petitioner's license on probation, the Virginia Board of Medicine made findings concerning many of the cases which I have addressed in this decision. Although I do not rely on these findings, I note that they are consistent with the Findings which I have made concerning the manner in which Petitioner conducted his practice of medicine.

One provision of the order placing Petitioner's license on probation was to direct that Petitioner's surgical practice be audited at least monthly by an approved board-certified general surgeon. I.G. Ex. 17 at 12. Petitioner complied with this requirement. The surgeon who reviewed Petitioner's practice, Dr. Mansfield, monitored Petitioner's practice for a period of 19 months. Tr. at 706. Petitioner cooperated throughout this period. Id. Petitioner made all of his office records available for review by Dr. Mansfield and also for review by State inspectors. Tr. at 706 - 707. Petitioner accepted suggestions that were made by Dr. Mansfield concerning Petitioner's practice. Tr. at 710 - 711. During the 19-month period that Petitioner was monitored by Dr. Mansfield, Petitioner conformed his office practice to professionally recognized standards of health care.[12] On June 27, 1995, the Virginia Board of Medicine ordered that Petitioner's probation be

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[12] There is evidence that, shortly prior to the commencement of Dr. Mansfield's review, Petitioner performed hernia surgeries in his office that should not have been performed in that setting. However, Dr. Mansfield counseled Petitioner to cease performing such surgeries in his office, and Petitioner complied.

terminated and ordered additionally that Petitioner's license to practice medicine be restored. P. Ex. 54.

Since November 1993, Petitioner has completed numerous courses in continuing medical education. P. Exs. 37, 50. I cannot conclude from Petitioner's completion of these courses that he has absorbed all of the information that the courses imparted, and that he has thereby improved his skills as a practitioner. However, it is reasonable to infer from Petitioner's diligence in completing these courses that he has sought to improve his professional skills.

V. The need for a three-year exclusion (Findings 13 and 14)

The I.G. rests her argument that I should impose a lengthy exclusion against Petitioner on the evidence establishing that Petitioner committed egregious errors and misconduct and on his refusal to acknowledge having committed all of these errors. Petitioner rests his argument that I should not impose any exclusion against him on the evidence which shows that Petitioner cares deeply about the welfare of his patients and that he has conformed his office practice to professionally recognized standards of care.

I would impose a very lengthy exclusion against Petitioner if I considered only the evidence relied on by the I.G. That evidence depicts a practitioner who is prone to making gross misjudgments about the kind of care to provide to his patients and who is prone to committing basic errors in his providing of care. That evidence depicts also a practitioner who does not always accept responsibility for his errors, who attempts to shift responsibility for his errors to other individuals, and who has attempted, dishonestly, to cover up some of his errors.

By the same token, the evidence relied on by Petitioner would, if considered in isolation, suggest that Petitioner is a trustworthy provider of care. I would not impose an exclusion against Petitioner if I considered only this evidence.

I draw several conclusions about Petitioner's trustworthiness. First, Petitioner has demonstrated a flawed decision making process with hospitalized patients which has led him, consistently, into making egregious errors in the management of his patients' care. The frequency and seriousness of these errors is powerful

evidence that Petitioner manifests a continuing tendency to make such errors. I am not persuaded by Petitioner's recent compliance with professionally recognized standards of health care in his office that he would not continue to commit such errors if he were to resume his full practice, including performing surgery in a hospital setting.[13]

Second, Petitioner's unwillingness to accept responsibility for all of the errors and misconduct he committed proves that Petitioner has not yet learned the full lesson taught by these errors and misconduct. This reinforces my conclusion that Petitioner did not show that he has eliminated his tendency to make gross judgment errors in his treatment of hospitalized patients.

Third, Petitioner's devotion to his patients, coupled with his compliance with conditions imposed on him by the Virginia Board of Medicine, proves that he is trying to overcome his tendency to commit errors. To an extent, that evidence is reinforced by the fact that Petitioner has acknowledged that he has made some judgment errors in the past.

An exclusion of three years takes into account this contrasting evidence. It provides sufficient time so that Petitioner may continue to reflect on and learn from his past errors. It provides protection to program beneficiaries and recipients during this period of time. I have not imposed an exclusion of more than three years because Petitioner should be able to fully reform his practice within three years. An exclusion of more than three years would be punitive, considering Petitioner's attitude towards his patients and his attempts, so far, to reform his practice.[14]

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[13] I do not have authority to exclude a practitioner from participating in some aspects of federally funded health care programs, but not others. Walter J. Mikolinski, Jr., DAB 1156 (1990). Thus, I may not exclude Petitioner from claiming reimbursement for care that he provides in a hospital, but permit him to claim reimbursement for care that he provides in his office.

[14] An exclusion of three years is consistent with the recommendation that MSVRO made to the I.G. I.G. Ex. 15 at 1, 48 - 50.

Throughout this case, Petitioner has asserted that there exists a shortage of physicians in Page County, Virginia and that the population of that county will be deprived of needed professional care by his exclusion. Page County is a county with a population of less than 70,000. The Act presumes that, in such a county, there is a shortage of medical professionals. Act, section 1156(b)(5). However, the fact that there exists a shortage of medical professionals in Page County, or even the possibility that Page County might be deprived of the needed services of a surgeon by virtue of Petitioner's exclusion, is not a sufficient basis to reduce the exclusion in this case. The remedial purpose of the Act to protect beneficiaries and recipients from an untrustworthy provider would be defeated if I were not to exclude Petitioner. In this case, the need for protection supersedes any need for medical professionals that may exist in Page County.

The fact that I have sustained an exclusion for three years means that Petitioner will be eligible to apply for reinstatement at the end of the three-year exclusion period. It does not mean that the I.G. must reinstate Petitioner, should Petitioner apply for reinstatement. The I.G. has authority to accept or not to accept an application for reinstatement. 42 C.F.R. § 1001.3002. Evidence that Petitioner has failed, during the period of his exclusion, to comply with professionally recognized standards of health care, could be a basis for the I.G. to deny reinstatement to Petitioner. Id.

VI. Conclusion

I conclude that the I.G. has authority to exclude Petitioner. I sustain an exclusion of three years.

/s/

Steven T. Kessel
Administrative Law Judge