

The Supreme Court of Ohio

FILED

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Gary C. Gelesh

Case No. 2010-1884 SUPREME COURT OF OHIO

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SUPREME COURT OF OHIO

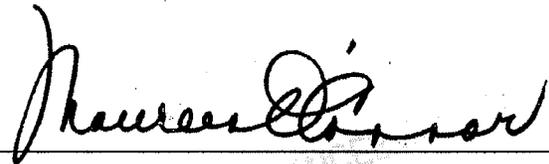
v.

ENTRY

State Medical Board of Ohio

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case and dismisses the appeal as not involving any substantial constitutional question.

(Franklin County Court of Appeals; No. 10AP169)



Maureen O'Connor
Chief Justice

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ORIGINAL

IN THE SUPREME COURT OF OHIO

Gary C. Gelesh, D.O.,

Appellant,

v.

State Medical Board of Ohio,

Appellee.

: Case No. **10-1884**
:
: On Appeal from the Franklin County
: Court of Appeals, Tenth Appellate District
:
: Court of Appeals
: Case No. 10 AP-169
:
:

NOTICE OF APPEAL OF APPELLANT GARY C. GELESH, D.O.

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SUPREME COURT OF OHIO

NOTICE OF APPEAL OF APPELLANT GARY C. GELESH, D.O.

Appellant Gary C. Gelesh, D.O. hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals Case No. 10 AP-169 on September 16, 2010.

This case involves substantial constitutional questions and is a case of public or great general interest.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing Notice of Appeal of Appellant Gary C. Gelesh, D.O. was served by U.S. Mail, postage prepaid, this 1st day of November 2010, upon:

Kyle Wilcox
Assistant Attorney General
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Eric J. Plinke
Gregory P. Mathews

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

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CLERK OF COURTS

Gary C. Gelesh, :
 :
 Plaintiff-Appellant, :
 :
 v. : No. 10AP-169
 : (C.P.C. No. 09CV-07-10873)
 State Medical Board of Ohio, :
 : (REGULAR CALENDAR)
 Defendant-Appellee. :

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on September 16, 2010, appellant's assignments of error are overruled. Therefore, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

TYACK, P.J., BROWN & McGRATH, JJ.

By  _____
Judge G. Gary Tyack, P.J.

[Cite as *Gelesh v. State Med. Bd. of Ohio*, 2010-Ohio-4378.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Gary C. Gelesh, :

Plaintiff-Appellant, :

v. :

State Medical Board of Ohio, :

Defendant-Appellee. :

No. 10AP-169
(C.P.C. No. 09CV-07-10873)

(REGULAR CALENDAR)

D E C I S I O N

Rendered on September 16, 2010

Dinsmore & Shohl, LLP, Eric J. Plinke and Gregory P. Mathews; Lambert & MacDonald, Co., LPA, John D. Lambert and Ida L. MacDonald, for appellant.

Richard Cordray, Attorney General, and Kyle C. Wilcox, for appellee.

APPEAL from the Franklin County Court of Common Pleas

TYACK, P. J.

{¶1} This is an appeal from the January 25, 2010 judgment of the Franklin County Court of Common Pleas affirming the State Medical Board's ("Board") June 11, 2009 order. The Board found that Gary C. Gelesh, D.O., had violated R.C. 4731.22(B)(6) in that he departed from, or failed to conform to, minimal standards of care of similar

practitioners under the same or similar circumstances, whether or not actual injury to a patient was established. For the reasons that follow, we affirm.

{¶2} At approximately 9:00 p.m. on February 7, 2002, a terminally ill 88-year-old patient ("Patient 1") with severe abdominal pain was transported from her assisted living facility to the emergency department of Akron General Medical Center. Previously, the patient had executed a do not resuscitate/comfort care only ("DNR/CC") directive. Appellant, Gary C. Gelesh, D.O., was the attending physician that evening and in charge of Patient 1's care. Dr. Gelesh ordered narcotics to alleviate the patient's pain, but even with increasingly large doses of morphine, at 1:05 a.m., on February 8, 2002, Patient 1 was still in extreme pain.

{¶3} Dr. Gelesh testified that he conveyed a verbal order for a benzodiazepine, either Versed or Ativan, to Denise Orndorf, R.N. Orndorf heard the order as one for 60 mg. of Anectine. Orndorf testified that she did not know what Anectine was, but she looked it up in a reference book and realized that Anectine was the brand name for succinylcholine. Succinylcholine is a neuromuscular blocking agent that paralyzes skeletal muscles including the respiratory muscles. It is used to paralyze the respiratory muscles to facilitate endotracheal intubation. If the drug is administered without respiratory support, the patient ceases breathing and dies.

{¶4} After retrieving the medication, Orndorf consulted with other nurses in the charting area, and they told her "Don't give that," to which Orndorf responded, "I wasn't going to." Orndorf returned to Patient 1's bedside and handed either the vial and an empty syringe, or a syringe containing Anectine to Dr. Gelesh. There was conflicting testimony: first, as to whether the nurse ever asked Dr. Gelesh if Anectine was the

medication he wanted; and second, whether Dr. Gelesh heard the question and did not answer or whether he did not hear the question. At 1:20 a.m., Dr. Gelesh administered the drug himself without confirming what it was. Patient 1 died within three minutes of receiving the medication.

{¶5} The Board issued a notice of opportunity for hearing pursuant to R.C. 119.07 to Dr. Gelesh on May 18, 2005. The notice alleged that Dr. Gelesh had departed from the minimal standards of care with respect to the administration of Anectine to Patient 1.

{¶6} Dr. Gelesh sought statutory immunity from professional disciplinary action on the grounds that he was providing comfort care under R.C. Chapter 2133, the "Modified Rights of the Terminally Ill Act and the Dnr Identification and Do-Not-Resuscitate Order Law." The Franklin County Court of Common Pleas denied the requested relief indicating that Dr. Gelesh had an adequate remedy by appeal of the Board's actions and decisions. This court affirmed the common pleas court's decision in *State ex rel. Gelesh v. State Med. Bd.*, 172 Ohio App.3d 365, 2007-Ohio-3328.

{¶7} On March 8, 2006, the Board issued a second notice of opportunity for hearing. The factual allegations were the same, but the notice added language that Dr. Gelesh acted "in bad faith, and/or outside the scope of your authority, and/or not in accordance with reasonable medical standards." The notice also denied that Dr. Gelesh's claim for immunity was proper.

{¶8} A hearing began on October 16, 2006. At the outset, the State announced that it intended to show that Dr. Gelesh intentionally killed Patient 1 by administering excessive amounts of morphine and by intentionally administering Anectine. The hearing

examiner decided that evidence and argument concerning excessive morphine and intent to kill was outside the scope of the hearing notice. Accordingly, the hearing examiner excluded the evidence and argument.

{¶9} After the hearing officer submitted her report and recommendation, the State moved to submit the excluded evidence to the Board for a ruling on admissibility. The Board heard argument from counsel and agreed to consider the additional evidence. The matter was remanded to allow Dr. Gelesh the opportunity to rebut the evidence.

{¶10} The hearing officer issued a report and recommendation on remand dated May 12, 2009. The hearing officer found that: (1) Dr. Gelesh did not intentionally order succinylcholine for Patient 1; (2) Dr. Gelesh did not order morphine for the purpose of causing Patient 1's death; and (3) Dr. Gelesh carried out his treatment of Patient 1 in good faith from beginning to end. However, the report also concluded that Dr. Gelesh did not verify or confirm the medication Anectine before he administered it, and that his failure to do so constituted a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established." R.C. 4731.22(B)(6). The hearing examiner recommended a stayed suspension of Dr. Gelesh's medical license and a period of probation.

{¶11} The Board took up the matter at its meeting of June 10, 2009. After discussion, the Board voted to confirm the hearing officer's findings of fact and conclusions of law, but to substitute an order that no further action be taken.

{¶12} Dr. Gelesh appealed the Board's order to the Franklin County Court of Common Pleas. On appeal, Dr. Gelesh argued that his due process rights were violated,

that the finding that he had deviated from the standard of care was reversible error, and that additionally he was entitled to statutory immunity since he was providing comfort care to Patient 1.

{¶13} The court of common pleas found the decision and order to be supported by reliable, probative, and substantial evidence, and in accordance with law. This appeal followed with Dr. Gelesh assigning the following as error:

[I.] The court erred in failing to invalidate the Board's order after it found that the Board had not complied with R.C. 119.07.

[II.] The court erred in finding that the Board did not deprive Appellant of due process after it found that the Board had not complied with R.C. 119.07.

[III.] Although the court was correct in finding that the Board inappropriately prosecuted an administrative action and sought to prove factual claims that were not contained in the notice of opportunity for hearing, the court erred in finding that the Board's conduct was not a denial of due process.

[IV.] The court erred in finding that Board's Order was supported by substantial, probative, and reliable evidence.

[V.] Although the court was correct in finding that the issues of intent to kill and excessive morphine were not in the notice of opportunity for hearing, the court erred in finding that the Board's conduct following issuance of the Amended Report and Recommendation and the remand hearing were in compliance with the due process clauses of the United States and Ohio Constitutions.

[VI.] Although the court was correct in finding that the Board should have allowed Appellant to introduce evidence of the cause of death of the patient at issue, it erred in finding that this error was "de minimus."

[VII.] The court erred in finding that the Board acted lawfully when it failed to grant immunity to Appellant under R.C. Chapter 2133.

{¶14} Pursuant to R.C. 119.12, when a trial court reviews an order of an administrative agency, it must consider the entire record to determine if the agency's order is supported by reliable, probative, and substantial evidence and is in accordance with law. If a party appeals the trial court's decision to affirm, reverse, vacate, or modify the agency's order, the appellate court must determine whether the trial court abused its discretion in its examination of the record for reliable, probative, and substantial evidence. *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621, 1993-Ohio-122. On questions of law, an appellate court's review is plenary. *Univ. Hosp., Univ of Cincinnati College of Medicine v. State Emp. Relations Bd.* (1992), 63 Ohio St.3d 339, 343.

{¶15} Reliable, probative, and substantial evidence has been defined as follows:

* * * "Reliable" evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. * * * "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. * * * "Substantial" evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Control Comm. (1992), 63 Ohio St.3d 570, 571.

(Footnotes omitted.)

{¶16} The term "abuse of discretion" connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary, or unconscionable. *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219.

{¶17} With this standard in mind, we address Dr. Gelesh's assignments of error.

{¶18} Assignments of error one, two, three, and five relate to R.C. 119.07 and due process concerns. Thus, they will be discussed together. It is axiomatic that due process

requires that one with a protected interest is entitled to notice and an opportunity to be heard in order to preserve the individual's rights under the due process clauses of the Ohio and United States Constitution. *Mullane v. Central Hanover Bank & Trust Co.* (1950), 339 U.S. 306, 314, 70 S.Ct. 652.

{¶19} R.C. 119.07 sets forth the procedural and statutory requirements for notice and the opportunity to be heard for a licensee in an administrative proceeding. Such notice "shall include the charges or other reasons for the proposed action, the law or rule directly involved, and a statement informing the party that the party is entitled to a hearing if the party requests it within thirty days." *Id.* Additionally, R.C. 119.07 provides that "[t]he failure of an agency to give the notices for any hearing required by sections 119.01 to 119.13 of the Revised Code in the manner provided in this section shall invalidate any order entered pursuant to the hearing."

{¶20} Dr. Gelesh contends that the second notice was defective because the assistant attorney general introduced allegations and evidence that were not contained in the notice. The State sought to prove that Dr. Gelesh had intentionally sought to hasten the death of Patient 1 by administering excessive amounts of morphine and that he sought to kill the patient by intentionally administering Anectine. Dr. Gelesh reasons that the State's attempt to expand the scope of the proceedings by adding these additional charges was outside the scope of the notice and therefore a violation of R.C. 119.07. Dr. Gelesh cites R.C. 119.07 for the proposition that the court of common pleas should have invalidated the Board's order because the notice was defective.

{¶21} In *Althof v. Ohio State Bd. of Psychology*, 10th Dist. No. 05AP-1169, 2007-Ohio-1010, a psychologist alleged a due process violation when the notice from the board

of psychology alleged that he engaged in sexual intercourse with patients, but it did not allege that he engaged in “inappropriate behavior” and “sexually intimate contact.” *Id.* at ¶5. The psychologist claimed that the board had found that he engaged in “inappropriate behavior” when he was specifically charged with having sexual intercourse. He claimed his due process rights were violated when the board considered conduct other than sexual intercourse.

{¶22} This court found that the notice provided fair warning that the psychologist was accused of sexual misconduct with his patients, and that the psychologist’s due process rights to reasonable notice and a fair hearing were not violated. *Id.* at ¶29.

{¶23} Similarly, in *Macheret v. State Med. Bd. of Ohio*, 10th Dist. No. 09AP-849, 2010-Ohio-3483, a physician was charged with engaging in sexual conduct with a patient without first terminating the physician-patient relationship. The physician argued that the Board violated his right to due process when it increased the hearing examiner’s proposed sanction based on uncharged conduct (the physician’s self-professed habit of exchanging hugs and air kisses with his patients) that was not included in the notice he received. This court found no due process violation because the Board disciplined the physician only for the violations charged in the notice and only considered the uncharged misconduct in setting the appropriate sanction. *Id.* at ¶28.

{¶24} The case of *Singer v. State Med. Bd. of Ohio* (Sept. 26, 1991), 10th Dist. No. 90AP-1204, 1991 WL 224968, is also instructive. In that case, Dr. Singer was on notice pursuant to R.C. 4731.22(A) and (B)(5) that he was charged with committing fraud on his license renewal application. The Board’s notice referenced R.C. 4731.22(B)(6) (failure to conform to minimal standards of care), but Dr. Singer argued that the notice

violated due process because he was unable to determine that one of the allegations was that his current practice was below standard. Therefore, he argued that he was not able to refute the charge by presenting testimony by experts and patients that his current practice performance was satisfactory. This court concluded that “[t]he hearing examiner clearly considered Singer’s current standard of practice to be relevant, although it was never directly addressed, Singer was not given notice that the issue would be raised, and no evidence was presented.” On appeal, this court found that any possible error with regard to the notice could have been found harmless in light of the fact that R.C. 4731.22(A) enabled the Board to revoke Dr. Singer’s license on the sole basis that he committed fraud in his license renewal application. *Id.*

{¶25} In the present case, it is undisputed that Dr. Gelesh was notified that he was charged with departing from the minimal standards of care with respect to the administration of Anectine. The second notice added a claim that he had acted in bad faith, and/or outside the scope of his authority, and/or not in accordance with reasonable medical standards, and that statutory immunity under R.C. Chapter 2133 was therefore, not appropriate.

{¶26} With respect to allegedly administering excessive morphine, the hearing officer struck argument and evidence related to the additional allegations. The hearing officer reasoned that the notice contained no mention of morphine at all. Only after the Board took up the matter pursuant to R.C. 119.09 was the issue of excessive morphine considered by the hearing officer and the Board.

{¶27} R.C. 119.09 permits the Board, through its hearing officer, to make evidentiary determinations, but if the hearing officer refuses to admit certain evidence, the

party offering the evidence (in this case the State) may make a proffer. After the hearing examiner submits her report and recommendation, the Board may then order additional testimony to be taken or permit the introduction of further documentary evidence.

{¶28} Here, the proffered evidence was relevant for the purpose of determining whether Dr. Gelesh's conduct was in bad faith or outside the scope of his authority, allegations specifically alleged in the second notice of hearing. Dr. Gelesh was aware that his state of mind was at issue in the case after he asserted statutory immunity from disciplinary proceedings because he was rendering comfort care to a terminally ill patient. Whether Dr. Gelesh was rendering comfort care in good faith or intentionally hastening the demise of Patient 1 became an issue once Dr. Gelesh raised the affirmative defense of statutory immunity pursuant to R.C. 2133.11. Therefore, it was not unreasonable or outside the scope of the notice for the Board to examine the entire course of care for Patient 1. Moreover, the evidence only was considered after Dr. Gelesh was given the opportunity to rebut such evidence.

{¶29} Dr. Gelesh argues that the admission of this evidence tainted the entire proceeding. We disagree. The hearing examiner took great pains to determine whether such evidence was germane to the case as set out in the second notice of hearing. The Board then considered the matter and, under its statutory purview, decided the evidence could have a bearing on their ultimate determination. Dr. Gelesh was given a full and fair opportunity to rebut the additional evidence, and he prevailed on his arguments. In fact, Dr. Gelesh was so successful in rebutting the State's theory, that the Board disagreed with the hearing examiner's recommendation and chose to impose no disciplinary sanctions. It is therefore apparent that the Board asked for, received a fuller picture of the

events of February 7 and 8, 2002, and agreed with the hearing examiner that Dr. Gelesh acted in good faith and did not intend to hasten the demise of Patient 1.

{¶30} As this court determined in *Macheret* and *Singer*, there was no due process violation because the only violation found was that charged in the notice. Therefore, as a matter of law, we conclude that, under the requirements of R.C. 119.07, Dr. Gelesh was provided with sufficient notice of the allegations against him. Nor is there a due process violation since he was given a fair opportunity to litigate the issues.

{¶31} Assignments of error one, two, three, and five are overruled.

{¶32} In his fourth assignment of error, Dr. Gelesh asserts the trial court abused its discretion when it found substantial, reliable, and probative evidence to support the Board's order. First, he contends that the State's expert, Dr. William Raymond Fraser, D.O., used the wrong standard under which to evaluate Dr. Gelesh's conduct. Dr. Gelesh contends that the issue was whether his conduct fell below the minimal standard of care, not what the best practice is.

{¶33} Dr. Fraser is Director of Emergency Medicine at Doctors Hospital in Columbus, Ohio. He is board certified in emergency medicine. In answer to a series of hypothetical questions, he set forth the minimal standard of care for the administration of medication in emergency medicine.

{¶34} Dr. Fraser testified that Dr. Gelesh's care of Patient 1 was appropriate except with regard to the administration of Anectine. Dr. Fraser then said that: "Any time there's verbal orders there's always the possibility of miscommunication, and I believe the best way to prevent that miscommunication from affecting patient outcomes is to verify the order yourself." (Tr. 216.)

{¶35} At that point, the hearing examiner spoke up as follows:

I need to break in at this moment. Doctor, you said the best way to do that is a certain method. And today -- Well, during this entire hearing I'm not going to be looking at what the best practices are, I'm going to be looking at what the minimal standards are. And, counsel, if you could explore minimal standards, that would be appropriate.

(Tr. 216-17.)

{¶36} Doctor Fraser then testified as to the minimum standard of care as follows:

I believe a minimum standard of care is to verify yourself; you simply ask the question, "What's in it.?"

(Tr. 217.) He then stated that the minimal standard of care requires the physician to know what the medication is that he is injecting. Id.

{¶37} The essence of Dr. Fraser's expert testimony was that the minimal standard of care requires a physician to have knowledge of what medication is in a syringe before personally administering the medication.

{¶38} Dr. Gelesh's expert was Gayle Galan, M.D., the chair of the emergency medical department at Southwest General Hospital in Cleveland, Ohio. Dr. Galan focused on a current requirement that a nurse verify a verbal order for medication at the time the order is given. Dr. Galan testified that this requirement was not in place in 2002. Dr. Galan was of the opinion that it is never acceptable to inject medication into a patient without knowing what it is, but that Dr. Gelesh had the right to depend on the nurse's expertise to bring him the medication that he asked for. Dr. Galan testified that adopting the standard proposed by Dr. Fraser would be impractical and render an emergency department non-functional.

{¶39} The Board and the hearing examiner agreed with Dr. Fraser. In fact, the Board questioned the opinions and knowledge of Dr. Galan. The Board is entitled to rely on its collective expertise in deciding whether there was a violation. In *Arlen v. State Med. Bd. of Ohio* (1980), 61 Ohio St.2d 168, 173, the Supreme Court of Ohio stated that "[t]his distinguished medical board is capable of interpreting technical requirements of the medical field and is quite capable of determining when certain conduct falls below a reasonable standard of medical care."

{¶40} The court of common pleas did not abuse its discretion in finding reliable, probative, and substantial evidence to support the Board's decision in the battle of the experts.

{¶41} Dr. Gelesh argues that the testimony of Orndorf was lacking in credibility because her investigatory statement contradicted her hearing testimony. The hearing officer tended to agree with Dr. Gelesh and discredited her testimony. Even after resolving such credibility issues in favor of Dr. Gelesh, the evidence still showed that Dr. Gelesh failed to confirm the medication he received and administered to Patient 1. Substantial, probative, and reliable evidence supported the Board's finding that Dr. Gelesh departed from the minimum standard of care. The court of common pleas did not abuse its discretion in overruling this assignment of error.

{¶42} The fourth assignment of error is overruled.

{¶43} In the sixth assignment of error, Dr. Gelesh argues reversible error exists because Dr. Gelesh was not allowed to introduce evidence of the cause of death of Patient 1.

{¶44} There was no autopsy of Patient 1, but the coroner determined the cause of death was respiratory arrest due to the administration of succinylcholine. (State's exhibit No. 5.) Dr. Gelesh sought to rebut that evidence with the testimony of Dr. Cyril H. Wecht, but was not permitted to do so. The hearing examiner believed that, pursuant to R.C. 313.19, the coroner's determination was conclusive and disallowed the introduction of the evidence.

{¶45} R.C. 313.19 provides that the coroner's verdict shall be the legally accepted cause of death, and states as follows:

The cause of death and the manner and mode in which the death occurred, as delivered by the coroner and incorporated in the coroner's verdict and in the death certificate filed with the division of vital statistics, shall be the legally accepted manner and mode in which such death occurred, and the legally accepted cause of death, unless the Court of Common Pleas of the county in which the death occurred, after a hearing, directs the coroner to change his decision as to such cause and manner and mode of death.

{¶46} The Supreme Court of Ohio, in the case of *Vargo v. Travelers Ins. Co.* (1987), 34 Ohio St.3d 27, stated:

Further, it must be noted that while the coroner's factual findings are not conclusive, neither are they a nullity. The coroner is a medical expert rendering an expert opinion on a medical question. * * * Therefore, to rebut the coroner's determination, as expressed in the coroner's report and the death certificate, competent credible evidence must be presented.

Id. at 30.

{¶47} Despite the hearing examiner's erroneous interpretation of R.C. 313.19, we agree with the court of common pleas that such error is de minimus. Dr. Gelesh was found to have administered Anectine without confirming the drug he was injecting.

This deviation from the minimal standard of care of similar practitioners under the same or similar circumstances is a violation of R.C. 4731.22(B)(6), whether or not actual injury to a patient was established. The sixth assignment of error is overruled.

{¶48} The seventh assignment of error concerns immunity from professional disciplinary action for providing comfort care. R.C. 2133.11 provides that once an attending physician makes an initial determination that a patient is in a terminal condition to a reasonable degree of medical certainty and in accordance with reasonable medical standards, the physician may provide comfort care “for the purpose of diminishing the qualified patient’s or other patient’s pain or discomfort and not for the purpose of postponing or causing the qualified patient’s or other patient’s death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient’s death, if the attending physician so prescribing, dispensing, administering, or causing to be administered * * * [is] carrying out in good faith the responsibility to provide comfort care described in division (E)(1) of section 2133.12 of the Revised Code.” Patient 1 was a “do not resuscitate/comfort care only” patient, and the Board acknowledged that Dr. Gelesh provided comfort care to her.

{¶49} Dr. Gelesh argues that the immunity provided by R.C. Chapter 2133 is not forfeited when the physician makes a good-faith mistake. The court of common pleas interpreted the statute differently and found that Dr. Gelesh’s good-faith administration of comfort care “does not excuse a mistake in medication, especially one such as succinylcholine.” (Decision on Merits of Appeal, at 15.)

{¶50} This court has stated that:

By its express terms, R.C. 2133.11 provides immunity to a physician, acting in good faith and within the scope of his or her authority, for administering or causing to be administered any medication while carrying out the responsibility to provide comfort care.

Gelesh at ¶11.

{¶51} Here, Dr. Gelesh was in good faith providing comfort care to an elderly woman on the verge of death, and therefore, Dr. Gelesh was entitled to immunity up to and including the time when he was administering increasing doses of narcotics and, in particular, morphine. However, the administration of succinylcholine cannot be considered comfort care. It was a medication error and not in accordance with minimal standards of care. Nor did the Patient 1's DNR/CC directive provide authority to administer succinylcholine under these circumstances, particularly with no respiratory support. We do not believe that R.C. Chapter 2133 provides immunity under these circumstances despite the fact that Dr. Gelesh acted in good faith with respect to his treatment of Patient 1 from the time she arrived in the emergency department until her death. The trial court did not abuse its discretion in so ruling.

{¶52} The seventh assignment of error is overruled.

{¶53} Based on the foregoing, appellant's seven assignments of error are overruled, and the judgment of the Franklin County Court of Common Pleas is affirmed.

Judgment affirmed.

BROWN and McGRATH, JJ., concur.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FILED
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FRANKLIN CO. OHIO
2010 FEB 23 PM 3:30
CLERK OF COURTS

Gary C. Gelesh, D.O.,

Appellant,

vs.

State Medical Board of Ohio,

Appellee.

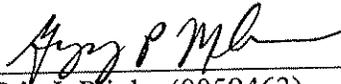
Case No. 09 CV 010873

Judge Holbrook

NOTICE OF APPEAL OF APPELLANT GARY C. GELESH, D.O.

Appellant Gary C. Gelesh, D.O., by and through the undersigned counsel, hereby gives this Notice of Appeal of this matter to the Tenth District Court of Appeals from the decision and final judgment of the Court of Common Pleas, Franklin County, Ohio, filed on January 25, 2010, which affirmed the Order of the State Medical Board of Ohio. The judgment entry was issued as a final and appealable order on January 25, 2010.

Respectfully submitted,


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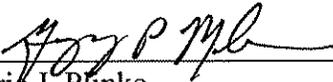
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FRANKLIN CO. OHIO
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10APE02 0169

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing has been sent via regular U.S. mail to Kyle Wilcox, Assistant Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215, this 23rd of February, 2010.



Eric J. Plinke
Gregory P. Mathews

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

TERMINATION
1/8

GARY CHARLES GELESH, D.O.,

Appellant

v.

STATE MEDICAL BOARD OF OHIO,

Appellee

Case No. 09CV-10873
JUDGE HOLBROOK

FINAL APPEALABLE ORDER

**JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S
JUNE 10, 2009, ORDER**

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the June 10, 2009, Order of the State Medical Board of Ohio which found that Dr. Gelesh violated O.R.C. 4731.22(B)(6) but ordered no further action be taken. For the reasons stated in the decision of this Court rendered and filed on January 12, 2010, which decision is incorporated by reference as if fully rewritten herein, it is hereby:

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the June 10, 2009, Order of the State Medical Board in the matter of Gary C. Gelesh, D.O., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

Date

JUDGE HOLBROOK

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FRANKLIN CO. OHIO
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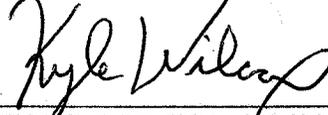
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*Mr. Plinke
approved
via email
on 1-22-10*

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FILED
COMMON PLEAS COURT
FRANKLIN CO., OHIO
2010 JAN 12 PM 4:45
CLERK OF COURTS

**IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION**

GARY C. GELESH, D.O.,

CASE NO. 09CV-10873

APPELLANT,

JUDGE HOLBROOK

VS.

**STATE MEDICAL BOARD
OF OHIO,**

APPELLEE.

DECISION ON MERITS OF APPEAL

ENTERED THIS 12 DAY OF JANUARY, 2010.

HOLBROOK, J.

The instant matter is before the Court upon appeal by Gary Gelesh, D.O from an Order of the Ohio State Medical Board (Board). Board found that Dr. Gelesh deviated from the minimal standards of care in his care and treatment of a patient, a violation of R.C. 4731.22(B)(6), but ordered that no disciplinary action be taken against Dr. Gelesh. The Board's Order was issued June 10, 2009 and the current appeal was filed July 21, 2009. In a separate mandamus case filed by Appellant for declaratory and injunctive relief Dr. Gelesh asserted that he was immune from disciplinary action due to the fact that he was providing "comfort care" under R.C. Chapter 2133. *State ex rel. Gelesh v. State Medical Board of Ohio*, Franklin County Court of Common Pleas, Case No. 05 CV 13735, Affirmed on appeal in *State ex rel. Gelesh v. State Med. Bd.*, 172 Ohio App. 3d 365, 874 N.E.2d 1256, 2007-Ohio-3328,. Judge Frye denied the requested relief and indicated that Appellant had an adequate remedy by appeal of the Board's actions and decisions. The Court of Appeals

affirmed his decision. This matter has been fully briefed and the extensive record of proceedings has been submitted. Upon full consideration of the facts, arguments and applicable law, the Court affirms the decision of the Board.

FACTUAL AND PROCEDURAL HISTORY

The circumstances in this appeal arise from the treatment of an 88 year old female patient (patient 1), admitted to the emergency room of Akron General Medical Center on the evening of February 7, 2002. She was experiencing severe abdominal pain. Dr. Gelesh was the attending physician with a shift from 3:30 p.m. to midnight. The patient had executed a do not resuscitate/comfort care only directive ("DNR/CC"). Appellant evaluated the patient and ordered narcotics in an effort to lessen her pain. A nursing shift change occurred at 11:00 p.m. and Denise Orndorf, R.N. then assisted Appellant. The night shift doctors came and assumed responsibility for the other patients in the emergency room, but Appellant remained to attend patient 1. Appellant has stated that he ordered benzodiazepine. Orndorf has stated that 60 mg. of Anectine, which is also called succinylcholine, was ordered. After Orndorf verified what the drug was, she doubted that Anectine was what the doctor wanted, she reported this concern to two fellow nurses, who told her they would not administer the drug. The drug is a paralytic and will cause respiratory depression. Orndorf then returned to the room and asked if the doctor wanted 60 mg. of Anectine. Appellant then either filled a syringe and injected the patient or injected an already filled syringe. Within three minutes, patient 1 expired.

Appellant has consistently maintained that after determining that Patient 1 was a comfort-care-only patient, he proceeded to provide comfort-care treatment and

patient 1 died in the course of that treatment. Appellant has denied that he knew he was injecting Anectine.

The Board issued a Notice of Opportunity for Hearing pursuant to R.C. 119.07 to Appellant on May 18, 2005. This was the "First Notice". It notified Appellant that the Board proposed discipline as to the care and treatment of Patient 1. It was stated that: 1) Dr. Gelesh ordered Anectine for patient 1 and that she had signed a DNR/CC; 2) Nurse Orndorf spoke to Appellant regarding the order; and 3) Appellant administered Anectine resulting in the patient's death. This conduct was a deviation from the minimal standards of care in his care and treatment of Patient 1, in violation of R.C. 4731.22(B)(6). After this notice Appellant sought immunity under the "comfort care" provision of R.C. Chapter 2133. A second Notice of Opportunity for Hearing ("Second Notice") was issued March 8, 2006. The modification from the first notice was that the state alleged that Dr. Gelesh acted "in bad faith, and/or outside the scope of your authority, and/or not in accordance with reasonable medical standards". It also denied that Appellant's claim for immunity was proper. A hearing was requested and conducted by a Hearing Officer for the Board.

The hearing began October 16, 2006, continued over a number of days and was concluded January 3, 2007. At the beginning of the hearing, the assistant attorney general sought to advance an additional allegation against Dr. Gelesh. Counsel sought to show that Appellant intentionally killed Patient 1 by administering excessive amounts of morphine and by intentionally administering Anectine. The Hearing Examiner excluded any evidence and argument from the State related to

morphine and any intent to kill.

The Hearing Officer offered her Amended Report and Recommendation to the Board on December 31, 2008. The Hearing Officer found that Appellant had failed to meet the standard of care as to his injection of Anectine and a three month probation period was recommended. Both Appellant and the state objected to the report and the state moved to proffer the evidence and arguments that were excluded by the Hearing Officer. The Board considered the state's proffer of the excluded evidence relating to intent and determined that a remand would be appropriate to allow Appellant to present evidence in rebuttal to the state's proffer. After further evidence, the Hearing Officer gave her Report and Recommendation dated May 12, 2009. That recommendation determined that there was no evidence of intent either as to morphine overdose or administering Anectine. As they had to the first recommendation, both sides objected to the report on remand. The Board considered the entirety of the reports and recommendations and objections by counsel, as well as oral argument. As noted above, the Board ultimately, in a vote of 6-3 with two abstentions, found that Appellant deviated from the minimum standard of care, but chose to impose no discipline.

Appellant seeks to have the Court reverse the Board and find that there was no departure from the standard of care and further that immunity should attach as Appellant was providing comfort care. The position of the state is that at a minimum, Appellant deviated from the standard of care by injecting the wrong drug into the patient. It is also contended that in the worst scenario, Appellant intentionally caused her death.

STANDARD OF REVIEW

Several opinions have considered the standard of review in appeals brought under R.C. 119.12 from decisions of administrative agencies, including those from the Medical Board. Chapter 119 provides that there must be reliable, probative and substantial evidence to support the agency's decision. *University of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 407 N.E.2d 1265 still stands as the illustrative holding for review in a Chapter 119 appeal. While the review is a hybrid examination of facts and law, the Court cannot simply substitute its judgment on the evidence. In *Rossiter v. State Med. Bd.*,¹ it was reaffirmed that when reviewing such an order, the Court must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession.² Under the applicable standard, the Court must affirm the order if it is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place, Inc. v. Ohio Liquor Control Comm.*³, the Ohio Supreme Court defined such evidence to be: "(1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value." If the evidence meets the requisite standard, a reviewing Court may not modify a sanction if such sanction is

¹ 155 Ohio App. 3d 689; 2004-Ohio-128; 802 N.E.2d 1149

² Citing *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619, 614 N.E.2d 748

³ (1992) 63 Ohio St. 3d 570, 571, 589 N.E.2d 1303

authorized by statute.⁴ If the sanction is within the range of permissible alternatives, then the Court must affirm.

The reviewing Courts have determined that from a due process standpoint, a proper evidentiary basis must be provided before levying a sanction. While a full adversarial and evidentiary proceeding may not be required, there must be some sort of reliable evidentiary review, including sworn testimony, as well as a full consideration of the circumstances of the case.⁵ With the above standard of review in mind, the Court will consider the assigned errors offered by Appellant.

ASSIGNMENTS OF ERROR

Appellant has offered six assignments of error. They are listed as presented in Appellant's Merits Brief.

First Assignment of Error: The Board's Order is contrary to law because the Board's notices for hearing, hearings, and adjudication were not in compliance with R.C. 119.07 and/or the due process clauses of the United States and Ohio Constitutions.

Second Assignment of Error: The Board's finding that Dr. Gelesh departed from the minimal standard of care was not supported by substantial, probative, and reliable evidence nor by a preponderance of the evidence.

Third Assignment of Error: The Board's conduct following issuance of the Amended Report and Recommendation, including filing of objections and various pleadings and motions and the submission of excluded argument and evidence in

⁴ *Henry's Cafe, Inc. v. Board of Liquor Control* (1959), 170 Ohio St. 233, 163 N.E.2d 678. Citing also to *Hale v. Ohio State Veterinary Med. Bd.* (1988), 47 Ohio App.3d 167, 548 N.E.2d 247

⁵ *Goldman v. State Medical Bd.* (1996), 110 Ohio App. 3d 124, 673 N.E.2d 677, Dismissed by *Goldman v. State Medical Bd.*(1996), 77 Ohio St. 3d 1411, 670 N.E.2d 1001

contempt of the law of the case, was not in compliance with R.C. Chapter 119 and/or the due process clauses of the United States and Ohio Constitutions.

Fourth Assignment of Error: The Board acted contrary to law when it refused to permit Dr. Gelesh to introduce evidence of the cause of death of the patient at issue.

Fifth Assignment of Error: The Board's Order is contrary to law because the Board erred and exceeded its statutory authority when it failed to grant immunity to Appellant under R.C. Chapter 2133.

Sixth Assignment of Error: The Board acted contrary to law and violated the United States and Ohio Constitutions by failing to dismiss its allegations against Appellant.

ARGUMENT ANALYSIS

Appellant's first assigned error relates to the Notices sent by the Board informing him of its proposed disciplinary proceedings. There is no dispute that R.C. 119.07 and Section 16, Article I, of the Ohio Constitution and the Fourteenth Amendment to the United States Constitution mandate that due-process rights, procedural and substantive, must be accorded Appellant. Ohio Courts have used the test in *Mathews v. Eldridge*⁶, as the basis for due process analysis in administrative hearings. *Mathews* requires the court to weigh three factors to determine whether the process granted in the administrative proceeding is constitutionally adequate (1) the private interest at stake, (2) the risk of an erroneous deprivation of that interest and the probable value of additional procedural safeguards, and (3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements

⁶ (1976), 424 U.S. 319, 335, 96 S. Ct. 893, 903, 47 L. Ed. 2d 18, 33-34

would entail.⁷ Courts reviewing due process under administrative law look to fundamental fairness."⁸ The application of procedural due process is flexible and requires only that the agency provide reasonable notice and opportunity to be heard."⁹

The physician in *Gross v. Ohio State Med. Bd.*¹⁰ raised the issue of a lack of due process related to the notice of proposed discipline. The Court reviewed the argument and the circumstances and found that "the board's notice informed Dr. Gross of (1) the allegation against him; (2) the statute directly involved, namely, former R.C. 4731.22(B)(22); and (3) reasons for the board's proposed action. The board's notice also provided Dr. Gross with an opportunity to request a hearing." [P24] The Court further noted that the doctor was given a full opportunity to present evidence both on his behalf and in rebuttal, as well as an opportunity to address the Board. [P25]

The Tenth District Court of Appeals has held that the State may not, consistent with principles of due process, prosecute an administrative action and seek to prove factual claims that are not contained in a notice of opportunity for hearing.¹¹ Had the Board acted upon the proffered evidence, determined a violation and imposed discipline as to the dosage of morphine or found intent, then Appellant would have a substantive argument for denial of due process. Since the record indicates that the Board sent those specific allegations back for a separate hearing and no finding of fact or action by the Board reflected negatively on Appellant as to these allegations, there has been no denial of due process.

⁷ *Mathews*, at 335, 96 S. Ct. at 903, 47 L. Ed. 2d at 33-34

⁸ *Sohi v. Ohio State Dental Bd.* (1998), 130 Ohio App. 3d 414, 422, 720 N.E.2d 187

⁹ *Alcover v. Ohio St. Med. Bd.*, (Dec. 10, 1987), Cuyahoga App. No. 54292

¹⁰ Franklin App. No. 08AP-437, 2008-Ohio-6826

¹¹ *Johnson v. State Med. Bd. of Ohio* (Sept. 28, 1999), Franklin App. No. 98AP-1324

The second assigned error is that the Board erred in finding that Dr. Gelesh departed from the minimal standard of care in administering Anectine to Patient 1. Appellant contends that this finding was not supported by substantial, probative, and reliable evidence. In particular, Appellant believes the testimony of the Board's expert, Dr. William Frazier, was unpersuasive, unreliable, and not consistent with R.C. 4731.22(B)(6). The Board's expert opined that Appellant failed to confirm the order for the drug with the nurse and by doing so departed from, or failed to conform to, minimal standards of care of similar practitioners under the same or similar circumstances in violation of R.C. 4731.22(B)(6). Appellant offers that the Board found this violation based solely upon the testimony of Dr. Frazier. The Hearing Officer gave serious consideration to the actual events leading to the injection by Appellant. The evidence was clearly in dispute as to what drug Appellant asked for. While Appellant casts blame upon the nurse, the utterance of Benzodiazepine, Ativan or Versed is substantially different than Anectine. With hindsight, it is obvious that the nurse should have been more emphatic in her concerns. Nonetheless, the circumstances in evidence offer more than sufficient evidence to find that Appellant shared in the mistake.

As to the standard of care, the Hearing Officer made a specific finding. It is as follows:

“***With regard to the minimal standard of care pertaining to the confirmation of a medication before administering it personally, the Hearing Examiner found reliable and persuasive the testimony of Dr. Fraser, who testified on behalf of the State. In addition, the Hearing Examiner found Dr. Gelesh's testimony during his deposition to be persuasive as well.

First, the Hearing Examiner found Dr. Fraser's opinion persuasive that a physician has a duty to confirm a medication before he personally administers it, whether it is given to him in a filled syringe or whether he is given an empty syringe and a vial of medication.³⁵ In addition, Dr. Gelesh testified during his deposition that *both* the nurse and the physician share a duty to confirm the medication when it is handed to a physician to administer it, that it is a "dual" duty.

Under the standard of care articulated by Dr. Fraser, with which Dr. Gelesh's statements are consistent, the standard of care requires that, if the nurse fails to confirm the medication when handing it to the physician who is to administer it, then the physician must ask or otherwise verify the medication before administering it. According to Dr. Gelesh's testimony, confirmations can be as simple as the nurse echoing the medication order when receiving it, or, similarly, when a nurse is bringing medication to the physician who will administer it, the nurse may state the medication and the physician can confirm simply by echoing it.

The Hearing Examiner accepts the testimony at hearing by Dr. Gelesh and others that, ordinarily, when a physician gives a medication order to a nurse, the nurse performs the order without any further confirmation by the physician, and the physician is not obliged to undertake affirmative steps to make sure that his or her order was understood and is being properly carried out. However, in this case, the key difference was that Dr. Gelesh administered the medication himself and did not delegate the task to a nurse.

Last, the Hearing Examiner notes that the Board is not required to agree with the experts' medical opinions offered during the hearing, even those of its own

expert, Dr. Fraser. The Board may draw on its collective medical expertise and experience, and make its own decision as to the minimal standard of care to be applied, as long as its states it reasons for doing so.”

(Hearing Officer’s Amended Report and Recommendation, page 41)

Although Appellant maintains that the evidence presented by the State in this regard was not persuasive or reliable, the Court must disagree.

The February 11, 2009 minutes of the Board reflect that the Board members clearly understood the nature of the issue and several acknowledged that the duty to administer a drug was shared by the nurse and the doctor. While Appellant takes issue with Dr. Frazier using the term “best practice”, the Hearing Officer was able to clear up the doctor’s opinion that it referred to his concept of meeting a minimum standard of care. Appellant believes that his expert, Dr. Gayle Galan, was more credible and persuasive. It is clear from the Board’s discussion, that several found the opinions and knowledge of Dr. Galan, questionable. This Court is not in a position to disregard their cumulative experience in the field of medicine and substitute judgment on the standard of care.

As to the evidentiary value of testimony, Appellant also posits that the testimony and prior information given by Nurse Orndorf was unreliable and discredited the entire case against him. The evidence reflects that a written statement prior to the hearing reflected that the nurse questioned Dr. Gelesh regarding the order and that Dr. Gelesh responded in the affirmative that, yes, he had wanted the Anectine. The hearing testimony on direct and on cross-examination of the nurse was that Appellant took the drug from Ms. Orndorf without response. A chaplain, in the

room, Chaplain Richard Gibson, offered a similar recollection, but stated that it appeared that the nurse was not going to give the injection. The evidence as found by the Hearing Officer as to this issue is in her first report, Findings of Fact #5 "The reliable evidence does not establish that, when the nurse returned to Patient I's room with Anectine, she confirmed with Dr. Gelesh that Anectine was the medication he wanted." The evidence does not support any contention that Appellant did not administer the injection. The issue as to Ms. Orndorf's credibility is therefore diminished and does not rise to a reversible error. Appellant's second assigned error is not well taken.

The third assigned error by Appellant is that the Board's conduct following issuance of the Amended Report and Recommendation, including filing of objections and various pleadings and motions and the submission of excluded argument and evidence in contempt of the law of the case, was not in compliance with R.C. Chapter 119 and/or the due process clauses of the United States and Ohio Constitutions. This argument might have some validity had there been any adverse finding or action taken against Appellant on the issue raised. The Hearing Officer, on remand, found no basis to conclude that Appellant acted with any intent to kill patient 1 or that the morphine doses administered were a deviation or departure from the standard of care. These were the only issues remanded. The Board has substantial discretion to address matters before it. The death of a patient should bear substantial scrutiny if it occurs under questionable circumstances. It is without argument that questions surrounded patient 1's death. The Hearing Officer immediately refused to consider intent or excess morphine administration because it was not in the notices provided to

Appellant. Since the issue was raised, the Board chose to remand for further consideration those issues. It gave Appellant the right to rebut with new evidence any of the proffered evidence. While not technically following the parameters of R.C. 119.07 notice, due process was not denied. This is especially so, since the outcome on remand was in Appellant's favor.

While Appellant has offered that the evidence tainted the Board and its considerations of the underlying issue of standard of care, there is no evidence to support this speculation. The third assignment of error is without merit.

Appellant's fourth assigned error is that the Board acted contrary to law when it refused to permit Dr. Gelesh to introduce evidence of the cause of death of the patient at issue. The record reflects that Appellant intended to have Dr. Cyril Wecht offer expert testimony as to cause of death of patient 1. The Summit County Coroner listed the cause of death to be succinylcholine. The proffered testimony of Dr. Wecht was that patient 1 died of the multiple system failures that were occurring. He opined that the succinylcholine would not have acted quickly enough in the time between the intravenous injection and her time of death to be the causative factor. The Hearing Officer concluded that the cause of death could not be attacked by Appellant as the death certificate was conclusive evidence as to cause of death. While this position does not seem correct, any error by failure to admit the expert opinion is de minimis. The final conclusion of the Hearing Officer and the Board was that the departure from the standard of care was the failure to confirm a medication before it is personally administered. It was concluded that there might have been no departure if the nurse had administered the medication, but Appellant in a rare occurrence, gave the

injection himself. Whether the ultimate cause of death was from respiratory paralysis from succinylcholine or from multiple failures of patient 1's organs and system was not determinative of the above found violation. Appellant's fourth error is overruled.

The fifth assignment of error is Board erred and exceeded its statutory authority when it failed to grant immunity to Appellant under R.C. Chapter 2133.11. Judge Frye and the Tenth District Court of Appeals have given some consideration to this issue. The statute in section (A) states: "Subject to division (D) of this section, an attending physician, consulting physician, health care facility, and health care personnel acting under the direction of an attending physician are not subject to criminal prosecution, are not liable in damages in a tort or other civil action, and are not subject to professional disciplinary action for any of the following:

* * *

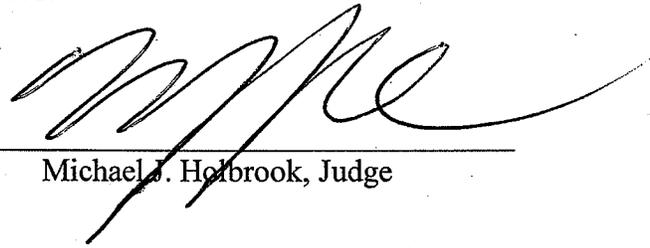
(6) Prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to a qualified patient or other patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death, if the attending physician so prescribing, dispensing, administering, or causing to be administered or the health care personnel acting under the direction of the attending physician so dispensing, administering, or causing to be administered are carrying out in

good faith the responsibility to provide comfort care described in division (E)(1) of section 2133.12 of the Revised Code.”

The holding of the trial court and the appellate court establish that the Board will have the first opportunity to determine if a physician’s actions fall within the grant of immunity. The first observation is that while Appellant has consistently maintained that he was giving comfort care to an elderly woman on the verge of death, such commendable effort does not excuse a mistake in medication, especially one such as succinylcholine. The second observation is that the dosage of morphine has never been found by the Hearing Officer or the Board to have been a departure from the standard of care. Questions may exist with respect to those circumstances, but no adverse action was taken and therefore there is no discernible error. Appellant is not entitled to the claim of immunity under R.C. 2133.

In the sixth assignment of error, it is asserted that the Board acted contrary to law and violated the United States and Ohio Constitutions by failing to dismiss its allegations against Appellant. While this appears to be reconstituted argument offered previously, the Court will briefly address Appellant’s issue. Appellant asserts that Nurse Orndorf misled the Board by giving a different statement to the Board investigator than was testified to at hearing. As noted by the Hearing Officer, whether Orndorf handed Appellant a vial and a syringe or a filled syringe is not the dispositive issue. What was the ultimate determination by the Board was that a violation of R.C. 4731.22(B)(6) occurred when Appellant departed from, or failed to conform to, minimal standards of care of similar practitioners under the same or similar circumstances. The departure or failure was in not determining what he was injecting into the patient. The Court must

note that the circumstances presented in this matter could have resulted in far graver consequences to Appellant. The evidence, at a minimum would have supported some sanction. The Board determined no sanction would be levied. That is within its discretion. The decision and order is supported by reliable, probative, and substantial evidence and further in accordance with law. Counsel for the Board shall prepare a Judgment Entry pursuant to Local Rule 25.01.



Michael J. Holbrook, Judge

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BEFORE THE STATE MEDICAL BOARD OF OHIO

GARY C. GELESH, D.O.
1909 Brookwood Drive
Akron, OH 44313,

Appellant,

vs.

STATE MEDICAL BOARD OF OHIO
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

Appellee,

09 C VF 7 10873

Case No. _____

Judge _____

APPEAL FROM THE ENTRY
OF ORDER OF JUNE 10, 2009
MAILED JULY 7, 2009

STATE MEDICAL BOARD
OF OHIO
2009 JUL 21 PM 2:35

APPELLANT'S NOTICE OF APPEAL

Now comes Appellant, Gary C. Gelesh, D.O., by and through counsel, and pursuant to Ohio Revised Code Section 119.12, hereby gives notice of his appeal of the Entry of Order of the Appellee, State Medical Board of Ohio ("Board"), which found that the conduct of Appellant departed from or failed to conform to the minimal standard of care. The Board's Entry of Order was dated June 10, 2009, and mailed on July 7, 2009. The Board's Entry of Order is not supported by substantial, probative, and reliable evidence nor is it in accordance with law. Appellant appeals based on the following grounds:

1. The Board erred when it failed to grant immunity to Appellant under R.C. Chapter 2133.
2. The Board erred when it refused to permit Appellant to introduce evidence of the cause of death of the patient at issue.
3. The Board's hearing on remand was not conducted in compliance with the due process clauses of the United States and Ohio Constitutions.

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FRANKLIN CO. OHIO
2009 JUL 21 PM 2:50
CLERK OF COURTS

STATE MEDICAL BOARD
OF OHIO
2009 JUL 28 PM 4:21

4. The Board's notices for hearing, hearing and adjudication were not in compliance with R.C. 119.07 and/or the due process clauses of the United States and Ohio Constitutions.
5. The Board erred when it refused to enforce subpoenas on behalf of Appellant.
6. The Board's finding that Appellant departed from the minimal standard of care was not supported by the preponderance of the evidence
7. The Board's finding that Appellant departed from the minimal standard of care was not supported by substantial, probative, and reliable evidence.
8. The Board's conduct in the hearing and adjudication was not in compliance with R.C. 119.07 and/or the due process clauses of the United States and Ohio Constitutions.
9. The Board's conduct following issuance of the Amended Report and Recommendation, including filing of objections and various pleadings and motions and the submission of excluded argument and evidence in contempt of the law of the case, was not in compliance with R.C. Ch. 119 and/or the due process clauses of the United States and Ohio Constitutions.
10. The Board's rulings following issuance of the Amended Report and Recommendation and at its February 11, 2009, Board meeting, were not in compliance with R.C. Ch. 119 and/or the due process clauses of the United States and Ohio Constitutions.
11. The Board's conduct at its February 11, 2009, Board meeting was not in compliance with R.C. Ch. 119 and/or the due process clauses of the United States and Ohio Constitutions.
12. The Board exceeded its statutory authority in finding on March 8, 2006, that the immunities under R.C. Chapter 2133 did not apply to Appellant.
13. The Board acted contrary to law and violated the United States and Ohio Constitutions by failing to dismiss its allegations against Appellant.
14. The Board acted contrary to law and violated the United States and Ohio Constitutions by failing to produce at hearing all evidence in its possession which was exculpatory and/or favorable to Appellant.
15. The Board acted contrary to law and violated the United States and Ohio Constitutions by failing to have a witness, a Board employee under its control, attend the hearing when called and then excluding evidence for lack of authentication due to the witnesses absence.

STATE MEDICAL BOARD
OF OHIO
2009 JUL 28 PM 4: 21

16. The Board acted contrary to law and violated the United States and Ohio Constitutions by the delay in the adjudication of this matter to the prejudice of Appellant.
17. The Board applied R.C. 4731.22(F)(5) in a manner that was contrary to law and violated the United States and Ohio Constitutions to the prejudice of Appellant.

A copy of the Board's Entry of Order is attached hereto as Exhibit A.

Respectfully submitted,

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Akron, Ohio. 44308

Attorneys for Appellant, Gary C. Gelesh, D.O.

CERTIFICATE OF SERVICE

I hereby certify that on this 21st day of July, 2009, the foregoing Notice of Appeal was filed via hand delivery with the State Medical Board of Ohio, was filed via hand delivery with the Court of Common Pleas of Franklin County, Ohio, and that a copy was served by regular U.S. mail upon the following:

Kyle C. Wilcox
Assistant Attorney General
Ohio Attorney General's Office
Health and Human Services
30 East Broad Street, 26th Floor
Columbus, Ohio 43215


Eric J. Plinke

STATE MEDICAL BOARD
OF OHIO
2009 JUL 28 PM 4:21

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

June 10, 2009

Gary Charles Gelesh, D.O.
1909 Brookwood Drive
Akron, OH 44313

Dear Doctor Gelesh:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation on Remand of Patricia A. Davidson, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 10, 2009, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

A handwritten signature in black ink, appearing to read "Lance A. Talmage, M.D.", is written over the typed name.

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3160 5762
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3160 5779
RETURN RECEIPT REQUESTED

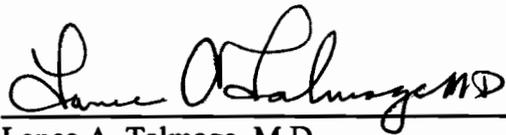
John D. Lambert & Ida L. MacDonald, Esqs.
CERTIFIED MAIL NO. 91 7108 2133 3936 3160 5786
RETURN RECEIPT REQUESTED

Mailed 7-7-09

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation on Remand of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 10, 2009, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Gary Charles Gelesh, D.O., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.
Secretary

(SEAL)

June 10, 2009

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

GARY CHARLES GELESH, D.O.

*

ENTRY OF ORDER

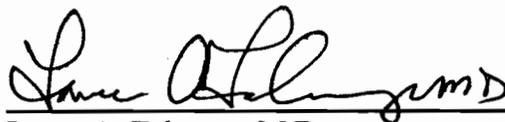
This matter came on for consideration before the State Medical Board of Ohio on June 10, 2009.

Upon the Report and Recommendation on Remand of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that no further action shall be taken in the matter of Gary Charles Gelesh, D.O.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.
Secretary

June 10, 2009

Date

2009 MAY 12 P 4: 31

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of

*

Gary Charles Gelesh, D.O.,

*

Hearing Examiner Davidson

Respondent.

*

**REPORT AND RECOMMENDATION
ON REMAND**

Basis for Hearing

In a notice of opportunity for hearing [Notice] dated March 8, 2006, the State Medical Board of Ohio [Board] notified Gary Charles Gelesh, D.O., that it proposed to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. (State's Exhibit [St. Ex.] IAA) In its Notice, the Board informed Dr. Gelesh of the factual allegations that formed the basis for the proposed action, as follows:

In the routine course of your osteopathic medical practice, you undertook the treatment of Patient 1, identified in the attached Patient Key. The Patient Key is confidential and shall be withheld from public disclosure. On or about February 7, 2002, Patient 1, approximately 88 years of age, was transported by ambulance from an assisted living facility to the emergency room of Akron General, Akron, Ohio, where you were providing services as an emergency room physician. Upon your examination of Patient 1, she was found to be hypotensive with complaints of abdominal pain. Patient 1 had a history of heart disease, and had executed a do not resuscitate/comfort care only directive. You concluded that Patient 1 was not a surgical candidate, and she was provided comfort care treatment in the emergency room under your direction.

On or about February 8, 2002, you requested that the nurse assisting you with the care of Patient 1 obtain medication for Patient 1. Hearing that you ordered Anectine (succinylcholine), the nurse returned to Patient 1's room with Anectine, and asked you if that was the medication you wanted. The nurse handed you the container of medication, and you administered the medication to the patient. Patient 1 died a short time thereafter of respiratory arrest due to the administration of succinylcholine.

In deposition, you testified that when the nurse returned to Patient 1's room with the medication, you heard the nurse say something, but you did not hear what she said. You further testified that you assumed the medication handed to you was what you had ordered, a benzodiazepine, although you could not recall whether you had ordered Ativan or Versed.

(St. Ex. IAA)

The Board charged that Dr. Gelesh's conduct as set forth in the Notice constituted a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that language is used in Ohio Revised Code [R.C.] 4731.22(B)(6).¹ In addition, the Board alleged that R.C. Chapter 2133 (which provides immunity to physicians who provide comfort care in certain circumstances) did not apply because Dr. Gelesh's actions, omissions, and/or conduct "were in bad faith, and/or outside of the scope of his authority, and/or not in accordance with reasonable medical standards." The Board advised Dr. Gelesh of his right to request a hearing, and received his request on March 31, 2006. (St. Ex. 1AA)

Hearing Dates: October 16 through 20, 2006; October 23 through 24, 2006; November 13 through 16, 2006; November 20, 2006; December 20 through 22, 2006; and January 3, 2007.

Following the hearing, the Hearing Examiner addressed posthearing motions and made additional evidentiary rulings, as set forth in the Amended Report and Recommendation [R&R], which was filed December 31, 2008. (St. Ex. 1-UUU)

Remand

At its meeting on February 11, 2009, the Board considered the R&R and post-R&R motions. The Board voted to admit certain exhibits and portions of hearing transcript that had been excluded during the hearing, and it remanded the matter to the Hearing Examiner for further proceedings. (St. Ex. 1-VVV) The minutes of the Board's meeting set forth the remand order as follows:

Mr. Jacobson moved, pursuant to section 119.09, Ohio Revised Code, to admit the state's proffered evidence concerning the administration of morphine as it relates to the deviation from the minimal standard of care² and the doctor's state of mind, and the police report as it relates to the doctor's credibility into the record. Mr. Jacobson further moved to remand the matter to the Hearing Examiner for the taking of additional evidence that directly rebuts the proffered evidence only, and that the entire process be completed and a new report and recommendation be issued by the hearing examiner within ninety (90) days.

Mr. Jacobson further moved that the Executive Director be directed to make all reasonable efforts to provide, to the extent not prohibited by law, current contact information for the board's investigator, to contact the investigator to encourage his testimony, and to make all necessary arrangements to permit and encourage his testimony by telephone if requested by either party, if he is not otherwise subject to subpoena.

(St. Ex. 1-VVV)

¹In this report, the term "minimal standards" is used to mean "minimal standards of care of similar practitioners under the same or similar circumstances."

²The State has repeatedly clarified that it was *not* alleging that the morphine ordered by Dr. Gelesh constituted a departure from the minimal standard of care. (See, *e.g.*, Tr. at 3149-3150; Rulings Transcript, Vol. II (Oct. 17, 2006) at pages 5-6; Entry dated 02/26/2009 in St. Ex. 1-VVV)

Hearing Dates: Additional hearing on remand took place on March 31, April 1, and April 20, 2009.

Appearances

For the State: Richard Cordray, Attorney General, by Kyle C. Wilcox, Assistant Attorney General.

For the Respondent: Eric J. Plinke, John D. Lambert, and Ida L. MacDonald, Esqs.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background

1. Gary Charles Gelesh, D.O., received his medical degree in 1977 and completed a residency program in emergency medicine at Akron General Medical Center [Akron General] in 1980. After working for several months in Pennsylvania, he accepted an offer to return to Akron General as an attending physician in the emergency department. Dr. Gelesh served in that position for 21 years. (Hearing Transcript [Tr.] at 60-65, 1666-1679; Respondent's Exhibits [Resp. Exs.] F, G)
2. While at Akron General, Dr. Gelesh was the director of a combined training program for internal medicine and emergency medicine. He also helped initiate the first paramedic training program in Akron and served as an EMS advisor. In addition, Dr. Gelesh was a professor of clinical emergency medicine at Northeastern Ohio University School of Medicine, devoting a significant amount of time to teaching duties at Akron General. Dr. Gelesh is board-certified by the American Board of Emergency Medicine. (Tr. at 1681-1697; Resp. Ex. F1)
3. During his years at Akron General, Dr. Gelesh was named Teacher of the Year four times in ten years, an award that is granted by vote of the residents. However, in 2002, Dr. Gelesh resigned his position at Akron General. (Tr. at 61-65, 1666-1680)
4. During his time at Akron General, Dr. Gelesh also served as the director of an emergency department at Mercy Hospital in Willard, Ohio, a position he resigned in 2004. Dr. Gelesh has also worked as an emergency physician in locum tenens positions in the following states where he is licensed to practice medicine: Ohio, Pennsylvania, Virginia, North Carolina, South Carolina, Georgia and Louisiana. At the hearing in 2006, Dr. Gelesh testified that he was working full-time in an emergency department in Louisiana, commuting from Ohio, where he still resides. Dr. Gelesh's certificate, number 34.002731, is currently in active status. (Tr. at 60, 65-67, 1698, 1715-1716; Resp. Ex. F1; Ohio eLicense Center at <<https://license.ohio.gov/lookup/default.asp>>, 5 May 2009)

February 7, 2002: The Patient's Arrival and Initial Care

5. At about 9:00 p.m. on February 7, 2002, Patient 1, an 88-year-old woman, was transported from the assisted-living facility [nursing home] where she resided to the emergency department [ED] at Akron General. All witnesses agreed that she was in acute distress. The EMS report indicates that Patient 1 had signed a “Do Not Resuscitate—Comfort Care Only” directive [DNR-CC directive].³ (Resp. Ex. III at 1; Tr. at 1026; St. Ex. 7 at 13, 41)
6. Medical records maintained by the nursing home reflect that Patient 1 had been taking a variety of medications, including Duragesic patch at 50 mcg/hr, Darvocet-N 100 as needed for pain, and Alprazolam [Xanax] three times per day. (Resp. Ex. III at 4-6)
7. Upon Patient 1's arrival in the ED at 9:10 p.m., Dr. Gelesh examined her. Among other things, he observed cyanosis at the nail beds and fingertips, distended abdomen and hyperactive bowel sounds with “exquisite tenderness just with slight palpation.” Although she was in extreme pain, Patient 1 was initially alert enough to respond to questions. While efforts were being made to confirm the DNR/CC status as noted by the EMS service, Dr. Gelesh performed a diagnostic work-up. (St. Ex. 7 at 13; Resp. Ex. MMM at 25-27)
8. After Patient 1 had been in the ED for thirty minutes, she received 30 mg of Toradol. However, this medication did not provide relief of her pain. (St. Exs. 3, 7)
9. At 9:50 p.m., Patient 1 received 1 mg of Dilaudid, but there was no relief of pain. At 10:20 p.m., she received 12.5 mg of Phenergan. (St. Exs. 3, 7)
10. The diagnostic studies showed bilateral pneumonia, distension of the colon and several loops of the small bowel, renal insufficiency, and hypokalemia. Liver enzymes, lactic acid and lipase were elevated. Urine output was very low, indicating severe dehydration. Patient 1 received a liter of IV fluids, after which her blood pressure was 100/40. Pulse oximetry was 85%. (St. Ex. 7 at 11, 13-15, 23, 25, 27, 31, 41)
11. Dr. Gelesh diagnosed the following: acute hypotension secondary to dehydration, acute abdominal pain that was probably secondary to mesenteric infarction or a ruptured abdominal aneurysm, pneumonia, renal insufficiency, and possible acute pancreatitis with elevated lipase level, or elevated lipase secondary to bowel infarction. (St. Ex. 9 at 13; Tr. at 218, 292, 328)
12. Dr. Gelesh stated that he discussed treatment options with Patient 1. He explained that her acute abdomen might require surgery, but Patient 1 declined surgery. Patient 1 also declined antibiotics to treat her pneumonia and declined IV fluids. Patient 1 asked only that Dr. Gelesh manage her pain. Dr. Gelesh concluded that Patient 1 was in a terminal condition, which was not disputed by the witnesses at hearing, including the physicians who reviewed the medical records. (Tr. at 85, 218, 292, 328, 442, 491; 1717-1718, 1772-1774, 1106-1109, 1191-1200; Resp. Ex. MMM at 25-28)

³ Patient 1 and her son had signed a DNR/CC directive on November 11, 2001, stating among other things that pain medication and oxygen could be given. (Resp. Ex. III at 1)

13. Dr. Gelesh testified that, at about 10:00 p.m., he spoke with Patient 1's primary-care physician, Dr. Amy Weidman, who confirmed the DNR/CC directive.⁴ Dr. Gelesh did not admit Patient 1 to the hospital but decided that comfort care would be provided in the ED. (Tr. at 85, 120, 292, 1026, 1717-1718, 1772-1774; Resp. Ex. MMM at 11-19, 25-26; St. Ex. 7 at 13-15)
14. Dr. Gelesh testified that, after confirming the DNR/CC directive, his purpose in caring for Patient 1 was to manage her pain and to make her "as comfortable as possible in the last few hours of her life." (Tr. at 1717-1718, 1772-1774)
15. A member of the hospital staff contacted Patient 1's son and daughter-in-law. When Nurse Denise Orndorf took over Patient 1's care at 11:00 p.m., Patient 1 was moaning and uncomfortable. At about 11:00 p.m., Patient 1 received another 1 mg dose of Dilaudid. However, there was no relief of pain. (St. Ex. 7 at 15; Tr. at 95-96, 132, 164-165, 425; Resp. Ex. MMM at 41)
16. Dr. Gelesh stated that, when Patient 1 received no relief from Toradol and two doses of Dilaudid, he discussed the possibility of a morphine drip with Dr. Weidman, who agreed. Dr. Gelesh testified that he ordered the drip with instructions to titrate the infusion to Patient 1's pain. (Tr. at 132, 138, 163-164, 1774-1775, 1807, 1809; Resp. Ex. MMM at 29-32, 41)
17. At 11:50 p.m., Patient 1 began receiving a morphine infusion of 100mg/100cc at 500 cc's per hour. A note in the chart states that, at 12:05 a.m., Patient 1's daughter-in-law was at her bedside, and the morphine was infused. (St. Ex. 7)
18. The chart indicates that, at 12:30 a.m., the patient's breathing was more sporadic, at 12 to 16 respirations per minute. Dr. Gelesh observed that, although the first bag of morphine had been infused, Patient 1 still had not experienced relief from pain. Dr. Gelesh testified that, because Patient 1 was still experiencing acute pain, he ordered a second bag of morphine. He commented at hearing that he wondered whether the first bag of morphine was defective. (Tr. at 91-92, 138, 163-164; Resp. Ex. MMM at 29-32, 41)
19. At 12:40 a.m., the nurse noted that there was "Ø change in pt's status." A staff member spoke with the patient's son, who chose a funeral home. (St. Ex. 7)
20. At 12:50 a.m., the second morphine infusion of 100 mg/100cc at 500 cc's per hour was started. The nursing home's chaplain was at the patient's bedside, and it was noted that the patient seemed to respond to the chaplain's voice. The respirations "remain snoring 12-14" per minute. (St. Exs. 3, 7)

⁴ Dr. Gelesh testified that he was aware of the DNR/CC directive but that the primary-care physician had not signed it. Dr. Gelesh asked Patient 1 about this, and she told him that she did not remember signing it. Therefore, Dr. Gelesh felt that he needed to confirm the DNR/CC directive before relying on it. Accordingly, Dr. Gelesh started a workup and paged Dr. Weidman, who later called and confirmed the patient's DNR/CC directive. (Tr. at 85, 1717-1718, 1772-1774; Resp. Ex. MMM at 11-19, 25-26)

21. At 1:05 a.m., the second bag of morphine was infused. Respirations were 10 to 12 per minute. (St. Exs. 3, 7)⁵

The Ordering of Medication That Was Later Administered at 1:20 a.m.

Dr. Gelesh's Testimony

22. Dr. Gelesh testified that, after the second bag of morphine had been infused, Patient 1 was still exhibiting distress and had developed spasms in her neck muscles. Dr. Gelesh testified that he decided to order a benzodiazepine, and had given a verbal order for that medication to Denise Orndorf, R.N. Dr. Gelesh testified that he does not recall the exact drug he ordered but that the only benzodiazepines he would have ordered were Versed or Ativan.⁶ (Tr. at 103, 105-106, 120-122)

Ms. Orndorf's Testimony

23. Ms. Orndorf testified that she had been employed at Akron General as a staff nurse in the ED since 1997 and that she had worked with Dr. Gelesh from the beginning of her employment. Ms. Orndorf had previously worked for two years in the ED at Mercy Medical Center in Canton, Ohio. (Tr. at 418-423)
24. Ms. Orndorf stated that, on February 7, 2002, her twelve-hour shift had started at 7:00 p.m. She testified that she had taken over the care of Patient 1 from another nurse at approximately 11:00 p.m., and that Patient 1 was moaning in pain and was no longer verbal at that time. (Tr. at 421-425, 428-429, 490-491)
25. Ms. Orndorf stated that Patient 1 was in a terminal condition. She testified that she had asked the patient's son about funeral-home arrangements at 12:40 a.m. because it was "inevitable that [Patient 1] was going to be passing away." (Tr. at 442, 491)
26. Ms. Orndorf testified that, after the second bag of morphine had been infused, Dr. Gelesh ordered an additional medication. She testified that she had heard him ask for "60 milligrams of Anectine."⁷ Ms. Orndorf testified that, when she heard the order, she did not question it because

⁵ Ms. Orndorf testified that she contacted the pharmacy regarding the second morphine order because she thought they would think it was a duplicate order and she was concerned that the pharmacy would "have questions" regarding the amount of morphine. She did not chart her contact with the pharmacy, and the pharmacy obviously provided the second bag of morphine. (Tr. at 444-445; St. Ex. 7)

⁶ Dr. Gelesh explained that, if someone had asked him shortly after the incident, he would probably have remembered the specific medication he had ordered and the exact amount. However, the first time that anyone notified him that there was a question regarding Patient 1's care was five weeks after it took place. After considering the matter, he could not remember the specific medication but recalled that he had intended to provide a benzodiazepine for Patient 1, according to his testimony. (Tr. at 103-106, 120-122)

⁷ Anectine is the brand name for succinylcholine, a neuromuscular blocking agent that paralyzes skeletal muscles including the respiratory muscles. The only use for this medication in the ED is to paralyze the respiratory muscles to facilitate endotracheal intubation for a patient who needs artificial respiration. Anectine takes effect in less than one minute, and its effect lasts several minutes. If Anectine is administered without artificial respiration, the patient ceases breathing and dies. (Tr. at 101-102, 210-212, 399, 452-453, 583, 1146-1147, 1203-1205; Resp. Ex. 2)

she did not know what Anectine was—that it is succinylcholine, with which she was familiar. Ms. Orndorf testified that she had never heard succinylcholine referred to as “Anectine” because, in her experience, the medication had always been referred to as “succinylcholine” or abbreviated as “sux.” She stated that she went to the medication room and looked up the medication. Ms. Orndorf testified that, when she realized that Anectine was succinylcholine, she was surprised and thought she had perhaps misheard what Dr. Gelesh had asked for. (Tr. at 447-449)

27. Ms. Orndorf knew that succinylcholine was used in the ED for intubation and that it would cause death unless the patient was given respiratory support. She testified that succinylcholine is never administered without intubating the patient. According to Dr. Gelesh, Ms. Orndorf, and the chart, intubation had not been ordered for Patient 1. (Tr. at 449-452, 510, 1726; St. Ex. 7)
28. Ms. Orndorf testified that, when she learned that Anectine is succinylcholine, she thought that perhaps she had misheard the order. However, she did not return to Dr. Gelesh to clarify whether she had misheard his order.⁸ Instead, she obtained a vial labeled “succinylcholine” from the automated medication dispenser. (Tr. at 447-451, 455, 532; Resp. Ex. SSS)⁹
29. At the hearing, Ms. Orndorf was shown an empty vial of succinylcholine (not the vial at issue but an exemplar for purposes of illustration). She testified that it was different in some ways from the vial she had obtained from the dispenser for Patient 1. Ms. Orndorf stated: “Well, I know at the time we only had hundred-milligram vials of succinylcholine, and this is a 200-milligram vial.” Ms. Orndorf explained that Akron General had changed from using 100-milligram vials to using prefilled syringes, and then to using 200-milligram vials. She testified that the sample shown to her was a 200-milligram vial, whereas she had obtained a different type of vial, a 100-milligram vial, for Patient 1 from the dispenser. (Tr. at 530-532)
30. The printed report from the dispensing machine documents that a 200-milligram vial was dispensed to Ms. Orndorf for Patient 1 at 1:08 a.m. on February 8, 2002. The pharmacy report also shows that a 200-milligram vial was dispensed for Patient 1. (Resp. Ex. SSS; St. Ex. 3)
31. Ms. Orndorf testified that she took the vial of succinylcholine to two other nurses in the ED, Deb Warner and Sue Zgodzinski. She told them that she believed Dr. Gelesh had ordered succinylcholine and she could not understand why. Ms. Orndorf testified that both Warner and Zgodzinski responded that “they would never administer it.” (Tr. at 449-452, 458-465)

Ms. Zgodzinski’s Testimony

32. Susan Zgodzinski, R.N., testified that she is a staff nurse in the ED at Akron General. She stated that she has worked at Akron General for eight years and has been a nurse for 27 years. Ms. Zgodzinski testified that she was responsible for Patient 1’s nursing care until 11:00 p.m., at which time she had turned over the patient’s care to Ms. Orndorf. (Tr. at 547-552)

⁸Akron General’s policy regarding the questioning of doctor’s orders is set forth below at pages 14-15.

⁹Detailed testimony regarding the Sure-Med system and the report generated for the evening of February 7-8, 2002, is set forth below under a separate heading.

33. Ms. Zgodzinski testified that she had inserted an IV into Patient 1's right forearm. On a drawing of Patient 1's room, she marked an X on Patient 1's right side to show where the IV was located. She further testified that, at some point, Dr. Gelesh had ordered that a nasogastric tube be inserted. Ms. Zgodzinski stated that she had objected, telling Dr. Gelesh that she believed the tube would be too intrusive and painful, considering that Patient 1 was a DNR/CC patient. She testified that Dr. Gelesh had readily changed his order. (Tr. at 555, 571-574, 577-578)¹⁰
34. Ms. Zgodzinski testified that, later that night, Ms. Orndorf approached her and Deb Warner with a vial of Anectine and an unopened syringe. Ms. Zgodzinski testified that Ms. Orndorf did not say "I think that Dr. Gelesh ordered Anectine," but that Ms. Orndorf was "very emphatic" in stating that "he ordered Anectine." Ms. Zgodzinski testified that she had advised, "Don't give it." She stated that Ms. Orndorf had turned away and walked into Patient 1's room. (Tr. at 559-561, 577)

Ms. Warner's Testimony

35. Deborah Warner, R.N., is a staff nurse in the ED at Akron General, where she has been employed for thirty-three years. She testified that she did not treat Patient 1. (Tr. at 591-594)
36. Ms. Warner stated that she recalls that she was at the nurses' charting area with Ms. Zgodzinski when Ms. Orndorf approached them. Ms. Warner stated that Ms. Orndorf had a vial of succinylcholine in her hand and said, "This is what Dr. Gelesh just ordered." Ms. Warner testified that both she and Ms. Zgodzinski had said, "Don't give that," to which Ms. Orndorf responded, "I wasn't going to." Ms. Warner testified that she herself had walked away at that point, so she could not say what Ms. Orndorf or Ms. Zgodzinski did after that. Ms. Warner stated that she had walked away to "take a deep breath and figure out what to do, and call the supervisor." (Tr. at 594-596, 605)
37. Ms. Warner testified that she did not recall seeing a syringe in Ms. Orndorf's hand but remembers seeing a vial. (Tr. at 620)
38. A few minutes later, Ms. Warner paged a nursing supervisor, Jeri Stauffer, R.N., with whom she spoke briefly. Shortly thereafter, Ms. Stauffer arrived in the emergency department with another supervisor. (Tr. at 597)
39. Ms. Warner testified that she had worked with Dr. Gelesh for 25 years, and that she had always thought of him as a good attending and a fine physician. She further testified that, in all of those years, she had never had a problem with Dr. Gelesh's orders. (Tr. at 600-603)

¹⁰ Dr. Michael Levy, who later testified as an expert in palliative care, stated that, when a patient has an acute abdomen with distension, tenderness and/or obstruction, dropping a nasogastric tube can relieve abdominal pain, and Dr. Gelesh's consideration of an NG tube was thus appropriate in a DNR/CC situation. (Tr. at 3061)

Delivery of the Medication to Dr. Gelesh in the Patient's Room, and Its Administration to the Patient at 1:20 a.m.

Testimony of Dr. Gelesh

40. Dr. Gelesh testified that, after he had given the verbal order for a benzodiazepine to Ms. Orndorf, she left the room and subsequently returned with a syringe of medication. Dr. Gelesh testified that he did not hear her say anything, but later clarified that he heard her say something but did not think she was talking to him and did not hear what she said. Dr. Gelesh stated that, believing that she was not speaking to him, he did not respond. (St. Ex. 6 at 41, Tr. at 107-110, 122-123; Resp. Ex. MMM at 41-44, 75)
41. Dr. Gelesh testified that he had turned around toward Ms. Orndorf, and she held out her hand with the syringe and handed it to him. He further testified that, because he was standing next to the IV port, he had assumed that she wanted him to give the medication. Dr. Gelesh stated that he could think of no other reason for her to hand the syringe to him. He stated that it is not unusual for a physician to administer medication in those circumstances. (St. Ex. 6 at 41; Tr. at 107-110, 122-123; Resp. Ex. MMM at 41-44, 75-76)
42. Dr. Gelesh acknowledged that he had administered a medication to Patient 1 at 1:20 a.m. using the IV port. Dr. Gelesh further testified that the only medication he personally administered to Patient 1 was the medication given at 1:20 a.m. Dr. Gelesh also testified that, when he administered the drug, he believed it was a benzodiazepine.¹¹ (Tr. at 100-101)
43. Dr. Gelesh also testified that, before the medication was put into the IV port, Patient 1 had developed “agonal” respirations. He explained that agonal respirations are not actually respirations but are a reflex gasp without inspiration. He stated that, unless artificial respiration is initiated, a patient with agonal respirations will die. (Tr. at 119, 124)
44. Dr. Gelesh testified that Patient 1 expired within three minutes of administration of that medication. He emphasized, however, that the patient's agonal respirations had indicated that, unless respiration was aided, she was very close to death before the medication was administered at 1:20 a.m. At the time she died, he thought that he had administered a beneficial medication and had no idea that her death could have resulted from succinylcholine. (Tr. at 100-101, 119, 124, 1718-1719)
45. Dr. Gelesh testified that, if Ms. Orndorf had heard him order Anectine, he would have expected her to challenge his order *before* the Anectine was administered, if she believed it was inappropriate. Dr. Gelesh testified that, in his experience, when a nurse thinks a mistake is about to be made, she consults the physician and explains her concerns. Dr. Gelesh further

¹¹ At hearing, Dr. Gelesh offered evidence (including the testimony of Cyril H. Wecht, M.D., J.D.) to dispute that succinylcholine had caused the patient's death. However, the Hearing Examiner excluded that evidence on the grounds that, under Ohio law, the death certificate is presumed to establish the cause of death unless challenged successfully in a court action in the county where the death occurred. In this case, the death certificate stated that the death of Patient 1 was caused by succinylcholine. (St. Ex. 1SS, Tr. at 1081-1094)

testified that he believes that Akron General had a nursing policy to that effect. (Tr. at 105, 155-156, 170-172, 1706-1709)

46. Dr. Gelesh testified that Ms. Orndorf had not challenged his order in any way. He added that her demeanor was “very matter of fact” and “business as usual.” He stated that there “was nothing in her demeanor that would indicate that a mistake was about to happen.” (Tr. at 1709)
47. Dr. Gelesh further testified that none of the nurses had given him any indication that a medication error was about to occur. Further, he stated that none of the nurses had advised him immediately after Anectine had been administered so that he could have supported the patient’s respiration with an ambu-bag until the effects of the medication had dissipated. (Tr. at 1709-1710, 1726-1728)¹²
48. Dr. Gelesh explained that the only purpose for using Anectine in the emergency department is to paralyze muscles temporarily for purposes of intubation and placement on a respirator. Therefore, a physician ordering Anectine would expect to have the nurses get an intubation tray prior to obtaining the medication. Dr. Gelesh stated that it takes time to prepare for intubation; therefore, setting up the intubation tray must be done prior to administering the paralytic agent. (Tr. at 1722-1726)
49. Dr. Gelesh acknowledged that he did not affirmatively confirm with the nurse, when she brought the medication to him, that the medication she was handing to him was a benzodiazepine. (Tr. at 105, 1762-1763) However, Dr. Gelesh disputed that the minimal standard of care at that time required him to take action at that point to verify the medication. (Tr. at 117-119)¹³

Testimony of Ms. Orndorf

50. Ms. Orndorf testified that she returned to Patient 1’s room with an empty syringe and a vial of succinylcholine. She believes that the family member and the chaplain were in the room. Ms. Orndorf testified that she asked Dr. Gelesh, “You want 60 milligrams of Anectine?” Ms. Orndorf testified that she had asked this question because she expected Dr. Gelesh to tell her that she had misheard him. (Tr. at 451-460, 478-479, 496, 534)
51. Ms. Orndorf testified that Dr. Gelesh did not answer her. She further testified that, although he gave her no answer, she did not repeat the question. When asked whether she had made eye contact with Dr. Gelesh when she asked her question, Ms. Orndorf answered that she could not recall. (Tr. at 451-460, 479, 496, 534)

¹² It was not disputed that, if intubation is not performed, respiratory support can still be provided by “bagging” the patient, which refers to administering air through the use of a manual resuscitator referred to as an “ambu-bag.” (Resp. Ex. DD; Tr. at 449-452, 510)

¹³ The opinion testimony of various experts regarding the standard of care is set forth below in detail (including Dr. Fraser on behalf of the State, Dr. Galan on behalf of Dr. Gelesh, and Dr. Gelesh himself).

52. The testimony of Ms. Orndorf was that, when she came into the room with the succinylcholine, Dr. Gelesh “was at the head of the bed and I was at the foot of the bed.” (Tr. at 538) At another point, she stated that Dr. Gelesh had been standing “near” the head of the bed. When she drew a diagram of the room, Ms. Orndorf placed Dr. Gelesh, the chaplain, and the IV on the patient’s left side. (Tr. at 477-481, 486, 530; St. Ex. 13)

53. Ms. Orndorf testified that Dr. Gelesh took the vial of succinylcholine and an empty syringe from her hand. She further testified that she had watched as Dr. Gelesh placed the tip of the syringe into the vial, drew the medication into the syringe, pushed the syringe into the patient’s IV port, and injected the medication into the IV. She said she was standing at the foot of the bed at that time. (Tr. at 451-457, 487, 496)

54. During the hearing, the State’s counsel asked Ms. Orndorf if she had done anything to stop Dr. Gelesh from administering Anectine to Patient 1. She answered that she had not. The following exchange ensued:

Q: Why not?

A: I think I was more in shock than anything. I don’t know honestly.

Q: Why were you in shock?

A: I honestly didn’t believe that that is what he had asked for.

(Tr. at 457)

55. Ms. Orndorf also testified that, after Dr. Gelesh administered the medication, she did not attempt to ventilate the patient. Ms. Orndorf explained:

I was in shock immediately when that happened. And then from that point, it was already administered. It was too late for me to do anything about that any more than following through with reporting it.

(Tr. at 505)

56. Ms. Orndorf acknowledged that, hypothetically, she could have bagged the patient, in that she had used ambu-bags many times and they were readily available in the ED. (Tr. at 500-507)

57. Ms. Orndorf testified repeatedly that she thought she might have misheard Dr. Gelesh when she heard him ask for Anectine:

Q: Now, when this order was given, do you recall if you heard it clearly?

A: Well, I heard “Anectine,” and when I looked it up I thought that there – maybe I misheard him.

(Tr. at 447-448)

Q: When you went to Dr. Gelesh and asked him if he wanted 60 milligrams of Anectine, what did you expect would happen?

A: I thought he was going to tell me I misheard him.

Q: Did he say that?

A: No.

Q: Did he say anything?

A: No.

(Tr. at 460)

A: * * * [W]hen I thought that he was asking for that [succinylcholine], I went to Deb and Sue, who was my charge nurse and another nurse taking care of the patient, and then I turned to him and asked him what he wants. And again, like I said, I honestly didn't believe that is what he asked for.

Q: And he took the medication without saying anything, you said?

A: Yes.

Q: And administered it?

A: Yes.

Q: And where were you at this time?

A: At the end of the bed.

Q: Okay. And that's the sole conversation that took place? You asked him and there was no response?

A: Correct.

(Tr. at 487)

Q: And I think your testimony was on direct, and I don't want to mischaracterize it, but you didn't believe – honestly didn't believe that Dr. Gelesh ordered Anectine – which you know as succinylcholine – that night, did you?

A: No, I honestly did not believe that's what he asked for.

(Tr. at 494)

58. At the hearing, Ms. Orndorf confirmed multiple times that, when she asked Dr. Gelesh if he wanted the Anectine, he did not respond. She stated that he did not in any way confirm or verify what the medication was. (Tr. at 460, 494, 538)

59. However, during the Board's investigation, Ms. Orndorf had previously given very different information to a Board investigator, Peter Vitucci. She provided a written statement in which she stated that Dr. Gelesh did respond verbally to her question. (Resp. Ex. KK) In her written statement, Ms. Orndorf had stated that Dr. Gelesh had answered as follows:

I took it [the succinylcholine] and went over to Debra Warner and Sue and I said I think Dr. Gelesh asked for succinylcholine. They both immediately stood

up and said I wouldn't give that and I said that I wouldn't. [Patient 1's] room was 5 or 10 feet away and I went in [and] asked Dr. Gelesh if he really wanted Anectine and he said Yes and took it. * * * I thought Dr. Gelesh would say I misheard him but he said Yes and took it.

(Resp. Ex. KK)

60. Ms. Orndorf testified that, after she observed Dr. Gelesh administer the medication, she completed her charting. She stated that she had written "60 mg Succinylcholine given by Dr. Gelesh."¹⁴ Then she went back to Ms. Warner and Ms. Zgodzinski. Ms. Orndorf explained that, although they usually rotate charge-nurse assignments, Ms. Warner was her supervisor that night. She also spoke with two hospital nursing supervisors, Karen Vargo and Jeri Stauffer. (Tr. at 458, 461-465; but see St. Ex. 7 at 11)
61. The chart shows that Ms. Orndorf wrote "Succinylcholine 60 mg IV" and then wrote "Dr. Gelesh" in the column where nurses and Dr. Gelesh had signed off on earlier orders. (St. Ex. 7 at 11) Ms. Orndorf confirmed that she is the one who wrote the notation regarding succinylcholine and that she added Dr. Gelesh's name next to it. (Tr. at 429-430)
62. Ms. Orndorf testified that she had documented the administration of Anectine in the medical record at the time it happened. She testified that she had charted all of the events as they occurred. She specifically denied that she had charted anything "later." She also denied having discussed charting with anyone after the event. (Tr. at 445-446, 461, 511-522, 534, 543)

Dr. Gelesh's Response to the Testimony of Ms. Orndorf

63. Dr. Gelesh testified that he was certain that Ms. Orndorf had not handed him a vial and an empty syringe. He stated that she had returned to the room with a syringe that had a needle attached, and that there had been medication in the body of the syringe. He stated that, "in 30 years of practicing emergency medicine, I have never had a nurse hand me a vial with a syringe and say, 'Here, draw up your own medication.'" (Tr. at 1818) Dr. Gelesh stated that Ms. Orndorf's testimony that she had handed him a vial and a syringe was "an outright lie." (Tr. at 1834)
64. Dr. Gelesh also testified that Ms. Orndorf herself did not confirm what the medication was before she handed it to him. (Tr. at 114, 1836)

¹⁴ According to the documents maintained by the hospital, the vial contained 200 milligrams of succinylcholine in 10 milliliters of fluid. (St. Ex. 3; Resp. Ex. 3) If Ms. Orndorf was truthful in testifying that she did not draw the medication into the syringe herself and was standing several feet away from Dr. Gelesh, then it is unclear how she would have known exactly how many milligrams of Anectine were actually drawn into the syringe, to support her chart notation that "60 mg" of Anectine was administered by Dr. Gelesh.

Testimony of Ms. Stauffer

65. Jeri Stauffer, R.N., began working at Akron General in 1988. In February 2002, she was a nursing coordinator, and her job was to “put out fires, check staffing, [and] answer questions” for the entire hospital. (Tr. at 1362-1363)
66. Ms. Stauffer testified that she had spent a lot of her time as a nursing coordinator in the ED and that she remembers Dr. Gelesh. (Tr. at 1363-1364) She testified that she had worked with Dr. Gelesh and found him to be a competent physician. She further testified that she had never known him to order an inappropriate medication. (Tr. at 1376)
67. Ms. Stauffer recalled that, on the morning of February 8, 2002, she responded to a page from Deborah Warner, who advised that Dr. Gelesh had asked Ms. Orndorf to get succinylcholine to be administered to an unventilated patient. Ms. Warner had asked whether it was permissible to give succinylcholine to an unventilated patient in the ED. Ms. Stauffer testified that she had responded that it was not permissible and that she would come to the ED. Ms. Stauffer explained that, at the time of the telephone conversation, she did not know whether the medication had been administered yet. (Tr. at 1363-1367)
68. Ms. Stauffer testified that she and another nurse coordinator had gone immediately to the ED. Ms. Stauffer approached Ms. Orndorf and asked how she was doing. Ms. Orndorf advised that the patient had expired. Ms. Stauffer testified that Ms. Orndorf did not appear to be in distress at that time. (Tr. at 1368-1371)
69. Ms. Stauffer stated that she had asked Ms. Orndorf to complete an incident report regarding the death of Patient 1. Ms. Stauffer explained that she considered the administration of succinylcholine to an unventilated patient to be a major event, and she thought the hospital administration should be advised of it. (Tr. at 1371-1372)
70. Nevertheless, Ms. Stauffer testified that she did not follow up on whether the incident report had been filed. In addition, she was not aware that an investigation had been initiated until some time later. Ms. Stauffer stated that she had been suspended for failing to comply with hospital policies, and she subsequently resigned her position at Akron General in March or April 2002. (Tr. at 1378-1381, 1388-1396, 1405-1406)
71. Ms. Stauffer testified that it was expected that the nursing policies regarding incident reports and questioning physician orders would be followed by all nursing staff, including ED nursing staff. (Tr. at 1374-1375, 1382-1384; Resp. Exs. T, U)
72. Ms. Stauffer testified that, had she been the nurse involved in this matter, she would not have retrieved the succinylcholine from the medicine dispenser, would not have brought it to the patient’s room, and would have challenged Dr. Gelesh regarding its administration. (Tr. at 1376-1378)

Akron General's Policies and Procedures for Questioning Medical Orders

73. According to an excerpt from its policy manual, Akron General has long maintained a policy for nurses to follow when questioning a doctor's orders. The version in effect in 2002 provided:

QUESTIONING MEDICAL ORDERS

Date Issued: 1977
Date Revised: 81, 86, 88, 89, 94, 96, 99

* * *

Objective

To provide guidelines for nurses who question the advisability of carrying out a physician's order.

Policies

1. If at any time a Registered Nurse questions the advisability of giving the ordered dosage of medication or instituting an ordered treatment, the nurse shall first consult with an RN, the Director Nursing / Patient Services or Nursing Coordinator. If there is still a question, the nurse shall call the physician to verify the accuracy of the order.
2. If the physician reaffirms the order and the nurse still questions the medical treatment or dosage of medication, she/he has the right to refuse to carry out the order. The nurse is to inform the physician of the decision.
3. The nurse is to inform the Director Nursing/Patient Services or the Nursing Coordinator who will inform the Nurse Administrator on-call for the patient care area.
4. The Director Nursing/Patient Services or the Nursing Coordinator shall notify the Chairman of the Department.
5. Chairman of the Department shall review the chart and document whether to proceed or not.
6. If the nurse continues to refuse, a conference will be held with nurse, the Department Chairman, the Senior Vice President of Patient Services, the physician who wrote the order and the Chairman of Nursing Council. These individuals will determine appropriate action related to the physician's order.

7. RN's may not be terminated for refusing to carry out an order of a physician.

(Resp. Ex. U)¹⁵

74. When Ms. Orndorf was questioned at the hearing regarding the policy, she characterized it as follows, and indicated that she had followed the hospital's policy:

Q: And did Akron General have any policies for nurses on challenging or questioning medical orders?

A: We have a policy not to give a medication that we feel is inappropriate or we don't want to give. We also have a chain-of-command policy that I followed regarding this medication.

(Tr. at 489)

Testimony of Patient 1's Daughter-in-law

75. Patient 1's daughter-in-law testified that she arrived at the hospital at approximately 11:15 or 11:30 p.m. on February 7, 2002.¹⁶ She testified that Patient 1 had never returned to assisted living after a hospitalization but had been in the nursing section of her nursing home as of February 7, 2002. When the daughter-in-law arrived at Akron General, staff directed her to Patient 1's room. She described the room as having partitions and curtains rather than walls. When she entered the cubicle, she found Dr. Gelesh and a nurse with Patient 1. Later, Chaplain Gibson entered the room. Chaplain Gibson was on the side of the bed with Dr. Gelesh, and the daughter-in-law was on the side of the bed with the nurse. (Tr. at 1021-1031)

76. The daughter-in-law noted that Patient 1 had labored breathing and glassy eyes. She believed that Patient 1 was dying. Dr. Gelesh told her that Patient 1 was in a very weakened condition, that she had a bowel blockage and was not a candidate for surgery. He said that he planned to keep Patient 1 in the ED and keep her as comfortable as possible. (Tr. at 1026, 1029, 1032, 1035-1036)

77. The daughter-in-law testified that she left the room to talk to her husband, who had called from Florida to find out about his mother's condition. She stated that the nurse occasionally left the room, but Dr. Gelesh remained in the room the entire time that she was there. (Tr. at 1030)

78. The daughter-in-law testified that she had returned to the room just as Patient 1 expired. She stated that Dr. Gelesh expressed his sympathy. She believes that Dr. Gelesh had stayed long

¹⁵ See, also, Ohio Administrative Code Chapter 4723-4, "Standards of Practice Relative to Registered Nurse or License Practical Nurse." A copy of these administrative rules is provided at Board Exhibit 5.

¹⁶ The witness' name is not set forth in order to protect the identity of Patient 1. However, the witness' identity is stated in a confidential witness key, under seal, admitted as Board Exhibit 1.

beyond the end of his shift to care for Patient 1. She testified that Dr. Gelesh had been very professional, and at no time appeared to be acting in a malicious manner. She further stated that he had been very comforting and kind.¹⁷ (Tr. at 1033-1034, 1041-1042)

79. Patient 1's daughter-in-law further testified that she saw no friction between the doctor and the nurse. The nurse did not appear to be upset, and the doctor and the nurse seemed to work well together. (Tr. at 1042)

Testimony of Chaplain Gibson

80. Chaplain Richard Gibson was in Patient 1's room at the time the medication was administered at 1:20 a.m. With regard to his background, he testified that he had attended college but had not received a degree. Prior to working as a minister, he had worked in the maintenance department at the nursing home from 1989 through 2000. Before that, he had worked in a testing laboratory at Goodyear. He stated that he had also taken a course through Akron University in "nursing assisting." Chaplain Gibson further testified that he was 76 years old and a licensed minister. He said that he was not employed. However, he stated that he provided services at the facility where Patient 1 had resided and also ministered to the residents. (Tr. at 723-724, 728-729, 741)
81. Chaplain Gibson testified that, at about 10:30 or 11:00 p.m. on February 7, 2002, he had received a message from Patient 1's nursing home requesting that he go to Akron General to see Patient 1. He testified that he went to Patient 1's room in the ED and spoke with the patient's daughter-in-law. He stated that they had said a prayer, and he sang "Amazing Grace." (Tr. at 725-726, 736, 752) He described Patient 1 as follows:

She was awful. Her circumstances appeared to be tremendously painful to her. She was sweating. She was groaning and moaning, and she was clearly hurting everywhere. But particularly her stomach was vibrating like she was in trouble in her stomach area.

(Tr. at 727)

82. Chaplain Gibson further stated that, until Patient 1 died, there was not a moment when she was not in pain. (Tr. at 732-733, 749)
83. Chaplain Gibson described the patient's room as very small and stated that everyone in the room was touching. He stated that Dr. Gelesh was on the same side of the bed as Chaplain Gibson, but Dr. Gelesh was closer to the bed. (Tr. at 727)

¹⁷ Dr. Gelesh stated that his shift had started at 3:30 p.m. and ended at midnight. He testified that it is not unusual for attending physicians in the ED to remain beyond their shifts when a patient's care is ongoing. (Tr. at 68, 74-76, 125)

84. Chaplain Gibson further testified at hearing as follows regarding the events that evening:
- Chaplain Gibson insisted that he had gotten the call from the nursing home by 11:00 p.m., because he had arrived at the hospital by 11:30 p.m.. (Tr. at 736-737)
 - At some point, one of the nurses put a medication patch on Patient 1's right shoulder. (Tr. at 733-734)
 - He saw an IV bag hanging. (Tr. at 737)
 - Dr. Gelesh asked the nurse to get something, and she left. (Tr. at 727, 733-734, 737)
 - The nurse returned to the room and asked Dr. Gelesh "if this is what it was he was looking for, and he indicated 'yes, it was.'" (Tr. at 729)
 - The nurse indicated to Dr. Gelesh that "she was not going to give the medicine." (Tr. at 728-729)
 - Dr. Gelesh took a vial from the nurse, and looked at it. He already had a syringe in his hand. (Tr. at 728-729, 839)
 - Dr. Gelesh filled the syringe with medication and injected it into Patient 1's IV. (Tr. at 728, 742-743)
 - "[A]nd within just a few seconds, all motion, all noise, everything stopped." (Tr. at 729)
 - After Patient 1 died, Chaplain Gibson and the daughter-in-law said a prayer. (Tr. at 752)
85. However, Chaplain Gibson agreed that, in March 2002, about one month after Patient 1's death, he was interviewed by the Akron Police Department, and that he made statements that were essentially as follows:
- He received a call from the nursing home at 11:30 p.m. and arrived at the hospital at 12:00 midnight. (Tr. at 790)
 - One of the nurses put a medication patch on Patient 1's ear. (Tr. at 792)
 - He did *not* remember seeing an IV bag. (Tr. at 791)
 - The nurse returned with *nothing but the shot*. (Tr. at 799)
 - He saw the doctor give Patient 1 a shot *in the arm*. (Tr. at 798-799)
86. Chaplain Gibson further testified that he recalls making additional statements during another interview conducted by the Akron Police Department in April 2002. He testified that he had told the police that he saw the nurse hand the doctor a syringe, and he acknowledged that he might have told the police in April 2002 that he did *not* see the nurse give Dr. Gelesh a vial. (Tr. at 814, 816)
87. Chaplain Gibson acknowledged that he has difficulty hearing. (Tr. at 730) He also acknowledged that it had been difficult to see what the doctor was doing due to their relative positions around Patient 1's bed. Finally, Chaplain Gibson acknowledged that he had not been at the hospital to watch the nurses and doctors but to comfort Patient 1 and her

family. He stated that he sometimes ignores the things going on around the patient because his sole concern is caring for the patient and family. (Tr. at 730-731, 738, 793-794, 832)¹⁸

Chronology of Events According to Patient Records

88. The hospital's medical records show the following chronology of events regarding the treatment Patient 1 received in the ED on February 7-8, 2002:

9:10 p.m. Patient arrived in the emergency department.
9:30 B/P 94/40, heart rate 70, respirations 20.
9:40 Patient received Toradol 30 mg IV. No relief in discomfort. Foley catheter inserted, no urine output.
9:50 Patient received Dilaudid 1 mg IV. No relief in discomfort.
10:00 B/P 85/27, heart rate 83, respirations 20.
10:20 B/P 81/38, heart rate 70, respirations 20, temperature 32.4° C [90.3° F] rectally.
10:20 IV inserted right forearm. Patient received Phenergan 12.5 mg IV.
10:45 "Bear hugger" applied for hypothermia.
11:00 Patient received second dose of Dilaudid 1 mg IV. No relief in discomfort. B/P 89/46, heart rate 70, respirations 20.
11:30 B/P 86/43, heart rate 73, respirations 16, oxygen saturation 71%.
Dr. Gelesh noted that patient had no relief from pain after two administrations of Dilaudid.
11:40 Message left on Patient 1's son's answering machine in Florida; daughter-in-law in Akron contacted.
11:50 Patient received morphine infusion of 100 mg/100 cc at 500 cc's per hr.
12:05 a.m. Morphine infused; daughter-in-law at bedside.
12:10 B/P 85/39, heart rate 70, respirations 12. Oxygen saturation not registering.
12:30 Respirations described as more sporadic, 12 – 16 per minute.
12:40 "No change in patient's status." Staff member spoke with son; funeral home chosen.
12:50 Second morphine infusion begun, 100 mg/100 cc at 500 cc's per hr. Chaplain at bedside. Respirations "snoring" at 12-14 per minute.
01:05 Morphine infused. Respirations at 10-12 per minute.
01:20 Patient received succinylcholine IV administered by Dr. Gelesh; dose was 60 mg according to nurse's note.
01:23 Patient's respirations ceased.
01:30 Patient pronounced dead by Dr. Gelesh.
01:40 Dr. Weidman paged.
01:45 Coroner notified by Ms. Orndorf of patient's death.

(St. Ex. 7 at 11-21, 45; St. Ex. 3)

¹⁸ The Hearing Examiner found the Chaplain to be an honest and sincere witness. However, he appeared very confused and uncertain at times during his testimony, and there were significant inconsistencies in his testimony. The Hearing Examiner's overall impression was of an individual whose memory of relevant events was not reliable on crucial matters.

89. Ms. Orndorf testified that she had contacted the coroner's office to report the death. She stated that she could not remember specifically what she had reported. She stated that, generally, she reports the time of death, the name of the family physician, whether the family physician intended to sign the death certificate, and names of the next of kin. (Tr. at 463, 520-521) She testified specifically, however, that she had *not* reported to the coroner that Patient 1 died of natural causes. Although she does not recall the specific conversation with the coroner's office, she stated that representatives from the coroner's office never ask that question. (Tr. at 521-522)

Events at the Hospital Immediately Following Patient 1's Death

Testimony of Dr. Gelesh

90. Dr. Gelesh testified that, following Patient 1's death, he signed the ED record and left. He testified that, when he signed the ED record, it did not contain the word "succinylcholine." He stated that Ms. Orndorf added that later. Dr. Gelesh testified that Ms. Orndorf completed the ED record for Patient 1 after he had left the hospital. (Tr. at 140-141, 1720-1721; St. Ex. 7 at 11)
91. Dr. Gelesh dictated a report regarding Patient 1's care. Neither his report nor his handwritten notations mention the use of succinylcholine. (St. Ex. 7 at 13-17)

Testimony of Dr. Mitstifer

92. Jack Mitstifer, M.D., testified that he is an emergency-medicine physician providing services at Akron General. He stated that he had been a resident at Akron General, completing the program in 2001, and had known Dr. Gelesh since that residency. (Tr. at 1048-1049)
93. Dr. Mitstifer testified that he was working in the ED at Akron General on the night that Patient 1 was there. His shift started at 11:30 p.m. on February 7, 2002, at which time Dr. Gelesh had briefed him on the patients in the ED but advised that he would stay to care for Patient 1. Dr. Mitstifer did not personally treat or attend to Patient 1. (Tr. at 1049-1052)
94. Dr. Mitstifer testified that, after Dr. Gelesh had left the ED that night, Ms. Orndorf and Greg Smith, a third-year resident physician, had approached him to discuss Patient 1. (Tr. at 1052) Dr. Mitstifer stated that Ms. Orndorf described the administration of Anectine to Patient 1 and expressed concern at that point about how she should document the events:

* * * [S]he just felt this was a highly unusual situation, and one of the questions she did ask me was, "How do I chart this?" And my response to her was to chart it exactly what she felt happened, and that I would discuss it with our chairman the next morning.

(Tr. at 1055)

Further Events Following Patient 1's Death

Initial Death Certificate

95. Amy Weidman, M.D., Patient 1's personal physician, signed the initial death certificate, which states that Patient 1 died primarily of "Intra-Abdominal Sepsis," with other significant causes listed as coronary artery disease, hypertension, and paroxysmal atrial fibrillation. The manner of death was listed as "natural." (St. Ex. 4; Tr. at 378)

The Hospital's Actions

96. Daniel Schelble, M.D., was the chief of the ED, and president of the corporation that provided emergency-physician services to Akron General and employed Dr. Gelesh and Dr. Mitstifer. On March 12, 2002, Dr. Schelble met with Dr. Gelesh to discuss Patient 1, and advised that the hospital had set up a committee to investigate the patient's death. (St. Ex. 6 at 57-58)
97. Dr. Gelesh testified that, until March 12, 2002, he had not been aware of the investigation into Patient 1's death. Dr. Gelesh confirmed that he was approached on that date by Dr. Schelble and that they had reviewed Patient 1's medical record together. Dr. Gelesh testified that he was "flabbergasted" when he saw the notation in the chart that he had ordered succinylcholine. (Tr. at 1718-1719; Resp. Ex. MMM at 57-59)
98. Dr. Gelesh testified that he was asked to take a personal leave of absence from Akron General on March 12, 2002. He stated that, at that time, the hospital set up a sentinel committee to investigate the unusual circumstances surrounding Patient 1's death. Dr. Schelble advised Dr. Gelesh that he anticipated that the leave of absence would last approximately six weeks. Dr. Gelesh testified that the investigation did not resolve in six weeks, and he resigned his position. (Tr. at 67-68, 125)

The Medical Examiner's Office

99. Michael McGill testified that he is employed as an investigator by the Summit County Medical Examiner's Office. He stated that he is certified through the American Board of Medical/Legal Death Investigation. (Tr. at 1311-1312)
100. Mr. McGill explained that, when contacted regarding a hospital death, his responsibility is to gather information to help determine whether there should be an investigation by the coroner. (Tr. at 1316-1318)
101. Mr. McGill testified that he had received a call regarding Patient 1 from Denise Orndorf, a nurse at Akron General, at 1:50 a.m. on February 8, 2002. Mr. McGill testified that Ms. Orndorf had provided information regarding Patient 1's death which suggested that Patient 1 had died of natural causes. He further testified that Ms. Orndorf did not advise him that Patient 1 had received a dose of Anectine. She did advise him that Patient 1 had a DNR/CC directive. (Tr. at 1313-1316, 1343)

102. Mr. McGill testified that Ms. Orndorf told him that she had contacted Dr. Weidner, Patient 1's personal physician, and that Dr. Weidner had advised that she intended to sign the death certificate identifying "cardiorespiratory failure" as Patient 1's cause of death. Based on the information provided by Ms. Orndorf, Mr. McGill determined that the hospital could release Patient 1's body to the funeral home. (Tr. at 1320, 1344-1345)
103. Mr. McGill testified that Ms. Orndorf had not provided him any information to suggest that Patient 1's death was caused by anything other than natural causes. (Tr. at 1339-1342)
104. Mr. McGill stated that, after his discussion with Ms. Orndorf on February 8, 2002, he had received information from Dr. Lisa Kohler, the Chief Medical Examiner, that contradicted the information that he had received from Ms. Orndorf. He stated that the new information had led his office to accept Patient 1's death as a coroner's case. (Tr. at 1339-1342)

Testimony of the Chief Medical Examiner

105. Lisa J. Kohler, M.D., testified that she is the Chief Medical Examiner for the Summit County Medical Examiner's Office. As part of her responsibilities, she investigated the death of Patient 1. (Tr. at 370-371, 377)
106. Dr. Kohler testified that she did not perform an autopsy of Patient 1's body because Ms. Orndorf had reported the death as due to natural causes, and it had not appeared at that time that the death would come under the jurisdiction of her office. Thus, Patient 1's body had been released to the funeral home without an autopsy. (Tr. at 377, 404, 411)
107. Subsequently, however, on March 15, 2002, Dr. Kohler was approached by Akron General's risk manager and attorney. At that time, she learned that there had been a "medication issue" involved in Patient 1's death. Dr. Kohler agreed to assume jurisdiction of the matter. After reviewing Akron General's records for Patient 1, Dr. Kohler contacted the Akron Police Department and the Summit County Prosecutor's Office. (Tr. at 377, 389-390)
108. On June 10, 2002, Dr. Kohler issued a Report of Investigation regarding the death of Patient 1. (St. Ex. 5) A section of that report, captioned "Report by Investigator: Michael McGill," provides as follows:

This Investigator for the Summit County Medical Examiner's Office was notified of the death of [Patient 1] at 0150 hours on 08 Feb 02, by Denise Orndorf, R.N., from Akron General Medical Center.

History obtained from Denise Orndorf, R.N., was that [Patient 1] had been admitted to Akron General Medical Center from [the nursing home] on 07 Feb 02, with an admitting diagnosis of abdominal pain and hypotension. Her past medical history included atrial fibrillation, pacemaker, hypertension, congestive heart failure, coronary artery disease, and pneumonia. Due to her 'Do Not Resuscitate/Comfort Care Only' status, she was not a surgical candidate and was given comfort care treatment in the Emergency Room.

[Patient 1] was pronounced dead at 0130 hours on 08 Feb 02, by Gary Gelesh, M.D., and was released to the Ciriello-Rose Hill Funeral Home at the request of her family.

Further information provided on 15 Mar 02, suggested that just prior to [Patient 1's] death, a medication was administered that without life support measures, would result in her death.

(St. Ex. 5)

109. On July 15, 2002, Dr. Kohler signed a “Vital Statistics Supplementary Medical Certification” which was the final death certificate filed by Dr. Kohler’s office. That document lists the cause of death as “Respiratory arrest due to administration of succinylcholine.” The manner of death is listed as “homicide,” but Dr. Kohler explained that “a medical ruling of homicide differs from a legal ruling of homicide.” She explained that, on a death certificate, a medical ruling of homicide simply indicates “death at the hands of another” and does *not* take into account the intention of the person whose actions caused the death, and does *not* have the same effect as a criminal finding of homicide. In other words, labeling a death as a “homicide” on the death certificate does not necessarily mean that a crime was committed.¹⁹ (Tr. at 378-386; St. Ex. 4)

Additional Testimony by Witnesses in the ED

Dr. Gelesh

110. Dr. Gelesh testified that, on the evening of February 7, 2002, he had been assigned to the acute care area of the ED. At 11:30 p.m., a third-year resident, Greg Smith, started his shift as an “acting attending” or “pretending attending,” a position the emergency department had created to help residents develop administrative skills. Jack Mitstifer, M.D., also started a shift at 11:30 p.m., but did not provide care to Patient 1. (Tr. at 75-79, 1053)
111. Dr. Gelesh submitted numerous letters of support written on his behalf. (Resp. Exs. S, NNN) He also submitted copies of laudatory statements about him by emergency-medicine residents at Akron General and a copy of a newspaper article titled *New man in charge of Mercy ER*. In addition, Dr. Gelesh provided copies of certificates he had received. (Resp. Ex. X)
112. Dr. Gelesh testified that he was never questioned by the Akron Police Department regarding Patient 1’s death. (Tr. at 127)

Ms. Zgodzinski

113. Ms. Zgodzinski testified that a nurse may challenge a physician’s orders, or question the physician about why he is ordering that item. She further testified that that she would not

¹⁹ Dr. Kohler was correct that labeling a death as a “homicide” does not mean that a crime has occurred. When the word “homicide” is modified with an additional term, such as “reckless homicide” or “vehicular homicide,” then the phrase indicates a criminal act, but the word “homicide” alone does *not* denote the commission of a crime. See R.C. Chapter 2903.

administer a medication that was harmful to a patient. Nevertheless, she stated that she would not stop a physician from administering it because she would have “no way of stopping him.” (Tr. at 563)

114. Ms. Zgodzinski reviewed the Akron General Policy on Questioning Medical Orders. Ms. Zgodzinski testified that she agrees with the policy as it applies to floor nurses, but stated that such a policy would be impractical in the emergency department. She stated that emergency department nurses do not have the time to conference with “senior vice-presidents and chairmen” while trying to manage the emergency department. (Tr. at 566-568; Resp. Ex. U)

Ms. Orndorf

115. Ms. Orndorf testified that she had *not* been asked to complete an incident report regarding Patient 1’s death. (Tr. at 522)
116. Ms. Orndorf testified that, approximately one month after the incident, someone at the hospital had approached her and sent her to “staff development” while the matter was being investigated. She also stated that she was subsequently on maternity leave, and that the hospital did not permit her to return to work until the Board of Nursing had closed its investigation. Ms. Orndorf testified that the Board of Nursing did not impose discipline. (Tr. at 465-466, 468-469, 475, 498)

Expert Witnesses

Dr. Fraser

117. William Raymond Fraser, D.O., testified on behalf of the State as an expert witness on ED standards for physicians.²⁰
118. Dr. Fraser agreed that Patient 1 was in a terminal condition in view of her DNR status. When Patient 1 presented to the emergency department, her death was imminent and there was no question that she would die that night. (Tr. at 218, 292, 328)
119. Dr. Fraser testified that the only criticism he had of Dr. Gelesh’s care was the administration of Anectine. Dr. Fraser testified that Dr. Gelesh’s conduct—in injecting a medication without first confirming that the medication was the medication he had ordered—was a departure from the standard of care. (Tr. at 188-190, 302-307, 342-343, 634-637, 640-641; St. Ex. 2)
120. Dr. Fraser testified that, if Dr. Gelesh had meant to order Ativan or Versed, but misspoke and ordered Anectine, that act, in itself, would *not* constitute a deviation from the standard of

²⁰ Dr. Fraser’s professional background is set forth in detail in his curriculum vitae and hearing testimony. He is currently employed as an emergency-medicine physician at Doctors Hospital in Columbus, Ohio, where he serves as the Director of Emergency Medicine Education and the Residency Director for the Emergency Medicine Residency. (Tr. at 178-183; St. Ex. 10)

care. Dr. Fraser testified that, in his opinion, misspeaking without implementation is not a violation of the standard of care. (Tr. at 239-240)

121. Dr. Fraser testified that administering a medication without first verifying its contents is a violation of the standard of care. Dr. Fraser stated that the prevailing standard of care would be for the person who injects the contents of a syringe into the patient to verify the contents of the syringe prior to injecting the medication into the patient. He explained that confirmation could be as simple as asking the person who hands you the syringe to identify the medication contained in the syringe. Dr. Fraser testified that, if the nurse handed Dr. Gelesh an already-filled syringe and he administered the medication without confirming the contents, the failure to confirm the contents of the syringe departs from the standard of care. (Tr. at 213, 215-217, 239-240, 649-650, 675)
122. Dr. Fraser testified that, if the nurse handed Dr. Gelesh a syringe and a vial of Anectine, and Dr. Gelesh drew the medication from the vial before injecting it, that conduct would also be a violation of the standard of care. (Tr. at 220-221) (It is obvious that, if he had held the vial in his hands to load the syringe, he easily could have verified the medication himself.)
123. Dr. Fraser stated that administering Anectine (succinylcholine) to Patient 1 was not within the scope of comfort care:

[C]omfort care would pertain only to treatment designed to alleviate pain and suffering as stated in her document. And the administration of Anectine would bring about her immediate demise if there were no plans to ventilate the patient.

(Tr. at 226-227; see also St. Ex. 2A)
124. Dr. Fraser testified that it is not unusual for a physician to administer a medication in an ED. He added, however, that most physicians, when planning to administer an injection, will draw the medication from the vial themselves. (Tr. at 213-214, 216)
125. Dr. Fraser testified that Ativan generally is supplied in a concentration of 2 mg per cc; Versed is 1 mg per cc. Anectine is supplied in a concentration of 20 mg per cc. He stated that Anectine is often drawn up into a 10 cc syringe. All three medications are available as clear solutions, and, if so, would look similar in a 10 cc syringe. (Tr. at 352-359)
126. Dr. Fraser stated that nurses question physician orders frequently. Physicians rely on nurses to challenge questionable orders as part of the verification process. He stated that, in his ED, if he gave an order that the nurse thought was unusual or wrong, the nurse would question him and ask for clarification. Moreover, the nurse would wait for a response from Dr. Fraser before taking further steps. However, he acknowledged that, if a nurse is intimidated by the physician, the nurse may question less and “follow orders more blindly.” (Tr. at 665-666)

Dr. Galan

127. Gayle Ann Galan, M.D., testified on behalf of Dr. Gelesh as an expert witness on emergency medicine.²¹ In her expert report, Dr. Galan opined that Dr. Gelesh appropriately evaluated Patient 1 and treated her pain in accordance with the DNR/CC directive. Dr. Galan reviewed in detail the symptoms and vital signs documented in the medical records, and she discussed the chemistry and hematology studies indicating that Patient 1 was suffering “multi-organ failure.” She testified that Patient 1 was in a terminal condition. (Tr. at 1191-1200; Resp. Exs. D, E)
128. Dr. Galan testified that Dr. Gelesh’s treatment plan and medication orders—other than the controversy over Anectine—were consistent with the standard of care of a patient who has issued a comfort-care-only directive. Dr. Galan further testified that ordering a benzodiazepine was appropriate under the circumstances. (Tr. at 1202-1203, 1211-1212)
129. Dr. Galan testified that an ED physician is *not* required to confirm that the medication a nurse brings is the medication he ordered. Dr. Galan testified that an ED physician should be able to rely on the nurses to bring the medications as ordered. She stated that, if the physician “cannot trust the nurse to accurately bring the medicines or implement the medicines, then the emergency physician would be expected to check every IV, every shot, every pill that’s administered by the nurse.”²² She added that, if that were the case, the emergency department could not function. (Tr. at 1207-1209)
130. Dr. Galan accepted that Dr. Gelesh had asked for a benzodiazepine. She opined that he had then reasonably expected the nurse to bring him that medication and had no further obligation to confirm the medication delivered. Further, she believed that he had administered the medication with the reasonable belief that it was the benzodiazepine he had ordered. She stated that his conduct met the minimal standard of care for an emergency physician. Dr. Galan disagreed with Dr. Fraser’s opinion that Dr. Gelesh should have confirmed with the nurse the contents of the medication prior to administering it. (Tr. at 1233-1238; Resp. Ex. D)
131. Dr. Galan testified that, even if the nurse handed Dr. Gelesh the vial of medication and he drew it into the syringe, his conduct was within the standard of care. She explained that, if Dr. Gelesh ordered a benzodiazepine, he would have been within the standard of care to assume that the vial contained the medication he ordered. Dr. Galan testified that *if* Dr. Gelesh had personally obtained the vial from the medication storage unit, he would have been responsible for checking the label on the vial. However, because the nurse obtained the medication from the storage unit, it was her responsibility to assure that it was the medication ordered, according to Dr. Galan. (Tr. at 1251-1253) Dr. Galan explained as follows:

²¹ Dr. Galan’s professional background is set forth in her curriculum vitae and her testimony. Dr. Galan is currently the Chairman of Emergency Medical Education at Southwest General Hospital in Cleveland, Ohio. In the past, she has served as the Chairman of the Emergency Department at University Hospitals of Cleveland and St. Vincent Charity Hospital. (Tr. at 1178-1179; Resp. Ex. C)

²² The issue in the present matter, however, does not involve a pill or injection given by a nurse. The standard of care at issue relates to medication *personally administered by the physician*.

Although it is a good practice [to check the vial], it is my opinion, based on my training, experience and directorship and chairman of several different departments, that emergency teams work together and the emergency physician does have the right to depend on the professionalism of the nurse that he has worked with before. And if she brings him the medicine that he has ordered and he draws it up and injects it, that meets the standard of care.

(Tr. at 1284)

132. Dr. Galan testified that the standards in 2002 would have required a nurse receiving an order for succinylcholine/Anectine to initiate procedures for assisting the patient's respiration. In addition, if the nurse was aware that Dr. Gelesh was administering Anectine without initiating respiratory assistance, the nurse should have documented that fact in the patient's chart. Moreover, if the nurse had objected to Dr. Gelesh that the medication was inappropriate, she should have documented that fact in the chart as well.²³ She further

²³ Evidence regarding nursing standards has limited relevance in this administrative action, as the purpose of this action is not to adjudicate the conduct of any nurse. Indeed, this Board does not have jurisdiction to decide whether Ms. Orndorf or any nurse violated Ohio law, and, generally, the question of whether a nurse violated her or his employer's rules is a decision for the employer to make in the first instance. However, evidence regarding compliance with nursing standards has some relevance in this action, in that it can provide an overall picture of responsibilities in the ED and can assist the finder of fact to assess the credibility of Dr. Gelesh and Ms. Orndorf and whether their testimony regarding their own behavior and others' behavior in the ED is more or less likely to be true. For example, if Ms. Orndorf may have violated her employer's rules and/or Ohio law, she could have a motive to misrepresent events.

Second, the purpose of this action is *not* to determine whether, in the event of an error by the physician, someone else could have prevented the error from causing harm to the patient. In other words, the issues before the Board do not include the apportioning of blame to all those who may have shared some responsibility for the patient's premature death. Rather, the central issue is to determine whether Dr. Gelesh's conduct failed to conform to minimal standards of care for an ED physician under the circumstances. In this regard, it is important to recognize that patient harm is not a requisite element of proof in a minimal-standards action, although it may be relevant to the seriousness of a violation. Thus, if Dr. Gelesh made an error that violated the minimal standard of care, the argument that someone else could have prevented his error from causing harm is beside the point when the issue is the physician's compliance with the minimal standard of care.

Third, the Hearing Examiner emphasizes that this incident involved two separate transactions between the physician and the nurse: (1) the verbal transmission of the order from the physician to the nurse, and (2) the physical transfer of the medication from the nurse to the physician, and the physician's acceptance of the medication and his personal administration of the medication to the patient. The Notice focuses primarily on the latter transaction and the physician's alleged failure to confirm/verify the medication before he administered it. Any problems or lapses that may have occurred surrounding the initial transmission/receipt of the order should be viewed as separate and distinct from the central focus of this action, which is the minimal standard of care when a physician receives medication from a nurse and personally administers it. Accordingly, excessive attention on compliance with nursing standards during the first transaction would be misplaced.

In determining as described above that, pursuant to the Notice, the Hearing Examiner should not focus on the conduct surrounding the first transaction but should focus primarily on Dr. Gelesh's conduct during the second transaction, the Hearing Examiner relied on the Notice as a whole and particularly on two specific allegations in the Notice. First, the Notice does *not* allege that Dr. Gelesh actually ordered Anectine for Patient 1. Rather, the Notice alleges that, "*hearing* that you ordered Anectine," the nurse retrieved Anectine and brought it to the Respondent, who administered it. Second, the Notice specifically alleges that Dr. Gelesh admitted that he had "*assumed* the medication handed to [him] was what [he] had ordered." Thus, the second transaction, or the physician's conduct surrounding the hand-off of medication, appears to be the focus of the allegations against Dr. Gelesh.

indicated that the nurse handing Dr. Gelesh succinylcholine should have notified him that this medication would require a standard paralytic protocol including at the very least oxygen/airway support and monitoring. (Tr. at 1220, 1224-1228, 1248-1249, 1255-1257; Resp. Ex. D)

133. Dr. Galan also testified that 60 milligrams of Anectine is a “sub-therapeutic dose.” She stated that the standard dose is 1.5 mg/kg of body weight. In a situation where the actual weight is unavailable, the standard dose is 100 mg. She stated that a dose of 60 mg will impair some of the patient’s muscle activity but may not cause breathing to cease. (Tr. at 1024-1025)
134. Dr. Galan stated that, if Dr. Gelesh misspoke and asked for Anectine believing that he had asked for Ativan, and the nurse gave him Anectine, his conduct would be within the standard of care. Dr. Galan explained that, because he had no indication from the nurse that it was a paralytic agent that would require intubation, Dr. Gelesh has no reason to know that he had misspoken. (Tr. at 1282-1283)
135. Dr. Galan testified that Dr. Gelesh’s conduct would have deviated from the standard of care if the nurse had indicated that the medication she handed him was Anectine, if he acknowledged that it was Anectine, and if he injected the Anectine without preparing to intubate or bag the patient. (Tr. at 1278, 1281)
136. Dr. Galan opined that Dr. Gelesh’s conduct was within the standard of care even if the nurse had brought the medication and had asked if he really wanted Anectine, but Dr. Gelesh did not hear her. (Tr. at 1252-1253)

If that occurred, then the nurse should have initiated procedures for assisted ventilation, according to Dr. Galan. Dr. Galan testified that, after the Anectine was administered in the sub-therapeutic dose, the patient should have been “bagged” until the drug’s effects had ceased.²⁴ She stated that, although the DNR/CC directive precludes intubation, it does not preclude the caregiver from providing comfort-care with oxygen.²⁵ (Tr. at 1228-1230)

137. With regard to the patient’s chart, Dr. Galan testified that the chart shows that Dr. Gelesh co-signed all his medication orders *except* for the Anectine order, and that someone else wrote his name under the reference to Anectine. Dr. Galan testified that this was very unusual. (Tr. at 1209-1210) In her supplemental report, Dr. Galan stated:

²⁴ Although much of Dr. Galan’s testimony was persuasive, the Hearing Examiner found that she focused excessively on whether the nurse could have prevented the death of Patient 1, which was not an issue in this matter. The primary issue is whether Dr. Gelesh’s acts, omissions and/or conduct constituted a departure from the minimal standards of care based on the events and circumstances presented to him.

²⁵ Dr. Fraser agreed that it would not violate a DNR/CC directive to provide artificial respiration via an ambu-bag to address complications resulting from a medication order. However, he testified that the administration of Anectine without providing respiratory assistance does *not* conform to the provision of comfort care. (Tr. at 226-227, 712)

The succinylcholine that was administered was written below Dr. Gelesh's signature, where he had endorsed the Toradol, Dilaudid, and Phenergan which was given. It is important to note that the order for succinylcholine was not cosigned or endorsed by Dr. Gelesh on the order sheet * * * but only written in by the nurse.

(Resp. Ex. E)

Dr. Gelesh

138. Dr. Gelesh also testified as an expert in emergency medicine, and he provided a written report. (Resp. Ex. G) His opinions in the report include the following:

My opinion is that under the circumstances present in this case, it was not a departure from the minimal standards of care for me to believe that the medication I received from the nurse was what I had ordered.

* * *

During the scope of my practice, I estimate that I have issued hundreds of thousands of orders, many for the administration of medication. By the nature of emergency medicine, it is not uncommon for the emergency physician to give verbal orders to the [ED] staff. When a single drug is ordered verbally, it is not unusual for the physician to request the medication, for the nurse to draw it up into a syringe and administer it to a patient or hand it to the physician to administer to the patient. If the nursing staff agrees that the medication and/or dosage are appropriate, there generally is no additional verification. In addition, physicians often give verbal orders to nurses over the phone. These physicians may or may not be in the hospital during the phone order. In these instances, the nurse writes down the order and gives the medication to the patient without any further verification of the medication.

* * *

In summary, as I had no reason to know or believe that the nurse thought she heard me order Anectine, an unindicated drug, rather than Ativan or Versed, both of which were appropriate medications for Patient 1, it was not a departure from the "minimal standards of care" for me to believe the medication provided to me was what I had ordered. ACEP and ACOEP do not identify any standards of care addressing the verification of medicine prior to its administration. More often than not, a medication order does not go through verification process before it is administered to a patient. I would consider this the norm for the practice for emergency medicine.²⁶

(Resp. Ex. G)

²⁶ Dr. Gelesh was apparently referring to the American College of Emergency Physicians and the American College of Osteopathic Emergency Physicians. However, if these organizations have written standards for patient care, the standards were not offered into evidence.

139. Dr. Gelesh stated his belief that the medication he had administered to Patient 1 was a benzodiazepine, and he further contended that the patient had expired as a natural result of her many severe disorders, not from the medication he administered.²⁷ (Resp. Ex. G)
140. At hearing, Dr. Gelesh testified that the standard of care does not require that a physician verbally verify a medication prior to administering it.²⁸ He explained that confirmation of medical orders usually occurs whenever the nurse receives the order and accepts it as an appropriate order. He testified that, when he gave his medication order to Ms. Orndorf and she accepted it without objection or discussion, and returned with a filled syringe that she gave to him, that constituted an acceptable confirmation, and he was within the standard of care to believe that the medication in the syringe was the medication that he had ordered. (Tr. at 105, 115-116, 166-167, 1762-1763)
141. Dr. Gelesh explained further:

On the medical floor the doctor will write an order on the chart. The nurse will pick up the order from the chart and administer it to the patient. That's a confirmation as far as I'm concerned. And the confirmation occurs whenever a nurse does not object to the order.²⁹

(Tr. at 115-116) Dr. Gelesh testified that, in thirty years of practice, he has never seen a physician verbally verify a medication order prior to administration. (Tr. at 105, 1762-1763)

142. Nevertheless, Dr. Gelesh acknowledged that any healthcare professional administering a medication by injecting it into a patient has a responsibility to know what medication he or she is injecting into the patient. (Tr. at 117-119)
143. However, Dr. Gelesh asserted that, with regard to Patient 1, the lack of objection from Ms. Orndorf was sufficient for him to know that the medication she brought was the medication he had ordered. Dr. Gelesh stated that a verification takes place when the nurse hands him a medication and does not object to it. (Tr. at 117-119)

²⁷ As explained above, the death certificate established that death was caused by administration of succinylcholine, and evidence regarding alternative theories was not admitted.

In addition, Dr. Gelesh, in his report, focused on the nurse's conduct, arguing that she had several opportunities to correct the alleged error but failed to do so. As explained above, the focus in this administrative action must remain on whether *Dr. Gelesh's conduct* violated the "minimal standard of care." If it did, the fact that someone else might have prevented his error from causing patient harm is immaterial.

²⁸ When witnesses referred to "verbal" confirmation, the Hearing Examiner understood them to mean a spoken or oral confirmation, which is how the term "verbal" is used in the Joint Commission's standards, below.

²⁹ It is important to note that, in the present action, the medication was not administered by a nurse pursuant to an instruction from the physician. Here, it is undisputed that Dr. Gelesh himself administered the medication.

144. The record also includes Dr. Gelesh's testimony given in September 2004 during his deposition. In that deposition, he testified regarding the various responsibilities of the physician and the nurse. He stated that one method of confirming an order is for the nurse to echo it back to the doctor, especially if the order sounds unusual. He also testified that "the nurse, when you give an order for medication, should clarify the medication for that." (Resp. Ex. MMM at 35-36)
145. In his deposition, Dr. Gelesh further testified that "there was not a confirmation" for the medication order at issue, and he testified that "it is a dual responsibility." He stated: "It's the responsibility of the nurse; it's the responsibility of the physician, that when a medication is being handed off, that there is some verification." He noted, however, that it is "frequently not done." (Resp. Ex. MMM at 43)

Dr. Wecht

146. Cyril H. Wecht, M.D., J.D.,³⁰ testified on behalf of Dr. Gelesh. He testified that Patient 1 was in a terminal condition when she was first treated in the ED. He further testified that, in an ED setting, it is reasonable for a physician to give a verbal order for a medication and expect an experienced nurse to comply with that order. Moreover, the physician is justified in believing that the medicine provided by the nurse is the medicine the physician ordered. He stated that it was not necessary for Dr. Gelesh to confirm with the nurse that the medicine she handed to him was the medicine he had ordered. Dr. Wecht further testified that the nurse should not have brought a contraindicated medicine into the room. (Tr. at 1106-1109; 1138-1141; Resp. Ex. R)
147. With regard to the minimal standard of care for a physician, Dr. Wecht testified that ordering a benzodiazepine would have been appropriate in light of Patient 1's condition. However, he testified that ordering Anectine under these circumstances "would be a deviation and departure from accepted and expected standards of care, yes, absolutely." He further stated that, if Dr. Gelesh withdrew medication from a vial labeled either "Anectine" or "succinylcholine" and administered it to the patient under these circumstances, that conduct would be a deviation from the standards of care. (Tr. at 1110-1111, 1149-1151)

Ms. Harlan

148. Camille Harlan, R.N., J.D., an attorney and registered nurse, testified as an expert on standards of care for nurses.³¹ (Tr. at 910-912; Resp. Ex. H)
149. Ms. Harlan testified that Anectine, Ativan, and Versed would be indistinguishable in a syringe. (Tr. at 949-950)

³⁰ Dr. Wecht's professional qualifications are set forth in his testimony and curriculum vitae. (Tr. at 1096-1101; Resp. Exs. Q, Q1)

³¹ Ms. Harlan stated that she has been licensed as a registered nurse in Ohio since 1981, that she is employed full-time in the ED at Upper Valley Medical Center in Troy, Ohio, and has served as an Acting Municipal Court Judge in Darke County, Ohio. (Tr. at 910-912; Resp. Ex. H)

150. Ms. Harlan testified that it is not unusual for a physician to administer a medication in the emergency department; however, it would be unusual for a physician to draw the medication from the vial. (Tr. at 948, 950)
151. Ms. Harlan testified that it is the responsibility of a nurse to question the physician when she believes a medication ordered by the physician is inappropriate for the situation. Moreover, the use of Anectine in these circumstances was so inappropriate that the nurse should never have removed the medication from the storage unit. Once it was removed, it should have been “handled like dynamite.” (Tr. at 920-921, 927, 929, 933, 937-944; Resp. Ex. I)³²
152. Ms. Harlan testified that Ms. Orndorf did not comply with the hospital’s policies and procedures for clarifying physician’s orders. (Tr. at 957-958; Resp. Ex. U)³³

Additional Evidence Regarding Standard of Care: Standards Established by the Joint Commission on Hospital Accreditation

153. The Respondent presented standards that had been developed by the Joint Commission on Hospital Accreditation Standards [Joint Commission] and adopted in 2004 regarding the transmission of information in hospitals.³⁴ The Respondent provided excerpts from the 2001, 2002, 2003 and 2004 Hospital Accreditation Standards to demonstrate that a specific standard for verification of verbal orders was not adopted until 2004. (Resp. Exs. CCCC, DDDD; GGGG, HHHH)
154. Dr. Galan testified regarding the Joint Commission’s standards. She stated that, in 2004, the Joint Commission initiated a standard, which had not existed before, requiring that nurses and others who receive verbal orders must read back the complete order to make sure the order is accurately transmitted. (Tr. at 3155-3159)
155. In the 2003 Hospital Accreditation Standards, there is no specific standard in standard IM.6 requiring a particular method for verifying physicians’ orders given verbally rather than in writing. (Resp. Ex. DDDD; Tr. at 3155-3157) However, in the 2004 Hospital Accreditation Standards, the following requirement is included:

³²As set forth more fully in footnote 23, evidence regarding nursing standards was *not* admitted with regard to considering any fault of Ms. Orndorf in the patient’s death or any violation committed by Ms. Orndorf. Such issues are not before this Board. The evidence was admitted for limited purposes, such as helping to assess the credibility of Ms. Orndorf’s testimony.

³³ Dr. Gelesh sought to present additional expert witnesses to testify regarding nursing standards, but the Hearing Examiner did not permit additional nursing experts, on the grounds it would be unduly cumulative, especially given that the heart of this action is the standard of care for physicians, not nurses.

³⁴The Joint Commission states at its website that approximately 88 percent of the nation’s hospitals currently are accredited by the Joint Commission, and the site provides information regarding the benefits of accreditation and the development of standards. The Joint Commission explains that its standards “address a hospital’s performance” in certain areas and “specify requirements to ensure that patient care is provided in a safe manner and in a secure environment.” (See “The Joint Commission – Facts about Hospital Accreditation,” at <http://www.jointcommission.org/AccreditationPrograms/Hospitals/hospital_facts.htm>, 5 May 2009), admitted as Board Ex. 6.

Elements of Performance for IM.6.50

* * *

4. The hospital uses a process for taking verbal or telephone orders or receiving critical test results that requires a verification “read-back” of the complete order or test result by the person receiving the order or test result.

(Resp. Ex. CCCC; Tr. at 3155-3163)

156. Dr. Galan testified that, in 2004, the standard required a nurse receiving a verbal order from a physician to verify the order by repeating the order back to the physician at the time the order is given. (Tr. at 3156-3159) She testified that, in 2002, when Dr. Gelesh treated Patient 1, there was no specific standard governing the transmission and receipt of verbal orders, and she opined that Dr. Gelesh had complied with the hospital standards in effect in 2002.³⁵ (Tr. at 3155, 3163) The Respondent argued that this is further evidence that Dr. Gelesh’s conduct was in conformance with the minimal standards of care in 2002. (Tr. at 3153-3156, 3405-3406)³⁶

The Administration of Morphine to Patient 1³⁷

Opinion of Dr. Levy

157. Michael H. Levy, M.D., Ph.D., is board certified in both internal medicine and medical oncology. For 25 years, he has specialized in the field of palliative care, which may also be referred to as “pain management.” He provided a written report of his opinions and testified at hearing. (Tr. at 3009-3011, 3016, 3018, 3032, 3086; Resp. Ex. L)

³⁵Dr. Galan’s testimony focused on the transmission of the order from the physician to the nurse, but the notice of opportunity for hearing, and the testimony of the State’s expert witness, Dr. Fraser, focused primarily on the physician’s subsequent receipt of the medication for the purpose of administering it to the patient, and his alleged failure to verify the medication before administering it.

The standards of the Joint Commission, as presented by Dr. Galan, focus on the transmission of the order but do not address the situation where one individual hands medication to another person to administer it, and whether the person accepting the medication to administer it must take action to confirm or verify the medication when the one handing him the medication has not done so.

³⁶ The Respondent did not argue that the Joint Commission’s standards are binding on the Board in determining the minimal standard of care for physicians in Ohio in an adjudicative action such as the present action. The Hearing Examiner concludes, however, that the Board may consider the Joint Commission’s standards and may find them useful and persuasive—or not—in its discretion. The Hearing Examiner notes that Dr. Michael Levy, who has been involved for many years in developing standards of care in the field of hospice and palliative medicine, testified that the Joint Commission sets standards for the accreditation of hospitals and then, “within each state, the Medical Practice Act and the Nursing Practice Act has the right to be more restrictive.” (Tr. at 3076-3077)

³⁷ The notice of opportunity includes no allegation that the amount of morphine is excessive or that Dr. Gelesh ordered morphine in a manner that constituted a departure from the minimal standard of care. Indeed, the notice includes no mention of morphine at all. Therefore, during the initial proceedings, the Hearing Examiner excluded allegations, evidence and arguments regarding excessive morphine dosing, based on considerations of due process. However, the issue is before the Hearing Examiner on remand, pursuant to the Board’s order of February 11, 2009.

158. Dr. Levy has been active in the development of standards for palliative care throughout the United States, and participated in the creation of the subspecialty board for palliative care. He explained that the American Board of Internal Medicine [ABIM] recognized hospice and palliative medicine as a full subspecialty in the 1990s and that he became certified by the Board of Hospice and Palliative Medicine in 1997. Dr. Levy testified that he was recertified in 2005 and is now a diplomate of the Board of Hospice and Palliative Medicine.³⁸ In addition, Dr. Levy is a diplomate of the ABIM and its subspecialty Board of Medical Oncology. (Tr. at 3009-3011; Resp. Ex. K)
159. Dr. Levy testified that, in 1997, the American Medical Association received a major grant to teach physicians about end-of-life care, and he helped create the curriculum and was a master trainer for the AMA program, Education for Physicians on End-of-Life Care. Dr. Levy is also a member of the National Comprehensive Cancer Network Guideline Panels. The network is a coalition of 21 comprehensive cancer centers in the United States, and he has been on the Pain Guideline Panel since 1998. In addition, he is the Chair of the Palliative Care Guideline Panel of the AMA. He explained that the panel members have created guidelines for palliative care. (Tr. at 3012-3013; Resp. Ex. K)
160. Dr. Levy has been employed since 1981 by the Fox Chase Cancer Center in Philadelphia, Pennsylvania, where he initially worked as an oncologist and also established the hospice program. He is currently the Director of the Pain and Palliative Care Program, the Medical Director of the Hospice Program, Chairperson of the Medical Ethics Committee, the Vice Chair for the Department of Medical Oncology, and a member of the executive committee staff. He testified that he spends 60% of his work in direct clinical care of patients, including patients in intensive care, on regular hospital floors, in the clinic, and in the center's room for unannounced patients in crisis, which he explained is a de facto emergency room although it is not a certified emergency department. (Tr. at 3009-3010)
161. Dr. Levy further stated that the National Quality Forum, which is funded and empowered by Congress to set up standards of care, was asked to set up standards for palliative and hospice care, and he was on the review committee in 2005 and 2006. He testified that the standards developed by that group "have then been accepted by the whole coalition of the National Quality Forum, and are being looked at by the Center for Medicaid and Medicare Services as their standards." (Tr. at 3013-3014)
162. Further, Dr. Levy has lectured and led workshops on palliative care in 47 states and in nine other countries. He has published and provided peer review for numerous articles, book chapters, and other publications. (Tr. at 3016; Resp. Ex. K)
163. When asked to comment on national trends in pain management, Dr. Levy observed:

³⁸According to the website maintained by the American Board of Medical Specialties, the ABMS established in 2006 a new subspecialty certificate in Hospice and Palliative Medicine, which is deemed a subspecialty of ten specialties including Emergency Medicine, Internal Medicine, Anesthesiology, Surgery and others. (See <http://www.abms.org/Who_We_Help/Physicians/specialties.aspx>.)

Many organizations are trying to increase patients' access to appropriate pain management. The Joint Commission, the American Pain Society, American Academy of Pain Medicine, * * * state pain initiatives, there's a current pain-relief law that just got through Congress out of committee. So it continues to be an issue because studies continue to show that as many as 50 percent of patients with advanced cancer have suboptimal pain management. So we still have work to do.

(Tr. at 3079)

164. Dr. Levy stated that there are many misconceptions about “correct” dosing for opioids such as morphine. For example, he explained that the patient’s weight is not a major factor, although it may be considered when selecting an initial dose. He emphasized that, for a patient in severe pain, there is no “correct” dose for a particular weight and that the appropriate dose of Dilaudid or morphine is the dose that “is enough to relieve the symptoms.” (Tr. at 3021, 3097)
165. He explained: “There is no *a priori* perfect dose, ideal dose, unlike many drugs that have what we call a ceiling or what’s technically called a ‘low maximal efficacy,’ that a few drugs, like Dilantin or Theopholin, you get above a certain blood level, you get no benefit, only toxicity. There is no such ceiling with opioids, morphine in specific. The therapeutic window stays open and drifts upward, and you – essentially, if you have this much pain, you need this much pain medicine.” In short, “extreme pain needs extreme medication.” (Tr. at 3021, 3072)
166. Dr. Levy explained that the appropriate dose of morphine is best calculated by the physician and nurse observing the patient and assessing function and checking for side effects, and talking with the patient if he or she is able to communicate. When the patient is unable to communicate, the physician and nurse can assess nonverbal signs and adjust the dosage to make the patient comfortable. For example, there may be facial expression/grimacing, rigidity of muscles, guarding, and other signs of distress. (Tr. at 3021-3022, 3038)
167. Dr. Levy stated that the number of milligrams is largely irrelevant and that the determinative factor is “the assessment of this patient's pain.” He testified that, for many years, he has been trying to educate physicians that dosage should not focus on the specific number of milligrams but on the level of medication needed to achieve comfort for the individual patient. He cautioned against excessive reliance on doses noted in a reference work such as the Physicians Desk Reference, because it indicates only the dose submitted to the FDA for approval and merely provides a starting point when determining dosage for pain relief. (Tr. at 3025, 3031)
168. Dr. Levy noted that there are “many articles that will give you an average dose,” but that these doses tend to describe the patients, not the medication. He opined that there is no “normal” dose. Rather, there are starting points from which one adjusts based on observations of pain relief. Dr. Levy stated that the fact that a certain dose may be “more common in one’s experience or in an article” is a descriptions of patients, not of the medicine. (Tr. at 3056-3057, 3072)

169. Dr. Levy testified that he has had patients who needed only 10 milligrams of morphine to achieve comfort while he has had other patients “who needed 2,000 milligrams of morphine IV an hour.” (Tr. at 3025-3026)

170. With respect to accepted methods of administering large doses of morphine to a patient *in extremis*, Dr. Levy testified that, instead of beginning with a low starting dose and increasing the dose according to pain relief, one can start at a high rate and adjust downward as appropriate:

A. Often another way of adjusting the dose of morphine is that sometimes we can give a bolus load. So if I think someone needs a hundred milligrams an hour and they are in extremis, I will give them a hundred “push” and then run it at a hundred an hour.³⁹

And so a way of doing that is if this perhaps was not a patient-controlled analgesia pump, is to open it wide, which would be the 500 [cc per hour], until you see results, and then you back off.

Q. So 500, is that -- When you say "open it wide", I would assume that's one of the fastest rates you can infuse it?

A. It's according to the pump. But often 500 is—per hour is—you know, is what they set it when they put in the medicine and they want to flush that medicine through; that's not an uncommon number.

(Tr. at 3091)

171. With regard to amounts of morphine that he himself has ordered for patients, Dr. Levy testified:

A. As I had said earlier, I have given -- I've had patients who needed 2,000 milligrams of morphine intravenously an hour. I've had patients at home on 400 milligrams of Dilaudid an hour, a woman awake and taking care of her two and four year old. It was on a home pump. Four hundred milligrams of Dilaudid per hour is equivalent to * * * 1,600 milligrams of morphine.

Q. Have you ever personally administered 400 milligrams of morphine in a push situation, which is an injection?

A. Push? The only time that I've done that is when a patient is on * * * 800 milligrams of morphine an hour. * * * If you use a patient-controlled analgesia pump, it's not just a continuous, but there is a button that can give a preprogrammed amount in a bolus that the machine would give it

³⁹ Dr. Levy testified that a “bolus” dose is a rapid injection of medication in 60 seconds or less, usually by “push,” which is an injection using a syringe. He opined that a “continuance infusion dose” cannot be deemed to constitute a “bolus” dose, even when the dose is assertive. Specifically, he testified that Patient 1 received bolus doses of Dilaudid and Phenergan, but that a morphine drip such as that administered to Patient 1 would *not* be considered to constitute a bolus dose. (Tr. at 3026-3027)

rapidly * * * . When someone is on 800 milligrams an hour, which we have used, we typically give half of their hourly dose as their break-through dose, [so] they would be able to get 400 milligrams intravenously every 15 minutes as needed.

(Tr. at 3110-3111) Dr. Levy explained that this means that, pursuant to his medication order, the patient could hit the button four times in an hour to get 1,600 milligrams in addition to their 800 milligrams per hour. (Tr. at 3112)

172. When Dr. Levy was asked whether these patients receiving 800 or 2,000 milligrams of morphine per hour were receiving such large amounts because they had developed a high tolerance to morphine, he answered:

I'd say they had a lot of reason for pain. No, I wouldn't say that they were opioid tolerant. I would say that * * * their pain was not responding to their previous level, and therefore we needed more.

(Tr. at 3114-3115)

173. In addition, Dr. Levy testified that morphine does not necessarily cause dysphoria, euphoria, addiction, immunity/tolerance, or loss of function, and does not necessarily decrease respiration or hasten death. (Tr. at 3032-3033) He explained that morphine has a direct effect on the respiratory center, decreasing sensitivity to carbon dioxide, and it can reduce respirations. However, the effect of pain in the body is that it reduces or negates this side effect of morphine. In other words, pain is an antidote to the respiratory effect of morphine. Therefore, when a patient is in extreme pain, the physician can give a lot of morphine and not see respiratory depression. (Tr. at 3033-3034)

174. Dr. Levy testified that there are several explanations offered for this phenomenon. One is that the lack of respiratory depression from morphine given to patients in extreme pain is that, when a person has pain, the number of opioid receptors in the tissues increases, and this sort of soaks up the morphine given to the patient, creating a balance of relief without depression of respiration. Another explanation is that the morphine administered from outside the body tries to mimic the morphine made by the body itself (endorphins), but the body cannot make enough of its own morphine when tissue damage is significant, and the opioid receptors are not for the pharmaceutical morphine but “are for the morphine that the body, over evolution, has developed to protect itself.” (Tr. at 3033-3034)

175. Dr. Levy testified that, regardless of the theoretical model, it is well established that the body adapts and that, when there is a lot of pain, the body will tolerate a lot of morphine without the side effect of respiratory depression. Dr. Levy stated that he has seen this effect clinically. For example, a patient may need a morphine drip due to a fracture, but once the fracture is set and healing, the patient starts to get sleepy and respirations start to go down, because the source of pain has decreased and thus the need for morphine has also decreased. When the source of pain diminishes, a dose that was not previously toxic can become toxic as a result of the decrease in pain source. In that situation, Dr. Levy would start lowering

the dose 25% per day to avoid sleepiness, thus adjusting or titrating for comfort and function. (Tr. at 3020, 3034, 3036)⁴⁰

176. However, when a patient is dying in severe pain, Dr. Levy would not expect the source of the pain to diminish. On the contrary, he would expect the patient to need increasing doses of morphine, adjusted to achieve comfort. In addition, a patient in extreme pain at the end of life may have given instructions regarding comfort care, and would rather be comfortable than alert. In that event, Dr. Levy does not decrease dosage to avoid drowsiness. Indeed, depending on the patient's instructions and/or discussion with family members, he would not decrease the morphine dose to avoid sedation and diminution of respiratory rate. In such cases, the patient and physician "accept comfort even if it diminishes function." Sometimes a dying patient will want increased medication to control pain even if it means sedation to a level that renders the patient unable to communicate with his family. Dr. Levy reiterated that, in such circumstances, the proper dose of morphine is the dose that will alleviate the patient's pain. He testified that, when a patient has indicated that he wants comfort care, he would provide an adequate dose of morphine to control the patient's pain symptoms even if the unintended consequence is a loss of function, including loss of function that may hasten death. (Tr. at 3035-3037, 3046, 3100-3101)

177. Dr. Levy explained that, in such circumstances, his intent is to reduce pain. The diminution of function in these circumstances is a foreseen but unintended consequence. Dr. Levy explained that, under the ethics doctrine known as the "double effect" doctrine (which was first expounded by Thomas Aquinas), a physician who seeks the beneficial effect of relieving pain in such circumstances has acted ethically despite the unintended effect, and this principle of medical ethics is reflected in laws such as Ohio's law providing certain immunities to physicians who provide comfort care in end-of-life situations. (Tr. at 3042-3047)

178. With regard to the effect of morphine in the body, Dr. Levy stated that, when a patient is given a bolus dose of morphine, he would expect the effect to peak in 15 minutes. If no relief is seen in 15 minutes, "it would be typical to double the dose at that point and continue until" a measurable level of comfort is observed. (Tr. at 3049, 3067, 3074)

179. Dr. Levy testified that, based on the pharmacokinetics of morphine, "if you're not seeing any relief after 15 minutes, it would be appropriate to double the dose." He stated that it is "a very important principle that's unlike other medications, that you double the dose at least every 15 minutes until you see relief."⁴¹ (Tr. at 3067) He testified that he would

⁴⁰ With regard to respiration generally, Dr. Levy testified that a rate as low as 10 respirations per minute is within the normal range. He stated that, with patients who are not imminently dying, the standard at his hospital is that, if the rate of respiration falls below ten, they reduce the morphine by 25% and contact the treating physician. However, with a comfort-care patient who is imminently dying, Dr. Levy testified that he would not decrease the level of morphine based on a respiration rate falling below 10 per minute. (Tr. at 3108)

⁴¹ Dr. Levy clarified that it is recommended but not required that a physician double the dose when no relief of distress is observed. Accordingly, he would not consider it to be a violation of the minimal standard of care for a physician to order a repeat dose of Dilaudid or morphine rather than doubling the dose. (Tr. at 3074)

double the dose of morphine on a regular basis until he saw clinical benefit or observed side effects in the absence of benefit, at which point he would recognize the need to add other medications that work in different parts of the nervous system. Further, Dr. Levy stated that, even if he thought there might be something wrong with the first bag of morphine because there did not seem to be any pain relief, he would still double the dose of morphine, as he would know in 15 minutes whether there was any background of morphine from the first bag or not. (Tr. at 3041, 3088)

180. Dr. Levy explained that, if the morphine doses continue to increase and the physician is not seeing relief of the patient's distress, then the physician needs to look at other classes of medications to use as adjuncts, such as benzodiazepines or barbiturates. Dr. Levy testified that there is a "small subset of patients" for whom morphine will not control the symptoms adequately, and who need another type of medication to achieve pain relief. (Tr. at 3035-3038, 3048-3050, 3067)

181. Regarding the treatment of Patient 1 by Dr. Gelesh, Dr. Levy rendered a number of opinions. He opined that the bolus doses of Toradol, Dilaudid, and Phenergan were appropriate, and that, when the patient did not respond to those medications, it was appropriate for Dr. Gelesh to order a morphine drip, that is, a continuous intravenous infusion of morphine, rather than order further bolus doses of Dilaudid. Dr. Levy opined that the sequence and amounts of pain medications ordered, including both doses of morphine, were within the minimal standard of care. (Tr. at 3025-3027, 3039-3040, 3067-3068, 3078)

182. Specifically, Dr. Levy commented that the Toradol was a reasonable choice because it would be equal to 10 milligrams of morphine and is appropriate when there is an inflammatory process, as was reasonably likely given this patient's abdominal distress. Next, one milligram of Dilaudid was "very appropriate" because Dilaudid is four times as potent as morphine. He commented that ordering two milligrams of morphine for someone who did not respond to Toradol would be "silly," and that starting at four milligrams to see if the combination would work was "good." With respect to Phenergan, Dr. Levy stated that it is a tranquilizer, often given postoperatively to enhance the effect of morphine, and it was "a standard at that time." He explained that Phenergan is not an analgesic but helps quiet the patient. (Tr. at 3069-3070)

183. Dr. Levy noted that another milligram of Dilaudid was given but was equally ineffective, as the patient was still in distress following the second dose of Dilaudid. At that point, the patient had received 2 milligrams of Dilaudid, the equivalent of eight milligrams of morphine, and "it would be appropriate to start a drip, whether it's Dilaudid, which is hydromorphone, or morphine. They're equally effective." Therefore, Dr. Levy opined that starting a morphine drip at a milligram per milliliter was "an appropriate next step." (Tr. at 3070)

184. Dr. Levy noted that Patient 1 had a history of multiple medical illnesses and presented with acute deterioration of her medical condition, with "some type of abdominal catastrophe going on," and that she "was clearly imminently dying." He noted that, when the patient

arrived in the ED, she was able to state that she did not want surgery but wanted comfort measures. (Tr. at 3022)

185. Dr. Levy testified that the written order for Patient 1's morphine presents no cause for concern and was not a violation of the minimal standard of care. He stated that he was aware that the drip contained 100 milligrams in 100 milliliters of solution, which he said was "a starting dose." He agreed that the nursing narrative showing an arrow, numbers, and "gtt" [drip], indicated that the morphine drip would be titrated up to 500cc's an hour on the pump to achieve comfort. Further, he agreed that, if the morphine were infused at the rate indicated by the nurse's note, then 100 milligrams of morphine would have been infused in about 12 minutes. (Tr. at 3020-3026, 3029, 3056, 3070, 3075, 3089-3090)
186. Dr. Levy further opined that the upward adjustment of the morphine dose, the second dose, was also within the minimal standard of care. He stated that the second dose of morphine was justified by the patient's continued signs of distress. He noted several factors: that there was no indication in the patient's chart that her pain had been alleviated in any manner by the first morphine drip; that her respirations were still at 12, which is within the normal range; and that her family member was at her bedside.⁴² He found nothing to question in Dr. Gelesh's ordering of the second bag of morphine, or with regard to the morphine dosing in any respect. In reaching this conclusion, Dr. Levy was aware that Dr. Gelesh had ordered two morphine drips representing a total of 200 milligrams of morphine in one hour and 15 minutes. He stated that the number of milligrams is not the critical number, noting that he himself has ordered more milligrams of morphine per hour than was ordered for Patient 1. He felt that, if anything, the amount of morphine ordered may not have been enough, rather than too much. (Tr. at 3024-3030, 3040, 3047-3048, 3070, 3093-3097, 3106-3109, 3112-3113)
187. Dr. Levy stated that, in Patient 1's records, the written order does not include specific instructions for adjusting the morphine dose, which would be required by current standards.⁴³

⁴² Several times in his testimony, Dr. Levy mentioned family members as a factor when determining palliative measures in end-of-life situations. He indicated among other things that it may be desirable to maintain the patient's alertness when possible while waiting for family members to arrive and that, after family members are present, higher doses of morphine may be provided as appropriate, often in consultation with family members. (Tr. at 3022, 3039, 3046-3047, 3062-3063, 3094, 3100) With regard to Patient 1's second dose of morphine, Dr. Levy commented merely that her family member had arrived before the second dose of morphine was ordered. (Tr. at 3094)

⁴³ Dr. Levy testified that, in 2002, the lack of written instructions for titration of morphine would not have been unusual because doctors and nurses would often collaborate, get a drip started and then adjust it. He explained that, although the written order did not include the specifics that are the current standard for palliative care, when there is "a pain crisis, it's not uncommon that there is a verbal understanding and things just get going." In his own work at the Fox Chase Cancer Center, the physicians typically give instructions for a starting dose and then state that the dose may be increased by specific amounts at specific intervals, so that the nurses can then observe and increase the dose as needed. By "current standards," Dr. Levy means standards *not* in effect in 2002 but developed in the last five years by the Joint Commission on Accreditation of Hospitals and probably effective in 2004. Although Dr. Levy said he could not opine with certainty whether each dose of morphine was ordered to be titrated judiciously (due to the lack of written parameters in the chart), he opined that the morphine overall was judiciously ordered "based on the fact that the patient was still in distress, the dose was increased, and the respiratory rate was still above 12." He stated that it is judicious to continue to increase the dose of medication until evidence of relief is observed, and that he saw no indication in the patient records

188. Dr. Levy noted that, after the first dose of morphine, the patient was still in pain, as documented by the nurse's note at 12:40 a.m. that there had been "no change in the patient's status," more than thirty minutes after the first dose had been infused. Dr. Levy concluded, therefore, that the first dose of morphine had not been sufficient to relieve pain and that Dr. Gelesh's ordering of another 100 milligrams was justified and constituted appropriate care. Dr. Levy also noted that, after the first infusion of 100 milligrams of morphine was completed at 12:05 a.m., the patient's respirations were at 12 per minute. At 12:50 a.m., when the second morphine drip was started, the respirations were recorded at 12 to 14 per minute. (St. Ex. 7) At 1:05 a.m., when the second dose of morphine was completely infused, the respirations were recorded at 10-12 per minute, which is still within the normal range of respirations. Dr. Levy opined that the subsequent decrease in respirations to 10-12 per minute shows "the beginning of an opioid effect" although the respirations remained in the normal range, which supports the conclusion that the morphine dosing for Patient 1 was appropriate. (Tr. at 3093-3097, 3106-3109, 3112-3113)
189. When asked whether the morphine dosing was "unusual," Dr. Levy responded that it was unusual that a physician would have the knowledge and skill to be comfortable with ordering the dose needed by the patient when it was a higher-than-average dose. (Tr. at 3030, 3071-3072) Dr. Levy opined that the morphine dosing for Patient 1 may have been "relatively uncommon," but it was "appropriate." (Tr. at 3073)
190. When asked to explain how the dose was uncommon, Dr. Levy stated that it was uncommon "for the average patient" but "not uncommon for a patient who is imminently dying in a pain crisis." Dr. Levy further stated that the dose was "uncommon" because "pain management is still under-taught and, therefore, we find that many physicians are not comfortable giving these doses that patients need." He noted that it is common for the palliative-care specialists at his medical center to get consults on surgical patients whose pain is not relieved by two milligrams of morphine an hour "because the surgical residents are uncomfortable giving more." (Tr. at 3078, 3081)
191. Dr. Levy commented that "opiates are not well taught in medical school," because students are taught the chemistry of the medication and the bad side effects, but not adequately taught how to balance the side effects with the bad effect of unrelieved pain and to comprehend "the wide therapeutic index of opioids in general." Therefore, when physicians do not have experience in using these medications at the levels needed by patients in extreme pain, they often develop arbitrary limits of what they are willing to prescribe and may rely incorrectly on the Physician's Desk Reference. (Tr. at 3030-3032)
192. Based on his lectures across the country for many years, Dr. Levy stated that, at that the time of Patient 1's treatment, it was "the rare physician in the emergency room who would be that confident and that skilled to provide this level of care." (Tr. at 3071-3072)

193. Dr. Levy also answered questions regarding whether Patient 1 was opioid-naïve at the time of her treatment by Dr. Gelesh on February 7-8, 2002. Dr. Levy stated that, according to the records, on January 11, 2002, Patient 1 had been prescribed a Fentanyl patch every three days at a dose of 25 micrograms of Fentanyl per hour. He further noted that, on January 25, 2002, the treating physician had increased the dose to a 50-microgram patch, and that there was no indication of any order to discontinue that medication. Dr. Levy testified that Fentanyl is approximately 100 times more potent than morphine. He explained that the patch dose that goes through the skin is considered to be equal to an intravenous dose, so that, therefore, Patient 1 had been receiving the equivalent of five milligrams of morphine per hour intravenously. (Tr. at 3117-3119; Resp. Ex. III)
194. It was Dr. Levy's opinion that the dosage increase from 25 micrograms per hour to 50 micrograms of Fentanyl per hour demonstrated that Patient 1's pain had not been relieved at the lower dose. He opined that the doubling of the dose by the treating physician was a significant but judicious increase. Dr. Levy also noted that Fentanyl stays in the body a long time, as much as seven days. (Tr. at 3114, 3119-3120)
195. Dr. Levy also opined that ordering a benzodiazepine when a patient continues to exhibit distress after large doses of morphine is appropriate and within the minimal standards of care. When morphine does not provide full relief, the physician can use other medications "and a common one is Ativan." He stated that Versed has a quicker onset of effect but wears off more quickly. (Tr. at 3048-3049)
196. Dr. Levy testified that, in his opinion, Dr. Gelesh followed and abided by the patient's DNR/CC directives with regard to palliative care. Based on his review of the patient's medical records, Dr. Levy opined that all the treatments ordered by Dr. Gelesh "were aimed at comfort care." (Tr. at 3064, 3114) [Dr. Levy's testimony reflects that, in reaching this conclusion, he accepted that Dr. Gelesh ordered or intended to order a benzodiazepine after the morphine.]

Opinion of Dr. Fraser Regarding the Administration of Morphine

197. With regard to the administration of morphine, Dr. Fraser stated that, after he provided his report on Patient 1's care, he had been asked to provide a supplemental report with regard to the administration of morphine, which he did. (St. Ex. 2A) In his report, Dr. Fraser stated that the administration of 200 mg of morphine during the period of time would be well beyond the normal dosing for an opiate-naïve patient and that such a large dose would be sufficient to depress respiration to the point that breathing would stop. He opined that it would be unlikely that such large doses would be required in an elderly, frail woman to provide relief of pain. Nonetheless, Dr. Fraser concluded as follows:

[H]aving not been at the bedside providing [Patient 1]'s care and assessing her level of discomfort, I cannot conclusively state that the morphine dosing was excessive.

(St. Ex. 2A)

198. During the hearing, Dr. Fraser testified that he stood by his opinion that the morphine dosing was not excessive. (Tr. at 293)
199. Dr. Fraser testified that the dosages of Toradol, Dilaudid, Dilaudid, and Phenergan were “appropriate,” and that he looked upon the ordering of these medications “as being titration, giving the medication to try to achieve the effect, the amelioration of her pain, which was apparently considerable.” (Tr. at 236)
200. However, Dr. Fraser was concerned that the morphine was given in a big “chunk,” with “bolus-type” speed without adjustments over time. Dr. Fraser stated that, when he was a resident in California, they treated patients in horrible pain and would typically give them 100-milligram bags of morphine over the course of a day, although sometimes faster than that, and that the rate was around five to ten milligrams per hour at the most. Thus, the rate of dosage for Patient 1, infusion in fifteen minutes, had caught his eye and appeared to be phenomenal. (Tr. at 236-239, 293)
201. However, Dr. Fraser stated his opinion that Dr. Gelesh’s conduct regarding the morphine administered to Patient 1 “would *not* be a breach of minimal standards.” (Tr. at vol. III, proffer 1, page 3)

Dr. Gelesh’s Testimony Regarding the Administration of Morphine

202. Dr. Gelesh testified that the amount of morphine was not excessive because “the only reason I’m at this bedside is to make sure she’s comfortable,” and the amount of morphine to give in a palliative-care situation is the amount required to control the patient’s pain. He stated that Patient 1 was in a terminal condition; she “was going to pass away soon, and the only thing that Patient 1 asked of me is to control her pain.” He stated that, in his clinical evaluation at the patient’s bedside, “Patient 1 remained in pain throughout the – almost the entire palliative care.” (Tr. at 132; 1774-1775)
203. Dr. Gelesh stated that there is no specific standard as to how much morphine should be ordered. He testified that, when a patient is receiving palliative care, the amount of morphine is based on the patient’s response to the medication. He stated that sometimes the pain is so severe that the fright/flight response is triggered, which causes large amounts of adrenaline in the system, and normal amounts of morphine or other narcotic medications do not control the pain. (Tr. at 1813-1814)

Opinion of Dr. Galan Regarding the Administration of Morphine

204. Dr. Galan testified that Dr. Gelesh had engaged in judicious titration of medication by using a series of medications, starting with Toradol 30 milligrams and continuing with Dilaudid 1 milligram, which was ordered twice, and also Phenergan 12.5 milligrams, which has an antiemetic effect to prevent vomiting. She noted that the patient had “continued to have pain and scream out when she was touched,” prior to the second dose of Dilaudid. Dr. Galan opined that the subsequent administration of morphine was “appropriate for a patient who was having severe pain at the end of life.” (Tr. at 1262-1264, 3143-3146; see. also, Vol. VII Proffer)

205. Dr. Galan noted that Dr. Gelesh had previously ordered two milligrams of Dilaudid, which is far more potent than morphine, but the patient was still having discomfort.⁴⁴ Thus, she opined that placing the patient on a morphine drip was appropriate to decrease the pain level of a terminal patient. Dr. Galan stated that titrating a morphine drip according to clinical response is a “very common and reasonable way to titrate a morphine drip on a patient who has severe pain.” She stated that the rate was set forth in Dr. Gelesh’s dictation, requiring clinical assessment of “how well this patient is responding to the pain medication” rather than requiring an exact concentration and rate. (Tr. at 1270-1273)
206. Dr. Galan further opined that it was the nurse who set up the infusion rate for Patient 1 at 500 cc’s per hour. She inferred this from the chart, noting that the rate was not specifically written by Dr. Gelesh but was identified and documented by the nurse as being 500 cc’s per hour. (Tr. at 1271-1272)
207. Dr. Galan testified that patients who have severe burns, severe fractures, or severe abdominal distress, may require extremely large amounts of morphine. She explained: “Individuals who have severe pain may require very large amounts of morphine, and it is more important to address what their pain response is than the exact concentration of the drip or the exact time over which it’s administered.” Dr. Galan stated that she has seen patients with severe burns or abdominal catastrophes “who are in so much pain that a hundred milligrams of morphine doesn’t even touch them.” She testified that Patient 1 received, while each bag of morphine was being infused, about eight milligrams of morphine per minute, which was appropriate in these circumstances and was not unlike the titration that a patient can self-administer when using a patient-controlled pump to deliver morphine. Further, she noted that Patient 1 received no morphine between 12:10 a.m. and 12:50 p.m., at which point the second morphine drip was started. (Tr. at 1265-1267, 1271-1273, 3144-3146, 3152)
208. Dr. Galan concluded that Patient 1 was not responding to the morphine drip and still had severe pain. She testified that the amount and rate of morphine “was appropriate based on the clinical response of the patient and the concentration of the medication.” (Tr. at 1269, 1274; Vol. VII Proffer)
209. When Dr. Galan was asked whether she herself had ever given a patient 200 milligrams of morphine within one hour, she answered, “Yes.” She stated that she had ordered that amount of morphine twice for patients who needed comfort care in the emergency department when dying. (Tr. at 3181-3182)
210. Dr. Galan also focused on the patient’s respirations, noting that a normal respiratory rate is between 10 and 20 respirations per minute. Dr. Galan found nothing alarming in the patient’s respiration rate after the administrations of morphine. She relied on the fact that the patient had respirations of 12 at the end of her first morphine drip, and, forty minutes later at

⁴⁴ The Palliative Medicine Handbook, available on the internet at <<http://book.pallcare.info/index.php?tid=125>>, May 4, 2009) states that hydromorphone is 3.75 times to 7.5 times more potent than morphine. However, the handbook states that, when converting between hydromorphone and morphine, one should use the “lower equivalent dose of the range.” That is consistent with Dr. Levy’s statement that hydromorphone/Dilaudid is four times more potent than morphine and that 1mg of Dilaudid is equivalent to 4 mg of morphine.

12:40 p.m., had respirations of 12-14. Dr. Galan pointed to the nurse's note regarding a "snoring" respiration at the latter time, which, according to Dr. Galan, showed that Patient 1 "was beginning to relax" but "had no respiration depression." (Tr. at 3145-3146)

211. Dr. Galan opined that Dr. Gelesh did not deviate from the minimal standard of care in the administration of morphine. She explained that Patient 1 was in severe pain with an acute abdominal event and had not responded to a very powerful narcotic, Dilaudid. She concluded that, in the circumstances, a morphine drip at the rate of 8 milligrams per minute for 15 minutes was a "very judicious amount of morphine for a patient in severe pain." Further, she found that Dr. Gelesh had adjusted the amount of morphine to the amount of pain; she concluded that ordering a repeat dose of the same amount of morphine was an appropriate response to the pain being suffered by the patient and constituted a judicious titration to the pain level, in an attempt to relieve the patient's pain and comfort her. Dr. Galan opined that Dr. Gelesh "acted as a prudent and reasonable physician, to judiciously, meaning wisely, give the patient an appropriate amount of medication, and then see in fact if that medication had the effect that it was intended to have." (Tr. at 3151-3154)
212. Dr. Galan further opined that the administration of morphine by Dr. Gelesh was consistent with the patient's comfort-care order. She explained that morphine drips are commonly used by hospices and oncologists to comfort patients experiencing a terminal event. (Tr. at 3154)
213. Dr. Galan also testified regarding the printouts from the Sure-Med Automated Medication Distribution System, a computerized medication-dispensing system used at Akron General in 2002. The three-page printout shows the medications dispensed for many different patients from the Sure-Med machine on the evening of February 7-8, 2002. The portions relating to Patient 1 are as follows:

Date/Time	Operator Name	Quantity Dispensed	Dose Amount	Doctor Name	Order Number
KETOROLAC 30 MG INJECTION (TORADOL)					
Thu Feb 7 21:18 2002	Zgodzinski, Sue	1 INJECTION	1 MG	761000311571	Unclassified
	TOTAL QUANTITY	1 INJECTION			
* * *					
HYDROMORPHONE 1 MG, SYRINGE (DILAUDID)					
Thu Feb 7 21:33 2002	Zgodzinski, Sue	1 SYRINGE	1 MG	761000306852	Schedule C II
Thu Feb 7 22:53 2002	Orndorf, Denise	1 SYRINGE	1 MG	GEMS, INC	
	TOTAL QUANTITY	2 SYRINGE			
PROMETHAZINE 25 MG AMPULE (PHENERGAN)					
Thu Feb 7 21:33 2002	Zgodzinski, Sue	1 AMPULE	1 MG	761000317784	Unclassified
	TOTAL QUANTITY	1 AMPULE			
* * *					
SUCCINYLCHOLINE 200 MG VIAL (ANECTINE)					
Fri Feb 8 01:08 2002	Orndorf, Denise	1 VIAL	1 MG	761000301358	Unclassified
	TOTAL QUANTITY	1 VIAL			

(Resp. Ex. SSS)

214. Dr. Galan testified that the Sure-Med report shows the dispensing of Toradol, Dilaudid and Anectine from the machine in the ED but does not list the morphine for Patient 1, which was dispensed by the pharmacy as documented on the Pharmacon report. (Tr. at 3164, 3167-3173; St. Ex. 3; Resp. Ex. SSS)
215. Dr. Galan testified that the nurse whose name appears under Operator Name would have entered the information into the Sure-Med machine regarding medication and dose, and the system would have recorded the amount dispensed. Dr. Galan observed that the dose entered for the Dilaudid, which is 1 milligram, is consistent with the amount charted by the nurse as having been given to the patient. (Tr. at 3169-3170, 3172; (Resp. Ex. SSS)
216. Dr. Galan testified that, with regard to the Anectine, the dose entered by the operator was also 1 milligram. Dr. Galan stated that the “1 mg” entered in the Sure-Med system by Ms. Orndorf is not consistent with her note in the patient’s chart that 60 milligrams of Anectine was ordered and administered. Also, Dr. Galan testified that the standard dose of Anectine is 100 mg, or 1 mg per kilogram of weight. She explained that a dose of 1 mg of Anectine would have little effect and that even 60 milligrams would be a sub-therapeutic dose that would be insufficient to cause respiration to cease. (Tr. at 3170, 3173; Resp. Ex. SSS)
217. In contrast, Dr. Galan testified, a dose of 1 milligram would have been the appropriate dose for a benzodiazepine such as Ativan or Versed (which is the medication that Dr. Gelesh testified that he had ordered). (Tr. at 3172-3173)
218. Dr. Galan further testified that the Sure-Med report shows that the Anectine was dispensed in a vial rather than a syringe, and that both the Sure-Med report and the pharmacy report state that Anectine was provided in a vial containing 200 milligrams of Anectine in 10 milliliters of fluid. (Tr. at 3171; Resp. Ex. SSS; St. Ex. 3)
219. When asked why the dose amount for the Toradol is listed on the Sure-Med report as “1 MG” but the amount shown as having been dispensed is a 30-milligram syringe, Dr. Galan stated that Toradol is not dispensed in a vial but comes in “one injectible form” of 30 milligrams and that “one” injection was obtained and given. (Tr. at 3176-3177) She explained that, although “the dose amount that is listed here states one milligram * * * this is one injection, and it’s given as one injection, so it ends up being 30 milligrams.” She believes that the nurse must have entered 1 milligram as the dose but would nonetheless have received one syringe with a 30-milligram dose in it. She stated that obtaining one syringe is different from obtaining a vial from which different amounts can be extracted, as one can obtain 1 milligram or many milligrams from the vial. Dr. Galan believed that the nurse should have entered a dose amount of 30 milligrams for the Toradol. Further, she indicated that, if a nurse entered “1 mg” as the dose amount, the machine would never provide only 1 milligram of Toradol because it comes as a 30-milligram syringe. (Tr. at 3178-3180, 3189-3191)
220. Dr. Galan acknowledged that she herself had not entered information into a Sure-Med machine but she testified that she has observed nurses obtaining medication from an

automated medication-dispensing system, the Pyxus system, which is similar to the Sure-Med machine. (Tr. at 3182-3183)

Additional Testimony regarding the Sure-Med Automated Dispensing System

221. William T. Winsley, R.Ph, is a registered pharmacist who holds two degrees in pharmacy, has served as a pharmacist in two different hospitals, is the Executive Director of the Ohio State Board of Pharmacy, and has been involved with numerous investigations of pharmacies. He testified that he is familiar with Sure-Med systems generally and agreed that the Pyxus system is very similar. (Tr. at 3352-3357)
222. Interpreting the Sure-Med report regarding the dispensing of Anectine for Patient 1, Mr. Winsley testified that the report gives him the following information: that the medication obtained from the system was Anectine/succinylcholine; that it was dispensed for a particular patient (Patient 1's name is listed); that it was dispensed at 1:08 on Friday, February 8, 2002, and that it was probably 1:08 in the morning because the machine probably used the 24-hour clock; that the medication was removed by a person identifying herself as Denise Orndorf; that she removed a vial containing 200 milligrams of Anectine; that the physician is not specifically identified but the medical practice is listed instead; and that the category of drug is set forth as unclassified. (Tr. at 3361-3363)
223. Mr. Winsley stated that the column for "Dose Amount" does not provide valid information and that this "field was not used at that time and was not accurate." He explained using a different entry for a different patient: on page 36 at the top, there is a record of dispensing 4 capsules of diphenhydramine, a 25-milligram capsule, and the operator obtained four capsules, but the dose amount is listed as "4 mg." Mr. Winsley stated that such a dose would require a nurse to take apart one of the capsules and extract about one-sixth of the powder, which does not make sense. Therefore, he concluded that the "dose amount" field is not a valid field. (Tr. at 3362-3363, 3382) Mr. Winsley stated that, similarly, a dose of 1 mg for Anectine does not make sense because it is not an effective dose unless the person weighs less than four pounds. (Tr. at 3361-3362, 3382)
224. Mr. Winsley testified that, because many of the dose amounts shown on the report do not make sense, he believes that operators did not enter a dose amount as shown in the "dose amount" field. When asked whether it was true that the system could not determine what amount of medication to dispense, unless the operator entered some number, an amount of 1 or 2 or 3, etc., Mr. Winsley answered: "That particular machine that was sitting in Akron General, I don't know what iteration it was. I will tell you that comparable machines at the time period, the answer to your question is no." He indicated that the operator for the Anectine probably entered that she was removing a 200 milligram vial of Anectine because that is what the report says was removed, but he qualified that, with this "particular Sure Med machine at that time, I was not there. I cannot answer whether that one asked them to put in a dose, but it's obvious that the dose that is put in, based on this entire report, is a meaningless figure." (Tr. at 3361-3366, 3375-3379, 3382, 3388-3390)

225. However, on further cross-examination, Mr. Winsley testified that, while it is clear that the individual operator had to enter his/her identification to access the machine and obtain drugs, it would be speculation to say what was entered by the operator beyond the first two columns. Mr. Winsley testified that some of the columns of information are automatically provided by the Sure-Med system (such as the date and time), and some must be entered by the operator. Ultimately, he testified that, “not knowing the machine, the exact machine that they had” at Akron General, he could not tell “which ones of these columns that the nurse had to key in, in order to get drugs out.” (Tr. at 3361-3366, 3375-3379, 3382, 3388-3390)

Testimony of Records Custodians of Akron Police Department

226. Sergeant Frank Williams appeared in response to a subpoena issued at the Respondent’s request, but it cannot be said that he testified “on behalf of” Dr. Gelesh. He testified that he is employed by the Akron Police Department [APD], where he is responsible for all evidence submitted for safekeeping in the property room. Sgt. Williams testified that he had received a subpoena issued by the Board in October 2006 and that, upon receiving the subpoena, he had retrieved all the requested evidence in the property room, and had copied what he could. Sgt. Williams testified that there were three items in his possession that he did not provide in response to the subpoena: an empty vial of succinylcholine; a videotape showing a demonstration of the administration of succinylcholine, and the original copy of Patient 1’s medical records from Akron General.⁴⁵ (Tr. at 1513-1514, 1520, 1567)

227. Sgt. Williams confirmed that certain items, including several cassette tapes of witness interviews, had not been in the property room at the time he initially gathered evidence in response to the subpoena. He testified that he had subsequently gathered cassette tapes and provided them for review, and these tapes were marked as Respondent’s Exhibits NN, PP, RR, SS and TT. (Tr. at 1538-1542)

228. Detective Russ McFarland also testified in response to a subpoena issued at the Respondent’s request. He stated that he is employed by the APD in the Crimes Against Persons Unit. He testified that he had misplaced three tape-recordings made during the investigation of Patient 1’s death and that, despite having made great efforts to find the tapes, he had been unable to locate them. (Tr. at 1583-1653)

229. Detective Michael L. Shaeffer also testified in response to a subpoena issued at Respondent’s request. He stated that he is employed by the APD in the Crimes Against Persons Unit, and had been asked by his supervisor to help search for tape-recordings of interviews conducted during the investigation of Patient 1’s death. Detective Shaeffer testified that he had located some tape-recordings during his search. (Tr. at 1857-1891)

230. According to a written record made by the APD, Daniel T. Schelble, M.D., was interviewed in April 2002, at which time he described, among others things, his recollection of

⁴⁵ Sgt. Williams brought to the hearing the medical records for Patient 1, and the Hearing Examiner performed an *in camera* review, finding no significant difference between the documents in the Akron Police Department file and those possessed by the Respondent. (Tr. at 1626-1635)

conversations with Dr. Gelesh in March 2002.⁴⁶ According to the interview record, Dr. Schelble made statements including the following: that he did not speak with Dr. Gelesh about Patient 1's case until the afternoon of March 12, 2002, partly because Dr. Gelesh had not been working a full-time schedule due to the serious illness of his widowed mother who lived in another state; that when he first met with Dr. Gelesh on March 12 and showed him the patient's records, Dr. Gelesh indicated that he did not remember the case other than what was on the chart and in his dictation, and that he did not remember anything about succinylcholine being given to the patient; that Dr. Schelble asked Dr. Gelesh to review the records at home and think about it; and that the next morning, Dr. Gelesh said that he still did not remember succinylcholine being administered or other information about this case beyond what was in his dictation and the patient's chart. (St. Reb.Ex. 1)

231. Dr. Schelble was not available to be cross-examined at hearing regarding his recollections and reported statements of Dr. Gelesh because Dr. Schelble killed himself in November 2005.⁴⁷

Testimony of Peter Vitucci

232. Peter Vitucci, a Board investigator, verified that Exhibit KK is a copy of the written statement that Denise Orndorf made and provided to him. (Tr. at 3203-3204)⁴⁸

CLOSING OF THE HEARING RECORD

During the remand proceedings, a number of additional procedural exhibits were admitted, including procedural motions, Board minutes, and entries, which were compiled as three exhibits, State Exhibits 1-UUU, 1-VVV, and 1-WWW. (Tr. at 3394-3395) In addition, the record was held open through April 24, 2009, for the purpose of receiving documentation to authenticate Respondent's Exhibit UUU. (Tr. at 3346-3347) On April 24, 2009, the Respondent submitted the authenticating letter from the state medical examiner, and Respondent's Exhibit UUU was admitted into the record. The record closed at that time.

⁴⁶ With regard to statements reportedly made by Dr. Gelesh to Dr. Schelble, as described by Dr. Schelble to the APD and recorded in an interview record, the Hearing Examiner notes that initially the interview document was excluded from evidence on the grounds that it presents multiple levels of hearsay testimony (that is, the document constitutes a written statement by the APD, regarding oral statements by Dr. Schelble, regarding oral statements by Dr. Gelesh) and that Dr. Schelble was not available to be cross-examined regarding his recollections due to his death. However, on February 11, 2009, the Board voted to admit the document to the record, and it is part of the evidence considered on remand. (St. Ex. 1-WWW)

⁴⁷ The Respondent presented police reports and other evidence regarding Dr. Schelble's suicide. Counsel for Respondent stated that, while the suicide was horrible, it was necessary for the Respondent to present this evidence to rebut the reliability of Dr. Schelble as a witness for the State, because Dr. Schelble was not in fact a witness who testified at hearing but his statements of hearsay were admitted into the record without Respondent's being able to cross-examine him. Respondent's counsel stated that, when one reviews the suicide reports, it is evident that "this is not a simple suicide" and Dr. Schelble was "not a well man." The Hearing Examiner admitted some public records but excluded photographs. (Tr. at 3270-3281, Resp. Ex. XXX, YYY)

⁴⁸ The Respondent's counsel noted that the issue of authenticating Resp. Ex. KK was resolved as far as the Respondent was concerned when the Hearing Examiner admitted the exhibit into the record. However, he noted that the State had been raising questions about the document, making it advisable to have Mr. Vitucci's testimony on the matter. (Tr. at 3200)

LEGAL ISSUES

1. Whether Dr. Gelesh is protected from disciplinary action under R.C. 2133.11

Under R.C. 2133.11, physicians have immunity from Board disciplinary action for certain conduct in the course of providing comfort care in situations where a patient has executed a DNR/CC declaration. As in effect in 2002, R.C. 2133.11 provides in part as follows:

(A) Subject to division (D) of this section, an attending physician, consulting physician, health care facility, and health care personnel acting under the direction of an attending physician are not subject to criminal prosecution [and] are not * * * subject to professional disciplinary action for any of following:

* * *

(1) Giving effect to a declaration, if the physician, facility, or personnel gives effect to the declaration in good faith and does not have actual knowledge that the declaration has been revoked or does not substantially comply with this chapter;

* * *

(5) Making determinations other than those described in division (B) of this section, or otherwise acting under this chapter, if the determinations or other actions are made in good faith and in accordance with reasonable medical standards;

(6) Prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to a qualified patient or other patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death, if the attending physician so prescribing, dispensing, administering, or causing to be administered * * * [is] carrying out in good faith the responsibility to provide comfort care described in division (E)(1) of section 2133.12 of the Revised Code. (Emphasis added)

(B) Subject to division (D) of this section, an attending or consulting physician is not subject to criminal prosecution * * * and is not subject to professional disciplinary action if the physician makes any of the following determinations in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards:

(1) A determination that a declarant or a patient as described in section 2133.08 of the Revised Code is in a terminal condition;

* * *

[The omitted subsections deal with patients in a "permanently unconscious state" and those unable to make informed decisions.]

* * *

(D) This section does not grant an immunity * * * from professional disciplinary action to health care personnel for actions that are outside the scope of their authority.

R.C. 2133.12(E)(1) provides in part:

Sections 2133.01 to 2133.15 of the Revised Code do not affect the responsibility of the attending physician of a qualified patient or other patient * * * to provide comfort care to the patient. Nothing in sections 2133.01 to 2133.15 of the Revised Code precludes the attending physician * * * who carries out the responsibility to provide comfort care to the patient in good faith and while acting within the scope of the attending physician's authority from prescribing, dispensing, administering, or causing to be administered any particular medical procedure, treatment, intervention, or other measure to the patient, including, but not limited to, prescribing, personally furnishing, administering, or causing to be administered by judicious titration or in another manner any form of medication, *for the purpose of diminishing the qualified patient's or other patient's pain or discomfort and not for the purpose of postponing or causing the qualified patient's or other patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death.* (Emphasis added)

R.C. 2133.24(D) provides that nothing in R.C. 2133.21 to 2133.26 “condones, authorizes, or approves of mercy killing, assisted suicide, or euthanasia.”

In December 2005, Dr. Gelesh filed a complaint for declaratory and injunctive relief, joined with a petition for a writ of mandamus, in *State ex. rel. Gelesh v. State Medical Board*, Case No. 05CVH-13735 (Franklin Co. Common Pleas). Dr. Gelesh argued that his treatment of Patient 1 had been comfort care under R.C. 2133.11 and that he was therefore immune from disciplinary action by the Board. Dr. Gelesh further argued that, because the Board had not alleged (in its May 2005 Notice) that he failed to act in good faith when providing comfort care to Patient 1, the common pleas court must conclude that he was entitled to statutory immunity. Accordingly, Dr. Gelesh asked the court to issue an injunction ordering the Board to refrain from further disciplinary action against him. (St. Ex. 1-OO at pages 1-2)

In March 2006, the Board issued a new Notice (St. Ex. 1AA), in which it added an allegation that Dr. Gelesh's conduct was “in bad faith, and/or outside of the scope of his authority, and/or not in accordance with reasonable medical standards.” The Board dismissed the 2005 notice (which is St. Ex. 1A) in an order issued in April 2006. (St. Ex. 1EE)

In September 2006, the court denied Dr. Gelesh's request for an injunction to stop the Board's hearing from proceeding. The court ruled that, before a court can address the issue of whether immunity is appropriate in this matter, the Board “should in the first instance make all factual findings relative to conduct by Dr. Gelesh, including whether ‘immunity’ is legally available to him.” (St. Ex. 1-OO at 4) Accordingly, the Hearing Examiner has set forth below in the Findings of Fact and Conclusions of Law several findings and conclusions relating to R.C. 2133.11. In addition, the court found that the absence of an allegation of bad faith was not fatal to the Board's administrative complaint: “Ordinarily, an immunity predicated upon a question like ‘good faith’ is

considered an affirmative defense. The burden of asserting and proving an affirmative defense falls upon the party relying upon it, and need not be anticipated in advance by the other side.” (St. Ex. 1-OO at 2-5) The Court of Appeals affirmed in *Gelesh v. State Med. Bd.*, 2007-Ohio-3328 (June 29, 2007) (with one judge dissenting). (Bd. Ex. 4)

On October 16, 2006, the day on which the administrative hearing was scheduled to begin, Dr. Gelesh’s counsel filed a motion to halt the proceedings. An argument was made, among others, that the proceedings pursuant to the 2006 notice were barred by the immunity provided in R.C. 2133.11. (St. Ex. 1RR; Tr. at 9-24) The Hearing Examiner ruled that the hearing would proceed, in order to make “factual findings relative to conduct by Dr. Gelesh, including whether ‘immunity’ is legally available to him,” as the common pleas court had instructed the Board to do when an immunity claim is disputed. Accordingly, in this report and recommendation, the Hearing Examiner has set forth findings of fact and conclusions of law with regard to the immunity defense raised by Dr. Gelesh (in the Findings of Fact and Conclusions of Law, below).

2. Exclusion of Evidence on Issues Not Alleged in the Notice of Opportunity for Hearing⁴⁹

The notice of opportunity for hearing [Notice] is set forth on pages 1-2 of this report. The original notice is also in the record as State’s Exhibit 1A. As discussed above, the factual allegations in the Notice describe two interactions between the physician and the nurse: (1) the nurse’s receipt of a verbal medication order from the physician; and (2) the physical transfer of medication from the nurse to the physician and the physician’s acceptance of the medication, followed by the physician’s personal administration of the medication to the patient.

In short, the factual allegations and legal charges in the Notice, considered together, appear to allege that Dr. Gelesh failed to conform to the minimal standard of care by failing to verify a medication before administering it. Several features of the notice support this characterization. First, the Notice did *not* allege that the Respondent had actually ordered Anectine; rather, the State alleges that the nurse, *hearing* an order for Anectine, brought Anectine to the physician. Second, the Notice specifically alleges that the physician had already admitted that he had *assumed* that the medication handed to him was the medication that he had ordered, a benzodiazepine. Thus, the Notice appeared to be focusing on a failure to verify medication before administering it, due to an unjustified act or omission in assuming what the medication was, without expressly confirming that assumption. The State appeared to be alleging that, regardless of whether the physician misspoke or the nurse misheard, the physician had a duty to verify/confirm the medication before administering it.

After Dr. Gelesh filed an action in common pleas court seeking immunity under R.C. 2133.11, the Board issued a new Notice, in which the factual allegations were unchanged. The only difference was an assertion that R.C. 2133 was inapplicable because Dr. Gelesh’s actions, omissions, and/or

⁴⁹This legal issue was noted in the R&R filed December 31, 2008, but not discussed in detail. Ordinarily, an evidentiary ruling can be described and discussed to some extent without negating the purpose of the objection and ruling. In this situation, however, the ruling involved more than excluding evidence, in that the question presented was whether entire allegations and issues should be removed from consideration because they were beyond the allegations and issues in the Notice. For the Hearing Examiner to present the details of the allegations, issues, evidence, and arguments would have meant that much of the excluded material was then included. However, now that the allegations, issues, and evidence have been admitted on motion to the Board, the Hearing Examiner provides a detailed analysis of the question.

conduct were “not in accordance with reasonable medical standards” and/or “were in bad faith, and/or outside of the scope of his authority.”

However, during its opening statement, the State included the following:

The facts in this case will show that Dr. Gelesh knew exactly what he was doing when he ordered the Anectine, or succinylcholine. * * * Nowhere in Ohio law is a physician granted immunity from the deliberate or intentional act of terminating a patient’s life. * * * The State will provide testimony at this hearing to prove these allegations.

(Tr. at 43-44)

The Hearing Examiner interrupted the proceedings to inquire about these allegations, which the Hearing Examiner had not previously heard: “The State is not going to try to prove, is it, that there was a deliberate act with the intent of causing death, is it? I heard the word ‘deliberate,’ and I was confused.” (Tr. at 44)

The State responded: “We believe that the facts, from what we have determined through the interviews of our witnesses, will show that, indeed, that is what happened.” (Tr. at 44) A discussion followed, during which the State argued among other things that, given the legal claim in the Notice that R.C. Chapter 2133 was not applicable due to a list of factors including bad faith, the Respondent could have inferred and should have inferred that the State was alleging that all the Respondent’s actions and omissions as alleged were done deliberately with the intent to cause the patient’s death.

Later during the first day of hearing, the State sought to prove that the morphine ordered by Dr. Gelesh was excessive, and the Respondent objected on the grounds that the Notice did not allege that the Respondent had acted improperly in ordering an excessive amount of morphine and that the Notice did not even mention the word “morphine.”

The State argued that its Notice had included an assertion that the immunity statute was inapplicable because Dr. Gelesh’s conduct was “in bad faith, and/or outside of the scope of his authority, and/or not in accordance with reasonable medical standards.” The State argued that evidence regarding excessive morphine was relevant to the question of whether Dr. Gelesh had acted in bad faith. Accepting that the evidence had relevance, the Hearing Examiner allowed questioning on the issue of excessive morphine dosing and intentional killing.

However, after the end of the first day of hearing, upon further consideration of the law and having a clearer understanding of the events at issue and the parties’ arguments, the Hearing Examiner reached conclusions regarding notice and due process, including the following:

- (1) Under principles of due process, the State, in a notice of opportunity for hearing in an administrative action, must give the Respondent adequate notice of the factual and legal claims being made against him. See, generally, *Johnson v. State Med. Bd.* (1999), Franklin App. No. 98AP-1324.

(2) In order to satisfy the requirements of due process, the Notice must include a precise statement of the factual and legal issues that will be presented at hearing by the State.

Johnson, supra. The Hearing Examiner believed that the statement of the factual and legal issues must be reasonably clear, plain, specific and direct.

(3) Where the State, in a disciplinary decision and order, resolves factual disputes and relies on material facts that were not alleged in the notice of opportunity for hearing, that reliance constitutes a violation of the requirement of due process of law.

(4) In the present matter, although the State may have been correct that evidence regarding excessive morphine doses and specific intent to kill would be *relevant* to the legal issues under the immunity statute, relevance is not the only criterion that must be addressed when admitting evidence. In this case, the Hearing Examiner concluded that allegations regarding excessive morphine dose and a specific intent to kill the patient could be pursued only if the Notice provided a reasonably clear, plain, specific, and direct statement of these allegations/issues.⁵⁰

(5) In the present matter, the Notice did not include any allegation that Dr. Gelesh's orders regarding morphine for Patient 1 were unwarranted, excessive, or otherwise not in accordance with "reasonable medical standards" under R.C. 2133.11 or not in conformance with "minimal standards of care" under R.C. 4731.22(B)(6). The Notice does not mention morphine in any way and did not give notice to the Respondent that the State would pursue an allegation, issue, or theory relating to morphine doses.

(6) An allegation that a physician has engaged in deliberate actions with the specific intent to kill his patient is an extremely serious and extraordinary allegation, and a physician accused of such conduct should not have to infer the accusation from a general recitation of

⁵⁰ R.C. 119.07 and Ohio Admin. Code § 4731-13-11 state that a notice of opportunity for hearing must set forth the charges and other items, but they do not provide further elaboration regarding requirements for the charges.

In *Johnson v. State Med. Bd.* (1999), Franklin App. No. 98AP-1324, the Court of Appeals stated that it had not established a "bright line test" for assessing the sufficiency of the administrative notice of "the nature of the charges" that will be pursued at the hearing. However, the Court observed that due process requires that the Board must provide "fair notice of the precise nature" of the charges that will be raised at the hearing.

The Court observed that the notice was found to be sufficient in a case where the Board had outlined "the instances of improper practices and treatment" and had listed the prescriptions that were improper, and had also separately summarized the physician's "improper practices" for each of the patients listed in the notice. In the present matter, the Hearing Examiner concluded that the alleged improper prescribing/ordering of morphine was the type of "improper practice" or "improper treatment" that must be specifically alleged.

The question of whether the intentional killing of the dying patient ("mercy killing" or euthanasia) was sufficiently alleged in the Notice was a less clear-cut issue: the Notice alleged a death and also alleged bad faith, so one could argue that a respondent could have inferred that the Board would attempt to prove at hearing that there was an intentional killing, which is murder. The Hearing Examiner ultimately concluded, however, that an allegation of murder is so extraordinary in an administrative action under R.C. 4731.22(B) that the Notice must plainly allege an intentional killing in order to pursue that issue at the disciplinary hearing, and further concluded that there was language in the Notice that did not appear consistent with inferring an allegation of murder.

conditions under which an immunity statute is inapplicable. The Hearing Examiner was of the opinion that, if the State intends to prove at hearing that a physician deliberately and knowingly ordered a drug that causes immediate death *and* that he deliberately and knowingly administered that drug to a patient with the specific intent to kill the patient,⁵¹ then the Notice must include an allegation to that effect, and it must be reasonably clear, plain, specific and direct.

(7) In the Hearing Examiner's opinion, the Notice did not include any allegation of improper prescribing of morphine or improper treatment with regard to morphine. In addition, the Notice did not include a clear, plain, specific and direct allegation of purposefully causing the death of the patient. These were significant, material allegations and not merely subsidiary, included issues underlying the allegations in the Notice.

(8) In the Notice, there is a statement that the immunity statute did not apply because the physician's conduct was "in bad faith, and/or outside of the scope of his authority, and/or not in accordance with reasonable medical standards." The Hearing Examiner concluded that this statement was not sufficient to put the Respondent on notice that the State would seek to establish that the morphine doses he ordered were excessive and that he had committed acts constituting aggravated murder, that is, that he purposely killed a patient with prior calculation and design.

(9) The fact that the Respondent may have been able to deduce, upon receiving the supplemental report from the State's expert witness, Dr. Fraser, that the State was now going to pursue additional allegations regarding morphine dosage, did not change the Hearing Examiner's conclusions regarding the Notice. The Hearing Examiner concluded that, to have orderly process and due process of law, the charging document should contain the allegations and issues to be pursued at hearing by the State, rather than requiring respondents to deduce, from the topics discussed in experts' reports, the allegations to be defended at the hearing. Further, it is well established that a notice of opportunity for hearing can be amended to add another allegation regarding improper prescribing and/or treatment, as necessary to conform to the evidence.

Having concluded that the allegations/issues regarding morphine and intent to kill were not sufficiently alleged in the Notice, the Hearing Examiner then ordered, at the beginning of the second day of hearing, that evidence regarding these two allegations/issues must be excluded from the first day's transcript. During the remainder of the sixteen-day hearing, the Hearing Examiner excluded these issues, but maintained proffers and arguments for review. (*E.g.*, Tr. at 135-137; 192-210, 223, 229-237, 251-253, 293, 298, 304, 341-342, 719, 856-861)

After the Hearing Examiner filed the Amended Report & Recommendation on December 31, 2008, the State filed a motion in January 2009 entitled "Motion to Place Proffered Evidence and Argument Before the Board." (St. Ex. 1-VVV) On February 11, 2009, the Board granted the motion and remanded the matter for further hearing and report. (St. Ex. 1-WWW)

⁵¹ Under R.C. 2903.01(A), "aggravated murder" is described as follows: "No person shall *purposefully, and with prior calculation and design*, cause the death of another * * * ." Under R.C. 2903.02(A), the crime of "murder" is described: "No person shall *purposefully cause the death* of another or the unlawful termination of another's pregnancy." (Emphasis added)

On remand, the Hearing Examiner has considered all the evidence and arguments, including the evidence admitted pursuant to the Board's remand order. Findings have been made on the issues of excessive morphine and intent to kill, and are set forth in the Findings of Fact and Conclusions of Law.

DETERMINATIONS REGARDING CREDIBILITY, PERSUASIVENESS, AND WEIGHT OF EVIDENCE

The issue before the Board is whether Dr. Gelesh's care and treatment of Patient 1 departed from, or failed to conform to, minimal standards of care of similar practitioners under the same or similar circumstances ("minimal standards of care"). Thus, the focus must remain on the acts, omissions and conduct of Dr. Gelesh under the circumstances presented to him.

Credibility Assessments Underlying the Findings of Fact - Overview

With respect to the factual allegations in the Notice regarding the treatment given to Patient 1, credibility assessments were particularly important where allegations were disputed and witnesses gave varying views of the events. However, some allegations were not disputed. The following discussion sets forth which allegations were disputed, and gives an overview for purposes of the subsequent discussion regarding specific issues of credibility.

Allegation in the Notice: "*On or about February 8, 2002, you requested that the nurse assisting you with the care of Patient 1 obtain medication for Patient 1.*"

This allegation was not disputed, and the Hearing Examiner accepts it as true, as set forth in the Findings of Fact below.

Allegation in the Notice: "*Hearing that you ordered Anectine (succinylcholine), the nurse returned to Patient 1's room with Anectine*"

This allegation was disputed. It is noteworthy that the Notice does not explicitly allege that Dr. Gelesh *ordered* "Anectine" or that he ever *said* "Anectine." Rather, the Notice alleges merely that the nurse *heard* "Anectine" and brought it to the patient's room. Thus, the Notice does not focus on what the physician actually ordered. Instead, the Notice places the emphasis on what happened when the nurse returned to the room with the medication and whether there was a verification of the medication by the physician, before he administered it personally. In other words, the Notice alleges a violation of minimal standards that does not depend on, or require a finding with respect to, what medication was actually ordered by Dr. Gelesh.

As set forth more fully below, in the discussion of the witnesses' credibility, the Hearing Examiner is convinced that the following fact was established by the evidence: the nurse, hearing an order for Anectine, returned to Patient 1's room with Anectine, which is succinylcholine.

Allegation in the Notice: “The nurse returned . . . with Anectine and asked you if that was the medication you wanted.”

The underlined allegation was disputed. For the reasons set forth below in the discussion of witnesses’ credibility, the Hearing Examiner found that the credible evidence does not support a finding that the nurse asked Dr. Gelesh if Anectine was the medication he wanted. The Hearing Examiner believes that the nurse attempted, ineffectively, to ask Dr. Gelesh about the medication but that she did *not* actually communicate to him a question as to whether he had ordered Anectine. The Hearing Examiner believes that Dr. Gelesh reasonably did not realize the nurse was addressing him and, in addition, that he did not hear or understand any question relating to the medication he had ordered, which was also reasonable under the circumstances, as discussed more fully below.

Allegation in the Notice: “*The nurse handed you the container of medication, and you administered the medication to the patient. Patient 1 died a short time thereafter of respiratory arrest due to the administration of succinylcholine.*”

Dr. Gelesh did not dispute that Ms. Orndorf handed him a medication in Patient 1’s room at about 1:20 a.m., and that he personally administered that medication to Patient 1 by injecting it into the IV port, and that the patient died shortly thereafter. Dr. Gelesh disputed, however, that the medication was succinylcholine. He further asserted that, if it was succinylcholine, he had no knowledge of it.

The Hearing Examiner finds that the medication administered to the patient was in fact succinylcholine, and further finds that the above-quoted allegation in the Notice was proven by the evidence. The evidence supporting these findings includes the following:

- Ms. Orndorf handed Dr. Gelesh a medication in some type of container (either a filled syringe *or* a vial with an empty syringe). This is not disputed.
- Ms. Orndorf testified that the medication she had obtained from the medication dispenser and brought to the patient’s room for Patient 1 was succinylcholine. Her testimony on this point was credible and was also supported by the dispensing records.
- The evidence established that, at about 1:20 a.m., Dr. Gelesh administered to Patient 1 the medication that he had received from Ms. Orndorf.
- It is undisputed that that patient died within a short time after Dr. Gelesh administered the medication.
- It is undisputed that succinylcholine causes death within a few minutes (if there is no respiration support).
- The final death certificate established that the cause of death was an administration of succinylcholine.

However, the Hearing Examiner is convinced that Dr. Gelesh intended to order a benzodiazepine and believed he had ordered a benzodiazepine, and was, therefore, not aware that the container he received from Ms. Orndorf contained succinylcholine, as set forth more fully below in the discussion of witnesses’ credibility. (The question of whether he ought to have been aware of the contents of the container, by affirmatively taking steps

to confirm its contents, is a separate question. The present discussion focuses on a factual determination as to what actually happened, as opposed to what should have been done.)

Allegation in the Notice: “In deposition, you testified that when the nurse returned to Patient 1’s room with the medication, you heard the nurse say something, but you did not hear what she said. You further testified that you assumed the medication handed to you was what you had ordered, a benzodiazepine, although you could not recall whether you had ordered Ativan or Versed.”

It is true that Dr. Gelesh gave such testimony during his prehearing deposition. However, the focus at hearing was not on whether Dr. Gelesh had made these statement during a deposition testimony but whether he continued to maintain these views and whether his testimony was credible. Regarding the allegations listed above, the Hearing Examiner notes that:

- It is undisputed that Dr. Gelesh did not seek to confirm that the medication handed to him was a benzodiazepine. He acknowledged this.
- Dr. Gelesh further acknowledged that his belief that the medication brought to him for Patient 1 was a benzodiazepine was based solely on what he had ordered. Therefore, Dr. Gelesh admitted at hearing that he had made an assumption that the medication handed to him was a benzodiazepine, on the basis of what he had ordered. He further acknowledged that he could not remember which benzodiazepine he had ordered.

The question of whether it was within the minimal standard of care for Dr. Gelesh to make this assumption, and to act upon it, is a question of the minimal standard of care, to be determined based on medical expertise.⁵²

Witnesses’ Testimony – Specific Credibility Assessments

1. *The order given by Dr. Gelesh: did he order Anectine?*

The Notice alleges only that the nurse *heard* an order for Anectine, not that such an order was given by Dr. Gelesh.⁵³ Initially, the Hearing Examiner believed that the allegation that the nurse had heard “Anectine” was tantamount to an allegation that Dr. Gelesh had ordered Anectine. However, on further consideration, the Hearing Examiner concluded that, if the Board had wanted to allege that Dr. Gelesh actually ordered Anectine, it could easily have done so. The Board could simply have alleged: “You ordered Anectine for Patient 1.” The absence of a clear and unequivocal allegation regarding the actual order is significant: the Hearing Examiner concludes that, as there is no allegation in the Notice regarding what order was actually given, the Hearing Examiner need not make a finding on that factual issue.

⁵²The discussion regarding the minimal standard of care is set forth below at page 67. The Hearing Examiner adopted the opinion of the Board’s expert witness, but the Board may choose to rely on another expert and/or may also draw on its own medical expertise in determining the minimal standard of care.

⁵³This part of the Notice also supports a conclusion that the Notice did not provide fair notice of a charge that the Respondent purposefully caused the patient’s death with deliberate calculation: if the Notice was meant to inform the Respondent of that theory, that the Respondent had committed a serious crime, then the Notice would more likely have alleged unequivocally that the Respondent did in fact order Anectine.

Further, as stated previously, the Hearing Examiner concludes that it is not necessary to decide whether Dr. Gelesh misspoke when giving the order or the nurse misheard when receiving the order. The factual allegations in the Notice focus on whether Dr. Gelesh failed to confirm the medication before administering it. Also, the minimal standard of care propounded by the State's expert witness, and accepted by the Hearing Examiner, focuses primarily on a failure to confirm the medication,⁵⁴ which means that the standard can be applied regardless of whether the physician misspoke or the nurse misheard.

2. *What happened when the nurse returned to the patient's room with the medication? (What did the nurse and Dr. Gelesh say and do?)*
 - a. Overall credibility and persuasiveness of Ms. Orndorf's testimony.

The Hearing Examiner separately analyzed two different phases of the incident: first, the events surrounding the order and retrieval of the medication, and, second, the events surrounding the nurse's return to the room with the medication. The Hearing Examiner found as follows:

- Ms. Orndorf's testimony regarding the first transaction was credible for the most part, but
- Ms. Orndorf was generally not a reliable witness with regard to the events that occurred when she returned to the room with the medication, as discussed below in detail.

With regard to the receipt of the order, the Hearing Examiner believes that Ms. Orndorf heard or believed that she heard an order for Anectine and that she did not know that Anectine was succinylcholine until she looked it up in the medication room. Her asserted lack of knowledge regarding Anectine is corroborated by her lack of reaction to the order when she received it from Dr. Gelesh, in contrast to her strong reaction after she went to the medication room. She did not go directly to consult her colleagues when she received the order but only after she been to the medication room. In addition, Ms. Orndorf's tone and demeanor, when she conceded during the hearing that she had not known the brand name of succinylcholine, reflected believable chagrin and embarrassment at not having known the brand name. While it may not be typical for an experienced ED nurse to be unaware of the brand name of a drug used in the ED, the Hearing Examiner believes that this particular nurse had not known it. Further, a person unfamiliar with the word Anectine would be unlikely to substitute that word for Ativan, a very common medication, or for Versed. Further, the nurse had little motive to misrepresent this event, as her conduct in receiving an order for medication and looking it up were not particularly controversial, especially when contrasted with her conduct when she returned to the patient's room.

⁵⁴ Dr. Fraser testified that an ED physician who administers a medication personally must confirm what the medication is, regardless of what he believes he previously ordered. He also opined that, if Dr. Gelesh mistakenly ordered Anectine, his act of misspeaking, in and of itself, was not a violation of the standard of care, and that it was Dr. Gelesh's implementation and his failure to confirm the medication, that constituted the violation. The Hearing Examiner accepted this opinion regarding the minimal standard of care.

Moreover, the evidence as a whole suggests that Ms. Orndorf was very sure that she had heard “Anectine” but was very unsure about what this meant and what she should do about it. With regard to the verbal order and her retrieval of the medication, Ms. Orndorf’s testimony was firm and clear. Indeed, her colleague, Sue Zgodzinski, commented on how emphatic Ms. Orndorf had been when telling them what Dr. Gelesh had ordered. Indeed, the Hearing Examiner believes that Ms. Orndorf’s certainty of hearing “Anectine” was reflected in her behavior: her strong conviction that she had heard “Anectine” lessened her incentive to go back and ask Dr. Gelesh what he had said, and it served to heighten her uneasiness about what she should do. If she had really thought that there was a fair chance she may have misheard, she would have returned to Dr. Gelesh immediately for a routine clarification. Instead, she went to her colleagues, and the Hearing Examiner believes that the reason for this was that Ms. Orndorf was sure that she had heard an order for “Anectine,” and was surprised and concerned to discover that Anectine was succinylcholine.

When Ms. Orndorf testified repeatedly that she “couldn’t believe it” and thought she must have misheard the order, the Hearing Examiner understood her to be expressing surprise, shock, and dismay—rather than actual disbelief in what she had heard.⁵⁵ In the Hearing Examiner’s assessment, Ms. Orndorf’s comments about shock and disbelief were expressions of amazement at the unusual nature of the order rather than real doubt regarding her hearing, because her *conduct* reflected strong conviction that she had heard “Anectine.” The Hearing Examiner believes that Ms. Orndorf was very surprised and troubled at learning what Anectine was, and also believes that the unprecedented nature of the order affected Ms. Orndorf’s ability to approach Dr. Gelesh directly and clearly.

However, the Hearing Examiner also believes that, at hearing, Ms. Orndorf emphasized her shock in an attempt to explain and excuse why she had not behaved more prudently and carefully when returning to the patient’s room. Ms. Orndorf’s testimony, including her tone of voice and demeanor, suggested that she was concerned that her conduct had, at the very least, violated the hospital’s nursing rules, and that she was trying to make her conduct look as favorable as possible.

Memory. In addition, when assessing Ms. Orndorf’s statements about what she did and did not remember about retrieving the Anectine and giving it to Dr. Gelesh, the Hearing Examiner concluded that Ms. Orndorf should have had a very clear recollection of the crucial events because she had been experiencing heightened interest and concern at that time. She testified that she was already concerned when the second bag of morphine was ordered, and thus her focus on this patient’s care was increased. Further, she had exhibited—by going to consult her colleagues—a belief that something unusual or untoward might be happening. Further, two nursing supervisors talked with her immediately after the patient’s death. Thus, Ms. Orndorf would have had a strong motive to make sure she noted, documented, and remembered precisely what happened.

⁵⁵ For example, it is commonplace to hear a person say, after the death of a loved one, “I just can’t believe it,” which expresses surprise, dismay, and/or being unable to cope yet with the event, rather than genuine disbelief that the event has occurred. Similarly, expressions of disbelief regarding, for example, destruction of homes by a flood do not convey real uncertainty that the destruction has occurred, but are emotional responses of amazement regarding extraordinary events.

Nonetheless, her testimony was uncertain on several points; she did not describe her delivery of the succinylcholine in the same straightforward, definite, assured manner in which she had described the ordering and retrieval of the medication. For example, Ms. Orndorf could not recall whether or not she had had Dr. Gelesh's attention (eye contact) when she asked him about the medication, which was not credible. It is difficult to comprehend, given the concern she had about the medication, that she did not carefully observe Dr. Gelesh's response to her alleged inquiry. Further, when asked about the hospital's nursing policy about challenging physicians' orders, she gave an equivocal answer that was partly incorrect. It was not likely that she lacked familiarity with the content of that policy.

Further, Ms. Orndorf was very sure at the hearing that the vial of Anectine that she received from the automated dispenser was a 100-milligram vial, but the records from the Sure-Med machine and the pharmacy both state that a 200-milligram vial was dispensed to Ms. Orndorf that night. (This inaccuracy does not mean that she was lying, and the size of the vial was hardly a major point, but it indicates that this witness showed certainty about a matter as to which her testimony was completely contradicted by other more reliable evidence—and, accordingly, her testimony as a whole is therefore less credible.)

Inconsistencies. The finding that Ms. Orndorf's testimony is especially unreliable regarding what happened upon her return to the patient's room is also based on inconsistencies between her statements and her conduct. For example, if she felt that the ordering of Anectine was so unbelievable and inappropriate, it is difficult to understand why she did not engage in stronger efforts to make sure that Dr. Gelesh fully understood her concerns. Unlike other circumstances in the ED when every minute counts, there was no need for hurry in these circumstances. A delay of a few minutes to consult carefully with Dr. Gelesh—or at least to repeat her question when he did not answer her—would not have posed a problem. Another example of conduct that is difficult to reconcile is that the nurse stood by and watched from the end of the bed while the medication was (allegedly) drawn into a syringe by Dr. Gelesh and administered to the patient, while she did nothing. Earlier during that night, Ms. Zgodzinski had not hesitated to challenge an order by Dr. Gelesh for Patient 1, and other evidence indicated Dr. Gelesh was reasonable and well-liked, so it does not make sense that Ms. Orndorf would not approach Dr. Gelesh directly, clearly, and definitely regarding an order that she knew was incorrect.

Charting the Anectine order. In further support of the finding that Ms. Orndorf's testimony regarding the second "transaction" was not reliable, the Hearing Examiner notes that Dr. Mitstifer testified credibly that, after Dr. Gelesh had left the hospital, Ms. Orndorf had consulted with him about how she should chart the administration of the succinylcholine. In contrast, Ms. Orndorf testified that she had charted the succinylcholine at the time it happened, before Dr. Gelesh signed the chart and left, and she denied having asked about charting. Furthermore, the Hearing Examiner believed Dr. Gelesh when he said he had been "flabbergasted" to learn, weeks later, that succinylcholine had been administered according to the chart.

Moreover, Ms. Orndorf's charting of the Anectine administration was not adequate according to reliable experts. Ms. Orndorf charted only that succinylcholine 60 mg had been administered by Dr. Gelesh at 1:20 a.m. However, she made no notation regarding the absence of an order for intubation or that she had questioned the physician about the order and that he had confirmed it. These charting omissions reduce the credibility of Ms. Orndorf's testimony.

Conversation with medical examiner's office. In addition, according to the medical examiner's investigator, Ms. Orndorf provided information to him, shortly after Patient 1's death, that led him to believe that Patient 1 had died of natural causes. She did not mention to the medical examiner that Patient 1 had received a dose of succinylcholine without respiratory support.

Testimony regarding incident report; compliance with hospital policy. In addition, Ms. Orndorf did not complete an incident report regarding the incident as instructed by Ms. Stauffer, the nursing coordinator that evening. Even if Ms. Stauffer was not truthful when she testified that she had instructed Ms. Orndorf to complete an incident report, Ms. Orndorf would have known that an event this serious required an incident report. Further, Ms. Orndorf's testimony on one point during the hearing was especially unreliable: she asserted that she had followed the hospital's policies and procedures for challenging a physician's orders, but a review of those policies and procedures indicates that she had obviously *not* followed all the required procedures, based on her own description of her actions that night.

Complete contradiction of statement given to Board investigator. A significant area of inconsistency is that, before the hearing, Ms. Orndorf stated unequivocally to a Board investigator that Dr. Gelesh had answered "yes" to her question about the medication when she returned to the room. She said this twice in her written statement. (Resp. Ex. KK) At hearing, however, she stated repeatedly that Dr. Gelesh had *not* answered her question. Thus, she gave wholly inconsistent statements on a crucial fact.

- b. Overall credibility of Dr. Gelesh's testimony. The Hearing Examiner recognizes that serious allegations have been made against Dr. Gelesh, and he would have a strong motive to misrepresent events. However, the Hearing Examiner did not conclude that Dr. Gelesh knowingly gave false testimony during the hearing.

Some of the facts in favor of his credibility are as follows. Dr. Gelesh served successfully as an attending physician and instructor of emergency medicine for many years. He was respected and well-liked by residents, who repeatedly voted him to be a superior teacher. Ms. Zgodzinski confirmed that Dr. Gelesh had readily changed an order that same night for Patient 1 when she suggested it. Ms. Warner, the lead nurse in the ED that night, testified that she had worked with Dr. Gelesh for twenty-five years, and she had always thought of him as a good attending and a fine physician. She further testified that, in all those years, she had never had a problem with Dr. Gelesh's orders. Ms. Stauffer testified that she had worked with Dr. Gelesh for several years, and found him to be a competent physician; she had never known him to order an inappropriate

medication. This evidence persuaded the Hearing Examiner that Dr. Gelesh, when challenged by a nurse, would be receptive and reasonable, and that he generally demonstrated commendable professional skills and behavior.

Further, the Hearing Examiner considered the likelihood that a well-respected physician in a teaching hospital would deliberately order Anectine with the plan of personally injecting it into the patient to kill her, or asking a nurse to administer it, under circumstances including the following: (a) that the physician had every reason to know that the pharmacy or the automated medication-dispensing system would record his order for Anectine; (b) that the physician had every reason to expect that nurses would challenge such an order and refuse to participate in retrieving it and/or administering the medication without intubation; and (c) that there was no evidence of a reason for the physician to take such a massive risk for a patient he had not met until she arrived in the ED a few hours before.

Based on viewing Dr. Gelesh's demeanor at the hearing, and considering the consistency of his statements with other evidence, the Hearing Examiner concludes that Dr. Gelesh's testimony was reliable on numerous critical facts, including the following: that he had intended to order a benzodiazepine, that he thought he had done so, and that he thought he was injecting a benzodiazepine when he administered the medication into the IV port.

However, although the Hearing Examiner found Dr. Gelesh to be a sincere witness who testified in good faith, the Hearing Examiner did not accept his hearing testimony 100% on all issues. When Dr. Gelesh was adamant about certain details regarding what occurred during Patient 1's treatment, the Hearing Examiner had strong doubts as to how much detail he truly remembered about the events, for the following reasons.

Dr. Gelesh was not informed that there was a problem with his treatment of Patient 1 until about six weeks after the treatment had occurred, and, due to the passage of time and the intervening treatment of many patients, the Hearing Examiner believes that Dr. Gelesh did not have a strong, accurate, specific recall of all of the events on February 7-8, 2002, with regard to Patient 1's care.

The Hearing Examiner believes that, when Dr. Gelesh was first notified by Dr. Schelble of the investigation into Patient 1's care, Dr. Gelesh did not specifically recall the details of the patient's treatment. The Hearing Examiner believed this before considering Dr. Schelble's interview record and still believes it. It is logical to conclude that workers who have been doing the same kind of work for 20 years are unlikely to remember the specific details of a particular night's shift unless something very unusual happened during that shift to make it especially memorable, and, here, Dr. Gelesh (prior to learning of the investigation) had no reason to view that shift as unusual or especially memorable. An emergency department, by its nature, is a setting where medical crises and catastrophic situations abound.

However, the Hearing Examiner accepts that Dr. Gelesh was able to refresh his recollection to some extent by reviewing and discussing the patient's chart many times

during the course of weeks that followed the time he first learned of the inquiry into Patient 1's treatment. The Hearing Examiner believes that Dr. Gelesh—after scrutinizing the patient's records and discussing the events, over and over—eventually formed a strong view regarding that night's events, which he sincerely held but which was probably *not* reliable in all respects. The Hearing Examiner is convinced that, during the four years between the events in 2002 and the hearing in 2006, Dr. Gelesh's strong beliefs of what *must have* happened that night developed into a firm conviction of what *had actually* happened. Therefore, the Hearing Examiner is persuaded that, when Dr. Gelesh testified about his recollection of certain details, his testimony appeared sincere although he may actually have had little genuine recollection of those details. That is, his testimony may not have been accurate about certain events, but he was not trying to mislead the Board.

In addition, the Hearing Examiner noted that Dr. Gelesh's testimony at the 2006 hearing was not 100% consistent with his testimony at a 2004 deposition. For example, the opinion he expressed on the standard of care changed to some extent. For example, in his deposition testimony, Dr. Gelesh made very candid statements regarding the dual responsibility for administering the correct medication, but, at the hearing, he was emphatic that the responsibility for verification rested solely upon the nurse.

Further, one of Dr. Gelesh's statements about his reason for administering a benzodiazepine did not ring true to the Hearing Examiner—that a benzodiazepine was a good choice of medication because it not only causes relaxation but also has an amnestic effect, in that patients will forget traumatic/painful events. The Hearing Examiner did not see why it would benefit a terminal patient to forget traumatic/painful events.

Nonetheless, considering all the evidence, the Hearing Examiner generally found Dr. Gelesh to be a sincere and credible witness.

- c. Did the nurse ask Dr. Gelesh, before handing him the medication, whether he really wanted Anectine? As stated above in the overview, the Hearing Examiner found that Ms. Orndorf did *not* actually communicate a question to Dr. Gelesh as to whether Anectine was what he had really ordered.

First and foremost, it is important to note that, at the hearing, both Dr. Gelesh and Ms. Orndorf agreed that he had *not* responded to her when she spoke, which corroborates his testimony that he had not understood her to be addressing him.⁵⁶ Ms. Orndorf's admission that Dr. Gelesh did not answer her question is persuasive evidence that he had not heard or understood her.

In addition, Ms. Orndorf's detour to consult her colleagues first is significant. It demonstrates that she did not view the interaction with the physician as a routine verification of medication that she could approach confidently and directly with the physician; she

⁵⁶ Ms. Orndorf's testimony on this point at hearing, under oath, was completely opposite to what she had told the Board during its investigation. The Hearing Examiner believes that the truth came out during the hearing.

obviously had doubts and uneasiness. The Hearing Examiner believed Dr. Gelesh's testimony that he was not facing the entrance when Ms. Orndorf entered the room, and further believes that she spoke quickly, to get it over with, and, in addition, in her uneasiness, she spoke tentatively rather than directly and clearly. Therefore, Dr. Gelesh was unaware that she was addressing him and did not understand what she said.

In addition, another persuasive item of evidence was that Ms. Orndorf acknowledged that, when Dr. Gelesh did not answer her, she had not repeated her question but had simply held out her hand with the medication in it. This corroborates that she wanted to complete the transaction as quickly as possible and did not take care to make sure that Dr. Gelesh understood her.

Moreover, as stated above in detail, Ms. Orndorf's testimony overall was not credible with regard to what happened when she returned to the patient's room with the medication. Her statement that Dr. Gelesh had answered "yes" when asked if he really wanted Anectine was a linchpin in the case against Dr. Gelesh, but Ms. Orndorf completely repudiated that statement during the hearing, several times. In contrast, Dr. Gelesh was credible when he testified that the nurse may have said something as she entered the room, but his back was turned, and that, when he turned around toward her, she had simply handed him the medication, and he had not known that she was talking to him or understood what she said.

The Hearing Examiner concludes that Ms. Orndorf made an effort to communicate a question to Dr. Gelesh but she did not express her concerns to him in a manner that he could reasonably hear and understand. In sum, the reliable evidence is *not* sufficient to prove the allegation in the Notice that the nurse confirmed with Dr. Gelesh that Anectine was the medication he wanted.

- d. Did the nurse hand Dr. Gelesh a filled syringe, or a vial of medication and an empty syringe?

The Notice alleges *only* that the nurse handed Dr. Gelesh a "container" of medication. Due to the wording of the allegation, and due to the minimal standard of care presented by the Board's expert and accepted by the Hearing Examiner,⁵⁷ the Hearing Examiner concludes that it is not necessary to make a finding of fact on the issue of whether Ms. Orndorf handed Dr. Gelesh a filled syringe or an empty syringe with a vial of medication.

However, to the extent that the Board may find a discussion of the evidence useful in gaining an overall picture of the transaction, the Hearing Examiner provides the following discussion. For the following reasons, the Hearing Examiner believes that the reliable evidence does not establish by a preponderance of the evidence that Ms. Orndorf handed Dr. Gelesh a vial of medication with an empty syringe, which he then filled. First, for the reasons discussed above, the Hearing Examiner found that Ms. Orndorf's testimony

⁵⁷ As discussed below, the State's expert opined, and the Hearing Examiner accepted, that a physician in these circumstances who administers a medication personally must confirm what the medication is, regardless of whether the medication is handed to him in a filled syringe or whether the medication is provided to the physician in a vial with an empty syringe for the physician to fill.

regarding events when she returned to the patient's room was not credible. Further, the Hearing Examiner reviewed other testimony regarding what Ms. Orndorf had handed to Dr. Gelesh. Chaplain Gibson agreed that he may have reported to police (soon after the incident, when his recollection was likely to be much better) that he did *not* see a vial and that the nurse had handed Dr. Gelesh only a syringe. Ms. Warner did not notice a syringe, and she did not see what Ms. Orndorf did after their talk. Ms. Zgodzinski and Ms. Warner recalled seeing a vial but did not testify whether it was full or empty. Further, Dr. Gelesh testified that, if a nurse had handed him an empty syringe with a vial, essentially saying "Fill it yourself, Doctor," he would definitely have remembered that as something unusual, and his testimony on that point rang true.

Overall, the Hearing Examiner found the weight of the reliable evidence to be evenly balanced as to what type of container Ms. Orndorf handed to Dr. Gelesh. When the weight of the evidence is even, then the party having the burden of proof cannot prevail. Here, the State had the burden of proof to establish its factual allegations, and it did not prove by a preponderance of the evidence that Dr. Gelesh was given a vial of medication and an empty syringe.

DETERMINATION REGARDING STANDARD OF CARE

With regard to the minimal standard of care that applies to the verification of a medication before administering it personally, the Hearing Examiner found reliable and persuasive the testimony of Dr. Fraser, who testified on behalf of the State. In addition, the Hearing Examiner found Dr. Gelesh's testimony during his deposition to be persuasive.

First, the Hearing Examiner found persuasive Dr. Fraser's opinion that a physician has a duty to confirm a medication before he personally administers it, whether it is given to him in a filled syringe or whether he is given a vial of medication and an empty syringe. Dr. Gelesh stated during his deposition that both the nurse and the physician share a duty to confirm the medication when a nurse hands medication to a physician to administer it, that it is a "dual" duty. (Resp. Ex. MMM at 43) The Hearing Examiner did not adopt the testimony of Dr. Galan on this standard.

Based on the testimony of Dr. Fraser, the Hearing Examiner concluded that, under the standard of care applicable in February 2002, when a nurse hands medication to a physician to administer it, the physician must verify the medication before administering it if the nurse has not already verified it when handing the medication to him. The verification can be as simple as a few words during the transfer, such as "two milligrams of Ativan" or "What's in here?"

With regard to the standard of care for physicians in 2002, the Hearing Examiner accepts the testimony of Dr. Gelesh and others that, ordinarily, when a physician gave a medication order to a nurse who was going to implement the order, the nurse could perform the order without any further supervision or confirmation by the physician. A physician was not obliged to undertake affirmative steps to make sure that his or her order was being properly carried out. However, in this case, the key difference was that Dr. Gelesh administered the medication himself and did not delegate the task to a nurse (or, to be more precise, he allowed the nurse to return the task to him for performance).

Last, the Hearing Examiner notes that the members of the Board are not required to accept the medical opinions offered by expert witnesses during the hearing, even those of the Board's own expert, Dr. Fraser. The Board may draw on its collective medical expertise and experience, and make its own decision as to the minimal standard of care to be applied, as long as it states its reasons for doing so.

FINDINGS OF FACT

1. In the routine course of his practice, Gary Charles Gelesh, D.O., undertook the treatment of Patient 1 on February 7, 2002. Patient 1 is identified in a confidential patient key, placed under seal in the record. Patient 1, who was 88 years old, was transported from her nursing home by ambulance to the emergency department ("ED") of Akron General Medical Center, where Dr. Gelesh was providing services as an emergency-medicine physician. Patient 1 had executed a DNR/CC ("do not resuscitate/comfort care only") directive, and she was in a terminal condition during the relevant periods of time. Patient 1's daughter-in-law testified credibly that Patient 1 had been living in the nursing section of her nursing home because she had not yet returned to the assisted-living section after a hospitalization.
2. On February 8, 2002, Dr. Gelesh asked the nurse assisting him with the care of Patient 1 to obtain a medication for Patient 1.
3. The nurse, hearing Dr. Gelesh order Anectine or believing that she heard an order for Anectine, which is succinylcholine, returned to Patient 1's room with a container of Anectine.
4. The reliable evidence does not establish that, when the nurse returned to Patient 1's room with Anectine, she confirmed Dr. Gelesh's order by asking him whether he wanted Anectine. The reliable evidence establishes that, while the nurse attempted to communicate a question to Dr. Gelesh about the medication, she did *not* effectively communicate a question to him as to whether he had ordered Anectine. Dr. Gelesh was not aware of any question by the nurse regarding the medication she handed to him.
5. The nurse handed the container of medication to Dr. Gelesh, and Dr. Gelesh administered an unknown amount of succinylcholine to the Patient 1. Shortly thereafter, Patient 1 died. According to the death certificate, the cause of death was succinylcholine.
6. Dr. Gelesh intended to order a benzodiazepine, and he thought he had ordered one. When the nurse entered the room and handed him the medication, he assumed that it was a benzodiazepine. He did not affirmatively verify that the medication was a benzodiazepine before he administered it.
7. Dr. Gelesh did not intentionally order succinylcholine for Patient 1. The administration of succinylcholine to Patient 1 was accidental, inadvertent, and unintended; Dr. Gelesh did not administer it for the purpose of causing the immediate death of Patient 1. The reasons for these findings include the following:

- Dr. Gelesh's testimony was credible with regard to what he had intended to order and what he believed he had actually ordered, a benzodiazepine.
- Dr. Gelesh, having practiced medicine for many years at Akron General, had reason to know that the medication-dispensing system would record the medications retrieved pursuant to his orders and that an order of succinylcholine for Patient 1 would be recorded and easily traced to him. It was obvious that he had not ordered intubation, the only reason to order succinylcholine for Patient 1 in the ED.
- The evidence is clear that the medication order was given openly to the nurse in the presence of at least one witness. (The chaplain was there, but it is uncertain whether the daughter-in-law was there at the time of the medication order.) Dr. Gelesh could not possibly have expected that his order would be unknown or hidden in some way.
- There is no evidence to support a finding that Dr. Gelesh could reasonably expect that a nurse at Akron General would administer succinylcholine under the circumstances, or would allow him to administer it unchallenged. There is no evidence to support a finding that Dr. Gelesh could reasonably expect that the nurse would remain silent about an order for succinylcholine or the administration of succinylcholine when the patient was not being intubated.
- For a respected ED physician in a busy, urban, teaching hospital to order succinylcholine under these circumstances for a patient not being intubated, with the plan and intent to cause the patient's immediate death, the physician would have to be mentally unbalanced, ferociously arrogant, and/or extraordinarily stupid. The record includes no evidence that Dr. Gelesh has or had any of these traits. Dr. Gelesh did not exhibit such traits at the hearing.

To the contrary, the evidence established that Dr. Gelesh is viewed by his colleagues as an excellent physician who has received awards for the high quality of his teaching and has been praised by experienced nurses for his care of patients and his demeanor in the ED. There was no reason for him to risk more than 20 years of respected service as a physician by committing a mercy-killing publicly in a large, busy hospital, for a patient he had met only a few hours before. The Hearing Examiner noted nothing to suggest that Dr. Gelesh would commit a serious felony and risk his whole career for a patient he knew only briefly in the ED.

8. Dr. Gelesh ordered morphine for Patient 1 for the purpose of diminishing her pain or discomfort and not for the purpose of causing her death, even though the medication may have appeared to hasten or increased the risk of her death. The amount of morphine ordered by Dr. Gelesh was not excessive under the circumstances.

CONCLUSIONS OF LAW

Minimal standards of care – R.C. 4731.22(B)(6)

1. The evidence presented at hearing supports a conclusion that the conduct of Gary Charles Gelesh, D.O., in administering Anectine (succinylcholine) to Patient 1 as set forth above in the Findings of Fact, constitutes a “departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in R.C. 4731.22(B)(6).

Discussion: Both Dr. Gelesh and Ms. Orndorf testified that Dr. Gelesh did not verify or confirm the medication before administering it. Under the minimal standards of care applicable to a physician in these circumstances, Dr. Gelesh was obliged to confirm the medication before administering it. As set forth by Dr. Fraser, whose opinion on this point was persuasive, the minimal standard of care required a verification or confirmation by Dr. Gelesh, regardless of whether the nurse misheard the medication order or whether Dr. Gelesh misspoke, and also regardless of whether the medication was handed to him in a filled syringe or in a vial with an empty syringe for him to fill.

2. To the extent that the issue was presented in this action, the Hearing Examiner concludes that Dr. Gelesh’s morphine orders for Patient 1 did not constitute a “departure from, or the failure to conform to, minimal standards of care” as that language is used in R.C. 4731.22(B)(6). In addition, the morphine orders were in “accordance with reasonable medical standards” as that language is used in R.C. Chapter 2133.

Immunity – R.C. Chapter 2133

3. The evidence presented at hearing supports a finding that Dr. Gelesh carried out his treatment of Patient 1 in good faith from beginning to end.
4. Nonetheless, under R.C. Chapter 2133, the administration of succinylcholine by Dr. Gelesh under the circumstances presented here
 - a. did not constitute comfort care;
 - b. was not in accordance with reasonable medical standards;
 - c. was outside the scope of authority for providers of comfort care; *and/or*
 - d. was outside the scope of authority given specifically by Patient 1 in her DNR/CC directive.

Discussion: It is undisputed that the patient was in a terminal condition during the relevant periods of time. However, the administration of succinylcholine (where respiration is not being assisted) cannot be deemed to constitute comfort care, or treatment in accordance with reasonable medical standards, according to Drs. Fraser and Wecht. Dr. Galan’s testimony also indicated that administering succinylcholine would not be part of reasonable comfort care for Patient 1. Further, Patient 1’s DNR/CC directive did not provide authority to administer succinylcholine in these circumstances.

5. R.C. 2133.11 did not bar the Board from initiating and pursuing an administrative action with regard to the administration of succinylcholine by Dr. Gelesh. The immunity provided by R.C. 2133.11 applies only to Dr. Gelesh's conduct up to and including the administration of morphine.

Discussion of Proposed Order

Although a violation of the minimal standard of care has been found, the proposed order does not involve severe penalties, for several reasons. First, the evidence indicates that Dr. Gelesh is generally a very competent physician with no history of problematic orders for patient care, and the Hearing Examiner concluded that this episode was unusual, an aberration.

Second, Dr. Gelesh has already suffered a great deal from his mistake. He resigned his position at Akron General in 2002, within a few months of the incident, and in the past several years has been taking locum tenens positions in other states involving substantial travel from his home.

Third, the Hearing Examiner believes that Dr. Gelesh is unlikely ever to make this kind of mistake again. He has been through years of Board investigation and adjudicative action, and he heard substantial testimony at hearing regarding standards for verification of medication orders.

Nonetheless, to ensure that Dr. Gelesh is fully educated with respect to current standards for avoiding medication errors, the Hearing Examiner recommends a course or courses for Dr. Gelesh regarding the prevention of medication errors. The fact that the Joint Commission published standards in 2004 for verifying certain types of communications shows that this is a developing area of medical procedure, and education is likely to be useful regarding up-to-date standards.

R.C. 4731.22(B) lists the types of discipline that the Board may impose, and an educational requirement is not among them. However, the statute provides that the Board may impose probation, and the terms of a probationary period may include an educational component. Therefore, the educational requirement has been made part of the probationary terms.

Last, a stayed suspension is included because a violation of the minimal standard of care was found, and, although it was a single mistake, it had serious consequences.

PROPOSED ORDER

It is hereby ORDERED that:

- A. SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Gary Charles Gelesh, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of six months. Such suspension is **STAYED**, subject to the

following PROBATIONARY terms, conditions, and limitations:

B. **PROBATION:** Dr. Gelesh's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least one year:

1. **Obey the Law:** Dr. Gelesh shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in the state in which he is practicing.
2. **Declarations of Compliance:** Dr. Gelesh shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Gelesh's certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
3. **Personal Appearances:** Dr. Gelesh shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Gelesh's certificate is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
4. **Course or Courses in the Prevention of Medication Errors:** Before the end of his probation or as otherwise approved by the Board, Dr. Gelesh shall provide acceptable documentation of successful completion of a course or courses regarding the prevention of medication errors. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Gelesh submits the documentation of successful completion of the course or courses, he shall also submit to the Board a written report describing the course(s), setting forth what he learned and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Termination of Probation:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Gelesh's certificate will be fully restored.

C. VIOLATION OF THE TERMS OF THIS ORDER: If Dr. Gelesh violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

D. REQUIRED REPORTING AND DOCUMENTATION OF REPORTING:

1. **Required Reporting to Employers and Hospitals:** Within 30 days of the effective date of this Board Order, Dr. Gelesh shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Gelesh shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide healthcare services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Gelesh provides any health-care services or health-care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within 30 days of the effective date of this Board Order, Dr. Gelesh shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

This requirement shall continue until Dr. Gelesh receives from the Board written notification of his successful completion of probation.

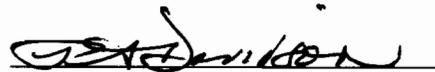
2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Board Order, Dr. Gelesh shall provide a copy of this Board Order to the proper licensing authority of any state or jurisdiction in which he currently any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Gelesh further agrees to provide a copy of this Board Order at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license.

This requirement shall continue until Dr. Gelesh receives from the Board written notification of his successful completion of probation.

3. **Documentation that the Required Reporting Has Been Performed:** Dr. Gelesh shall provide the Board with **one** of the following documents as proof of each required notification within 30 days of the date of each notification required above: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email

transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

This Order shall become effective immediately upon mailing of notification of approval by the Board.



Patricia A. Davidson
Hearing Examiner

State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JUNE 10, 2009

REPORTS AND RECOMMENDATIONS, MOTIONS FOR RECONSIDERATION & PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Madia announced that the Board would now consider the Reports and Recommendations, the Motion for Reconsideration and the Proposed Findings and Proposed Order appearing on its agenda. The matter of Muhammad Z. Shrayyef, M.D., will not be considered this month, as the Board has not been able to verify Dr. Shrayyef's receipt of the Report and Recommendation.

Dr. Madia asked whether each member of the Board had received, read and considered the hearing record; the Findings of Fact, Conclusions of Law and Proposed Orders, and any objections filed in the matters of Gary Charles Gelesh, D.O.; David Miles Barrere, M.D.; Jack David Bennett, M.D.; Shannon Lin Boyer; Heather Victoria Downey; Abby R. Uridel, M.T.; and David Wei Wang, M.D.; the Motion for Reconsideration in the Matter of Jeffrey E. White, M.D.; and the Proposed Findings and Proposed Order in the matter of Andrew Beistel, D.O. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Varyani	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- aye

Dr. Madia asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Varyani	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye

Dr. Steinbergh - aye
Dr. Madia - aye

Dr. Madia noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Madia advised that during these proceedings no oral motions may be made by either party.

The original Reports and Recommendations and Proposed Findings and Proposed Order shall be maintained in the exhibits section of this Journal.

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GARY CHARLES GELESH, D.O.

Dr. Madia directed the Board's attention to the matter of Gary Charles Gelesh, D.O. He advised that objections were filed by both the Respondent and the State to Hearing Examiner Davidson's Report and Recommendation on Remand and were previously distributed to Board members.

Dr. Madia continued that a request to address the Board has been timely filed on behalf of Dr. Gelesh. Five minutes would be allowed for that address.

Dr. Gelesh was accompanied by his attorney, Eric J. Plinke, Esq. Mr. Plinke stated that this case dates back to the standard of care in emergency medicine in 2002. The last time they were before the Board, the Board was presented with some information new to the record and the Board asked for a remand. They are now back on that remand with a new Report and Recommendation.

Mr. Plinke stated that in the Report and Recommendation before the Board, there are certain things from his objections with which he agrees and disagrees, and which he will not address. The one term that the Hearing Examiner used, and which he thinks is particularly applicable to this case, is "aberration." Through the course of Dr. Gelesh's career, it is clear that he has been an upstanding, contributing member of the medical community, particularly here in Ohio. This case is an aberration, and he thinks that any person applying a high level, or any level, of intellectual honesty to this case has to come to that conclusion. This was a case where the nurse had misled the Board previously in what she described as having happened. Despite that, the State comes in February and asserts that this is a case of a physician who acted intentionally to hasten the demise of a patient. Mr. Plinke stated that that is a completely baseless charge from this record. Actually, the evidence is so strongly to the contrary, that that charge simply cannot be sustained. That's what the record on remand shows.

Mr. Plinke stated that the record also shows that the first piece of paper upon which this nurse recorded this medication order that she “honestly didn’t believe” had been made, shows a dosage amount of one mg. He commented that that introduces a new element to this case. Mr. Plinke stated that when the nurse says that she “honestly didn’t believe” the order, he thinks that she’s coming very close to what the truth of this matter is. He added that he thinks that as you peel back the layers of this onion, you have to come to the conclusion that this nurse honestly didn’t know what the order was. She wasn’t at all certain as to what had been said, and took no action whatsoever to try to clear up that order. Otherwise, he doesn’t think that any nurse in Ohio would do what happened in this case, which is that she has to say now that she knowingly handed a medicine to a physician, knowing that it would cause harm to the patient and didn’t do what nurses do every single day in the emergency room.

Mr. Plinke stated that, with all that being said in the remand record, he’s not sure how the Hearing Examiner takes that evidence and actually comes up with greater discipline than had been proposed the last time they were here. He thinks that the remand record is more supportive of Dr. Gelesh than the previous record. Despite that, the Proposed Order is for a stayed suspension with a one-year probation. Mr. Plinke stated that he doesn’t think that that is the appropriate discipline in this case, and he thinks that, based on the seven and a half years that have transpired and the otherwise fine conduct of Dr. Gelesh, as a physician in the State of Ohio, the Board should either dismiss this action or take no further action, based on the record.

Dr. Gelesh addressed the Board, stating that he’s waited a long time to come to speak with the Board. It’s been seven long years. Dr. Gelesh stated that he’s an emergency physician who practiced emergency medicine in the State of Ohio and other states for about 31½ years. He stated that it’s kind of surreal standing before the Board because this is a position he never expected himself to be in. As one of the Board members mentioned before, his record is spotless; yet he stands before the Board because of one instance. That instance occurred seven and a half years ago. Nothing like that happened in his first 24 years of practice, and nothing like that happened in the next seven and a half years of practice. He stated that it’s just like the Hearing Examiner said, it’s an aberration.

Dr. Gelesh stated that in February there was much discussion about treating him fairly. After all that has transpired in this very, very long hearing, he feels that the only way there can be any fair treatment in this is to not to have any type of disciplinary action. He stated that there are several reasons for that. First, he received a citation letter that said that he didn’t meet the standard of care.

Dr. Madia advised Dr. Gelesh that he has one more minute.

Dr. Gelesh stated that in 2002 the Joint Commission had no written standards concerning verbal orders. There were no written standards in 2003. You do not find anything in the Joint Commission manual that says anything about verbal orders in 2004, and that has been changed three times since then. As far as the verbal orders, when he practiced medicine in 2002, since there were no written standards, he learned just the way the physicians on the Board learned; he learned by watching other physicians. Being in a teaching institution for greater than 20 years, he had an opportunity to observe a large number of physicians in a

variety of specialties, and their practice habits on verbal orders were not any different than his. If there are no written standards on verbal orders, and everyone is practicing in this way, it's not a deviation of the standard, and therefore there should not be any disciplinary actions.

Dr. Gelesh stated that the second thing is the statement that says he acted in bad faith. Dr. Gelesh stated that in 31½ years of practice in emergency medicine, he has taken care of over 100,000 patients, and everyone of those patients he treated in good faith. That includes Patient 1.

Dr. Madia asked Dr. Gelesh to conclude his statement.

Dr. Gelesh stated that he's asking on his record, and the fact that the information presented at this hearing, to have this case dismissed.

Dr. Madia asked whether the Assistant Attorney General wished to respond.

John Fulkerson, Section Chief of the Attorney General's Health and Human Services Section, addressed the Board in Mr. Wilcox's absence. Mr. Wilkerson stated that he'd like to hit some key points in the factual record, and he encouraged the Board to read the State's Objections to the final Report and Recommendation in this matter. He stated that he believes they do a very good job in setting forth the relief the State is asking from the Board, and the facts in this case.

Mr. Fulkerson stated that before he talks about what this case is about, he'd like to talk about what it is not about. It's not disputed that Dr. Gelesh was caring for a dying patient who had little time left. What is disputed is that his care and comfort of the patient did, in fact, hasten the patient's death. The idea of "do no harm" is a fundamental concept with which the Board members are very familiar, and it is a core tenet of the practice of medicine. Dr. Gelesh ignored that in this case, and he violated the Medical Practices Act, which is why he's here. It's why Dr. Gelesh was terminated from his position with Akron General following these events, and why he settled the civil matter with the patient's family. Mr. Fulkerson stated that not to trivialize this patient's life in a very serious matter, but a doctor should not take a sinking ship and drill larger holes in the hull. That's exactly what happened here.

Mr. Fulkerson stated that he'd like to walk down a little bit of the time line of events and highlight why they're important for him to consider. This patient was a frail 88-year-old woman who arrived at Akron General at 9:00 p.m. in February 2002. Palliative care was initiated around 11:30 p.m., when the shift was ending, and Dr. Gelesh decided to stay on when his replacements arrived. When he decided to stay on, as was outlined in the State's objections, his drug regimen and treatment became extremely aggressive. He ordered 100 mg of morphine in a 100 mg bag infused at 500 cc per hour, twice within approximately an hour and a half of time. It was only after that that Dr. Gelesh asked the nurse to get 60 mg of Anectine. At that point, Dr. Gelesh had told the patient's chaplain, who was in the room, that "it wouldn't be long now." Mr. Fulkerson stated that that's not an aberration. An aberration not what happened in this case. At around 1:20 a.m., Dr. Gelesh administered the Anectine and the patient was dead within a few minutes.

Mr. Fulkerson stated that the record in this case contradicts Mr. Plinke's statement about this "blame the nurse" theory. There is ample evidence in the record to show that the nurse understood the order, that she heard it, that she consulted with other nurses to make sure that she was doing what had been ordered. She, in fact, at the advice of other nurses and her supervisor, did not administer the drug. She handed the vial and the empty syringe to the doctor for him to administer. Everyone knew what was going to happen in this case when this happened.

Mr. Fulkerson stated that the Hearing Examiner conveniently ignored the key points in this case, and simply lost her way in analyzing a resolution of this case. Those key points and contradictions are outlined in detail in the State's Objections. Mr. Fulkerson stated that you can't ignore every piece of contrary evidence to support a conclusion without at least addressing them and dealing with those points.

Dr. Madia advised Mr. Fulkerson that he has one minute to conclude his statement.

Mr. Fulkerson again stated that this was not an aberration case. This was intentionally hastening a patient's death. The relief and Order the State is seeking from the Board is detailed at the end of the State's Objections. He stated that this is a case deserving of the harshest punishment that the Board can deploy.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. DAVIDSON'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF GARY CHARLES GELESH, D.O. DR. VARYANI SECONDED THE MOTION.

Dr. Madia stated that he would now entertain discussion in the above matter.

Dr. Varyani stated that the Institute of Medicine has come out and for the last five years we have known about medication errors and harm to the patient by physicians and/or healthcare workers. Dr. Varyani stated that he does not believe that this is an aberration. He did hear Dr. Gelesh say that there was a dispute about the verbal order. He stated that he doesn't think that the verbal order comes into play in this case because the injection was carried out by the physician himself. Dr. Varyani stated that he doesn't know whether the succinylcholine was filled by Dr. Gelesh or by somebody else, but even in 2002 there was a standard. It may not be written as much as now, but when you're injecting, a physician or a nurse is supposed to put a sticker on. In 2002 there were stickers. In 2009 there are stickers. He stated that if a physician is going to inject a medication, he has to make sure, it's his duty to make sure, that what he's injecting is what he wants to inject, and it has to be confirmed by himself. So the verbal order theory he doesn't buy because the medication, succinylcholine, was injected by Dr. Gelesh himself.

Dr. Varyani stated that he read through all the charts and he has a problem with Dr. Gelesh's witness, Gayle M. Galen, M.D., and her knowledge of medication orders because that was in 2005. In 2005 physicians knew that they were committing errors, not because they wanted to, but because they just happened. Now, physicians are more concerned about the safety of the patient. Dr. Varyani stated that he is not disputing that the patient had an accident. He understands that. What he is worried about is that, if Dr. Gelesh injected the medication himself, in 2002 it was his duty to make sure of what he was injecting,

whether he was injecting succinylcholine or Ativan.

Dr. Varyani stated that, because of the lapse in time, he is in agreement with this Proposed Order. He stated that the Order is, basically, a slap on the wrist, but it needs to be.

Dr. Mahajan stated that he agrees with Dr. Varyani. He stated that what was done was not right, but he agrees with the Proposed Order.

Dr. Madia stated that he concurs, adding that he came to the same conclusion that once you inject, and as an anesthesiologist he uses Anectine several times every day, he knows how Ativan looks and how Anectine looks, what kind of syringes are used, so it is very hard to mismatch between a benzodiazepine and Anectine. Regardless, you should be responsible for what you're injecting, whether by a nurse or by a physician. Dr. Madia agreed with the Proposed Order.

Dr. Steinbergh stated that the bottom line for her is that she believes that the drug was ordered, and that Dr. Gelesh injected it. She stated that there is a whole lot more about this case that concerned her. She takes a look at Dr. Gelesh and the character that she thinks that he has developed over the years, the amount of teaching he's done over the years, and the awards that he's received over the years. She stated that she doesn't know Dr. Gelesh, but she takes a look at this physician and feels that he's a very appropriate physician. He had a patient in severe pain that night. She was an 88-year-old lady who had acute abdominal pain, she had bilateral pneumonia, and she had multi-system failure. Over the hours that transpired Dr. Gelesh did everything correctly. He worked her up, waited until he got the DNR order to be certain, he talked to the patient, and it was clear that she didn't want to have anything else done except to have pain relief. Dr. Gelesh did go into the palliative care mode.

Dr. Steinbergh stated that the fact that Dr. Gelesh stayed over his shift was important to her, and not in the negative sense. She never saw this as a sinister act, but the fact that he stayed over would have been consistent with his training of compassion for the patient, compassion for the family, and that he wouldn't leave the patient alone at this time or turn this patient over to another physician who then would have to rethink the case and revise what was going to be done or not revise.

Dr. Steinbergh stated that she believes that the record reflects that the patient was in agony. Every person who was in that room and every person who gave testimony said that. She was in enormous pain, and it is the doctor's role to relieve that pain. That's what he was there for. Dr. Steinbergh stated that those who have been in the room with a dying patient and understand the pain levels and the responsibility of caring for that patient know that it is up to the physician. It is a very uncomfortable position. Dr. Steinbergh stated that she takes a look at Dr. Gelesh and she asks whether he was fatigued and his judgment was clouded. She stated that she doesn't know.

Dr. Steinbergh stated that she read through this many times, and she believes that the nurse heard the order. There's such a big difference between 60 mg of Anectine and ordering Ativan or Versed, that she has to believe that piece. She continued that the nurse didn't know what Anectine was, so she went out and

looked it up and found out that it was succinylcholine. It immediately stimulates her to think that this isn't good. We're in palliative care here, the patient's dying, she's not going to be intubated, so what are we going to do? When succinylcholine is used, the patient needs to be either intubated or supported somehow in a respiratory fashion because if you inject it without appropriate support, the patient will go into respiratory failure and die. So the nurse talked to two other nurses and said, "Look, this is what Dr. Gelesh ordered." Dr. Steinbergh stated that the hearing record says that no one, all the nurses that gave testimony, ever said anything bad about Dr. Gelesh. He's not a disruptive physician. He's a physician whom others have respected. Earlier in the evening, one of the nurses had disagreed with him about the placement of a nasogastric tube, which he wanted to place in order to relieve the pressure on the abdomen and presumably relieve some pain. The nurse told him that she thought it was going to be more painful if he put that tube in, and he agreed. This shows he was thoughtful about it. They seemed to have a team approach to this. Everybody knew what was going on.

Dr. Steinbergh continued that the nurse went out and talked to two other nurses and said that she's not believing that Dr. Gelesh is giving the order for this. The other nurses said that they wouldn't give it, but no one ever walks in and says to Dr. Gelesh, "We need to talk to you about this." No one said that. The record says that Nurse Orndorf goes in and says something to the doctor. He said that he didn't hear it. Dr. Steinbergh stated that there was no clear communication. At a time like this, there has to be clear communication. She stated that physicians know that from patient-safety systems today. In 2002 people communicated. When you're talking about a patient and patient care, you communicate about it. Dr. Steinbergh stated that there was a tremendous lack of communication where the nurse did not address the doctor. She should have said, "Dr. Gelesh, I need your attention." The minute she realized what he said, she should have wondered, "Is it true that he ordered this? Did I hear this wrong?" Two other nurses were also told about this and no one did anything.

Dr. Steinbergh stated that it made no difference to her whether the medication was in a vial or the syringe. The nurse came in with that medication, knowing what she knows, and she's complicit in the case. Dr. Steinbergh stated that she doesn't mean that in a sinister way, but she's complicit. She knows what the doctor is going to do, or she presumes that the doctor is going to do that, and sure enough, he did; but she brings it in to be given to the patient. Dr. Steinbergh stated that she finds great fault with that. She added that Dr. Gelesh injected the Anectine, and she's certain that it was Anectine.

Dr. Steinbergh stated that the interesting piece about doing the remand for her was that, even though she voted against the remand, it provided her with a lot of information from the palliative-care expert, and from the other emergency room doctors who testified on behalf of Dr. Gelesh. She stated that she felt that the record pretty much supported Dr. Gelesh. The palliative-care person gave her a great deal of thought about the use of morphine. The Board did not charge Dr. Gelesh with any inappropriate use of morphine. The palliative-care-medicine doctor said that you use morphine for pain relief, and you use it, and use it, and use it until the pain is gone. Dr. Steinbergh stated that she thinks that Dr. Gelesh's desire was to see this patient without pain.

Dr. Steinbergh stated that she supports Dr. Gelesh, although she doesn't think that he made the right

decision at the end. It's an illegal thing that he did. At some point he crossed the line. She stated that she doesn't know why, and she doesn't know if it was a result of fatigue. She does sincerely believe that it was not in bad faith. Dr. Steinbergh stated that she often thinks about the decisions that she makes and how they will affect the patient. She stated that there was no tragic death here. The woman was dying and Dr. Gelesh was relieving her pain.

Dr. Varyani stated that he's not disagreeing with Dr. Steinbergh on the morphine issue, and Dr. Gelesh's treatment of the patient. Where Dr. Gelesh has gone off is, even in 2002 you may give a verbal order, but most of the time, if an emergency room doctor ordered something, it was given by the nurse. The physician would not go about injecting people usually. Once you inject by yourself, the verbal order is canceled because you are injecting the medication to the patient yourself. That's where his problem is regarding standard of care. The standard of care in 2002 was, and still is, if you give a verbal order, you're telling the nurse to do X, Y, Z for you. But, if, in the meantime, the nurse comes and hands you, or you snatch the syringe and give it yourself, the verbal order is canceled. When you inject, you need to make sure that you're injecting what you want. It is upon you. That's where the standard of care was breached in this case.

Dr. Varyani stated that, after seven years, he's sure that Dr. Gelesh has suffered a lot, and has thought about it a lot. He's pretty sure that Dr. Gelesh will always wonder why he injected the medication. Dr. Varyani stated that he's not saying that Dr. Gelesh is a bad physician or a good physician. He stated that his decision, as a Board member, is whether or not Dr. Gelesh followed standards of care. Once he took the medication and injected it, it was below standard of care.

Dr. Steinbergh stated that she agrees with Dr. Varyani. She stated that the question for her, then, is what should the Board do about this. There are a lot of things in the objections filed by Mr. Plinke that went through her mind. She noted that Mr. Plinke asks why Dr. Gelesh would put his license at risk in this particular incident by doing something that is inappropriate. She stated that Dr. Gelesh had been an ER physician for over 21 years at that time and had a good reputation, so why would he put his license at risk? Dr. Steinbergh stated that she doesn't think that he was thinking about his medical license at this time. She added that she doesn't know that there is anything else that needs to be done in this case. She stated that the Board certainly wouldn't dismiss a case like this. Dr. Steinbergh questioned whether or not Dr. Gelesh needs any further education. She noted that patient-safety systems are in place today and it doesn't take much to avail oneself of that. Dr. Steinbergh stated that, in terms of medical errors, the real question is whether or not it was a true medical error. She stated that she felt it was a combination of things. She doesn't feel that the Board needs to take any further action against Dr. Gelesh. She stated that he's been through it, and he's learned through this. Dr. Steinbergh stated that in some cases the Board sees, there's no question about what went on and what the Board should do about it; but, in terms of minimal standards of care for this particular practitioner, the Board has no evidence that anything ever occurred like this before, and she's convinced that nothing like this is ever going to happen again in his life.

DR. STEINBERGH MOVED TO AMEND THE PROPOSED ORDER TO SUBSTITUTE AN ORDER THAT NO FURTHER ACTION BE TAKEN.

Dr. Varyani stated that he was very concerned about Dr. Galan's knowledge of medication, and he was wondering what the Board can do about it. He stated that, in defense of Dr. Gelesh, Dr. Galan made a lot of statements. He noted that her testimony occurred between 2005 and 2007, and he wonders whether her knowledge of medication errors and medication delivery has progressed.

DR. AMATO SECONDED DR. STEINBERGH'S MOTION.

Mr. Jacobson joined the meeting during the previous discussion.

Dr. Varyani asked Mr. Jacobson whether he had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law and Proposed Orders, and any objections filed in the matters of Gary Charles Gelesh, D.O.; David Miles Barrere, M.D.; Jack David Bennett, M.D.; Shannon Lin Boyer; Heather Victoria Downey; Abby R. Uridel, M.T.; and David Wei Wang, M.D.; the Motion for Reconsideration in the Matter of Jeffrey E. White, M.D.; and the Proposed Findings & Proposed Order in the matter of Andrew Beistel, D.O., and whether he understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. Mr. Jacobson responded "yes" to both questions.

A vote was taken on Dr. Steinbergh's motion to amend:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Dr. Varyani	- nay
	Mr. Jacobson	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- nay
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Madia	- nay

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. DAVIDSON'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF GARY CHARLES GELESH, D.O. DR. AMATO SECONDED THE MOTION. A vote was taken:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Talmage	- abstain

Dr. Suppan	- aye
Dr. Varyani	- nay
Mr. Jacobson	- aye
Mr. Hairston	- aye
Dr. Amato	- aye
Dr. Stephens	- nay
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Madia	- nay

The motion carried.

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

GARY CHARLES GELESH, D.O.

*

ORDER AND ENTRY

On May 18, 2005, the State Medical Board of Ohio issued a Notice of Opportunity for Hearing to Gary Charles Gelesh, D.O., based upon allegations that Dr. Gelesh's acts, conduct and/or omissions with regard to one patient constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Subsequently, on March 8, 2006, the Board issued a second Notice of Opportunity for Hearing to Dr. Gelesh, which supersedes and replaces the Notice of Opportunity for Hearing issued to Dr. Gelesh on May 18, 2005.

Therefore, it is ORDERED that the Notice of Opportunity for Hearing issued to Gary Charles Gelesh, D.O., on May 18, 2005, be and is hereby DISMISSED.

This Order is entered by the State Medical Board of Ohio and on its behalf on this 18th day of April 2006.

Lance A. Talmage, M.D.
Lance A. Talmage, M.D. *by BAJ*

(SEAL)

April 18, 2006
Date

CERTIFIED MAIL #7003 0500 0002 4332 6166
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.
41 South High Street
Columbus, OH 43215

CERTIFIED MAIL #7003 0500 0002 4332 6173
RETURN RECEIPT REQUESTED



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

March 8, 2006

Gary Charles Gelesh, D.O.
550 Highlands Drive
Akron, Ohio 44333-2679

Dear Doctor Gelesh:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) In the routine course of your osteopathic medical practice, you undertook the treatment of Patient 1 identified in the attached Patient Key. The Patient Key is confidential and shall be withheld from public disclosure.

On or about February 7, 2002, Patient 1, approximately 88 years of age, was transported by ambulance from an assisted living facility to the emergency room of Akron General Medical Center, Akron, Ohio, where you were providing services as an emergency room physician. Upon your examination of Patient 1, she was found to be hypotensive with complaints of abdominal pain. Patient 1 had a history of heart disease, and had executed a do not resuscitate/comfort care only directive. You concluded that Patient 1 was not a surgical candidate and she was provided comfort care treatment in the emergency room under your direction.

On or about February 8, 2002, you requested that the nurse assisting you with the care of Patient 1 obtain medication for Patient 1. Hearing that you ordered Anectine (succinylcholine), the nurse returned to Patient 1's room with Anectine, and asked you if that was the medication you wanted. The nurse handed you the container of medication, and you administered the medication to the patient. Patient 1 died a short time thereafter of respiratory arrest due to the administration of succinylcholine.

In deposition, you testified that when the nurse returned to Patient 1's room with the medication, you heard the nurse say something, but you did not hear what she said. You further testified that you assumed the medication handed to you was what

Mailed 3-9-06

you had ordered, a benzodiazepine, although you could not recall whether you had ordered Ativan or Versed.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively were in bad faith, and/or outside of the scope of your authority, and/or not in accordance with reasonable medical standards. Therefore, Chapter 2133., Ohio Revised Code, as in effect at that time, is not applicable.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

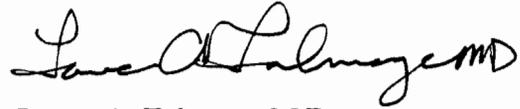
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage MD". The signature is fluid and cursive, with the "MD" clearly visible at the end.

Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4330 8490
RETURN RECEIPT REQUESTED

cc: Eric J. Plinke, Esq.
41 South High Street
Columbus, Ohio 43215

CERTIFIED MAIL # 7003 0500 0002 4330 8506
RETURN RECEIPT REQUESTED



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

May 18, 2005

Gary Charles Gelesh, D.O.
550 Highlands Drive
Akron, Ohio 44333-2679

Dear Doctor Gelesh:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) In the routine course of your osteopathic medical practice, you undertook the treatment of Patient 1 identified in the attached Patient Key. The Patient Key is confidential and shall be withheld from public disclosure.

On or about February 7, 2002, Patient 1, approximately 88 years of age, was transported by ambulance from an assisted living facility to the emergency room of Akron General Medical Center, Akron, Ohio, where you were providing services as an emergency room physician. Upon your examination of Patient 1, she was found to be hypotensive with complaints of abdominal pain. Patient 1 had a history of heart disease, and had executed a do not resuscitate/comfort care only directive. You concluded that Patient 1 was not a surgical candidate and she was provided comfort care treatment in the emergency room under your direction.

On or about February 8, 2002, you requested that the nurse assisting you with the care of Patient 1 obtain medication for Patient 1. Hearing that you ordered Anectine (succinylcholine), the nurse returned to Patient 1's room with Anectine, and asked you if that was the medication you wanted. The nurse handed you the container of medication, and you administered the medication to the patient. Patient 1 died a short time thereafter of respiratory arrest due to the administration of succinylcholine.

In deposition, you testified that when the nurse returned to Patient 1's room with the medication, you heard the nurse say something, but you did not hear what she said. You further testified that you assumed the medication handed to you was what you had ordered, a benzodiazepine, although you could not recall whether you had ordered Ativan or Versed.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

MAILED 5-19-05

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4340 6837
RETURN RECEIPT REQUESTED

CC: Walter F. Ehrnfelt, Esq.
Gemini Tower I, Suite 550
1991 Crocker Road
Cleveland, Ohio 44145

CERTIFIED MAIL # 7003 0500 0002 4340 6844
RETURN RECEIPT REQUESTED