

State Medical Board of Ohio

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Executive Director

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July 8, 2009

Steven Paul Sherry, D.O.
7927 Vanderbilt Drive NW
North Canton, OH 44720

RE: Case No. 08-CRF-124

Dear Doctor Sherry:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 8, 2009, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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 that reads "Lance A. Talmage, M.D." The signature is written in a cursive style.

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3184 0064
RETURN RECEIPT REQUESTED

Mailed 7-10-09



CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 8, 2009, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Steven Paul Sherry, D.O., Case No. 08-CRF-124, 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.

(SEAL)


Lance A. Talmage, M.D.
Secretary

July 8, 2009
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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CASE NO. 08-CRF-124

*

STEVEN PAUL SHERRY, D.O.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on July 8, 2009.

Upon the Report and Recommendation of R. Gregory Porter, 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 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.

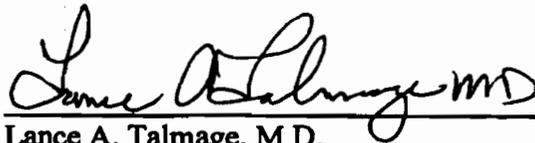
It is hereby ORDERED that:

The certificate of Steven Paul Sherry, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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



(SEAL)



Lance A. Talmage, M.D.
Secretary

July 8, 2009
Date

2009 JUN -5 P 12:11

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of

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Case No. 08-CRF-124

Steven Paul Sherry, D.O.,

*

Hearing Examiner Porter

Respondent.

*

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated October 8, 2008, the State Medical Board of Ohio [Board] notified Steven Paul Sherry, D.O., that it intended to determine whether to impose discipline against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on allegations concerning Dr. Sherry's treatment of ten specified patients, and further alleged that Dr. Sherry's conduct violated Sections 4731.22(B)(2) and (6), Ohio Revised Code. The Board advised Dr. Sherry of his right to request a hearing in this matter, and received his written request on or about November 5, 2008. (State Exhibits [St. Exs.] 13, 14)

Appearances

Richard Cordray, Attorney General, and Barbara J. Pfeiffer, Assistant Attorney General, for the State of Ohio

Steven Paul Sherry, D.O., *pro se*

Hearing Date: April 20, 2009

PROCEDURAL MATTERS

1. In Dr. Sherry's February 13, 2009, written report, he had inadvertently used Patient 2's initials in his heading for Patient 4. With the agreement of the parties, the Hearing Examiner substituted the correct initials post-hearing. (Respondent's Exhibit [Resp. Ex.] A; Hearing Transcript [Tr.] at 272)
2. The Hearing Examiner paginated Respondent's Exhibit A post-hearing.

SUMMARY OF THE EVIDENCE

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

Background Information

1. Steven Paul Sherry, D.O., obtained his osteopathic medical degree in 1998 from the University of Health Sciences, College of Osteopathic Medicine, in Kansas City, Missouri. Dr. Sherry completed an internship and emergency medicine residency from 1998 through 2002. In 2002, he was licensed to practice osteopathic medicine and surgery in Ohio. (Tr. at 13-15)

Dr. Sherry testified that, as of the date of the hearing, he was not board certified in any specialty. He noted that he has attempted board certification in emergency medicine on three occasions; his last attempt occurred approximately two weeks prior to the hearing and he had not yet received the results. (Tr. at 14-15)

2. Dr. Sherry testified concerning his employment history through the time period relevant to this matter:¹
 - Alliance Community Hospital, following completion of residency in 2002 until May 2003. Dr. Sherry testified, "I was let go short of the contract expiring. They said that they felt that I had too many patient complaints." (Tr. at 15-17)
 - Mercy Medical Center in Canton, Ohio, [Mercy] through Stark County Emergency Physicians [SCEP], from about July 2003 through about September 2004. Dr. Sherry acknowledged that SCEP had not offered to renew his contract in 2004, but Dr. Sherry testified that he had first told SCEP that he did not intend to remain with that group after his contract expired. (Tr. at 17-20)
 - Emergency Consultants, Inc., [ECI] from about February 2003 through about February 2005. Dr. Sherry testified that ECI is a large group that contracts with many hospitals. Dr. Sherry testified that he had moonlighted part-time at Samaritan Regional Health Systems in Ashland, Ohio, [Samaritan] until about September 2004. After leaving Mercy in September 2004, he had started working full-time for ECI at Ashland. Dr. Sherry testified concerning his separation from ECI, "They fired me because they said that I had too many patient complaints." (Tr. at 17-18, 20-21)
3. Nicole Wadsworth, D.O., testified as an expert witness on behalf of the State. Dr. Wadsworth obtained her osteopathic medical degree in 1997 from the Ohio University College of Osteopathic Medicine [OUCOM]. In 1998, she completed a rotating internship at Doctors Hospital of Stark County in Massillon, Ohio. Subsequently, from 1998 through 2001, Dr. Wadsworth completed a residency in emergency medicine at South Pointe

¹ The latest event alleged in the October 8, 2008, notice of opportunity for hearing occurred on or about March 13, 2005. (State's Exhibit 13)

Hospital in Warrensville Heights, Ohio, where she served as Chief Resident from 2000 through 2001. Dr. Wadsworth was licensed to practice osteopathic medicine and surgery in Ohio in 1998. She was certified in emergency medicine by the American Osteopathic Board of Emergency Medicine in 2003. (St. Ex. 11; Tr. at 155-157)

Since completing her residency, Dr. Wadsworth has served as (1) Assistant Professor of Emergency Medicine at OUCOM; (2) emergency medicine physician at O'Bleness Memorial Hospital [O'Bleness] in Athens, Ohio, where she became assistant director of the Emergency Department [ED] in 2005 and medical director of the ED in 2007; and (3) Assistant Dean at OUCOM where since 2003 she has assisted in the development of curricula for first- and second-year medical students. Dr. Wadsworth testified that, in the last 18 to 24 months, she has devoted approximately 20 hours per week working as an emergency medicine physician in the ED. Dr. Wadsworth further testified that she usually works as the only physician in the ED while she is there, aside from some overlap at the beginning and end of her shifts. (St. Ex. 11; Tr. at 158-161)

4. Dr. Wadsworth testified that her duties as the medical director for the ED include addressing patient complaints and doing chart reviews. (Tr. at 161)

Patient 1

Dr. Wadsworth

5. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 1:

Patient No. 1 was a 63-year-old female who presented to Samaritan Regional emergency department at 10:05 [p.m.] on January 22nd, 2005. She presented because of a concern of positive blood cultures. Her physician had called her and asked her to be evaluated. Her past medical history was complicated, including diabetes, high blood pressure, hypothyroidism, anxiety, gastroesophageal reflux disease, fibromyalgia, chronic abdominal pain, short gut syndrome, and MVP or mitral valve prolapse. Patient [1] had an extensive medication list also.

Patient [1] was initially evaluated [in the ED]. Her vital signs were recorded. Blood pressure [was] slightly elevated and * * * temperature again slightly elevated at 99.4. It was noted that she had had surgery two years prior, had had an infection requiring some extensive surgical treatment for that.²

When the patient arrived at the emergency department, a CBC [complete blood count] and basic metabolic profile were performed by Dr. Sherry and those were normal. Dr. Sherry consulted the [patient's] physician and follow-up was arranged for the following day.

² In her written report, Dr. Wadsworth stated: "Patient [1] underwent a rotator cuff repair in September 2003, developed a post operative infection requiring 2 incision and drainage procedures and then an open debridement procedure in October 2004." (St. Ex. 12 at 2)

On the following day, the patient presented again to the emergency department with progressive weakness and nausea and then subsequently was transferred to the Cleveland Clinic Foundation, where she was [treated] for bacteremia and the removal of a port that was thought to be the origin of her infection.

(Tr. at 167-168)

6. Prior to Patient 1's visit to the Cleveland Clinic, a nurse from Mercy wrote on the January 22, 2005, intake sheet, as follows:

[Patient] had labs/blood cultures drawn at Cleveland Clinic. [She] received phone call tonight from CCF physician that blood cultures were [positive].
* * * [Patient] was supposed to have [right] shoulder replacement but was found to have joint infection so [surgery] was stopped. [Patient] was advised by Dr. Bamriak at CCF to come to hospital.

(St. Ex. 1 at 11)

On his chart, Dr. Sherry noted that Patient 1 "has no s/s [signs or symptoms] of anything." He further noted her current antibiotics to be "None." He also noted that he had spoken with Dr. Bamriak at 10:32 p.m. and arranged for follow-up the next day. Nothing further is documented in Dr. Sherry's notes or elsewhere in the medical records concerning Dr. Sherry's conversation with Dr. Bamriak. (St. Ex. 1 at 15-17)

Patient 1 was discharged on January 22, 2005, and it was noted that she had been treated for "[rule out] blood infection" and anemia. She was instructed to follow up with her physician the next day and to continue taking her home medications. Dr. Sherry did not prescribe antibiotics for Patient 1. (St. Ex. 1 at 23)

7. Dr. Wadsworth defined bacteremia as the presence of bacteria in the bloodstream. Dr. Wadsworth further testified that the appropriate treatment for bacteremia is antibiotics. With regard to the selection of an antibiotic, Dr. Wadsworth testified, "[A]n educated guess is made based upon the patient's previous history and where that potential infection could be coming from." Dr. Wadsworth further testified that Dr. Sherry's failure to provide antibiotics prior to Patient 1's discharge constituted:

- a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in his selection of drugs or other modalities for treatment of disease; and
- a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances.

(Tr. at 169-171)

Dr. Sherry

8. Dr. Sherry testified that, when he spoke to Dr. Bamriak, Dr. Bamriak advised that he had obtained a positive blood culture from Patient 1 and was concerned that she might have sepsis. (Tr. at 26-29; St. Ex. 1 at 17)

Dr. Sherry testified that a positive blood culture does not automatically mean that Patient 1 had sepsis. (Tr. at 26)

9. Dr. Sherry acknowledged that he had discharged Patient 1 without antibiotics, but that he had learned from speaking with Dr. Bamriak that Dr. Bamriak was treating Patient 1 with IV Vancomycin, and that he believes that Patient 1 had received Vancomycin that morning. Dr. Sherry acknowledged that he had not documented that conversation in the medical record. (Resp. Ex. A at 2; Tr. at 29, 32) When asked how he could recall that information at hearing, Dr. Sherry testified:

Because—Well, several reasons. I knew that she was on Vancomycin. She had even—We had the report that she had a level checked earlier that same day, and she was therapeutic on that.

Secondly, if she was not already on some antibiotics and she had a history of positive blood cultures, I would have started her on some antibiotics just as a matter of course.

(Tr. at 32-33)

Dr. Sherry acknowledged that, in Patient 1's medical record for the January 22, 2005, visit, on the line labeled "Current Antibiotics," Dr. Sherry circled the word, "None." (St. Ex. 1 at 15; Tr. at 30-31) Moreover, Dr. Sherry acknowledged that a list of Patient 1's medications did not include mention of Vancomycin. (St. Ex. 1 at 11; Tr. at 31-32) Finally, it became evident from Dr. Sherry's testimony and the medical record that Dr. Sherry had misread references to Vancomycin that were made during a subsequent visit by Patient 1 one month later on *February 22, 2005*. (St. Ex. 1 at 5-9; Tr. at 33-34)

10. When asked whether his understanding that he had misread the medical record causes him to rethink his conversation with Patient 1's physician, Dr. Sherry replied:

Certainly to an extent. Like I said before, his concern was he wanted to see if she was septic. That was the concern and that's what I was looking at, and that's what I was checking.

And by no means was this patient septic. She was not unstable. She said that she felt good and she was only there on the advice of her doctor to go get checked out.

(Tr. at 36)

11. When asked if it had fallen below the minimal standard of care to not treat Patient 1 with antibiotics on January 22, 2005, Dr. Sherry replied:

Absolutely not. The patient was still treated appropriately, she was not sick, she was not septic. My labs came back looking good. Her white count was not elevated, and she was very stable at the time that I saw her.

(Tr. at 38)

12. Dr. Sherry acknowledged that it is “certainly possible” that the nausea and progressive weakness that Patient 1 had experienced the following day had been consistent with untreated bacteremia. (Tr. at 35)

Dr. Wadsworth

13. During cross-examination, Dr. Sherry asked Dr. Wadsworth:

In your opinion, do you give antibiotics to a patient who appears to be completely normal, completely stable in every way, is certainly not sick, has no complaints whatsoever, and you were asked to evaluate them for sepsis just based on they had a history of a positive blood culture?

Are you going to go ahead and give them antibiotics and send them on home on them?

(Tr. at 227) Dr. Wadsworth responded, “In this particular instance, I would have given her antibiotics.” (Tr. at 227)

Dr. Sherry then asked Dr. Wadsworth whether that would be true for patients in general, to which she replied that it would depend on the patient’s history. (Tr. at 227) Dr. Sherry then asked Dr. Wadsworth:

Since I had discussed this case with a patient’s primary physician at the time of presentation, and he said that he would be following up on that patient the next day, do you think that it would be completely out of line to not give antibiotics in an otherwise stable patient and let the patient’s own physician follow up on that patient tomorrow and give possibly more appropriate antibiotics since he knew what the cultures were and what they had come back for?

(Tr. at 228)

Dr. Wadsworth replied, “That seems like it could be an approach.” (Tr. at 228)

Patient 2

Dr. Wadsworth

14. In her written report, Dr. Wadsworth noted that Patient 2 was a 54-year-old male who presented to the Emergency Department at Samaritan Regional Health Systems on September 9, 2003, at 2:10 p.m. Dr. Wadsworth further stated:

[Patient 2 presented] with a chief complaint of left shoulder pain. [As documented in the nurse's assessment, Patient 1] reported the pain was on and off for 3 days[,] had increased pain at rest, radiation of pain to the back and had associated symptoms of shortness of breath, diaphoresis [sweating] and nausea with the pain. [Patient 2] had no previous health problems, family medical history documented as previously healthy. Work up in the ED included a chest x-ray which showed a 12 mm granuloma, normal left shoulder x-ray and normal lab tests. There is not an EKG [electrocardiogram] interpretation by Dr. Sherry, the computer interpretation was sinus rhythm with extensive non specific T wave changes. [Patient 2] was discharged at [4:20 p.m.] on 9.9.03. Patient represented to Samaritan Regional Health Systems ED on 9.10.03 in full cardiac arrest and was subsequently pronounced dead when resuscitation efforts failed.

(St. Ex. 12 at 3)

15. The EKG ordered by Dr. Sherry includes a computer-generated notation printed at the top:

Sinus rhythm
Extensive T wave changes are nonspecific

Borderline EKG

* Unconfirmed Analysis *

(St. Ex. 2 at 11)

16. Dr. Wadsworth testified that "T wave changes may mean that there is some abnormality within the heart muscle* * *." Further, "the T wave represents what's called repolarization of the ventricle and something is causing that not to occur properly, which is then reflected in the EKG." Dr. Wadsworth testified that it would have been ideal to compare the EKG result with an earlier EKG to see if there has been a change. If an earlier EKG was not available, then the T wave changes must be correlated with the patient's symptoms. (Tr. at 174)
17. Dr. Wadsworth testified that she would have had a strong suspicion of cardiac disease based on Patient 2's "age, gender, and symptom constellation." (Tr. at 175)
Dr. Wadsworth acknowledged that the cardiac enzyme lab results obtained by Dr. Sherry had been normal; however, cardiac enzymes may remain normal until some time has passed following damage to heart muscle. She testified that troponin can take four to six

hours to elevate following damage to the heart, and CK-MB even longer. Dr. Wadsworth testified that, accordingly, she would have kept Patient 2 in the ED and obtained repeat labs and EKGs in addition to observing him for changes in symptomology. Dr. Wadsworth further testified that the standard of care requires a physician to obtain serial laboratory tests on cardiac patients. (Tr. at 174-177, 228-233)

The medical record indicates that Patient 2's troponin I level had been 0.11 NG/ML, with the reference range being 0.0 – 0.5 NG/ML. His CK-MB was 1.9 NG/ML with the reference range being 0.0 – 5.0 NG/ML. (St. Ex. 2 at 19)

18. Dr. Wadsworth testified that Dr. Sherry's care and treatment of Patient 2 constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Wadsworth further testified that, in her opinion: "Dr. Sherry did not correlate the left shoulder pain with other symptoms as described by the additional documentation by the nursing staff of more serious underlying pathology, and he discounted the EKG [that], although not specific, was abnormal." (Tr. at 172-173)

Moreover, Dr. Wadsworth testified that Dr. Sherry's care and treatment of Patient 2 constituted a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. Dr. Wadsworth testified that Patient 2 "was not treated with any anti-platelet medications for the concern of cardiac disease * * *." (Tr. at 178)

19. Dr. Wadsworth testified that, in her opinion, at the time Dr. Sherry saw Patient 2, Patient 2 had not yet been experiencing a heart attack, "but was probably suffering from what could be termed anginal equivalent or a sign or symptom that could be equivalent to chest pain. And this patient experienced shoulder pain." Dr. Wadsworth further opined that that had been a precursor to the heart attack. (Tr. at 179)

Dr. Sherry

20. Dr. Sherry acknowledged that the nurse's assessment indicates that Patient 2 had complained of left shoulder pain off and on for three days, that the pain increased at rest, that it radiated to his back, and that he also complained of shortness of breath, nausea, and diaphoresis. However, Dr. Sherry testified that, prior to seeing a patient, he generally reviews only the chief complaint recorded in the nurse's assessment but not anything else on that document. He explained, "I have found that very often, the nursing assessment can be biased as to why the patient is actually there, and, in fact, numerous times, I've gone to see the patient and what they tell me is completely different than what they tell the nurse." In Patient 2's case, the chief complaint recorded in the nurse's assessment had been "[Left] shoulder pain." (Tr. at 41; St. Ex. 2 at 3)

Dr. Sherry further testified that, when he saw Patient 2, Patient 2 told him that "he had some pain in the left shoulder which was worse with movement." Dr. Sherry testified that he had documented in the medical record that Patient 2 had had left shoulder pain for three days. Dr. Sherry further testified that Patient 2 had advised that the pain seemed more

noticeable at rest because, at rest, Patient 2's mind was not occupied with anything else. (Tr. at 41-42; See also St. Ex. 2 at 5)

With regard to shortness of breath, Dr. Sherry testified that Patient 2 "said that he's always short of breath, but he felt that was because he was out of shape." With regard to diaphoresis, Dr. Sherry testified that Patient 2 told him that that was "because he's out of shape, he sweats off and on all the time anyway. He said that was nothing new." Finally, Dr. Sherry testified that Patient 2 did not tell him about any nausea. (Tr. at 42-43)

Dr. Sherry's testimony conflicts with his ED notes. In the medical record, Dr. Sherry documented that Patient 2's shoulder pain was aggravated by "nothing" and alleviated by "rest." The musculoskeletal exam was noted to be normal. No range of motion examination was documented, nor was any discussion concerning shortness of breath or diaphoresis. (St. Ex. 2 at 5-7, 21)

21. Dr. Sherry testified that his diagnosis of Patient 2 was left shoulder pain. (Tr. at 52; St. Ex. 2 at 21)
22. Dr. Sherry acknowledged that, if there had been a problem with Patient 2's heart at the time the EKG was performed, it is possible that cardiac enzyme lab values could have been normal. Dr. Sherry testified that there is a lag between the onset of a myocardial infarction [MI] and an elevation in cardiac enzymes. Dr. Sherry noted that troponin can peak in 12 to 24 hours, and the CK-MB fraction can peak in about half that time. (Tr. at 49-50)

Dr. Sherry testified that extensive T wave changes could be indicative of a heart abnormality or problem, but that it could also have been normal for the patient. (Tr. at 48-49)

When asked why he had not kept Patient 2 in the ED and retested him, Dr. Sherry replied: "Because keeping the patients in the emergency room for less than 24 hours, you still can't rule it out regardless of what numbers you find. Even if they [the cardiac enzymes] come back normal again, you still can't rule it out." (Tr. at 50) Dr. Sherry further testified that he could not have kept Patient 2 in the ED for observation for 24 hours, and that Patient 2 would have had to have been admitted. When asked why he did not admit Patient 2, Dr. Sherry replied: "Clinically, it wasn't indicated. On my discussion with him on the results of the labs, the x-ray, everything about him, he had no risk factors otherwise. It simply wasn't indicated." (Tr. at 50-51)

23. Dr. Sherry testified that he was not present in the ED when the patient later returned by squad, but is aware that Patient 2 returned in full cardiac arrest, that efforts to revive him failed, and that he died. (Tr. at 56)
24. Dr. Sherry testified that Patient 2's family had filed a lawsuit against him; consequently, he "remember[s] everything about this patient." (Tr. at 61-62)

Patient 3

Dr. Wadsworth

25. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 3:

Patient No. 3 was a 21-year-old male who presented to Mercy Medical Center on May 6th, 2004, around 10:00 p.m. by squad.

Patient [3] complained of dizziness, chest pain, and syncope or passing out while the patient was playing basketball. He had a previous episode and had been evaluated in the emergency department for that one week prior.

Initial vital signs are recorded. He showed a low blood pressure of 88 over 45, heart rate was 96, and temperature slightly elevated at 100.1 with a normal pulse oximetry of 96 percent.

The patient had a past medical history of asthma and hydrocephalus, and he had a shunt in place [for the hydrocephalus].

The evaluation in the emergency department included history and physical examination, EKG, chest x-ray and blood tests and/or static vital signs. The patient was treated with IV fluids. It was noted that the troponin I, the heart enzyme, was slightly elevated, and that the patient had EKG changes that could be consistent with pericarditis.

The patient had a second EKG which was unchanged in the emergency department. Had an—He had an elevated white blood cell count and a renal test that was abnormal also.

It was discussed with the patient that he may have pericarditis, and was advised to return with any further problems. And the patient was discharged with improvement of his symptoms, although it was noted that he complained of dizziness upon discharge.

(Tr. at 179-181)

26. Dr. Wadsworth testified: "In a young patient with syncope or passing out, particularly while playing or exercising, in my mind raises the concern of hypertrophic heart disease, which could represent serious underlying pathology, and further evaluation would be necessary to identify that [or rule it out]." (Tr. at 182)

During cross-examination, Dr. Wadsworth testified that hypertrophic heart disease can be ruled out by an echocardiogram, or by listening for a particular murmur on physical examination. When asked why Dr. Sherry should have performed an echocardiogram if he

had already ruled out hypertrophic heart disease by listening for the murmur,³ Dr. Wadsworth replied, “In my opinion, the stakes were raised in the particular instance. He had had a previous admission to the emergency department. He was back again with similar symptoms, he had some abnormalities in his evaluation.” (Tr. at 233-234)

In response to further questions, Dr. Wadsworth testified that she believes that Dr. Sherry’s treatment for pericarditis had been appropriate, but criticized Dr. Sherry for failing to arrange for follow-up and failing to follow up on the abnormal troponin I lab result. (Tr. at 234-237)

27. Dr. Wadsworth testified that, in her opinion, Dr. Sherry’s care and treatment of Patient 3 constituted a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Wadsworth further testified:

The reason why was that the EKG was not interpreted correctly and that the troponin test was not followed up on. In an instance like that, if there is a test that you don’t believe, or is not clinically relevant, I think as an emergency physician, it is still your duty to either repeat that test or follow up on it in some way to confirm indeed that it is a false test.

(Tr. at 181) Dr. Wadsworth added that, if, for example, the troponin increased, “it may have been more supportive of the pericarditis or that some underlying cardiac pathology existed in this patient.” (Tr. at 182)

Dr. Wadsworth further testified that Dr. Sherry’s failure to “arrange for further evaluation of Patient 3, including an echocardiogram or lab testing[,]” constituted a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. (Tr. at 184)

Dr. Sherry

28. Dr. Sherry acknowledged that a 21-year-old who passes out during exercise could be suffering from hypertrophic heart disease, which is a life-threatening condition. Dr. Sherry implied that he had evaluated Patient 3 for that condition by listening for a particular heart murmur while the patient was squatting and ruled it out. (Tr. at 72, 233)
29. Dr. Sherry acknowledged that the EKG revealed both downsloping of the PR segment and ST elevation, and that the combination of those occurring multiple times is indicative of pericarditis. Dr. Sherry stated that he had informed Patient 3 of the possibility of pericarditis. (Tr. at 67-68; see also St. Ex. 3 at 55)

³ The Hearing Examiner was unable to find documentation that Dr. Sherry had listened for this murmur which, according to Dr. Sherry, requires the patient to squat, nor did Dr. Sherry document ruling out or considering hypertrophic heart disease. (St. Ex. 3; Tr. at 233)

Dr. Sherry testified that lab results had indicated that Patient 3's troponin had been slightly elevated. However, Dr. Sherry testified that he had interpreted that to have resulted from Patient 3 having recently engaged in strenuous, "weekend warrior-type" athletic activities. Nevertheless, Dr. Sherry acknowledged that such a result could also be indicative of pericarditis.

30. When asked whether his role as an emergency medicine physician is to rule out the most potentially dangerous or life-threatening illness or illness, Dr. Sherry replied, "No." He further testified, "My role is to determine the most likely cause of the patient's chief complaint and treat them appropriately." (Tr. at 63-64)

Patient 4

Dr. Wadsworth

31. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 4:

[Patient 4] was a 30-year-old female who presented to an external stat care on July 12th, 2004, at 11:10 a.m. Her chief complaint at that time was left-sided chest pain and shortness of breath which had started at 4:00 a.m. on that same date. Patient had reported similar symptoms for several months, along with fatigue.

Patient also had some vomiting and diaphoresis or sweating with that episode. It was noted by the physician at the stat care that the chest x-rays showed a right-sided pneumothorax, and Mercy Medical emergency department was contacted and transfer arrangements were made where Dr. Sherry assumed care of the patient.

Initial evaluation, vital signs were recorded showed a blood pressure that was low, 93 over 27, and a heart rate of 60 with pulse oxygenation of 100 percent on ten liters of oxygen. Dr. Sherry interpreted the chest x-ray as a 30 to 40 percent pneumothorax and placed a chest tube who—the resident he supervised, a resident did that initially.

* * *

* * * It was noted that the chest tube wasn't placed correctly and then Dr. Sherry subsequently replaced the chest tube, which my interpretation of the records was done prior to Dr. Sherry receiving the x-ray report that the chest tube was outside of the chest and that there was no pneumothorax.⁴

(Tr. at 184-186)

⁴ Dr. Sherry testified that he had evaluated only the x-ray taken at the StatCare prior to allowing the resident to insert a chest tube. After the resident inserted the chest tube, Dr. Sherry ordered the first chest x-ray taken at Mercy. (Tr. at 81-85) The radiologist's report for that x-ray states, among other things, that "[t]he lungs are well-inflated and clear with no pneumothorax." (St. Ex. 4 at 45) Dr. Sherry testified that he had reviewed the x-ray—without the radiologist's report—prior to removing and replacing the chest tube. (Tr. at 83-84)

32. Dr. Wadsworth testified that she is concerned that “it appeared based upon the record review that the patient’s symptoms were on the left side, but the findings were on the right side * * * [and] Dr. Sherry’s dictated report [stated] that the patient had decreased breath sounds on the left side and not the right side.” (Tr. at 186-187; St. Ex. 4 at 31)

Dr. Wadsworth further testified: “[T]he patient was having left-sided chest pain. It was interpreted that the chest x-ray showed a right-sided pneumothorax, but the physical exam revealed decreased breath sounds on the left side, so that there [were] inconsistencies between the tests and the examination and the history.” Dr. Wadsworth noted that the chest tubes were placed on Patient 4’s right side. (Tr. at 187-188; St. Ex. 4 at 31)

Dr. Wadsworth also testified that pneumothorax is usually painful, and “most of the time” a patient can identify the side of the chest from which the pain emanates. (Tr. at 188-189)

33. Dr. Wadsworth testified that Dr. Sherry’s failure to correlate Patient 4’s symptoms to the original and post-placement x-rays constituted a departure from or the failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (Tr. at 189)

Dr. Wadsworth further testified that Dr. Sherry’s failure to properly interpret the second chest x-ray constituted a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. (Tr. at 191)

34. During his cross-examination of Dr. Wadsworth, Dr. Sherry described a situation where, after being presented with a patient whose history and presentation fit a patient with pneumothorax, the patient appears to be deteriorating, including increased shortness of breath, “very diaphoretic,” and greatly increased breathing effort. Dr. Sherry asked if it would be prudent to take the necessary steps to correct the situation, to which Dr. Wadsworth replied:

Based upon the information you just presented, I agree with you. But based upon the documentation that I had access to, that did not appear to be the case.

And to follow up on what you said about the patient being in extremis, and having compromise with the pneumothorax, my first intervention wouldn’t have been a chest tube. I would have done a needle decompression.

(Tr. at 238-239)

35. When Dr. Sherry asked Dr. Wadsworth why the placement of an unnecessary chest tube would be so significant, she replied, “I think anytime you do an invasive procedure that’s not necessary, that creates pain and difficulty for the patient in addition to the potential for complications related to that procedure.” (Tr. at 239)

Dr. Sherry

36. In his written report concerning Patient 4, Dr. Sherry stated:

This patient presented with acute onset of chest pain and shortness of breath which woke her from sleep. She was initially seen by a physician at a local StatCare, had a chest x-ray which was read and she was diagnosed with pneumothorax. I discussed this case with the StatCare physician prior to the patients transfer to my [ED]. This patients history was very indicative of a pneumothorax which included a 30 year old smoker with coughing for several months, sudden onset of additional symptoms after hard coughing * * *; shortness of breath, non-radiating chest pain, and vitals showing respirations of 36 on initial presentation. A chest x-ray read by the StatCare physician showed a pneumothorax, which I agreed with upon review of the films sent with the patient. On arrival, I evaluated this patient and found her blood pressure was dropping and she was becoming more unstable, and so in light of the history, discussion with StatCare physician and my personal reading of the chest x-ray, elected to place a chest tube.⁵ Although chest tube placement is considered an invasive procedure, the patient seemed to be deteriorating and so the benefits outweighed the risks of delay in this case.

In this case, there was no departure from or failure to conform to minimal standards of care of similar practitioners and an error in reading an x-ray by 2 involved physicians does not necessarily reflect a deviation from standard of care.

(Resp. Ex. A at 3)

37. Dr. Sherry testified that he had determined that Patient 4 suffered from pneumothorax “[b]y clinically evaluating the patient and by looking at the chest x-ray that the patient brought with her.” Dr. Sherry testified that he read the x-ray himself and it had appeared to him that Patient 4 had a right-sided pneumothorax. Dr. Sherry agreed that he had documented that the patient had chest pain, but that he had not specified in the medical record which side the pain was on. When directed to the chief complaint as recorded in the nurse’s assessment, Dr. Sherry acknowledged that it states that the patient’s chest pain was on her left side. When asked whether patients feel pain on the same side as a pneumothorax, Dr. Sherry testified that they can, although in the case of a tension pneumothorax, the patient can feel pain on the side opposite the pneumothorax. (Tr. at 78-81)
38. Dr. Sherry testified that, after the first, unsuccessful placement of a chest tube by a resident under his supervision, an x-ray was obtained to determine whether the tube had been properly placed. Dr. Sherry testified that he had reviewed the x-ray himself, which had been placed on the hospital’s computer system, and noted that the chest tube had been placed outside of the rib cage. Dr. Sherry then removed the chest tube, placed a new one

⁵ Dr. Sherry acknowledged that he had not documented the deteriorating condition of the patient. (Tr. at 86)

himself, and obtained a second x-ray to determine proper placement. (Tr. at 81-85; St. Ex. 4 at 43, 45)

The radiologist's report for the first x-ray that Dr. Sherry had ordered, taken prior to the correct placement of a chest tube, states, among other things, that "[t]he lungs are well-inflated and clear with no pneumothorax." Dr. Sherry testified that he had not seen the radiologist's report prior to replacing the chest tube, only the x-ray itself. Nevertheless, he acknowledged that, in hindsight, the patient had not required a chest tube. (Tr. at 85-86)

39. Dr. Sherry's statement in his written expert report that Patient 4's history included "sudden onset of additional symptoms after hard coughing" is not supported by the medical records, and contradicts Dr. Sherry's ED records. In his dictated ED Report, Dr. Sherry had stated, among other things: "[Patient 4] states that at 4:00 a.m. this morning she had developed shortness of breath and pain. She has never had a problem like this in the past. There is no history of any coughing episodes or other problems." (St. Ex. 4 at 31)

Some medicals records, such as records from the stat care facility, and some of the records from the Mercy ED, including a discharge summary and a history and physical examination report, both of which had been authored by another physician, confirm that Patient 4 had been coughing for several months. However, no medical documentation referenced during hearing corroborates Dr. Sherry's assertion that Patient 4 suffered a sudden onset of symptoms as the result of hard coughing, nor could the Hearing Examiner find any such record. (St. Ex. 4 at 9, 11; second pages 5, 15, 31; Resp. Ex. A at 3)

Patient 5

Dr. Wadsworth

40. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 5:

Patient No. 5 was an 83-year-old male who presented to Samaritan Regional Emergency Department on February 28th, 2005, at 1:16 [p.m.].

The chief complaint was left lower quadrant abdominal pain. The patient also reported having chest pain and shortness of breath, which had started suddenly. The patient had significant past medical history of Alzheimer's disease, heart disease, a heart dysrhythmia, and chronic obstructive lung disease.

The patient was treated in the emergency department for cardiac or heart dysrhythmia after lab testing [which] included chest x-ray, [EKG], blood work, and urine test.

I was unable to see where the interpretation of the tests were in the ED record other than there was a documentation of a flutter of the EKG.

The patient was subsequently admitted and then when the chest x-ray was read the next day, it was found that the patient had a 90 percent pneumothorax or collapsed lung.

The patient was then treated and then discharged from the facility.

(Tr. at 192-193)

41. Dr. Wadsworth testified that Dr. Sherry “should have either reviewed the x-ray or contacted the radiologist to know what the results were prior to making a final disposition on the patient.” (Tr. at 194-195)
42. Dr. Wadsworth testified that Dr. Sherry’s failure to evaluate the chest x-ray he had ordered constituted (1) a departure from or the failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances, and (2) a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. (Tr. at 195-196)
43. Dr. Wadsworth testified that, in her opinion, the pneumothorax had likely contributed to Patient 5’s cardiac dysrhythmia. (Tr. at 240)

Testimony of Dr. Sherry

44. Dr. Sherry testified that, upon Patient 5’s arrival at the ED, he had ordered lab tests, an EKG, and a chest x-ray. Dr. Sherry testified that Patient 5 had had an atrial flutter that he treated successfully with Cardizem. Dr. Sherry testified that the patient was then admitted to the ICU. (Tr. at 87-88)

Dr. Sherry testified that he had apparently not seen the chest x-ray for Patient 5, which had revealed a pneumothorax. When asked why he had not reviewed the x-ray, Dr. Sherry testified that, at that hospital, if a radiologist is on duty, the x-ray technician takes the x-ray to the radiologist who reads the film and calls the ED physician concerning any abnormalities. Dr. Sherry implied that, if there are no abnormalities, the radiologist does *not* contact the ED physician. Dr. Sherry further testified that, if there is no radiologist on duty, the x-ray technician takes the film directly to the ED physician. Dr. Sherry stated that, with respect to Patient 5, the radiologist had evidently been on duty because he had not received the x-ray, and he had assumed that the x-ray results had been negative because he was not called by the radiologist. Dr. Sherry noted that ED films were generally read by the radiologist very quickly, and he had assumed that that had occurred in Patient 5’s case. Moreover, Dr. Sherry testified that he did not do any checking to verify if the x-ray had been read “[b]ecause we’re notified of any abnormalities.” At hearing, Dr. Sherry speculated that the radiologist had either left for the day or the x-ray tech had placed the film in the wrong stack. Dr. Sherry testified that, in any case, the x-ray was not read by the radiologist until the following day. (Tr. at 88-91)

When asked whether an emergency medicine physician such as Dr. Sherry should follow up and obtain the results of tests he has ordered, Dr. Sherry agreed that it is important to do that; however, he had also been required to follow the protocols of the hospital where he had been working. (Tr. at 91-92)

45. Dr. Sherry testified that his ED report concerning Patient 5 indicates that Patient 5's pain had resolved spontaneously during his stay in the ED. Dr. Sherry acknowledged that that finding is not consistent with untreated pneumothorax. (Tr. at 93)

Patient 6

Dr. Wadsworth

46. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 6:

18-year-old male presented to Samaritan Regional Health Systems February 1st, 2004, at 1:45 p.m., chief complaint of right arm injury as well as a head injury after sledding. There was reported loss of consciousness related to the head injury, and there was also nursing documentation that there was a deformity of the wrist.

The patient was evaluated and x-rays of the wrist were obtained as well as a CAT scan of the head. Dr. Sherry, after reviewing the wrist films, attempted two closed reductions of the wrist fracture, and noted that there was * * * less than optimal reduction of the fracture.⁶

Patient was splinted, discharged, and referred to [an orthopedic surgeon] in two to three days for his wrist fracture.

(Tr. at 197-198)

47. Dr. Wadsworth noted that Patient 6 was right-hand dominant, and the injury had occurred to his right wrist. (Tr. at 199)
48. Dr. Wadsworth testified that Dr. Sherry's failure to involve an orthopedic surgeon earlier in the management of Patient 6 constituted (1) a departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, and (2) a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities of treatment of disease. (Tr. at 200-202)
49. Dr. Wadsworth noted that she did *not* fault Dr. Sherry for being unable to obtain an optimal reduction of the fracture. (Tr. at 202-203)

⁶ The x-ray taken after Dr. Sherry's second reduction was admitted to the hearing record as State's Exhibit 6A.

50. Dr. Wadsworth stated that on February 3, 2004, Patient 4 underwent surgical treatment of his wrist fracture. (St. Ex. 12 at 7)

Dr. Sherry

51. Dr. Sherry testified that, after obtaining and reading an x-ray, which revealed a fracture of the distal radius, he had attempted to reduce and splint Patient 6's fracture. Dr. Sherry further testified that he had obtained another x-ray, and reduced and splinted the fracture a second time because he was unhappy with the results of the first reduction. Dr. Sherry acknowledged that the x-ray following the second reduction, a copy of which was admitted to the record as State's Exhibit 6A, reveals that the reduction was still not optimal. Dr. Sherry testified that he had instructed Patient 6 to follow up with an orthopedic surgeon in two to three days for complete reduction of the fracture. (Tr. at 95-102)
52. When asked why he had not contacted an orthopedic surgeon to see Patient 6 while Patient 6 was in the ED, Dr. Sherry replied: "Because it wasn't necessary. It wasn't indicated. There was no indication for an emergent referral [to] an orthopaedic surgeon in this case. There was no neurovascular compromise. The bone had been stabilized and appropriate referral was recommended." (Tr. at 101)

Dr. Sherry testified that he had recommended that Patient 6 see an orthopedic surgeon in two to three days because "[u]sually the orthopaedic surgeons like to let a couple of days pass before we follow up with these fractures to allow the swelling to go down and they can more appropriately either reduce it in their office or whatever they're going to do." (Tr. at 102)

Dr. Wadsworth

53. Dr. Wadsworth testified that she agrees with Dr. Sherry's assessment that Patient 6's situation had not been emergent; nevertheless, Patient 6 did not have adequate treatment in the ED and an orthopedic surgeon should have been consulted at least by telephone early on in his care. Dr. Wadsworth further testified that, depending on the physician: "The orthopedic surgeon may very well say, 'Splint them. I'll see them tomorrow morning.' They may say, 'I'll come in and evaluate them tonight.'" However, an orthopedist should have made that decision. (Tr. at 201; see also St. Ex. 6A)

Patient 7

Dr. Wadsworth

54. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 7:

[Patient 7] was a 63-year-old female who presented to Alliance Community Hospital emergency department on February 25th, 2003, at 9:49 a.m. via the ambulance for shortness of breath. Patient had significant past medical history of diabetes, hypertension, coronary heart disease, and chronic lung disease.

She was identified as having respiratory failure, and was intubated and placed on a ventilator approximately 41 minutes after arrival to the emergency department, and she was subsequently admitted to the intensive care unit for her condition. She improved and was subsequently discharged.

It was noted during the course of evaluation Dr. Sherry did order laboratory evaluation, x-ray, ECG, and attempted central line four times.

(Tr. at 203) Further, Dr. Wadsworth stated in her written report that Dr. Sherry had noted that Patient 7's blood work revealed an elevated potassium level. (St. Ex. 12 at 8) The medical records indicate that Patient 7's potassium level had been 7.7 mmol/L with the reference range being 3.6 – 5.2 mmol/L. (St. Ex. 7 at 21, 323)

55. Dr. Wadsworth testified: “My primary concern was [that] the elevated potassium level was not addressed or treated in light of the acute illness of the patient, that the elevated potassium could have been directly responsible for her compromise, and that quicker care would have been appropriate.” She further testified that an elevated potassium level of 7.7 can cause cardiac failure—the heart could beat abnormally or stop beating. (Tr. at 204)

Dr. Wadsworth further testified that the degree of concern with respect to an elevated potassium level depends partly on the patient's condition. Dr. Wadsworth noted that, in Patient 7's case, her presentation of respiratory failure related to congestive heart failure may have resulted directly from a heart arrhythmia that in turn resulted from an elevated potassium level. Dr. Wadsworth testified that Patient 7 should have been given the appropriate series of medications to “bind up the potassium and remove it from the system.” (Tr. at 205-207)

56. Dr. Wadsworth testified that Dr. Sherry's treatment of Patient 7 had constituted (1) a departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, and (2) a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities of treatment of disease. (Tr. at 204, 207-208)

Dr. Sherry

57. Dr. Sherry testified that, after Patient 7's arrival at the ED, he had ordered lab tests including a test for Patient 7's potassium level. Dr. Sherry testified that the results had indicated that her potassium level was 7.7, which is very high. Dr. Sherry further testified that that result had “[a]pparently” been called in to the ED at 11:21 a.m.; however, he had not been made aware of it right away. Moreover, Dr. Sherry testified that he can not recall if he had learned of the potassium level after Patient 7 had been transferred to the ICU, or while she was still in the ED. Furthermore, Dr. Sherry testified that he “would like to think” that, if made aware of the potassium level, he would have addressed it.

(Tr. at 103-108; St. Ex. 7 at 323) When asked if there is any reason why he would not have addressed it immediately, Dr. Sherry testified:

There might be. You have to remember that at the time that I saw this patient, I had been out of residency for five, six, seven months. I was still, at that point, relying a lot on people like El Mobasher [the admitting physician] to help me do the things that I needed to do to follow the protocol to address what needed addressed at the time.

I think I would have treated a 7.7 if I would have been aware of it. * * * If I had talked to El Mobasher and I told him it was a 7.7, he well may have said, "Is she otherwise stable? If she was, send her over here and I'll address it right now."

So I don't recall exactly what the chronology of everything that took place was.

(Tr. at 108-109) Dr. Sherry added that, if he had been aware of Patient 7's potassium level, he does not believe that it's possible that he would have chosen not to treat it. (Tr. at 109)

Patient 8

Dr. Wadsworth

58. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 8:

Patient No. 8 was a 69-year-old male who presented to Samaritan Regional Health Systems emergency department at 1:20 on March 13th, 2005, for a chief complaint of near syncope or almost passing out.

Patient No. 8's medical history included stroke, myocardial infarction, and he had had stent placement, hypertension and seizure disorder. Patient also reported that he had shortness of breath while he was walking to the bathroom.

Emergency medical system was initiated and the patient was brought into the emergency department. His evaluation in the emergency department included a CAT scan, laboratory testing, chest x-ray, patient had slightly low hemoglobin/hematocrit, I'll qualify it was [not] significant but it was lower than the acceptable range, his d-dimer⁷ was elevated and his INR⁸ was subtherapeutic.

⁷ Dr. Wadsworth testified that d-dimer "is a byproduct of clot production in the body, and when it's elevated, although it's not a specific test, it can * * * lead you to believe that there may be some clotting process occurring. Most notably, it is associated with pulmonary embolus or clots in the lungs." (Tr. at 209-210)

⁸ Dr. Wadsworth testified that INR stands for International Normalizing Ratio, and that that is a standardized measure of how quickly the blood clots. (Tr. at 209)

* * *

* * * One of the medications that the patient was on was Coumadin, which is a blood thinner, and hence why the INR was drawn.

Additional abnormal lab tests were an elevated LDH and alkaline phosphatase, a BNP, which is brain natriuretic peptide, and a subtherapeutic Dilantin level, which is a seizure medication.

It was noted that his blood pressure was low at 95 over 73, and the remainder of his vital signs were within normal range. He was treated with IV fluids. His blood pressure, upon repeat, was 102 over 62, so it had improved; and the patient reported that he was feeling better and discharged at 5:40 p.m.

Subsequent to discharge, the patient's son had called and reported that the patient was dizzy and he was concerned that the patient should not have been discharged, and it was recommended by the emergency department staff to either return to the emergency department or for them to call the primary care provider, which the son said he would do.

It was documented that Dr. Sherry was aware of the phone call. And then the son called back about 20 minutes later, asked to speak with the primary care physician, was transferred to the physician on call and then the EMS, it looks like was activated at 6:43.

[When the EMS arrived,] Patient [8] was noted to be tachycardic with a heart rate of 120 and his blood pressure was low, 70 over doppler.

* * *

Patient was wheezing, and diaphoretic or sweating. They treated him with an albuterol treatment for the wheezing. And then at 7:12 became unresponsive and identified as having cardiac arrest. Attempts were made at resuscitation, which were unsuccessful.

(Tr. at 208-212)

59. Dr. Wadsworth testified that Dr. Sherry's care and treatment of Patient 8 had constituted a departure from or failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Wadsworth expressed concern that Patient 8 had had multiple medical problems that might have caused his complaint of near-syncope, including a history of cardiac problems, stroke, and seizure disorder. She further expressed concern that Patient 8 had a history of hypertension but presented with hypotension. Moreover, Patient 8 "had abnormal blood tests that did not appear to be further evaluated or delineated which could have accounted for the syncope, including the elevated d-dimer." Additionally, Dr. Wadsworth testified that Patient 8's Dilantin level was subtherapeutic

which could have caused a seizure which led to the near-syncope. Finally, Patient 8's INR had been subtherapeutic, and Patient 8 may have had a stroke or other clotting event that led to his near-syncope. (Tr. at 212-213)

Dr. Wadsworth further testified that Dr. Sherry's care and treatment of Patient 8 had constituted a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities of treatment of disease. Dr. Wadsworth opined that Dr. Sherry had failed to "follow up on abnormal lab tests or perform additional testing based upon the patient's complaint and evaluation that was documented." (Tr. at 213)

60. During his cross-examination of Dr. Wadsworth, Dr. Sherry presented a scenario wherein Patient 8 had been a frequent visitor to the ED, Dr. Sherry had been very familiar with Patient 8, knew that Patient 8 was noncompliant with regard to taking his blood pressure medication, knew that Patient 8 would go days without taking his blood pressure medication and then, out of concern that his wife would notice he hadn't been taking his medication, would take two or three times the normal dose of his blood pressure medication.⁹ (Tr. at 251-252)

Presented with that scenario, Dr. Wadsworth acknowledged that a patient who takes three times his normal dose of blood pressure medication could become hypotensive. However, Dr. Wadsworth testified that she would want to know what the patient took. Dr. Wadsworth further testified that she did not find any documentation that Patient 8 had taken an excessive dose of medication. (Tr. at 252-253)

Dr. Sherry then expanded on the scenario and indicated that Patient 8 eventually said that he felt better and wanted to go home, and Patient 8's wife told Dr. Sherry that he was back to baseline and that she wanted to take him home.¹⁰ Dr. Sherry asked Dr. Wadsworth whether, when presented with that scenario, he should have admitted Patient 8 because the patient had had an elevated d-dimer. Dr. Wadsworth replied:

Specifically, in regards to this case, there were several abnormal tests that were not addressed. It is not clear whether that was baseline for him or not based upon the documentation that I reviewed.

In a general way, with the patient that you described, the recurrent visit—ED visit patient, *if they were at baseline and I could prove laboratory tests were at baseline*, [and] the family felt that he was at baseline, I would feel perfectly comfortable having a conversation with sending him home.

(Tr. at 253-255) (Emphasis added)

⁹ None of these assertions are documented in the patient record. (St. Ex. 8)

¹⁰ The medical record documents that, at 5:29 p.m., Patient 8 "[f]eels good – ready to go home." However, there is no documentation that Patient 8's wife or anyone else had advised Dr. Sherry that Patient 8 was back to baseline. (St. Ex. 8 at 47)

Dr. Sherry

61. Dr. Sherry acknowledged that Patient 8 had a blood pressure of 102/60 upon discharge from the ED, which is a low value. However, Dr. Sherry testified that he had been very familiar with this patient, who was regularly noncompliant with his blood pressure medication. (Tr. at 127-128) In his written report, Dr. Sherry had stated that Patient 8 “presented to the [ED] very frequently for various, vague symptoms as well as complaints such as the near syncope.” (Resp. Ex. A at 5) Moreover, Dr. Sherry testified:

Very often he would come into the emergency room because he had again just started his blood pressure medication, and it brought his blood pressure down too low either because he was taking it inappropriately, he had taken too many and that’s why his blood pressure was low, and that’s why he would come into the emergency room. Normally, he didn’t even take his blood pressure medication.¹¹

(Tr. at 128)

62. Dr. Sherry testified that he is aware that Patient 8’s son had called the ED less than an hour after Patient 8’s discharge and complained that Patient 8 became dizzy when he stood up and that he should not have been discharged from the ED. Dr. Sherry further testified that he had seen and attempted to resuscitate the patient when Patient 8 was transported back to the ED. (Tr. at 129-131)

Patient 9

Dr. Wadsworth

63. Dr. Wadsworth testified as follows concerning Dr. Sherry’s care and treatment of Patient 9. She testified that Patient 9 was a 76-year-old male who presented to the Samaritan ED on June 1, 2004, at 1:51 p.m. Dr. Wadsworth further testified:

The patient’s chief complaint was shortness of breath and infection. The patient, it was documented that he had reports of fatigue, chills, and increased drainage from his biliary tube.

Vital signs were recorded which showed that his blood pressure was low at 89 over 50. His heart rate was slightly tachycardic at 108, and his temperature was slightly elevated at 99.2.

He had a past medical history of pancreatic cancer and recent GI bleeding. Laboratory evaluation was conducted as well as chest x-ray. The chest x-ray

¹¹ None of these assertions are documented in the medical record for Patient 8. (St. Ex. 8)

report from the radiologist showed either pleural thickening or effusion, which is a collection of fluid, and atelectasis, either chronic or acute.

So it wasn't clear to the radiologist what that represented. The white blood cell count was normal. His hemoglobin and hematocrit were low. His kidney tests showed an elevated BUN and creatine, and his liver function tests were elevated as well.¹²

* * *

The patient was treated in the emergency department with IV fluids as well as oral fluids, and discharged at 5:00. His blood pressure noted at discharge was still low at 90 over 60.

Subsequently, the blood cultures [came back] positive, and it was recommended that the patient be seen in the emergency department or by his primary care physician, and it was noted that the patient had gone to Ohio State and was admitted to the intensive care unit.

(Tr. at 217)

64. Dr. Wadsworth opined that Dr. Sherry's care and treatment of Patient 9 constituted a departure from or failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Wadsworth testified that Patient 9 should have been admitted for further evaluation and treatment rather than discharged. Moreover, Dr. Wadsworth stated: "Dr. Sherry did not address the slight temperature and hypotension of an immunocompromised patient or the low red blood cell count in light of a recent GI bleed and the low blood pressure. In my opinion this represents a departure from the minimal standard of care." (Tr. at 217-218; St. Ex. 12 at 10)

Dr. Wadsworth further stated:

In my opinion Dr. Sherry failed to maintain a minimal standard in the selection or administration of drugs as he did not treat the hypotension in [Patient 9] to an adequate level of resolution. The patient was given IV fluids which did not correct the patient's condition and [Patient 9] was not given any further treatment for the low blood pressure.

(St. Ex. 12 at 10)

¹² Dr. Wadsworth testified that Patient 9's recent gastrointestinal bleeding could have caused the low hemoglobin and hematocrit. She further testified that the elevated BUN and creatine could have resulted from dehydration or some underlying kidney disease. Dr. Wadsworth suspects that Patient 9's elevated liver enzymes were related to his pancreatic cancer. (Tr. at 216)

Dr. Sherry

65. In his written report, Dr. Sherry stated:

This patient presented for a small amount of drainage around his surgically placed biliary tube. When asked about the other complaints of fatigue and chills off and on for the last few days which he initially gave to the triage nurse, he stated that it was not really new as he had cycles like that which would wax and wane and he was in the [ED] only to have the drainage checked. His spouse stated that his overall condition was much better. Drainage cultures were obtained as well as labs and x-rays which were discussed with the patient and his spouse. Although his blood pressure remained slightly low during his stay, it was considered baseline as per the patient and his spouse and a temperature of 99.2 is certainly not a fever and was also considered baseline for this patient. There was nothing new on the lab or x-ray results and considering that he felt better and his spouse stated he was much better overall, it was deemed safe to discharge him home with close follow-up. He had a good family support system in place and his spouse was very familiar with his condition and treatment for it and was certainly willing and able to bring him back to the emergency department for any changes or concerns.

In this case, there was no departure from or failure to conform to minimal standards of care of similar practitioners.

(Resp. Ex. A)

66. Dr. Sherry testified that he did not review the nurse's assessment, other than the patient's chief complaint, prior to performing his physical examination of Patient 9; however, he reviewed it later. Dr. Sherry testified that he finds "that the nursing information clouds what the patient is actually there for." (Tr. at 132-133; St. Ex. 9 at 3)
67. Dr. Sherry agreed that Patient 9 had a history of pancreatic cancer and a recent incident of gastrointestinal bleeding. (Tr. at 135)

Dr. Sherry agreed that Patient 9 had presented with a biliary tube and was experiencing drainage from the tube. Dr. Sherry testified that the biliary tube had been placed to drain bile from the pancreas. (Tr. at 135)

Dr. Sherry agreed that Patient 9 presented with a low red blood cell count [low RBC]. (Tr. at 136; St. Ex. 9 at 17)

68. With regard to Patient 9's low red blood cell count, hypotension, and temperature of 99.2 degrees, Dr. Sherry testified: "All of those were considered to be baseline for this patient, especially with a history of a recent GI bleed, I would expect the hemoglobin to be somewhat decreased, a temperature of 99.2 is normal for many people. It's not a fever." (Tr. at 136)

Dr. Sherry further testified that Patient 9's fatigue and chills could have resulted from his anemia. Nevertheless, Dr. Sherry acknowledged that Patient 9's fatigue and chills could have been due to something other than anemia "[i]f you believe the temperature to be elevated * * *." However, Dr. Sherry testified that Patient 9's temperature of 99.2 degrees could have been normal for him. Dr. Sherry further testified that, by definition, a temperature is not a fever until it reaches 100.4 degrees. (Tr. at 136-137)

69. Dr. Sherry testified that Patient 9's biliary tube was not infected. He further testified that he diagnosed Patient 9 with biliary tube drainage. Moreover, Dr. Sherry testified that, as far as he could tell at that time, the drainage had been normal for Patient 9. Finally, Dr. Sherry testified that he had not provided any treatment for Patient 9. (Tr. at 138)
70. Dr. Sherry testified that Patient 9 was admitted to the ICU at OSU Medical Center approximately two days after his discharge from the ED. Dr. Sherry testified that blood cultures taken during Patient 9's ED visit had come back positive. (Tr. at 138-139)

Dr. Wadsworth

71. On cross-examination, Dr. Wadsworth acknowledged that a blood pressure of 90/60 could have been baseline for Patient 9. However, Dr. Wadsworth further testified that, given the patient's presentation, she would not be comfortable calling that the patient's baseline unless that blood pressure was well-documented to be his baseline. Moreover, Dr. Wadsworth testified that, even if the patient's wife told her that 90/60 was Patient 9's baseline blood pressure, based upon his history, fatigue, chills, indwelling device, and the fact that he was immunocompromised, she would have wanted to admit him anyway. Dr. Wadsworth testified, "I would be concerned that that patient potentially was septic considering his constellation of medical problems and hypotension." (Tr. at 255-257)
72. Dr. Wadsworth testified that she would not expect Patient 9 to be hypotensive based upon anemia if his recent GI bleed had been corrected. (Tr. at 262)

Dr. Sherry

73. Dr. Sherry disagreed that Patient 9 was immunocompromised. (Tr. at 135)

Patient 10

Dr. Wadsworth

74. Dr. Wadsworth testified as follows concerning Dr. Sherry's care and treatment of Patient 10:

Patient No. 10 is a 53-year-old male who presented to Samaritan Regional Health System on October 22nd, 2004, at 10:10 a.m. Patient's chief

complaint was right-sided numbness and dizziness. He had a past medical history of open heart surgery and eye surgery.

The vital signs were recorded, blood pressure was 167 over 78, slightly elevated. Heart rate of 47 which was noted to be low, remainder of the vital signs were within normal range.

Patient also reported some nausea, vomiting, diarrhea, and dizziness, pain on the right side of the neck, and right-sided face numb and tingling.

Evaluation in the emergency department included CT of the head, carotid dopplers as well as laboratory evaluation and CT of the chest. The [CT] Scan of the head was reported as a possible right posterior occipital lobe infarct or stroke. Carotid doppler showed some stenosis or narrowing of the right carotid artery, and a little bit more significant stenosis or narrowing of the left carotid artery.

The CT scan [of the chest] was negative for blood clots, but did show chronic obstructive lung disease, and a nonspecific opacity that may have represented a nonspecific alveolitis, some scarring and atelectasis, and there was a liver abnormality noted as well.

The blood count showed an elevated white blood cell count, an elevated d-dimer, an elevated LVH, and an elevated PTT. The nursing documentation had stated that the patient was still dizzy after treatment, medication, and Dr. Sherry's documentation showed the patient was feeling better at 3:40, and was discharged with follow up in three days. The discharge diagnosis was labyrinthitis and possible pneumonia.

On October 22nd, 2004, patient called back to the emergency department and reported the patient could not swallow. I didn't see anything that an action was done at that time. The next day at 9:00, October 23rd, the patient's wife called back and said the patient cannot swallow the medication due to a sore throat.

Dr. Sherry was notified and called in prescriptions for liquid medication, Histussin HC and Amoxicillin. The patient was then subsequently admitted on October 23rd with a diagnosis of stroke or CVA which was confirmed by MRI on October 25th.

(Tr. at 219-221)

75. Dr. Wadsworth opined that Dr. Sherry's care and treatment of Patient 10 constituted a departure from or failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Wadsworth testified that Dr. Sherry had "discounted the diagnosis of stroke as reported by the CT scan, and symptoms that were reported by the patient, although not specific and not reproducible on

his physical examination, still raised a concern of possible stroke or TIA.”¹³

Dr. Wadsworth further testified that, following Patient 10’s discharge, when his wife called the ED to report that Patient 10 could not swallow, that should have caused Dr. Sherry to suspect that the patient might have been having a stroke and needed further evaluation. Moreover, Dr. Wadsworth testified that difficulty swallowing is a symptom that would be consistent with stroke. (Tr. at 221-222, 226, 259)

Dr. Wadsworth further testified that the dizziness and nausea reported by Patient 10 could lead one to suspect stroke, and the “numbness also could be consistent with stroke, although it doesn’t a hundred percent correlate with the CT findings in this instance.” Dr. Wadsworth indicated that the right-sided infarct found on CT may have caused an alteration in his sensations on the same side of his face, but not numbness. (Tr. at 223-224)

Dr. Wadsworth testified that, in her opinion, Patient 10 should have been admitted to the hospital rather than discharged. (Tr. at 225)

76. Dr. Wadsworth opined that Dr. Sherry’s care and treatment of Patient 10 constituted a failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities of treatment of disease. Dr. Wadsworth testified that Dr. Sherry failed to treat Patient 10 with anti-platelet medication, and he prescribed antibiotics and cough medication based upon a telephone conversation without additional evaluation. (Tr. at 225-226)

77. Dr. Wadsworth acknowledged that numbness and tingling on the right side of the face and body would not be consistent with the radiologist’s reading of the head CT scan, which revealed “a right PICA [posterior internal carotid artery] infarct.” (Tr. at 258)

Dr. Wadsworth testified that no symptoms were documented that would be consistent with a right PICA infarct. (Tr. at 260-261)

78. Dr. Wadsworth testified that “a normal neurological examination would not be consistent with a CVA but could be consistent with a TIA or transient ischemic attack.” (Tr. at 258-259)

79. Dr. Wadsworth testified that she would not expect the patient’s dizziness to improve after being given Meclizine¹⁴ if the patient had been having a stroke, although under the circumstances it could have been a TIA that improved on its own. (Tr. at 260)

¹³ Dr. Wadsworth testified that a TIA [transient ischemic attack] does not result in a permanent neurological deficit, which differentiates it from a CVA [cerebrovascular accident] which can leave the patient with permanent neurological damage. Dr. Wadsworth further testified that TIA can be a precursor to a CVA. (Tr. at 263-264)

¹⁴ Dr. Wadsworth testified that Meclizine is a medication used to treat dizziness. (Tr. at 264)

Dr. Sherry

80. In his written report, Dr. Sherry stated:

This patient presented for right sided face, neck, arm and leg numbness and room-spinning dizziness. Otherwise, he had a normal physical exam including a normal neurological exam. As per my re-evaluation, he had improved symptoms and felt better and was amenable to discharge. Although [the] radiologist report indicated possible infarct in right posterior occipital lobe, a stroke in this area would not produce the symptoms of which the patient was complaining of. In addition, the clinical picture and exam overall did not support a stroke as a diagnosis and certainly not as indicated in the area identified on the head CT. When the patient's spouse called the [ED] the next day to report further problems, it was offered by the nurse who handled the call to return to the [ED], to which she refused, therefore, I am attempting to treat this new symptom with medications. Finally, a complaint of sore throat without other symptoms is not an expected symptom of pneumonia and treating the complaint of sore throat without being able to re-evaluate a patient with penicillin is a reasonable alternative.

In this case, there was no departure from or failure to conform to the minimal standards of care of similar practitioners.

(Resp. Ex. A)

81. Dr. Sherry testified that he had ordered CT scans of the head and chest, and a carotid doppler examination for Patient 10. Dr. Sherry further testified that he had reviewed the results of those exams during Patient 10's visit. The radiologist's report concerning the head CT included a finding that "[t]here is a low-density area in the right posterior occipital area; this may represent ischemic infarct, possibly acute," and suggested an "MRI for follow-up examination." Dr. Sherry acknowledged that that finding indicates the possibility of a stroke. However, he testified that the patient's symptoms, including dizziness and right-sided numbness, are not consistent with a stroke in the right posterior occipital area. (Tr. at 144-146; St. Ex. 10 at 15, 21)

With regard to the radiologist's suggestion to follow up with an MRI, Dr. Sherry testified that he had not ordered an MRI because his hospital did not have the capability and he did not believe it was indicated. Dr. Sherry further testified that they would have had to send Patient 10 to Columbus or Cleveland for the MRI. (Tr. at 148-149)

Dr. Sherry testified that the carotid doppler exam revealed "1 to 39 percent stenosis of the right proximal internal carotid artery," and "40 to 59 percent stenosis of the left mid internal carotid artery * * *." When asked if those results caused concern to Dr. Sherry as an ED physician, he replied: "Not really, no. If he's still getting half or more than half of the blood through, then it's not an emergent problem, no. Certainly, it's one that needs to be addressed." (Tr. at 146-148; St. Ex. 10 at 13)

82. Dr. Sherry testified that Patient 10's lab results included a finding that his d-dimer level was elevated. Dr. Sherry testified that an elevated d-dimer could be indicative of a pulmonary embolism or deep vein thrombosis [DVT], but not a stroke. Moreover, Dr. Sherry testified that none of the other lab results were indicative of a stroke. (Tr. at 149-150)
83. Dr. Sherry testified that he later learned that Patient 10 did, in fact, suffer a stroke, but believes that the stroke happened after Patient 10's discharge from the ED. (Tr. at 150)

Additional Information

84. In his closing argument,¹⁵ Dr. Sherry noted that all of the cases in question had occurred between four and six years ago, and that he is a better physician today than he was then. He acknowledged that he had made mistakes and that he may have missed some things. However, he stated that that does not constitute a deviation from the standard of care. He testified: "It's very difficult to see the patient when you're actually right there in front of them, you don't have all of the history, you don't know what the future holds for them, as we do in this hearing and these records." (Tr. at 278-279)

Dr. Sherry further stated that he does not believe it is "fair to be judged by people several years down the road [as to] what kind of physician you are." He stated that it would be more appropriate to discuss his performance with medical directors he has worked with since these cases occurred "to see has he really improved, is he learning, is he growing, is he a better doctor today than he was five, six, seven years ago." Dr. Sherry argued that his more recent performance would demonstrate that he cares about his patients and is not a careless physician.¹⁶ (Tr. at 279-280)

Finally, Dr. Sherry stated that his life has been destroyed by this action, and that he will have to rebuild his life. He asked for the opportunity to continue to practice medicine. (Tr. at 280-281)

FINDINGS OF FACT

1. From 2003 until 2005, in the routine course of his osteopathic practice as an emergency medicine physician, Steven Paul Sherry, D.O., undertook the care of Patients 1 through 10, who were identified on a confidential Patient Key.
 - a. On January 22, 2005, Patient 1 presented to the emergency department on the advice of her physician due to positive blood cultures. Dr. Sherry failed to treat Patient 1 with appropriate medication.

¹⁵ Dr. Sherry represented himself and made these statements while still under oath.

¹⁶ Dr. Sherry did not present any witnesses who could have provided this information.

In making this finding, the Hearing Examiner found Dr. Sherry's testimony concerning information not documented in the medical records to be unreliable. First, it is difficult for anyone to remember details concerning events that happened years before. Second, with respect to Patient 1, Dr. Sherry stated in his written report and in his testimony that Patient 1 had received Vancomycin on January 22, 2005, and that Patient 1's physician had told him that Patient 1 was being treated with antibiotics. When asked how he could remember that information at hearing, Dr. Sherry stated, in part, that he knows she had been on antibiotics because, if she had come in with positive blood culture and was *not* on antibiotics, he would have started her on antibiotics. However, as was demonstrated during the hearing, Patient 1 was not then receiving antibiotics.

It appears that, in his review of the medical records, Dr. Sherry had conflated two different events: (1) Patient 1's visit on January 22, 2005, when Dr. Sherry saw her for positive blood cultures; and (2) Patient 1's visit on *February* 22, 2005, when she was treated with IV Vancomycin by another physician in the ED. This evidently caused him to misremember these events. In any case, this clearly demonstrates that Dr. Sherry's memory is unreliable concerning information not documented in the medical records.

- b. On September 9, 2003, Patient 2 presented to the emergency department with complaints including left shoulder pain, shortness of breath, diaphoresis, and nausea. In his treatment of Patient 2, Dr. Sherry failed to correlate and/or document the correlation of Patient 2's symptoms with underlying pathology, failed to interpret and/or document the interpretation of an abnormal EKG result, and discharged Patient 2 without appropriate treatment. On September 10, 2003, Patient 2 re-presented to the emergency department in full cardiac arrest and was subsequently pronounced dead.

In his defense, Dr. Sherry testified concerning details of his care that are either not supported by the medical records or are directly contradicted by the medical records. For the reasons addressed in Finding of Fact 1.a, and despite Dr. Sherry's testimony that he remembers everything about Patient 2, the Hearing Examiner finds that Dr. Sherry's memory is unreliable concerning information not documented in the medical records.

Moreover, the Hearing Examiner finds incredible Dr. Sherry's testimony that continued observation and testing of Patient 2 was not clinically indicated. Such a statement indicates either dishonesty or a major deficit in Dr. Sherry's clinical knowledge.

- c. On May 6, 2004, Patient 3, a then 21-year-old male, presented to the emergency department with complaints including chest pain, dizziness and syncope, and it was reported that his symptoms commenced while he was playing basketball. Dr. Sherry failed to properly interpret and/or document the proper interpretation of Patient 3's abnormal EKG results and failed to order further appropriate testing and follow up.

- d. On July 12, 2004, Patient 4 presented to a stat care facility with complaints including left-sided chest pain, shortness of breath, coughing, fatigue, diaphoresis, and vomiting. Patient 4 was diagnosed with right-sided pneumothorax and transferred to the emergency department where Dr. Sherry undertook her care. Dr. Sherry interpreted Patient 4's chest x-ray as pneumothorax and opted to insert a chest tube. The chest tube was initially placed by a resident under Dr. Sherry's supervision. Dr. Sherry ordered a chest x-ray and, after reviewing that x-ray, replaced the chest tube because of incorrect positioning. Subsequently, Dr. Sherry received the radiologist's report indicating that Patient 4 did not have a pneumothorax. In Dr. Sherry's care of Patient 4, he failed to properly correlate and/or document the correlation of symptoms with x-ray findings, and failed to clarify Patient 4's diagnosis prior to performing an invasive procedure.
- e. On February 28, 2005, Patient 5 presented to the emergency department with complaints including left lower quadrant abdominal pain, chest pain and shortness of breath. Although tests including chest x-ray, EKG, blood work and urinalysis were ordered, Dr. Sherry failed to interpret and/or properly interpret and/or document the interpretation of Patient 5's chest x-ray.
- f. On February 1, 2004, Patient 6 presented to the emergency department with complaints including right arm injury following a sledding accident. Dr. Sherry performed two closed reductions, but according to a post-reduction x-ray report, adequate reduction had not been obtained. Dr. Sherry splinted Patient 6's arm and discharged him with instructions to follow up with an orthopedic surgeon in two to three days. On or about February 3, 2004, Patient 6 underwent surgical treatment of his wrist fracture. In his treatment of Patient 6, Dr. Sherry failed to involve an orthopedic surgeon earlier in the patient's treatment as was indicated.
- g. On February 25, 2003, Patient 7 presented to the emergency department with complaints including shortness of breath and a medical history of diabetes mellitus, hypertension, coronary heart disease and chronic lung disease. Although Dr. Sherry noted that Patient 7 exhibited a significantly elevated potassium level in her blood work, he failed to treat and/or document any treatment of such elevated potassium level.

Dr. Sherry's testimony that he had not been apprised of Patient 7's elevated potassium level is not credible in light of the seriousness of such a condition. It is hard to believe that hospital staff would have failed to bring that to his attention. Furthermore, Dr. Sherry's testimony to the effect that he did not respond immediately to Patient 7's condition because he was only a few months out of residency is not credible, nor is his testimony that the attending physician would have asked Dr. Sherry to send Patient 7 to the ICU if she was "otherwise stable." After having completed medical school and four years of internship and emergency medicine residency, Dr. Sherry should have been adequately prepared to manage Patient 7's condition or at least recognize the danger Patient 7 had been in.

- h. On March 13, 2005, Patient 8, a 69-year-old male, presented to the emergency department with complaints including near syncope and shortness of breath. Patient 8 had a past medical history including CVA, myocardial infarction with stent placement, hypertension and seizure disorder. Patient 8 exhibited low blood pressure and his blood count revealed low hemoglobin, elevated D-dimer, and subtherapeutic INR. Patient 8 was also found to have an elevated LDH, alkaline phosphatase, BNP, and a subtherapeutic Dilantin level. Dr. Sherry treated Patient 8 with IV fluids and discharged him home. Later that day, Patient 8 was re-transported to the emergency department for treatment of cardiac arrest and subsequently pronounced dead.
- i. On June 1, 2004, Patient 9 presented to the emergency department with complaints including shortness of breath and infection. Patient 9's past medical history included pancreatic cancer and recent gastrointestinal bleeding. Patient 9 exhibited a temperature of 99.2 and blood pressure of 89/50 and had a low blood cell count. Dr. Sherry failed to treat and/or failed to document the treatment of Patient 9's slight temperature and/or hypotension and/or low blood cell count.

Dr. Sherry testified that Patient 9's low red blood cell count, hypotension, and temperature were considered baseline for him. For the reasons addressed in Finding of Fact 1.a, the Hearing Examiner finds that this testimony is unreliable and is therefore not persuasive.

- j. On October 22, 2004, Patient 10 presented to the emergency department with complaints including right-sided numbness and dizziness and a past medical history of open heart surgery and eye surgery. Following tests and treatment, Dr. Sherry discharged Patient 10 later that day with diagnoses of labyrinthitis and possible pneumonia, with instructions to follow up in three days. Following discharge, Patient 10's wife called twice to report Patient 10 could not swallow. On October 23, 2004, Patient 10 was admitted with a diagnosis of CVA. In his treatment of Patient 10, Dr. Sherry failed to appropriately diagnose and/or treat Patient 10 and/or failed to prescribe appropriate medication.

CONCLUSIONS OF LAW

1. The conduct of Steven Paul Sherry, D.O., as described in the Findings of Fact, constitutes a "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.
2. The conduct of Dr. Sherry as described 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 Section 4731.22(B)(6), Ohio Revised Code.

DISCUSSION CONCERNING THE PROPOSED ORDER

The hearing record clearly demonstrates that Dr. Sherry's care and treatment of Patients 1 through 10 was substandard. His conduct seemed to evidence a lack of medical knowledge, lack of sound medical judgment, and/or carelessness. Although one of these cases may have occurred within a year of the completion of his residency; namely, Patient 7 whose elevated potassium went untreated under Dr. Sherry's care, it is incredible that a physician who completed medical school plus four years of internship and residency would fail to identify the significance of that and respond. Moreover, at hearing, several years after completing his residency, Dr. Sherry continued to defend a number of the inappropriate decisions he made in these cases. Accordingly, based upon the record in this matter, Dr. Sherry's continued practice presents a danger to the public, and he should be removed from practice. If, however, the Board determines that Dr. Sherry should keep his license, at a minimum, Dr. Sherry's medical license should be suspended and he should be required to undergo an assessment of his medical knowledge and skills and complete any necessary remedial education, followed by appropriate monitoring for an extended period of time.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Steven Paul Sherry, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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


R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

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

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EXCERPT FROM THE DRAFT MINUTES OF JULY 8, 2009

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDER

Dr. Madia announced that the Board would now consider the Reports and Recommendations and the Proposed Findings And Proposed Order appearing on its agenda.

Dr. Madia asked whether each member of the Board had received, read and considered the hearing record; the Findings of Fact, Conclusions and Proposed Orders; and any objections filed in the matters of Samer Ahmad Ali-Hasan, M.D.; James J. Anthony, M.D.; Romeo C. Enrique, M.D.; Michael Anthony Liston; Jason D. McComb, M.T.; Steven Paul Sherry, D.O.; and Muhammad Z. Shrayyef, M.D.; and the Proposed Findings and Proposed Order in the Matter of David Ronald Miller, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- 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. 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. They may, however, participate in the matters of Dr. Ali-Hasan, Dr. Enrique and Dr. Shrayyef, as those cases are not disciplinary in nature and concern only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Steinbergh indicated that she thought that Dr. Shrayyef's case was pulled from the agenda and she did not review his materials. She would therefore abstain from voting in his case.

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

.....

Dr. Talmage left the meeting during the previous discussion.

.....

STEVEN PAUL SHERRY, D.O.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF STEVEN PAUL SHERRY, D.O. MR. HAIRSTON SECONDED THE MOTION.

.....

A vote was taken on Dr. Varyani's motion to approve and confirm:

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

The motion carried.

State Medical Board of Ohio

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

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October 8, 2008

Case number: 08-CRF-124

Steven Paul Sherry, D.O.
7927 Vanderbilt Drive NW
North Canton, Ohio 44720

Dear Doctor Sherry:

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) From in or about 2003 to in or about 2005, in the routine course of your osteopathic practice as an emergency medicine physician, you undertook the care of Patients 1 through 10, identified on the attached Patient Key. The Patient Key is confidential and to be withheld from public disclosure.
 - (a) On or about January 22, 2005, Patient 1 presented to the emergency department with complaints including positive blood cultures. You failed to treat Patient 1 with appropriate medication.
 - (b) On or about September 9, 2003, Patient 2 presented to the emergency department with complaints including left shoulder pain, shortness of breath, diaphoresis, and nausea. In your treatment of Patient 2, you failed to correlate and/or document the correlation of Patient 2's symptoms with underlying pathology, failed to interpret and/or document the interpretation of an abnormal EKG result, and discharged Patient 2 without appropriate treatment. On or about September 10, 2003, Patient 2 re-presented to the emergency department in full cardiac arrest and was subsequently pronounced dead.
 - (c) On or about May 6, 2004, Patient 3, a then 21-year-old male, presented to the emergency department with complaints including chest pain, dizziness

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and syncope, and it was reported that symptoms commenced while Patient 3 was playing basketball. You failed to properly interpret and/or document the proper interpretation of Patient 3's abnormal EKG results and failed to order further appropriate testing and follow up.

- (d) On or about July 12, 2004, Patient 4 presented to a stat care facility with complaints including left-sided chest pain, shortness of breath, coughing, fatigue, diaphoresis, and vomiting. Patient 4 was diagnosed with right-sided pneumothorax and transferred to the emergency department where you undertook her care. You interpreted Patient 4's chest x-ray as 30-40% pneumothorax and opted to insert a chest tube, which was initially placed by a resident under your supervision, but replaced by you because of incorrect positioning. Subsequently you received a radiologist report that Patient 4 did not have a pneumothorax. In your care of Patient 4, you failed to properly correlate and/or document the correlation of symptoms with x-ray findings, and failed to clarify Patient 4's diagnosis prior to performing an invasive procedure.
- (e) On or about February 28, 2005, Patient 5 presented to the emergency department with complaints including left lower quadrant abdominal pain, chest pain and shortness of breath. Although tests including chest x-ray, EKG, blood work and urine analysis were ordered, you failed to interpret and/or properly interpret and/or document the interpretation of such tests.
- (f) On or about February 1, 2004, Patient 6 presented to the emergency department with complaints including right arm injury following a sledding accident. You performed two closed reductions, but according to a post-reduction x-ray report, adequate reduction had not been obtained. You discharged Patient 6 with a splint, sling and pain medication. On or about February 3, 2004, Patient 6 underwent surgical treatment of his wrist fracture. In your treatment of Patient 6, you failed to involve an orthopedic surgeon earlier in the treatment, and/or failed to establish and/or document the establishment of an adequate follow-up plan, and/or failed to perform adequate treatment of the wrist fracture prior to Patient 6's discharge.
- (g) On or about February 25, 2003, Patient 7 presented to the emergency department with complaints including shortness of breath and a past medical history of diabetes mellitus, hypertension, coronary heart disease and chronic lung disease. Although you noted that Patient 7 exhibited an elevated potassium level in her blood work, you failed to treat and/or document the treatment of such elevated potassium level.

- (h) On or about March 13, 2005, Patient 8, a 69-year-old male, presented to the emergency department with complaints including near syncope and shortness of breath. Patient 8 had a past medical history including CVA, myocardial infarction with stent placement, hypertension and seizure disorder. Patient 8 exhibited low blood pressure and his blood count revealed low hemoglobin, elevated D-dimer, and subtherapeutic INR. Patient 8 was also found to have an elevated LDH, alkaline phosphatase, BNP, and a subtherapeutic Dilantin level. You treated Patient 8 and discharged him home, but that same day, Patient 8 was re-transported to the emergency department for treatment of cardiac arrest and subsequently pronounced dead.
- (i) On or about June 1, 2004, Patient 9 presented to the emergency department with complaints including shortness of breath and infection. Patient 9's past medical history included pancreatic cancer and recent gastrointestinal bleeding. Patient 9 exhibited a temperature of 99.2 and blood pressure of 89/50 and had a low blood cell count. You failed to treat and/or failed to document the treatment of Patient 9's slight temperature and/or hypotension and/or low blood cell count.
- (j) On or about October 22, 2004, Patient 10 presented to the emergency department with complaints including right-sided numbness and dizziness and a past medical history of open heart surgery and eye surgery. Following tests and treatment, you discharged Patient 10 later that day with diagnoses of labyrinthitis and possible pneumonia, with instructions to follow up in three days. Following discharge, Patient 10's wife called twice to report Patient 10 could not swallow. On or about October 23, 2004, Patient 10 was admitted with diagnosis of CVA. In your treatment of Patient 10, you failed to appropriately diagnose and/or treat Patient 10 and/or failed to prescribe appropriate medication.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, 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.

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.

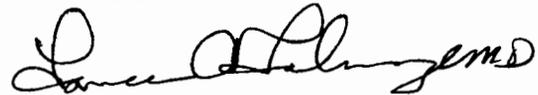
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at 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, M.D.", written in a cursive style.

Lance A. Talmage, M.D.
Secretary

LAT/KHM/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3934 3685 9223
RETURN RECEIPT REQUESTED