



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

December 4, 1992

Tarsem C. Garg, M.D.
2624 Lexington Avenue, Suite 210
Springfield, Ohio 45505

Dear Doctor Garg:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Kevin P. Byers, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of the Minutes of the State Medical Board, meeting in regular session on December 2, 1992, including a Motion amending the Findings of Fact and Conclusions of Law of the Hearing Examiner, and adopting an amended Order.

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

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

THE STATE MEDICAL BOARD OF OHIO

Carla S. O'Day, M.D.
Carla S. O'Day, M.D.
Secretary

CSO:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 055 326 074
RETURN RECEIPT REQUESTED

cc: William A. Todd, Esq.
Terri-Lynne B. Smiles, Esq.

CERTIFIED MAIL P 055 326 075
RETURN RECEIPT REQUESTED

Mailed 12/22/92



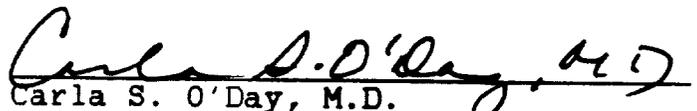
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CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Kevin P. Byers, Attorney Hearing Examiner, State Medical Board; and an excerpt of Minutes of the State Medical Board, meeting in regular session on December 2, 1992, including a Motion amending the Findings of Fact and Conclusions of Law of the Hearing Examiner, and adopting an amended Order, constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Tarsem C. Garg, M.D., 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.


Carla S. O'Day, M.D.
Secretary

(SEAL)


Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

TARSEM C. GARG, M.D.

*

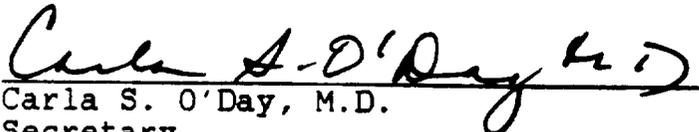
ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 2nd day of December, 1992.

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

It is hereby ORDERED that although sufficient basis exists to support the imposition of disciplinary action in this matter, it is the view of the State Medical Board of Ohio that no further action is warranted. Accordingly, it is hereby ORDERED that this matter be DISMISSED.

(SEAL)


Carla S. O'Day, M.D.
Secretary

12/14/92

Date

92 NOV -6 AM 11:51 REPORT AND RECOMMENDATION
IN THE MATTER OF TARSEM C. GARG, M.D.

On July 14, 15, and September 10, 1992, the Matter of Tarsem C. Garg, M.D. came on for hearing before Kevin P. Byers, Attorney Hearing Examiner for the State Medical Board of Ohio.

INTRODUCTION AND SUMMARY OF EVIDENCE

I. Basis for Hearing

- A. By letter dated February 12, 1992, mailed February 13, 1992 (State's Exhibit #1), the State Medical Board notified Dr. Garg that it intended to determine whether to discipline his certificate to practice medicine and surgery or reprimand or place him on probation due to his care and treatment of three patients, identified on the confidential patient key attached to State's Exhibit #1.

The Board alleged that Dr. Garg's acts, conduct, and/or omissions 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), Revised Code.

- B. By notice received by the Board on March 10, 1992, (State's Exhibit #2), Dr. Garg, through counsel, requested a hearing in this Matter.

II. Appearances

- A. On behalf of the State of Ohio: Lee I. Fisher, Attorney General, by Lisa A. Sotos, Assistant Attorney General
- B. On behalf of the Respondent: Porter, Wright, Morris & Arthur, by William A. Todd, Esq., and Terri-Lynn B. Smiles, Esq.

III. Testimony Heard

- A. Presented by the State
1. Malcolm A. Meyn, Jr., M.D.
 2. Karl Saddler
 3. Bonnie Lorraine

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4. Lorie Kay Bruns
 5. Janice Smallwood
 6. Patient 2
- B. Presented by the Respondent
1. Valeriy Mosanko, M.D.
 2. Constantine Pereyma, M.D.
 3. Tarsem C. Garg, M.D.
 4. Russell L. Anderson, Jr., M.D.

IV. Exhibits Examined

In addition to those noted previously, the following exhibits were identified and admitted into evidence in this Matter:

- A. Presented by the State
1. State's Exhibit #3: March 10, 1992 Notice of Appearance by Attorneys William M. Todd and Terri-Lynne B. Smiles on behalf of Dr. Garg.
 2. State's Exhibit #4: March 10, 1992 request for list of witnesses and documents served upon the State by Dr. Garg.
 3. State's Exhibit #5: March 11, 1992 letter to Dr. Garg from the State Medical Board advising him that a hearing set for March 24, 1992 was postponed until further notice pursuant to Section 119.09, Revised Code.
 4. State's Exhibit #6: March 16, 1992 letter to Dr. Garg from the State Medical Board scheduling his hearing for April 27 and 28, 1992.
 5. State's Exhibit #7: April 8, 1992 request for continuance filed by Dr. Garg.
 6. State's Exhibit #8: April 13, 1992 Entry of the State Medical Board granting the continuance and rescheduling the hearing for June 2 and 3, 1992.

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7. State's Exhibit #9: April 9, 1992 Notice of Appearance by Assistant Attorney General, Lisa A. Sotos representing the State.
8. State's Exhibit #10: April 9, 1992 request for list of witnesses and documents served upon Dr. Garg by the State.
9. State's Exhibit #11: May 18, 1992 request for continuance of hearing filed by Dr. Garg.
10. State's Exhibit #12: May 26, 1992 Entry of the State Medical Board granting the continuance and scheduling the Matter for a firm hearing date of July 14 and 15, 1992.
11. State's Exhibit #13: July 6, 1992 request for continuance filed by Dr. Garg.
12. State's Exhibit #14: July 13, 1992 Entry by the State Medical Board denying Dr. Garg's continuance request.
13. State's Exhibit #15: Curriculum vitae of Malcolm A. Meyn, Jr., M.D.
- * 14. State's Exhibit #16: Selected portions of the patient records for Patient 1.
- * 15. State's Exhibit #17: Selected portions of the patient records for Patient 2.
- * 16. State's Exhibit #18: Selected portions of the patient records for Patient 3.
17. State's Exhibit #19: Selected excerpts from literature, abstracts, and text books which were relied upon by Dr. Meyn in formulating his opinion herein.
- * 18. State's Exhibit #20: Dr. Garg's office records for Patient 1.
- * 19. State's Exhibit #21: Hospital records from Wilson Memorial Hospital, Sidney, Ohio, for Patient 1.
- * 20. State's Exhibit #22: Hospital records from Upper Valley Medical Center, Stouder Memorial Hospital, Troy, Ohio, for Patient 1.
- * 21. State's Exhibit #23: Medical records from the Cleveland Clinic Foundation for Patient 1.

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- * 22. State's Exhibit #24: Dr. Garg's office records for Patient 2.
- * 23. State's Exhibit #25: Hospital records from Upper Valley Medical Center, Stouder Memorial Hospital, Troy, Ohio, for Patient 2.
- * 24. State's Exhibit #26: Dr. Garg's office records for Patient 3.
- * 25. State's Exhibit #27: Hospital records from Upper Valley Medical Center, Stouder Memorial Hospital, Troy, Ohio, for Patient 3.
- 26. State's Exhibit #28: A State Medical Board subpoena duces tecum dated March 6, 1991 commanding Dr. Garg to produce his records for five named patients. (The patient key attached to the exhibit is sealed.)
- 27. State's Exhibit #29: A State Medical Board patient record verification form signed by a nurse employed by the State Medical Board, dated June 6, 1991. (The patient key attached to the exhibit is sealed.)
- * 28. State's Exhibit #30: Eighteen x-rays of Patient 1.
- 29. State's Exhibit #31: August 6, 1992 Motion for Rebuttal Testimony filed by the State.
- 30. State's Exhibit #32: August 7, 1992 Memorandum in Opposition to Motion for Rebuttal Testimony filed by the Respondent.
- 31. State's Exhibit #33: August 13, 1992 Entry granting the State's Motion for Rebuttal Testimony and setting the rebuttal hearing for September 10, 1992.
- 32. State's Exhibit #34A: September 9, 1992 partially redacted affidavit submitted by James M. Lorraine.
- * 33. State's Exhibit #35: October 5, 1988 deposition of Dr. Garg in the civil malpractice action related to Patient 1's death.
- 34. State's Exhibit #36: Chapter 7 from The Manual of Internal Fixation, Third Edition.
- 35. State's Exhibit #37: August 3, 1992 four-page letter from Dr. Meyn to Assistant Attorney General Sotos with an August 6 attachment and affidavit.

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B. Presented by the Respondent

- * 1. Respondent's Exhibit B: Dr. Garg's complete office chart for Patient 1.
- * 2. Respondent's Exhibit C: Dr. Garg's complete office chart for Patient 2.
- * 3. Respondent's Exhibit D: Dr. Garg's complete office chart for Patient 3.
- 4. Respondent's Exhibit E: Diagram of the hand showing musculature and neurovascular structures.
- 5. Respondent's Exhibit F: Another diagram of the hand showing comparable structures as Exhibit E.
- * 6. Respondent's Exhibit G: Operating room schedule for Stouder Memorial Hospital for the day of Patient 3's contracture release surgery.
- 7. Respondent's Exhibit H: The curriculum vitae of Russell L. Anderson, Jr., M.D.
- 8. Respondent's Exhibit I: Excerpts from The Manual of Internal Fixation, Third Edition.

V. Proffered Exhibits

- 1. Respondent's Exhibit A: July 1, 1992 article from The Journal of American Medical Association, entitled "The National Practitioner Data Bank Report from the First Year".
- 2. State's Exhibit #34: September 9, 1992 unredacted affidavit submitted by James M. Lorraine.

NOTE: THE EXHIBITS MARKED WITH AN ASTERISK HAVE BEEN SEALED TO PROTECT PATIENT CONFIDENTIALITY.

VI. Other Matters

The parties' joint motion for written closings was granted at hearing. The written arguments were timely filed and are admitted as Board Exhibits 1, 2, and 3. The Record closed on October 7, 1992.

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FINDINGS OF FACT

1. Tarsem C. Garg, M.D., was born and raised in India. He received his undergraduate education in that country and also went to medical school in India. He received the M.B.B.S. degree which is comparable to the M.D. degree in the United States. He graduated with his M.B.B.S. in 1967. Prior to graduation, he had completed an internship and then did one year of general surgical residency in 1967. After his one year general surgery residency, he worked for the government for approximately eight months and then relocated to England. He entered a rotating service for approximately six months as a senior resident at South-End General Hospital, South-End-on-the-Sea. He then began employment at the Bristol Doyle Infirmary in the Department of Emergency Medicine and Orthopedics. He was with Bristol Doyle for approximately one year. He then immigrated to the United States where he completed a one year general surgery residency at Norwalk General Hospital in Connecticut. He also served six months in a pediatric residency program after his general surgery residency. Beginning in July, 1971, he was in an orthopedic residency program at Montefiore Hospital and Medical Center in Bronx, New York. He completed this three-year residency and then joined the staff at Montefiore Hospital and Einstein College where he taught for approximately 18 months as a member of the Orthopedic Department. He then left his teaching position and began a practice in Troy, Ohio in January, 1976. He has practiced general orthopedics with an emphasis on hand surgery since that time. He became board certified in 1978. In 1990 he moved his practice to Springfield. He presently holds active staff privileges at the Community Hospital in Springfield and the Mercy Hospital in Springfield. He is on courtesy staff of the Upper Valley Medical Center and Stouder Hospital in Troy and Childrens' Medical Center in Dayton. Dr. Garg has never had any action taken against his medical privileges by a hospital. In Dr. Garg's present practice in Springfield he sees 25 to 40 patients in the office on each of the three one-half days he has office hours.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 17-30).

2. Dr. Malcom Meyn reviewed Dr. Garg's records and testified on behalf of the State in support of the allegations against Dr. Garg. He has been licensed in Ohio since 1976 and he has been board certified in orthopedic surgery since September, 1974. Dr. Meyn received his undergraduate degree from Tulane University in 1961. He graduated from Tulane University Medical School in 1965 and completed a one-year rotating internship at the Memorial Hospital in Long Beach, California. He was then drafted into the armed services and served as a general medical officer in Germany from 1966 through 1969. From 1969 through 1970 he served in a general

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surgical rotating residency through Harvard University. In 1970 he began an orthopedic training program at Tufts University in Boston. He completed this orthopedic program in 1973. He then relocated to New Orleans for a three-month fellowship with a hand surgeon. He then returned to Boston and became a teaching staff member at Tufts University Medical School. From 1973 through 1976 he taught and practiced orthopedic surgery at Tufts and associated hospitals. In 1976 he moved to Cincinnati and began his private practice of orthopedic surgery. Approximately eight years ago Dr. Meyn developed Parkinsons disease and two years later found it necessary to cease performing surgeries due to the symptoms of Parkinsons. Since that time he has continued to practice nonsurgical orthopedic medicine. He has also obtained a law degree and is a licensed attorney in the State of Ohio. Due to Dr. Meyn's dual training in medicine and law, he devotes a substantial amount of time to medical malpractice cases as a consulting physician and lawyer. He generally testifies on the behalf of the defendant-physician.

These facts are established by the testimony of Dr. Meyn (Tr. at 11-18) and State's Exhibit #15.

3. Dr. Russell L. Anderson is an orthopedic surgeon who is licensed in six states and the District of Columbia. He received his undergraduate education at the University of Pittsburgh and also his medical education at that institution. He completed a rotating internship at the Western Pennsylvania Hospital in Pittsburgh and then entered a general surgical residency at the Oakland Veteran's Administration Hospital in Pittsburgh. He followed this with a residency and fellowship in research and orthopedic pathology and completed a three-year orthopedic surgical residency in 1961 at the Health Centers of the University of Pittsburgh. Dr. Anderson then relocated to Washington, D.C., to serve as an instructor in orthopedic pathology at the Howard University School of Medicine. He also had a private orthopedic practice at this time. He then moved on to the Harlem Hospital as a teacher of residents and the Assistant Chief of Orthopedic Surgery from 1964 to 1966. In 1966 he became the Deputy Director of Orthopedic Surgery at Montefiore Hospital in Bronx, New York. In 1967 he was made the acting Director of Orthopedic Surgery at Morrisania Hospital in Bronx. In 1979 Dr. Anderson relocated to Chicago where he became the Chairman of the Trauma and Burn Unit at Edgewater Hospital. He also became affiliated with a private practice surgical group. In 1982 he moved to Florida and set up a private orthopedic surgical practice in Tallahassee. Her served one year as Chairman of Orthopedic Surgery at the Tallahassee Regional Medical Center concurrently with a chairmanship of the emergency room committee at the center. In 1989 Dr. Anderson relocated to California and again set up an orthopedic surgical practice. He is a Fellow of the American Academy of Orthopedic Surgeons, American College of Surgeons, International College of Surgeons, and the International Society of

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Orthopedic Surgeons and Traumatology. He has been board certified in orthopedic surgery since 1966. Dr. Anderson has also participated in a number of research projects and has published articles and presented papers at medical conventions. Dr. Anderson became acquainted with Dr. Garg during Dr. Garg's residency at the Montefiore Hospital in Bronx, New York. The two doctors have maintained a friendship over the years and usually visit one another personally on a yearly basis.

These facts are established by the testimony of Dr. Anderson (Tr. at 57-64) and Respondent's Exhibit H.

4. Dr. Garg began treating Patient 1 in April, 1983. The patient was a 16-year-old boy who complained of experiencing shoulder pain in August, 1982 while running. The patient reported no trauma to the shoulder but noticed a lump. As reported to Dr. Garg in April, 1983, the lump was growing consistently from its first observation in August, 1982. Upon initial physical examination, Dr. Garg found a marked anterior fullness of the left shoulder with no localized tenderness. Range of motion was unlimited except for external rotation which was limited to 45 degrees and forward flexion which was limited in the final 20 degrees. Upon palpation Dr. Garg determined that the mass was bony in nature and affixed to the humerus. He also reviewed x-rays which were carried in by the patient. Dr. Garg determined that the x-rays revealed a large mass located over the anterior lateral aspect of the proximal humerus with calcification. He felt that the appearance of the mass was consistent with osteochondroma. Dr. Garg, after the initial examination of the patient, felt that the mass had likely been present for quite some time and only recently had been irritated which led the patient to its discovery and belief that it had been growing in size. Dr. Garg recommended an excision biopsy to confirm his impression that the mass was not malignant. The preoperative radiology report suggests a differential diagnosis of parosteal sarcoma or post-traumatic calcification. A third possibility of osteochondroma was noted although the radiologist felt that with Patient 1's clinical history and severe soft tissue swelling, parosteal sarcoma was a "prime consideration." Before operating on Patient 1, Dr. Garg read this radiology report.

On April 21, 1983, Patient 1 was admitted to the local hospital for excisional biopsy. In Dr. Garg's operative note he lists the primary diagnosis as osteochondroma, left shoulder, with no recorded secondary diagnosis or complications. In his operative note, Dr. Garg also recorded that "x-rays showed osteochondroma arising from the anterior aspect of the humerus". The mass was friable and Dr. Garg removed the majority of it in pieces. Prior to excision, it was the size of an orange. A post-op radiology report reveals that the "ossified mass of the left shoulder has

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been completely removed without any demonstrable defect of the humerus." The pathology report of the specimen excised from Patient 1 reveals that the pathologist felt the lesion was benign and was likely fibrous dysplasia. However, he went on to note that the position and radiological appearance were atypical and that parosteal osteosarcoma must be considered. Therefore, a pathology consult was arranged with Dr. David Dahlin of the Mayo Clinic. In a letter dated May 4, 1983, Dr. Dahlin rendered his opinion based upon the specimens, x-rays, and other data provided. Dr. Dahlin felt that the mass was an "atypical heterotopic ossification, benign." Two of Dr. Dahlin's colleagues in the Mayo Clinic x-ray department opined that the mass was myositis ossificans. Dr. Dahlin advised that "it would seem appropriate to do no additional therapy unless recurrence makes it necessary."

These facts are established by State's Exhibits #16, #20, #21, #35 and Respondent's Exhibit B.

5. Dr. Garg testified that his initial impression of Patient 1's condition was that of an osteochondroma. This was based upon his palpation and review of the x-rays which Patient 1 carried into his office in April, 1983. Dr. Garg described an osteochondroma as a benign lesion which arises from the bone and actually grows out from it. It is a common occurrence in young people and he has treated similarly situated patients in the past for osteochondromas. Dr. Garg felt the only history which was suspicious for an osteochondroma was the patient's report of weakness and increasing mass size. Dr. Garg testified that because of these unusual complaints, he recommended that the patient travel to Dayton to undergo an immediate biopsy to rule out malignancy. Dr. Garg testified that he suggested a referral to Dayton because he does not like to treat "bone malignancies." However, the patient and his mother refused to consider treating with another orthopedist and according to Dr. Garg they were adamant that he perform the surgery. Dr. Garg testified that he initially intended to operate only to obtain a sufficient specimen to allow a biopsy. However, once he retracted tissue and viewed the mass, he decided to excise all of it. He also did this because it was his understanding that a large specimen was necessary to pathologically determine osteochondroma. Dr. Garg testified that his conversations with the local pathologist and review of the pathology report led him to suggest a second pathology opinion from an individual in New York. The local pathologist suggested using Dr. Dahlin at the Mayo Clinic and Dr. Garg readily agreed since he was aware of Dr. Dahlin's reputation. The following month Dr. Garg received a copy of Dr. Dahlin's report and was greatly relieved to see that Dr. Dahlin diagnosed the mass as myositis ossificans. After this evaluation by Dr. Dahlin, Dr. Garg informed the patient

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and his mother that a second excision of the mass would likely be necessary since myositis ossificans tends to recur or continue calcifying if excised prior to maturity.

Dr. Garg saw Patient 1 five days after the surgery, and also in May and August, 1983. At the August visit, four months post-operatively, Dr. Garg obtained an x-ray and determined that there was further "calcification" at the site. Dr. Garg felt that this was consistent with myositis ossificans since the mass was excised early in its life and was likely to recalcify. Dr. Garg's next visit with Patient 1 was in August, 1984, one year later. Office x-rays were again taken and Dr. Garg interpreted them as showing maturation of the mass which he felt was consistent with myositis ossificans. Approximately eight months later, Dr. Garg again saw Patient 1 in the office. He noted that Patient 1 had good range of motion, although there was increased mass size and it appeared to be more calcified. Dr. Garg recommended immediate excision and biopsy at this visit on April 3, 1985. Dr. Garg testified that, even though his records do not support him, he had an extensive discussion with the patient and his mother wherein he tried to convince them that they should go to Dayton for the next surgery because he still considered malignancy a possibility and he did not want to undertake treatment of a malignant bone growth in this patient. He did not recall telling them of his basis for his reluctance to continue treatment. Dr. Garg testified that the patient and his mother insisted that he do the surgery and that they would not treat with another orthopedist. He testified that he stressed the importance to them of immediate repeat biopsy at the time of the April 3, 1985 visit. Dr. Garg also ordered and obtained a bone scan in May, 1985 which was consistent with myositis ossificans. Dr. Garg testified that his office usually had to call the patient and prod him to return to the office and that many appointments were not kept as scheduled. Dr. Garg attributes the one year delay between his recommendation for a second surgery and the actual operation to delay by the patient and his mother. Dr. Garg's office notes indicate a patient "no show" on June 6, 1985.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 139-148, 181-186, and 203-206) and State's Exhibits #16, #20, #21, #35, and Respondent's Exhibit B.

6. On May 23, 1986 Patient 1, was admitted by Dr. Garg with a preoperative diagnosis of "myositis ossificans, left shoulder." Dr. Garg's operative note from May 24, 1986 reveals that upon identifying the mass and incising the periosteum, he found no definite cleavage between the humerus and the growth. Dr. Garg proceeded to excise the mass in pieces. Dr. Garg recorded in his operative note that it was necessary to use the osteotome for the majority of the dissection and he frequently examined the area

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under the image intensifier as surgery progressed. Dr. Garg found that the biceps tendon was completely incorporated into the mass. The tendon was freed and the bone around it was excised and Dr. Garg observed a marked hypertrophy in the underlying bone. Dr. Garg went on to record that most of the mass around the biceps tendon was excised, the bed was smoothed, and the calcification directly in the tendon was also excised. There was still quite a bit of mass remaining in the posterior aspect which was too far afield to be excised without an additional posterior excision. Dr. Garg decided not to excise this mass at the time. Dr. Garg recorded his postoperative diagnosis as "myositis ossificans, left shoulder." The local pathologist's report, dictated three days after Dr. Garg's second surgery, reveals that the pathologist reviewed multiple sections of tissue revealing different histological pictures. One fragment of tissue was composed of scattered bundles of striated muscle surrounded by fibrous tissue and boney trabeculae. Another fragment was composed of bundles of skeletal muscle showing transition towards fibrous tissue, chondroid tissue, and boney trabeculae. The pathologist also reviewed many fragments of tissue which were composed of relatively undifferentiated connective tissue showing scattered well-differentiated boney trabeculae. The pathologist noted that the small foci of dense hypocellular fibrous tissue surrounding boney trabeculae suggested a formation of periosteum. The pathological diagnosis recorded at this time was "myositis ossificans, left shoulder." A radiology report the day after the second surgery revealed a 5 cm. x 14 cm. area of calcification suggestive of myositis ossificans or calcified hematoma. The impression listed in this May 25, 1986 report was "[l]arge area of calcification in the soft tissues adjacent to the shoulder. Whether or not this has any boney involvement is uncertain." The radiologist recommended a CT scan or tomograms to further evaluate boney involvement since some radiographic views suggested a clear space between the calcification and the bone. Dr. Garg did not order any additional studies. Dr. Garg felt that his diagnosis was also supported by the post-op radiology report which found that there was likely a clear space between the mass and the bone, although he found no evidence of cleavage during the May 24, 1986 excision.

Dr. Garg recorded that he told Patient 1 and his parents about the remainder of the mass and that further treatment should be undertaken only after receipt of the pathology report. The patient was seen four days later in the office, was doing well, and the dressings were changed. On June 5, 1986, the patient returned and the sutures were removed and Dr. Garg noted that the incision was healed. Dr. Garg told the patient that the pathology report confirmed a non-malignant growth. Dr. Garg testified that, although his office notes do not indicate this, he had an extensive discussion with the patient on June 5, 1986 relative to a referral to Dayton to obtain further treatment. Dr. Garg explained that he

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suggested a referral because he knew another surgery was going to be necessary due to the unexcised portion of the lesion. Although he was still satisfied that his diagnosis was accurate, he testified that he was also concerned that the recurrence of the growth could have indicated malignancy. Dr. Garg told Patient 1 to return in three months. Approximately six weeks later, on July 21, 1986, the patient returned with a well-healed incision. Dr. Garg did not record the reason for this early visit although he did chart "[n]o change in symptoms. Occasional discomfort." Patient 1 was advised by Dr. Garg that a posterior approach may be necessary in the future to remove the rest of the lesion and that he should return in three to six months. Dr. Garg's records reflect a patient "no show" on September 29, 1986.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 148-151, 157, and 158), and by State's Exhibits #16, #22, and #35 and Respondent's Exhibit B.

7. On January 8, 1987 the patient returned for a six month follow-up as instructed by Dr. Garg. Patient 1 complained of increased discomfort and pain and Dr. Garg determined that there was marked limitation of motion and the mass had once again enlarged. Dr. Garg noted in his records that there was "essentially no glenohumeral motion". Dr. Garg ordered office x-rays and found that Patient 1's shoulder was subluxated due to a large calcific mass which Dr. Garg attributed to recurrence of the myositis ossificans. Dr. Garg did not record, nor does he recall, any weight loss by Patient 1. Dr. Garg testified that he recommended treatment elsewhere although Patient 1 had to be "convinced" to go to the Cleveland Clinic.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 158), State's Exhibits #20 and #35 and Respondent's Exhibit B.

8. Although Dr. Garg testified that he initiated Patient 1's referral to the Cleveland Clinic in January, 1987, his testimony was directly contradicted by Patient 1's wife and mother. Dr. Garg claimed that "it took a lot of convincing" to persuade Patient 1 and his family to pursue further treatment at the Cleveland Clinic. However, both witnesses who attended the last office visit in the company of Patient 1 specifically testified that there was no mention of referral to the Cleveland Clinic. Both rebuttal witnesses also testified that Dr. Garg discussed the planned third surgery with them and he did not express any reluctance about going forward with a third excision. Patient 1's wife suggested a second opinion to her husband because of her concern that Dr. Garg indicated how difficult the posterior approach would be. Her family physician was consulted, found swollen lymph nodes in the armpit, and referred Patient 1 to the Cleveland Clinic. These

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witnesses also testified that Dr. Garg never mentioned referrals to Patient 1 and his family at anytime during the course of treatment from 1983 through 1987 nor did he advise them that he suspected malignancy and that he would not personally perform a third excision. Dr. Garg's testimony that he encouraged earlier referrals to Dayton or Ohio State University was firmly contradicted by Patient 1's wife and mother.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 158, 160, 183-185, and 188-189), the testimony of Bonnie Lorraine (Tr. Vol. III at 15-47), the testimony of Lorie Bruns (Tr. Vol. III at 48-76), State's Exhibits #16, #20, and #35 and Respondent's Exhibit B.

9. Patient 1 was seen at the Cleveland Clinic on February 10. The clinical intake sheet indicates that Patient 1 had lost 40 pounds within the past five months and had experienced increasing pain in the shoulder. Examination revealed a rock hard bulky mass anteriorly in the shoulder and to a lesser extent posteriorly in the left shoulder. Range of motion was limited to about 25 degrees of normal with flexion of 25 degrees and abduction of about 25 degrees. Patient 1 could not internally rotate his left arm although he had full flexion and extension of the elbow. X-rays at that time showed a dense blastic lesion which occupied most of the upper half of the humerus. It did not appear to be in the joint itself and the distal portion was very dense on x-ray and had the appearance of myositis ossificans or parosteal osteogenic sarcoma. However, the proximal portion was lytic and had a typical sunburst appearance similar to conventional osteogenic sarcoma. The initial impression was osteogenic sarcoma, left shoulder. The same date at the Cleveland Clinic, Patient 1 underwent a bone scan. The radiologist determined that there was an intense irregular lobulated area of increased activity along the entire left shoulder with extension to the proximal left arm. The scintigraphic findings were consistent with osteogenic sarcoma of both soft tissue and osseous components. Arteriograms conducted on February 16, 1987 at the Cleveland Clinic indicated that there was a large hypervascular mass about the shoulder with associated lytic destruction of the proximal humerus and extensive ossification within the tumor mass compatible with an osteogenic sarcoma. An MRI conducted the same date revealed a large mass surrounding the proximal humerus lying immediately adjacent to the vessels but not surrounding them. The mass was found to be displacing a portion of the subscapularis muscle although it was difficult to evaluate whether the mass extended into the intercostal muscles. The distal extent of the mass was not well defined through MRI although abnormal signal intensity extended down to the midportion of the humerus medially and posteriorly to the region of the tricep muscle and adjacent to the brachial artery and nerve. On February 17, 1987 the Cleveland Clinic pathologist reviewed the biopsy from

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Dr. Garg's first surgery on April 22, 1983. The pathologist noted that "[t]his biopsy shows a rather large lesion containing spicules of bone separated by a fibroblastic stroma. The stroma itself is moderately cellular but shows minimal nuclear pleomorphism. No definite zonation is present. In areas the lesion shows histologic features of parosteal osteosarcoma, but this diagnosis requires radiographic correlation. Radiographs taken in 1983 were apparently interpreted as myositis ossificans, and the histologic features of this lesion could also be consistent with that diagnosis. Recent clinical and radiographic abnormalities, however, suggest that lesion is best classified as a parosteal osteosarcoma." The pathologist also reviewed the biopsy from Dr. Garg's second surgery on Patient 1, May 23, 1986. This review revealed that "[t]his biopsy shows spicules of bone with intervening cellular fibrous connective tissue. Other areas show nodules of hyaline cartilage. The histologic features of this specimen could be consistent with either a parosteal osteosarcoma or atypical variant of myositis ossificans, and radiographic correlation is required for diagnosis. Radiographs from May, 1986 are not currently available, but recent clinical progression and radiographic changes now suggest that this lesion is best classified as parosteal osteosarcoma."

After further studies and evaluation at the Cleveland Clinic, it was determined that a full arm amputation would be necessary. In a pathology report dated April 1, 1987, six specimens removed from Patient 1 were evaluated. These were the left upper extremity, two portions of the left upper lung lobe, one specimen from the left lower lung lobe, one specimen from the left lingula, and a specimen from the inferior pulmonary ligament lymph node. The pathologist found that Patient 1's left arm contained an osteosarcoma involving two growth patterns. A portion of the tumor was extremely radiodense, parosteal in location, relatively well-differentiated, and fibroblastic. These histologic features were consistent with parosteal osteosarcoma. Part of the specimen also showed a high grade osteosarcoma with focal prominent nuclear pleomorphism and dense cellularity. This high grade osteosarcoma had secondarily extended into the humeral head and metaphysis. It also extended into the shoulder joint and through the articular cartilage glenoid fossa. There was extensive soft tissue involvement in the region of the proximal humerus and the axillary soft tissue. Radiographic and histologic features of this tumor were consistent with a dedifferentiated parosteal osteosarcoma. The final pathological diagnosis of the specimens removed from Patient 1's left lung was "multiple foci of metastatic osteosarcoma." The inferior pulmonary ligament node was negative for tumor. Patient 1 died on May 30, 1988. The final diagnosis was "extensive lung metastasis, osteogenic sarcoma, left arm." Cause of death is noted in the hospital records as respiratory failure.

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These facts are established by State's Exhibits #16, #20, #23 and Respondent's Exhibit B.

10. In preparing for his testimony, Dr. Meyn reviewed all the available office and hospital records for Patient 1 as well as the 18 x-rays which were provided to him after the initial hearing in this Matter. He also reviewed a number of outside literature resources relative to the care rendered to the three patients at issue. Some of these resources were Campbell's Operative Orthopedics and the Journal of Bone and Joint Surgery. The outside resources which Dr. Meyn considered when rendering his opinions are contained within State's Exhibit #19.

Dr. Meyn testified that Dr. Garg's 1983 reliance upon the opinion of reputed pathologist Dr. David Dahlin was not a deviation from minimal standards of care. Due to the similarity between an ongoing myositis ossificans and a malignant tumor, it was not substandard care for Dr. Garg to rely on the pathologist's opinion after the initial surgery in April, 1983. In Dr. Garg's follow-up visits with Patient 1, he noted that there was residual calcification evident at the site of the mass and in a six month follow-up visit it was evident that solidification of the calcification was occurring. Range of motion in the patient's shoulder was also decreasing and Dr. Meyn testified that these symptoms considered as a whole should have indicated to Dr. Garg that this was at least an atypical myositis ossificans which should be followed closely or referred elsewhere. This is important because this is precisely what Dr. Dahlin noted in his diagnosis when he recommended "no additional therapy be rendered to the patient unless recurrence made it necessary." Dr. Meyn is of the opinion that the growth should not have been treated as a mere recurrence of the myositis ossificans but should have been thoroughly investigated immediately. Dr. Meyn testified that myositis ossificans is usually caused by trauma to the site which causes a hematoma in the muscle which eventually goes through a transformation and becomes calcified tissue. Dr. Meyn found no history or report of trauma to the shoulder which could have initiated myositis ossificans formation. Dr. Meyn also noted that the first pathologist who reviewed the April 1983 biopsy suggested a diagnosis of parosteal sarcoma although Dr. Dahlin subsequently opined that it was a benign growth. Dr. Meyn testified that if the growth had been myositis ossificans, it would have been fully matured by the January 1984 office visit. Due to its continuing growth and impingement of Patient 1's shoulder movement at that point, Dr. Meyn believes that more definitive studies, such as tomogram or CT scan, should have been ordered or a consultation with a bone tumor specialist obtained. Dr. Meyn's opinion is the same regarding the next office visit on August 14, 1984 when myositis ossificans would have been fully matured and not have

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been steadily growing with increased reports of pain. He believes that the x-rays from August 14, 1984 show a growth with all the characteristics of parosteal osteosarcoma. By the next visit on April 3, 1985, Dr. Meyn believes the growth was unmistakably identifiable as a malignancy.

The patient was not seen between May, 1985 and May, 1986. In May 1986 Dr. Garg noted after examination that there was marked increase in the size of the mass with continuing limitation of shoulder movement. Dr. Garg recommended a second operation for excision of the mass and x-rays were taken in the office which showed increased calcification. Dr. Meyn found through Dr. Garg's operative note that he described the mass as having no definite cleavage between the growth and the humerus. Dr. Meyn felt this was a clear indication that the mass was not myositis ossificans since it generally does not attach itself to surrounding bones but remains distinct from the bone. Dr. Garg found during the second surgery that the tumor was also invading the soft tissues around the shoulder and the tendons had been incorporated into the mass. This also, according to Dr. Meyn, is atypical for myositis ossificans. Dr. Meyn opined that Dr. Garg's operative note is a clear description of a malignant growth in Patient 1's shoulder due to the lack of cleavage and the tendon involvement. Although the postoperative pathology report diagnosed the specimen as myositis ossificans, Dr. Meyn believes that Dr. Garg's own observations and knowledge of the history of this patient should have led him to reject this pathology report and reconsider his diagnosis. Dr. Meyn also observed that the postoperative radiology report said the films were suggestive of myositis ossificans but further studies, such as CT scan or tomogram, should be considered to evaluate boney involvement. According to Dr. Garg's operative note, involvement of the bone at the mass site was obvious and he did not order additional studies.

Dr. Garg followed Patient 1 in the office until January 8, 1987, by which time the mass had grown to a size where the shoulder was subluxated. Dr. Garg ordered a CT scan which was completed on January 14, 1987 and indicated a malignancy of the left shoulder. The patient then referred himself through another physician to the Cleveland Clinic where he began treatment in February, 1987. Dr. Meyn testified that the records he reviewed indicated that after chemotherapy treatment began at the Cleveland Clinic, the patient underwent a forequarter amputation and wedge resection in April, 1987. He continued under chemotherapy through the Cleveland Clinic on a regular basis and approximately one year later, in May 1988, he expired from respiratory failure as a complication of metastasis from the malignancy in his shoulder. Dr. Meyn testified that Dr. Garg failed to conform with minimal standards of care by failing to appropriately consider that the growth which was atypical for

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myositis ossificans was actually a malignant sarcoma. He further testified that, if indeed Dr. Garg realized that the progression of the patient's malady was atypical for myositis ossificans and could indicate a malignancy, he failed to conform with minimal standards of care by failing to obtain investigative studies and consultations to pinpoint the type of malignancy and devise appropriate treatment plans.

These facts are established by the testimony of Dr. Meyn (Tr. at 18-62, 98-100, 121-122), State's Exhibits #16, #20, #21, #22, #23, #30, 37, and Respondent's Exhibit B.

11. Dr. Anderson testified that he did not review the hospital records and the x-rays for Patient 1 although he did review Dr. Garg's office records prior to his testimony. He testified that he has never treated a patient with parosteal osteosarcoma and it is extremely rare. He believes that Dr. Garg did not fail to conform with minimal standards of care since the average orthopedist would rely on an expert in the field of pathology such as Dr. Dahlin. Dr. Anderson testified that he frequently refers difficult tumor cases to experts and relies on them completely. He also testified that with a diagnosis of myositis ossificans, it would not be unusual for the mass to recur although he did note that Dr. Dahlin recommended no course of therapy unless a recurrence was obvious. Dr. Anderson also testified that there are no benefits to additional testing in certain types of situations, especially when a renowned expert has already rendered an opinion which confirms your diagnosis. He stated that the answer to any health problem is found within the patient, not within tests and "high-fangled technology we may have today", although he also testified that a diagnosis should be made only after culling through all of the available information. He also noted that there was no history of trauma for Patient 1 at the left shoulder, but opined that this was a young athlete when he first treated with Dr. Garg and young athletes are exposed to a lot of "self-trauma".

These facts are established by the testimony of Dr. Anderson (Tr. Vol. II at 65-74, 95-99, 104-113) and Respondent's Exhibit B.

12. On June 22, 1985 Patient 2 was a 17-year old boy who had been in an automobile accident and suffered a comminuted fracture of the left distal humerus. He was initially treated in the local emergency room with a closed reduction and on June 24, 1985 Dr. Garg admitted Patient 2 to the hospital to undergo an open reduction with application of hardware as necessary. Dr. Garg's operative note indicates that he identified the neurovascular bundle at the upper part of the incision and carefully preserved it. The fracture was identified, the ends were cleared, the fracture hematoma was evacuated, and the fracture was reduced and a bone-holding clamp was placed. A seven hole one-third tibia plate was contoured to

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the lateral surface of the humerus and held in place while drill holes were made and screws inserted. Dr. Garg encountered some difficulty putting the lag screws in and two of them broke and one drill hole had to be overdrilled to remove the screw remnant. Dr. Garg then switched to another type of screw. At the end of the procedure, Dr. Garg noted that the fixation was stable with good visible reduction and a full range of motion of the elbow. X-rays revealed satisfactory positioning of the fracture. Dr. Garg reinserted the neurovascular bundle and noted it was "intact visibly." Dr. Garg's discharge note indicates that Patient 2 did well although a neuropraxia of the radial nerve was evident when the patient awoke from surgery. Dr. Garg noted that the patient had active contraction of the quadriceps but could not contract the dorsiflexus and could not dorsiflex the MP joints. Dr. Garg immobilized the arm in a volar splint with the wrist in 40 degrees of dorsiflexion, the MP joints in 15 degrees of flexion, and the elbow in 90 degrees of flexion. The patient was instructed to utilize isometric exercises of the elbow extensors and flexors and he was followed in the office by Dr. Garg. The first visit in Dr. Garg's office was approximately 10 days after surgery when Dr. Garg noted that the patient still showed wrist drop. X-rays at that time revealed satisfactory alignment of the fracture. The patient was instructed to return in six days. The patient returned on July 8, 1985 as instructed and Dr. Garg again charted that he was unable to dorsiflex the wrist. Dr. Garg noted good range of motion of the elbow and removed the sutures at the surgical site. The patient returned in one week as instructed. Dr. Garg noted "essentially no change" and instructed the patient to return in two weeks for consideration of EMG and nerve conduction studies. On July 29, 1985 Dr. Garg sent the patient for EMG and nerve conduction studies. On August 5, 1985 Dr. Garg explained the EMG and nerve conduction studies to the patient and his parents. The report from the physiatrist who conducted the electroneuromyographic study revealed that he was unable to stimulate the radial nerve distal to the spiral groove and complete radial nerve denervation was noted. The physiatrist concluded after the first nerve study that this was an abnormal EMG study. He reported that it contained data compatible with a radial nerve palsy with complete denervation distal to the triceps takeoff. He recommended a repeat nerve study approximately one month later. On August 26, 1985 another consultation report was submitted by the physiatrist. He noted that the patient was still unable to extend the left wrist and fingers. Muscles innervated by the left radial nerve were sampled and showed complete denervation below the takeoff to the medial head of the triceps anconeus muscles. At this time the physiatrist's recommendation was that the patient receive a dorsal cock-up wrist orthosis allowing movement in the MP and PIP joints. Furthermore, the physiatrist recommended the use of a portable electrostimulator to stimulate the wrist and finger extensors at intermittent intervals. He also suggested a repeat study in one

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month. On September 30, 1985 the physiatrist noted that the patient was not using a galvanic portable stimulator as much as he should have been. The patient showed improved supination of the forearm but still no voluntary control of the wrist and finger extensors. The muscles of the radial nerve distal to the triceps were resampled and showed some improved supinator function but still with denervation potentials in the extensor carpi ulnaris. The physiatrist at this time also suggested exploration of the radial nerve prior to conducting another study. On October 18, 1985 another surgeon conducted exploratory surgery of the radial nerve in Patient 2's left arm. The surgeon found the radial nerve was underneath the upper portion of the plate which Dr. Garg had applied for internal fixation and one of the upper screws was actually piercing the nerve. The plate and screws were removed at that time and an extensive neurolysis of the nerve was conducted and the surgeon completed a nerve graft using a portion of Patient 2's sural nerve. In an October 22, 1985 letter to Dr. Garg, the surgeon opined that "the motor function to the radial nerve is lost. Hopefully we will be able to get some sensory return with the nerve graft." This doctor also indicated that he was anticipating tendon transfers in an effort to give Patient 2 "a functional hand." Patient 2 has lost significant function in his left hand and arm.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 162-181 and 206-208), the testimony of Patient 2 (Tr. Vol. III 89-91), State's Exhibits #24, #25 and Respondent's Exhibit C.

13. Dr. Garg testified that he identified, isolated, and carefully retracted the radial nerve out of the way. He also testified that the surgery was unduly complicated because of the hardness of the patient's bone and the broken screws which took additional time. He testified that entrapment of the radial nerve when placing a plate on the humerus is a well-known complication of the surgery. Dr. Garg defended his use of the posterior incision to apply the hardware as not only an accepted approach but the recommended approach. Dr. Garg did not immediately return the patient to surgery once he discovered the postoperative palsy because he believed that he had effectively protected the radial nerve during the surgery since he had visualized its entire length in the surgical field prior to closing. He attributed the palsy to the retraction of the nerve during the operation. Dr. Garg has had previous patients in similar circumstances require three to four months to regain total nerve functioning after retraction of the radial nerve. He also interpreted the first two physiatry reports to indicate that the nerve was gradually regenerating. He did not feel that he had compromised the nerve since there was some improvement evident through these diagnostic studies. Dr. Garg testified that he was very surprised when he received the letter

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from the surgeon who did the October 1985 surgery and discovered the entrapped radial nerve. He was surprised because he had isolated the nerve and carefully protected it during the procedure and "thought I had seen the nerve in its entirety." Although Dr. Garg was surprised to learn that the subsequent surgeon noted that one of the screws was actually piercing the radial nerve, he did not believe that it was truly the radial nerve which was pierced by the screw. He believes that the nerve had likely become entrapped under the plate during the process of drilling out the broken screws and reaffixing the plate to the humerus and that the compression of the plate on the humerus was the actual cause of the palsy rather than a screw piercing the nerve. He believes the second surgeon probably mistook fibrous tissue which was pierced by the screw for the radial nerve. Dr. Garg also testified that he spoke with the patient and his mother about referral to a specialist for follow up surgery. Patient 2 and his mother both testified and refuted his claim.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 162-181, 206-208), the testimony of Janice Smallwood (Tr. Vol. III at 80-81), the testimony of Patient 2 (Tr. Vol. III at 86), State's Exhibits #24, #25 and Respondent's Exhibit C.

14. Dr. Meyn testified that oblique fractures of the distal one-third of the humerus are often complicated by entrapment of the radial nerve in the fracture site. He testified that his review of the records revealed that Dr. Garg performed a closed reduction of the humerus fracture in an emergency room on June 22, 1985 and obtained films which showed that there was satisfactory alignment but there was a wide gap between the two ends of the bones. At the time of the emergency room visit, the neurovascular status of the arm was intact, meaning that prior to Dr. Garg's surgery there was no indication that the nerve had been damaged in any fashion. Dr. Meyn testified that because of the gap on the AP x-ray, he would assume that the nerve was entrapped between the fragments and was creating the gap between the bone pieces. He testified that open reduction of this fracture was clearly indicated. Dr. Meyn testified that Dr. Garg's choice of a posterior incision to expose the bone was an acceptable method although he termed it "unusual." He felt this was an inappropriate incision because of the higher risk of injury to the radial nerve. He also noted that this type of dissection is difficult because of the bleeding encountered inside the muscle tissue and significant retraction is necessary to move the nerve to allow application of the hardware. Dr. Meyn testified that when the patient awakened after surgery he exhibited symptoms of a radial nerve palsy which continued through the course of the next few months and were confirmed through EMG testing by a physiatrist. Ultimately, in October, 1985 another surgeon operated to remove the plate and determine the cause of the radial nerve

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palsy. At this time it was found that the radial nerve was being pierced by one of the screws holding the plate on the humerus. This surgeon resected the neuroma and performed a cable graft utilizing a piece of nerve from the outer calf of the leg.

Dr. Meyn testified that Dr. Garg's entrapment of the radial nerve beneath the plate at the time of surgery deviated from minimal standards of care. He felt that this was primarily due to Dr. Garg's choice of a posterior approach for this surgery. Although Dr. Meyn admitted that nerve entrapment with hardware application is a common complication, it is avoidable by careful inspection of the surgical field prior to closing. Dr. Meyn also opined that Dr. Garg failed to conform with minimal standards of care when he failed to recognize the complication in the recovery room and return Patient 2 immediately to the operating room to explore the wound and determine the cause of the palsy. Dr. Meyn testified that the patient ultimately underwent tendon transfers which involved moving the muscles from the anterior forearm to the back of the arm to supply function and hold the wrist up to allow the fingers and thumb to be used in a grasping fashion. Dr. Meyn also opined that because the radial nerve had actually been pierced by a screw, removal of the plate prior to October of 1985 would likely not have enabled the radial nerve to regenerate. However, an earlier exploratory surgery could have alleviated the need for a nerve graft from a remote site. He felt that if the injury had been immediately identified, an end-to-end repair of the nerve could have been accomplished and would have given a much greater chance of functional recovery without a graft. Dr. Meyn testified that had Dr. Garg used a different incision for Patient 2, he does not believe immediate return to surgery would have been necessary since alternative approaches posed less risk of injury to the radial nerve. Because Dr. Garg chose the posterior approach, Dr. Meyn felt that postoperative discovery of the radial nerve palsy indicated immediate return to surgery for exploration.

These facts are established by the testimony of Dr. Meyn (Tr. Vol. II at 62-80, 100-103, 118-119) and State's Exhibits #24, #25, #36 and Respondent's Exhibits C and I.

15. Dr. Anderson testified that Patient 2 presented in the emergency room with a comminuted midshaft humeral fracture after an automobile accident. Dr. Garg's records reflect that a closed reduction was attempted although it was not entirely satisfactory and the patient and his parents decided to undergo an open reduction as suggested by Dr. Garg. Dr. Anderson testified that Dr. Garg did not violate minimal standards of care by using a posterior approach to repair the fractured humerus nor was it substandard to have pierced the radial nerve with one of the screws which was securing the bone plate to Patient 2's humerus. Dr. Anderson explained that the risk of compromising the radial nerve in this type of surgery is a well-known complication of the surgery

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and merely because it happens, this does not indicate substandard care. Dr. Anderson also explained that merely because a patient who has undergone an open reduction near the radial nerve suffers a postoperative wrist drop and radial palsy, there is no reason to believe that the nerve has been seriously compromised or transected. He testified that there was no indication for immediate return to surgery for exploration and that it was in conformity with the standard of care to wait and evaluate the cause of the neurapraxia. He testified that an immediate return to surgery increases the risk of osteomyelitis and he felt it was proper to wait at least three weeks to evaluate the patient's condition and determine whether the cause was iatrogenic or as a foreseeable consequence of nerve retraction. Dr. Anderson did admit that after an electromyographic study indicates an ongoing problem with no or little regeneration, a second electromyographic study should be conducted and if this indicates the same, "then you now know to go in and probably do something and -- it's still not too late." Dr. Anderson also admitted that a normal neurovascular status, such as Patient 2's at the time of his emergency room treatment, should indicate to the surgeon that there was no nerve damage at the time of the fracture. Dr. Anderson also opined that once a nerve was compromised by transection or a screw piercing it, it did not matter at what point in time the subsequent repairs were undertaken. Dr. Anderson admitted that using the posterior approach for Patient 2 placed the radial nerve at greater risk.

These facts are established by the testimony of Dr. Anderson (Tr. at 74-83, 113-124, 133-138), State's Exhibits #24, #25 and Respondent's Exhibits C and I.

16. Dr. Garg first saw Patient 3 on September 24, 1987. The patient revealed a history of crushing her left little finger between a bench and a table on December 6, 1986. Since that time she had increasing discomfort and inability to straighten the finger. Dr. Garg's impression was that Patient 3 was suffering from Dupuytren's contracture. Dr. Garg prescribed dynamic splinting and upon a return visit November of 1987 he found no improvement. At this time he recommended surgical release and on January 29, 1988 Dr. Garg operated on Patient 3 for flexor contracture release. Dr. Garg had multiple surgeries scheduled that day at the hospital and upon entering the operating room he thought that Patient 3 was on the table for a carpal tunnel release. He therefore made an incision for the carpal tunnel procedure but was informed by hospital staff that this was a flexor contracture release operation. Dr. Garg then proceeded to use a Brunner zigzag incision on the left little finger of Patient 3, although the operative note indicates a V-Y plasty incision. Dissection was carried through the skin and subcutaneous tissues and the palmar fascia was identified and released proximally. Dr. Garg identified

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the digital nerves and traced them into the finger and the rest of the contracted tissue was excised. The finger could almost be fully extended when the skin was sutured. Palmer incision was then sutured and dressings applied. A volar splint was utilized to maintain the wrist at 30 degrees of dorsal flexion with the little finger in full extension. Dr. Garg advised the patient and her sister that he had initially made the wrong incision for the contracture release. Dr. Garg testified that due to the similarity of the incisions for carpal tunnel release and a flexor contracture release, he could have withheld telling the patient about his error and it would have never been discovered. However, he felt it was his moral obligation to tell the patient that he began to do the wrong operation on her. In postoperative visits the contracture of the left little finger remained and Dr. Garg prescribed local massage and dynamic splinting. Seven months after the operation, Dr. Garg's office note reveals that there were still continued problems straightening the PIP joint and Patient 3 lacked approximately 30 degrees of extension at the PIP joint although other joints had full range of motion. Two months later, in October 1988, Dr. Garg recommended that Patient 3 see a hand surgeon for a consultation due to the continued contracture of the left little finger. In January 1989 another surgeon operated on Patient 3 and found that the ulnar digital nerve had been transected. The surgeon found the ulnar digital nerve heavily imbedded in scar tissue over the entire length of the proximal phalanx and toward the distal aspect. The nerve appeared to have been transected just distal to several small dorsal branches which were preserved. A neuroma was resected and the fibrous tissue appeared to be much more extensive than that usually seen with simple scarring. The fibrous tissue involved the small subcutaneous ligaments of the finger and required extensive dissection and excision. This operation to repair the previously transected digital ulnar nerve took over two hours.

Dr. Garg testified that the patient had never complained to him postoperatively about loss of sensation in the finger and that his neurological evaluation of the finger postoperatively revealed no problems. He also testified that Dupytren's contractures recur approximately 50% of the time after surgical release. Dr. Garg understands the subsequent surgeon's operative note to indicate that the main digital nerve was not cut but one of its branches was transected and consequently developed a neuroma. He characterized the need for microscopic external and internal neurolysis at the second surgery as indicative of a recurrence of Dupytren's contracture. Dr. Garg also noted that the second surgeon utilized the same incision that he had used when doing the contracture release.

These facts are established by the testimony of Dr. Garg (Tr. Vol. II at 30-53, 190-197, 208-209) State's Exhibits #26, #27, and Respondent's Exhibits D, E, F, and G.

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17. Dr. Meyn testified that Dr. Garg's erroneous use of an incision for carpal tunnel release on a patient who was scheduled for a Dupytren's contracture release was below the minimal standards of care. He testified that the patient should have had an identifying arm band on and the OR schedules should have been available to Dr. Garg. He also noted that hospital staff were available for questions if Dr. Garg didn't know which patient he was operating on or what procedure was planned. Dr. Meyn testified that if Dr. Garg actually used a V-Y plasty incision, this was violative of minimal standards of care as well. A V-Y plasty incision would not give sufficient exposure to the underlying structures in a finger contracture nor would it allow adequate expansion of the skin. Dr. Meyn also testified that assuming Dr. Garg did not use a V-Y plasty incision on Patient 3, then he still violated minimal standards of care by failing to adequately document and explain the procedure utilized. Dr. Meyn testified that Dr. Garg's transection of the ulnar digital nerve was not a violation of minimal standards of care but his failure to identify the complication was substandard care. He opined that surgeons who are capable of doing contracture release operations should be capable of immediately identifying and repairing transected nerves. Dr. Meyn furthermore found violations of minimal standards of care evident through Dr. Garg's postoperative treatment of Patient 3. He never recorded a sensory examination which would have indicated a loss of sensation from the transected nerve. The surgeon who operated a second time on Patient 3's finger in January of 1989 recorded that she had numbness on the outer side of the finger as well as a painful neuroma. Dr. Meyn testified that his review of the records indicates that the patient's numbness due to the transected nerve extended from the proximal interphalangeal joint to the fingertip on the outside of the left little finger.

These facts are established by the testimony of Dr. Meyn (Tr. at 81-93, 103-105, 111-112, 116-117) State's Exhibits #26, #27, and Respondent's Exhibits D, E, F, and G.

18. Dr. Anderson agreed that transection of a digital nerve, standing alone, is not violative of minimal standards of care. He explained that a digital nerve can run an aberrant course and when cut it presents no major complication. He noted that such nerves are sensory only and do not assist functional movements. Dr. Anderson felt that the loss of some sensation following an operation for Dupytren's contracture release was not unusual or substandard care. Dr. Anderson further testified that Dr. Garg's erroneous incision on Patient 3 was not violative of minimal standards of care because doctors are human beings and human beings are not infallible. Dr. Anderson didn't see any harm in the additional incision in Patient 3's palm. Dr. Anderson also opined that failure to immediately repair a transected ulnar nerve during a contracture release operation was not violative of minimal standards of care. He

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testified that with the surgeon tracing out the nerve and believing it has not been compromised, there is no indication for repair. He also noted that the patient never offered any complaints about loss of sensation or numbness in her finger, therefore Dr. Garg was without notice of any postoperative complications due to the transected nerve. Dr. Anderson testified that the best test for determining postoperative numbness in a patient is to ask the patient about numbness or lack of sensation.

These facts are established by the testimony of Dr. Anderson (Tr. Vol. II at 83-91, 124-133), State's Exhibits #26, #27, and Respondent's Exhibits D, E, F, and G.

19. Valeriy Moysaenko received his M.D. from Ohio State University in 1971. He undertook a general surgical residency but prior to completion was inducted into the armed services. He served as a general medical officer in Southeast Asia and completed his residency upon his discharge from the Air Force. He then completed a fellowship at the University of Utah in surgery. He returned to Ohio and became the Director of the Surgical Residency Program at Wright Patterson Air Force Base until 1982 when he entered private practice in Troy, Ohio. He has been board certified in general surgery since 1978. Presently he serves as chairman of the oncology committee at his local hospital where he has active privileges. He has also served in the past on the surgical review committee, been chief of staff, been chairman of the credentials committee, and is also currently Director of the Ambulatory Surgery Unit. Dr. Moysaenko knows Dr. Garg through their overlapping surgical practices when Dr. Garg was practicing in Troy. He has also served as Dr. Garg's first surgical assistant. He characterized Dr. Garg's surgical technique as "very clean, very meticulous." Dr. Moysaenko and his family members treat with Dr. Garg. Dr. Moysaenko believes that Dr. Garg has a favorable reputation within the medical community where he practices.

Constantine Pereyma, M.D., received his medical training in Germany in 1950. He then immigrated to the United States and completed a one-year internship in Buffalo, New York. He completed a residency through the State University of New York in Brooklyn and stayed on staff at that university for seven years. His residency was in general surgery. He then became an instructor in surgery at a Veterans Administration Hospital and eventually became Chief of Surgery at the Veterans Administration Hospital in Clarksburg, West Virginia. He also was an instructor in anatomy at the medical school in Morgantown, West Virginia. After that he established his private practice in Troy, Ohio in 1959. He has maintained a general surgical practice in Troy since that time and has been board certified for approximately 40 years. Dr. Pereyma characterized Dr. Garg's surgical technique as clean with few

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complications and with a good pair of hands. He testified that Dr. Garg is an absolutely competent physician and that Dr. Garg has a favorable reputation within the Troy medical community. Dr. Pereyma also has his family members treat with Dr. Garg when they need medical care.

These facts are established by the testimony of Dr. Moysaenko (Tr. Vol. I at 145-157) and the testimony of Dr. Pereyma (Tr. Vol. II at 6-16).

CONCLUSIONS

1. Dr. Garg's care and treatment of Patient 1 after recurrence of the growth in his left shoulder and Dr. Garg's examination of the growth constitutes "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code.
2. Dr. Garg's care and treatment of Patient 2, specifically his iatrogenic injury to the radial nerve during a repair of the fractured distal humerus constitutes "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code.
3. Dr. Garg's care and treatment of Patient 3, specifically his failure to identify a transected ulnar digital nerve and his initial use of the incorrect incision for a Dupuytren's contracture release constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code.

* * * * *

Although Dr. Garg was justified in relying on the initial expert pathology diagnosis relative to Patient 1, upon recurrence of the atypical mass and a second partial excision of it, he should have enlisted additional consultants, directed the patient to expert caregivers, or ordered more sophisticated studies to again confirm his earlier diagnosis of myositis ossificans. Upon the second excision of the mass and his visualization of it, Dr. Garg should have recognized that this growth was not myositis ossificans and appropriate treatment for malignancy could have been initiated at that time. With Patient 2,

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Dr. Garg placed hardware on the distal humerus entrapping the radial nerve and piercing it with a screw which was holding the plate to the bone. Dr. Garg failed to recognize the iatrogenic injury inflicted upon the patient who ultimately underwent tendon transfers in order to regain partial function in the hand. Patient 3 was scheduled for a Dupuytren's contracture release although Dr. Garg made the wrong incision assuming the patient was scheduled for carpal tunnel surgery. Later in the operative procedure, Dr. Garg unknowingly transected the digital ulnar nerve and failed to postoperatively conduct a neurovascular examination which would have indicated the transected nerve. Of significant concern is Dr. Garg's sworn testimony about his undocumented conversations with Patients 1 and 2. The rebuttal witnesses have no present pecuniary interests in Dr. Garg and their testimony was internally consistent and directly contrary to Dr. Garg's recollections.

PROPOSED ORDER

It is hereby ORDERED that:

1. The certificate of Tarsem C. Garg, M.D., to practice medicine and surgery in the State of Ohio shall be REVOKED. Such revocation shall be STAYED and Dr. Garg's certificate shall be SUSPENDED for an indefinite period of time but not less than two (2) years.
2. The State Medical Board shall not consider reinstatement of Dr. Garg's certificate to practice unless and until all of the following minimum requirements are met:
 - a. Dr. Garg shall submit an application for reinstatement accompanied by appropriate fees. Dr. Garg shall not make such application for at least one (1) year from the effective date of this Order.
 - b. Dr. Garg shall take and successfully complete the equivalent of twelve (12) months of training or mini-residency in a post-graduate training program, approved in advance by the Board, in the area of orthopedic surgery and bone malignancy identification. Dr. Garg shall provide the Board with acceptable documentation verifying successful completion of such program.
 - c. Dr. Garg shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency.

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- d. In the event that Dr. Garg has not been engaged in the active practice of medicine and surgery for a period in excess of two (2) years prior to his application for reinstatement, the Board may exercise its discretion under Section 4731.222, Revised Code, and require additional evidence of his fitness to resume practice.
3. Upon reinstatement, Dr. Garg's certificate shall be subject to the following probationary terms, conditions, and limitations for a period of at least five (5) years:
 - a. Dr. Garg shall obey all federal, state, and local laws and all rules governing the practice of medicine in Ohio.
 - b. Dr. Garg shall submit quarterly declarations under penalty of perjury stating whether or not there has been compliance with all the provisions of probation.
 - c. Dr. Garg shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals or as otherwise directed by the Board.
 - d. Within thirty (30) days of reinstatement, Dr. Garg shall submit for the Board's prior approval the name of a monitoring orthopedic surgeon who shall review 25% of Dr. Garg's hospital surgical patient charts and shall submit a written report of such review to the Board on a quarterly basis. It shall be Dr. Garg's responsibility to ensure the monitoring physician's quarterly reports are submitted to the Board on a timely basis. In the event that the approved monitoring physician becomes unable or unwilling to so serve, Dr. Garg shall immediately so notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.
 4. Upon successful completion of probation, Dr. Garg's certificate will be fully restored.

This Order shall become effective thirty (30) days after mailing of notification of approval by the State Medical Board of Ohio. In the interim, Dr. Garg shall not undertake the treatment or care of any patient not already under his care.

KEVIN P. BYERS
Kevin P. Byers
Attorney Hearing Examiner

EXCERPT FROM THE MINUTES OF DECEMBER 2, 1992

REPORTS AND RECOMMENDATIONS

Dr. Gretter announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Gretter asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Allan B. Kunkel, M.D.; J. Herbert Manton, M.D.; Tarsem C. Garg, M.D.; Clarke P. Searle, M.D.; and Mohammed Galal Ziady, M.D. A roll call was taken:

ROLL CALL:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye
	Ms. Rolfes	- aye
	Dr. Gretter	- aye

Dr. Gretter 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:	Dr. O'Day	- aye
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye
	Ms. Rolfes	- aye
	Dr. Gretter	- aye

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

.....

REPORT AND RECOMMENDATION IN THE MATTER OF TARSEM C. GARG, M.D.

Dr. Gretter stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and order in the above matter. No objections were voiced by Board members present.

Dr. Gretter advised that a motion to address the Board was filed by Dr. Garg's attorney, but it was not filed in a timely manner. He asked for a motion to permit Mr. Todd to address the Board.

MR. ALBERT MOVED TO ALLOW MR. TODD TO ADDRESS THE BOARD. DR. HOM SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Day	- abstain
	Mr. Albert	- aye
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Dr. Agresta	- aye
	Ms. Rolfes	- aye

The motion carried.

Dr. Gretter advised Mr. Todd that there is not a court reporter present, but instead the Board's minutes serve as the Board's official record of the meeting. Mr. Todd stated that he did not have any objection to the absence of a court reporter.

Dr. Gretter reminded Mr. Todd that the Board members have read the entire hearing record, including the exhibits and any objections filed. He added that the Board will not retry the case at this time, and that pursuant to Section 4731.23(C), Revised Code, oral arguments made at this time are to address the proposed findings of fact and conclusions of the hearing examiner. Dr. Gretter stated that Mr. Todd would be allowed approximately five minutes for his address.

Mr. Todd thanked the Board for allowing Dr. Tarsem Garg to address the Board.

Dr. Tarsem Garg thanked the Board for allowing him the opportunity speak. He stated that he has been in practice for over 20 years, and he has a very busy practice. This case involves a small sample of cases picked out of his busy practice.

Concerning case #1, Dr. Tarsem Garg stated that he did not do anything wrong. He relied on the opinion of three renowned pathologists, who said the tumor was benign. He was not going to do an amputation on the basis of that.

Case #2 involved a well-known complication of the type of injury the patient had.

Concerning case #3, Dr. Tarsem Garg stated that he morally feels that he needs to be

truthful to his patients. He could very well have connected the two incisions and, if he had not told the patient, the patient would never have known that he had made an extra incision in the palm. This would have been a very well-accepted incision for the kind of condition he was treating. The incision was in the palm and it was over the palmar fascia.

Dr. Tarsem Garg stated that case #1 has mentally affected him to the extent that he has hardly practiced for a year. Even to this day, this case bothers him. There is nothing he can go back and do about that. He relied on an authority who has written extensively on that type of tumor. This person is a world authority. The expert said it was a benign tumor and recommended nothing further be done. The expert had consulted his staff and had all the facts, including x-rays and the entire pathological specimen.

Dr. Gretter asked Ms. Sotos to respond to Dr. Tarsem Garg's statements.

Ms. Sotos stated that this case concerns Dr. Tarsem Garg's care and treatment of three patients. Patient 1, a 16-year-old boy, came to Dr. Tarsem Garg concerning a mass in his arm. Dr. Tarsem Garg, an orthopaedic surgeon having no expertise in the area of bone tumors, chose to undertake the care and treatment of this patient. For almost a 4-year period, he treated this condition as myositis ossificans, when all indicators pointed to a diagnosis of parosteal osteosarcoma. He performed two surgeries on this patient, and would have performed a third had the family not referred themselves to the Cleveland Clinic. As a result of Dr. Tarsem Garg's failure to adequately diagnose and appropriately treat this patient, Patient 1 died at the age of 21 years. Before Patient 1 died, he underwent several surgeries, including a forequarter amputation. Dr. Tarsem Garg's primary defense in this case was blaming the family, saying under oath in hearing that he told the family that it was cancer and he referred this family repeatedly to other physicians and clinics. The family members testified at the hearing and refuted each and every one of Dr. Tarsem Garg's statements. Ms. Sotos continued that Dr. Tarsem Garg today told the Board that he hardly practiced for a year as a result of this case. There is no evidence of that in the record.

Ms. Sotos continued that Dr. Tarsem Garg pierced Patient 2's radial nerve with a screw during surgery to repair a fractured humerus. He failed to recognize this complication or to take adequate measures to correct it postoperatively. As a result, this patient lost motor function in his arm and had to undergo three more painful operations. To this day Patient 2 continues to have irreparable damage. Again, Dr. Tarsem Garg at hearing blamed the family. Family members again testified on rebuttal and refuted each and every one of his allegations.

Concerning Patient 3, Ms. Sotos stated that Dr. Tarsem Garg made the wrong incision for the surgery. When he proceeded to do the correct incision, he used the wrong procedure. He then transected the ulnar digital nerve, failing to recognize the transection during surgery or to correct it postoperatively. This patient had to undergo additional surgeries.

Ms. Sotos stated that there is a general pattern of Dr. Tarsem Garg's failure to conform to minimal standards in the diagnosis, surgical intervention, postoperative

care and recordkeeping with respect to the patients. The most troubling aspect is that Dr. Tarsem Garg failed to recognize at any point that he was in trouble. These patients suffered unnecessary pain, additional surgeries, and irreparable damage as a direct result of the care and treatment provided by Dr. Tarsem Garg. In one case a young man died. The only credible opinions offered in this case were those by the State's expert. These are serious and egregious charges. Ms. Sotos urged the Board to, at a minimum, adopt the discipline recommended by the Hearing Examiner.

DR. AGRESTA MOVED TO APPROVE AND CONFIRM MR. BYERS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF TARSEM C. GARG, M.D. DR. HEIDT SECONDED THE MOTION.

Dr. Gretter asked if there were any questions concerning the proposed findings of fact, conclusions, and order in the above matter.

Dr. Heidt stated that the problems of a parosteal sarcoma and a myositis ossificans are that microscopically they are very similar. A physician can be fooled, and there are many cases where the physician has been fooled with one diagnosis over the other. The initial biopsy was taken and read as benign at his hospital. It was sent to Dr. Dahlin, who is an excellent pathologist and an authority on this type of tumor, and he said it was benign. That would lead any competent orthopaedist down the garden path in not recognizing this as parosteal sarcoma. The outcome probably wouldn't have made a great deal of difference. These are very bad tumors in this age group, and most patients die.

Dr. Heidt stated that Dr. Tarsem Garg did use bad technique on Patient 2. He added that it is a common problem because the radial nerve in the mid third of the humerus sits right next to the bone. It circles around the back and is easy to hit. He believes most orthopaedic surgeons would hit it once or twice.

Concerning Patient 3, Dr. Tarsem Garg made a mistake. He admitted to the mistake.

Dr. Heidt concluded that he doesn't know where to go with this case. He stated that the three cases are explainable, even in the hands of a very competent orthopaedic surgeon.

Dr. Garg stated that Dr. Dahlin, in 1983, reported that the case was myositis ossificans. There was also a second report from a pathologist after the second surgery in 1985, which also diagnosed myositis ossificans. There were a lot of factors in the transcript. There was a question of cancer not having been discussed. Dr. Garg questioned why the physician would discuss cancer with the patient or his family when twice it was reported definitely that it is not cancer.

Dr. Garg stated that Patient 1 lived with the tumor in his shoulder and arm from 1982 to 1983. When it became a tumor it probably became a very aggressive tumor that would not respond to any kind of treatment. To place any wrong in this case would be unjustifiable.

Concerning Patient 2, Dr. Garg stated that, as he understands it, if you put a needle or a screw through a nerve, there is no way the patient will live without

pain. You can bisect the nerve and you will not have pain. Dr. Garg referred to the second surgeon's testimony that there was a screw going through the nerve. To believe that that didn't cause any pain is difficult to believe. When nerves are caught in sutures or something, it always causes a lot of pain. So the question is whether the nerve got caught under the screw at the time of surgery or whether it slipped under the plate later on. Dr. Garg stated that the answer is not clear, and when there is so much doubt, the Board can't place the blame on the surgeon. Dr. Garg stated that all physicians learn from their past mistakes and experiences. Dr. Tarsem Garg took the case back and did not find any problem with the nerve. The Board could conclude that he is lying, but the Board doesn't know that. There is tension created by stretching the nerve, but the physician knows the patient will recover and you don't keep going back in surgery all the time. It is just a matter of waiting, unless you believe the nerve has been cut.

Concerning the third case, there was question about whether a branch of the digital nerve was cut. Dr. Garg stated that he is not quite sure that is true. He stated that it is not clear whether the incision was proper or improper. The carpal tunnel incision that was made was a mistake for which Dr. Tarsem Garg accepted blame, and he told the family about it. The second incision is referred to as a V-Y plasty, which is supposed to be an extension of the original Brunner incisions. It doesn't say anywhere that it was not a V-Y plasty or a Brunner incision. If a second surgeon goes back in an operative case and says he saw a nerve cut, he has to be close to superhuman, because when you are going to the area after scarring occurs there is no way you can tell what you are seeing. So, whether the nerve was caught in the scar or whether it was cut is the question.

Dr. Stienecker stated that he would like to propose some amendments to the Proposed Conclusions and Order.

Ms. Rolfes stated that she would like to make some comments first. She has real problems with this case. Concerning Patient 1, there were differences of opinion. The growth in question was said to be atypical, and could have indicated parosteal sarcoma. She asked why Dr. Tarsem Garg didn't play it safe.

Dr. Garg stated that that would have meant amputating the arm. Why would you amputate the arm for a diagnosis of a benign tumor? Two different biopsies were performed and diagnosed as being noncancerous. The first biopsy was by a very highly respected pathologist. Why would a physician do anything but remove the mass? Dr. Tarsem Garg attempted to remove the rest of the mass during a second surgery. To amputate a noncancerous tumor would have been the worst case of malpractice anyone could imagine.

Dr. Gretter asked Dr. Heidt what should have been done after the diagnosis of myositis ossificans was made.

Dr. Heidt stated that the usual follow-up is to watch it. Usually myositis ossificans will stabilize after a year or two. The thing that bothers him about this case is that it was still growing after three years, which is not consistent with the original diagnosis. But Dr. Tarsem Garg again removed the tumor and got the same diagnosis from the pathologist. Since it was growing after three years, it

was probably not myositis ossificans.

Dr. Heidt stated that, in the second case, Dr. Tarsem Garg put the plate over the nerve. That was a problem.

Dr. Stienecker stated that if he put the plate over the nerve, it would be essentially the same as if you tied a ligature around it or cut it. If you pressed that nerve, it wouldn't function. You could put a screw through it or do anything to it and the patient might not feel it, either. The compression plate essentially denervates it, and he doesn't believe the patient would feel pain from it, no matter what size screw was put through it. Dr. Stienecker stated that that was a most unfortunate situation.

Dr. Garg stated that, unless a physician physiologically or anatomically severs the nerve, the plate would press so much that there would be no conduction going on. That's why there is pain from lumbar discs or cervical discs or hitting an elbow. You would feel pain in the distribution of that nerve. That's the reason he feels that the nerve could have slipped under the plate. It was under the plate when the surgeon found it, but it could have slipped initially or later. There was problem with the screws before. Maybe they weren't tight enough, and maybe there was a space between the humerus and the plate into which the nerve then slipped. It is possible. There is no way the Board can tell.

Dr. Gretter stated that that is correct. Unless the nerve is severed anatomically or physiologically, the issue is that, if you put a screw through it, most of the time you're just partially injuring the nerve and that's going to hurt all the time. If you put a plate on top and crush the nerve, you've interrupted it physiologically.

DR. STIENECKER MOVED THAT FINDING OF FACT #16 IN THE MATTER OF TARSEM C. GARG, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING FOR THE SENTENCE "DR. GARG THEN PROCEEDED TO USE A BRUNNER ZIGZAG INCISION ON THE LEFT LITTLE FINGER OF PATIENT 3, ALTHOUGH THE OPERATIVE NOTE INDICATES A V-Y PLASTY INCISION":

Dr. Garg then proceeded to make a V-Y plasty incision.

DR. STIENECKER FURTHER MOVED THAT CONCLUSION #3 IN THE MATTER OF TARSEM C. GARG, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING:

3. Dr. Garg's care and treatment of Patient 3, specifically his failure to identify a transected ulnar digital nerve and his initial use of the V-Y plasty incision for a Dupuytren's contracture release, do not rise to the level of "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances", as that clause is used in Section 4731.22(B)(6), Revised Code.

DR. STIENECKER FURTHER MOVED THAT THE UNNUMBERED FINAL PARAGRAPH OF THE CONCLUSIONS IN THE MATTER OF TARSEM C. GARG, M.D., BE AMENDED BY DELETING THE WORD "UNKNOWINGLY" IN LINE EIGHT ON PAGE 27 OF THE HEARING EXAMINER'S REPORT AND RECOMMENDATION.

HE FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF TARSEM C. GARG, M.D., BE AMENDED AS FOLLOWS:

1. By substituting "one (1) year" for "two (2) years" in paragraph 1.

2. By substituting the following for paragraph 2b:

"Dr. Garg shall take and successfully complete a minimum of 50 hours of training, approved in advance by the Board, in the areas of orthopaedic operative neurology and/or oncology. Dr. Garg shall provide the Board with acceptable documentation verifying successful completion of such programs."

3. By deleting paragraph 2c.

4. By deleting paragraph 3d.

5. By renumbering all remaining paragraphs as necessary.

Dr. Stienecker stated that he could find no statement by Dr. Tarsem Garg in the testimony which indicated that he performed a Brunner incision. He added that to say that Dr. Tarsem Garg "unknowingly" transected the nerve is to say that he did so, and there is no reliable, probative or substantial evidence that he did so.

Several other members of the Board indicated that to remove the word "unknowingly" indicates that Dr. Tarsem Garg knowingly transected the nerve.

Dr. Stienecker amended that portion of his motion, as follows:

DR. STIENECKER FURTHER MOVED THAT THE UNNUMBERED FINAL PARAGRAPH OF THE CONCLUSIONS IN THE MATTER OF TARSEM C. GARG, M.D., BE AMENDED BY DELETING THE WORDS "UNKNOWINGLY TRANSECTED THE DIGITAL ULNAR NERVE AND" IN LINES EIGHT AND NINE ON PAGE 27 OF THE HEARING EXAMINER'S REPORT AND RECOMMENDATION.

Dr. Stienecker stated that requiring Dr. Tarsem Garg to pass the SPEX is being punitive. Also, Dr. Tarsem Garg's problems, particularly in the cases of Patient 2 and Patient 3, wouldn't have been found by someone observing Dr. Tarsem Garg's hospital records. The problems came up months after the hospital operative records were written. Chart or practice review would not have brought the problems to light any sooner.

DR. AGRESTA SECONDED DR. STIENECKER'S MOTIONS TO AMEND.

Dr. Garg stated that the Board has testimony on the record from a specialist other than the State's witness. This other specialist is renowned. The Hearing Examiner branded this man as a friend of Dr. Tarsem Garg's. Dr. Garg stated that he doesn't know whether that expert was a friend, teacher or colleague. He noted that he personally meets with his teachers from time to time, but that doesn't give him the right to call them friends. Who is better to offer testimony than your teacher who has watched your practice from year to year?

Dr. Garg continued that he cannot find anything in the record which states with certainty that there was bad treatment of the patients, particularly in the cases of Patients 1 and 2.

DR. GARG MOVED TO AMEND THE PROPOSED AMENDMENT BY SUBSTITUTING THE FOLLOWING:

Although sufficient basis exists to support the imposition of disciplinary action in this matter, it is the view of the State Medical Board of Ohio that no further action is warranted. Accordingly, it is hereby ORDERED that this matter be DISMISSED.

DR. HEIDT SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Day	- abstain
	Mr. Albert	- nay
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- abstain
	Dr. Kaplansky	- abstain
	Dr. Heidt	- aye
	Dr. Hom	- nay
	Dr. Agresta	- aye
	Ms. Rolfes	- nay

The motion carried.

Dr. Heidt stated that he has mixed emotions on this case. He can see this surgeon's point of view and certainly has seen this happen in many other cases. Dr. Tarsem Garg is not practicing bad medicine. He's made a few mistakes. Dr. Heidt stated that he doesn't know if the Board should crucify someone for making a couple of mistakes.

Ms. Rolfes stated that the entire discussion from the start seems to be a rationalization of Dr. Tarsem Garg's behavior. A death resulted from the doctor's treatment of a patient. A person died, perhaps prematurely. Patients experienced a great deal of pain. Ms. Rolfes stated that dismissal of this case is absolutely inappropriate. Ms. Rolfes stated that taking Dr. Tarsem Garg out of practice for only a year is extremely generous. The Board must look carefully at its mission. Dr. Tarsem Garg made mistakes and people were badly hurt. Ms. Rolfes spoke against the amended amendment.

Dr. Kaplansky noted that the Board has already voted to adopt an amendment dismissing the case. He asked whether that made further action moot.

Dr. Gretter stated that the Board has voted on an amendment to an amendment. Now it must vote on the amended amendment.

Dr. Garg stated that he understands what Ms. Rolfes is saying, adding that it is especially difficult to understand why the Board wouldn't punish someone who has caused pain. The problem in this matter is that the Board cannot find fault with

the cases presented. In the case of Patient 1, two different pathologists reported that there wasn't cancer. In those circumstances, it wouldn't have made sense for a physician to do anything other than what Dr. Tarsem Garg did. To do anything more would have been to amputate the arm. In the case involving the radial nerve, there is no clear picture or evidence that it was the result of negligence or bad medicine or bad medical care. Nor is there evidence of the same in the third case. Dr. Garg stated that he would be the first one to say that the punishment should meet the crime. In this case, it doesn't. There is no proof of Dr. Tarsem Garg's having done anything wrong as far as a violation of minimal standards. He doesn't understand Dr. Heidt's statements about mistakes being made.

Dr. Garg continued that it is very easy to use hindsight. However, if a physician had done anything more than Dr. Tarsem Garg did based on the pathologists' reports, it would have been gross malpractice.

Dr. Garg stated that the Board may want to punish someone because it has studied the case for a year, but he personally doesn't believe that sanctions are required in this case.

Dr. Hom stated that she doesn't believe the Board has ever been punitive based on how much time it has invested in a case. The Board has dismissed cases after years of work when it has been determined that there wasn't enough evidence to penalize.

Dr. Hom continued that if the physician members and consumer members of the Board feel that substandard care has been provided patients in a case after reading the testimony, the Board has an obligation to require the physician to get additional education. There are issues involved in this case that the Board cannot dismiss. If the Board feels that the doctor is perfectly safe, dismissal is fair. Not everyone may agree with Dr. Garg's analysis of this case. That is why the Board must discuss it. The Board must decide whether it feels that Dr. Tarsem Garg has provided appropriate care. That is the Board's job.

Dr. Garg and Dr. Heidt both indicated that they did not find Dr. Tarsem Garg's treatment of the patients in question to constitute a violation of minimal standards of medical care.

Dr. Hom stated that dismissing the case leaves the Board with no options for requiring re-education of any kind.

Dr. Garg stated that he doesn't believe Dr. Tarsem Garg needs any re-education.

Dr. Agresta stated that the Board must ask whether Dr. Tarsem Garg could have done anything different in the care of each case. Many times patients have unfortunate outcomes. This doesn't necessarily mean that the physician is a poor physician or needs more training. Each physician on the Board must ask himself if or how he would have reacted differently in each case. A physician will not amputate a part of a patient's body without clear pathological indication. It is unfortunate that the problem went on so long, but the Board doesn't know if it was cancer right from the beginning. It may have become malignant during the five years involved. Dr. Agresta stated that two years of suspension is being punitive in this case. He is

also unsure whether a one-year suspension is appropriate.

Dr. Stienecker agreed with Dr. Agresta. The Board cannot redress the tragedy of the death of Patient 1. The Board is not here to try to redress it. Dr. Stienecker stated that he believes Dr. Tarsem Garg did what was indicated, with an unfortunate outcome.

Dr. Garg stated that the only fault he found was that the documentation could have been different. Perhaps Dr. Tarsem Garg could have better reported what he said to the patients' families. However, physicians learn from experience and perhaps the documentation will improve. Dr. Garg commented, however, that it is impossible to record everything said in the patient charts.

Ms. Noble asked whether the outcome in the case of Patient 1 would have been different had Dr. Tarsem Garg amputated immediately.

Dr. Heidt stated that you never can tell in cases such as these. This type of tumor is almost exclusively fatal. He added that it was probably a malignant tumor from the start. Performing an amputation might not even have gotten it all. The problem is that there was never a positive diagnosis until it was too late. That sometimes happens in medicine, especially with cases such as this.

A roll call vote was taken on Dr. Stienecker's motion to amend, as amended:

ROLL CALL VOTE:	Dr. O'Day	- abstain
	Mr. Albert	- nay
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- aye
	Dr. Kaplansky	- abstain
	Dr. Heidt	- aye
	Dr. Hom	- abstain
	Dr. Agresta	- aye
	Ms. Rolfes	- nay

The motion carried.

DR. GARG MOVED TO APPROVE AND CONFIRM MR. BYERS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF TARSEM C. GARG, M.D. DR. HEIDT SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Day	- abstain
	Mr. Albert	- nay
	Dr. Stienecker	- aye
	Dr. Garg	- aye
	Ms. Noble	- aye
	Dr. Kaplansky	- abstain
	Dr. Heidt	- aye
	Dr. Hom	- abstain
	Dr. Agresta	- aye

EXCERPT FROM THE MINUTES OF DECEMBER 2, 1992
IN THE MATTER OF TARSEM C. GARG, M.D.

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Ms. Rolfes - nay
Dr. Gretter - aye

The motion carried.

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STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

February 12, 1992

Tarsem C. Garg, M.D.
2624 Lexington Avenue, Suite 210
Springfield, OH 45505

Dear Doctor Garg:

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

- (1) On or about April 20, 1983 Patient 1, a then 16 year old athlete, identified on the attached Patient Key (Key Confidential--to be withheld from public disclosure), had A.P. lateral and axillary views of the left shoulder at your direction. The radiology report noted a large dense ossified mass "at the posteriolateral aspect of the upper humerus with associated marked soft tissue swelling. Parosteal sarcoma would be the prime suspect. Otherwise, post traumatic calcification of the soft tissue would be another consideration." The tumor was excised by you on or about April 22, 1983 and portions sent to the pathologist who interpreted the specimen as fibrous dysplasia. It was explicitly noted in the report that, "... the position and radiological appearance is not typical. The possibility of parosteal osteosarcoma must be considered." Shortly thereafter slides, tissue, clinical information and x-rays were sent to another pathologist who noted "areas very similar to parosteal osteosarcoma" but felt the lesion represented benign atypical heterotopic ossification. The report concluded that "It would seem appropriate to do no additional therapy unless recurrence makes it necessary."

Mailed 2/13/92

February 12, 1992

On a follow-up visit of January 31, 1984 you noted that Patient 1 was having continued discomfort accompanied by the presence of solidification of the calcification in the left upper arm. At that time you recommended excision in six months of what you still believed to be myositis ossificans. You noted that such pathology takes approximately one year to mature.

You continued to see Patient 1 intermittently for approximately two years. During that time, Patient 1's discomfort increased while his/her range of motion markedly decreased. On or about May 24, 1986 you attempted to excise what you still believed to be myositis ossificans. Post operative x-rays could not determine the presence of bony involvement and the report recommended further diagnostic testing for clarification.

On a follow-up visit of July 21, 1986 you noted that you advised the patient further excision would be necessary and to return in three to six months. On or about January 8, 1987 Patient 1 returned to you with increased discomfort, decreased range of motion and an enlarged mass. You diagnosed this condition as a recurrence of the myositis ossificans. On or about January 14, 1987 Patient 1 received a CT scan and plain films of the left shoulder. Both studies confirmed the presence of malignancy.

On or about February 10, 1987 Patient 1 self-referred to Cleveland Clinic at which time a complete work-up was performed and a diagnosis of parosteal osteosarcoma was made. The patient underwent chemotherapy, had a left arm amputation, and a wedge resection due to multiple metastatic nodules in the chest. On or about May 30, 1988 Patient 1 suffered from respiratory arrest and expired as a result of your failure to adequately diagnose and treat the malignancy described above.

- (2) On or about June 22, 1985 Patient 2, identified on the attached Patient Key (Key Confidential—to be withheld from public disclosure), presented to you with an oblique fracture of the distal one-third of the left humerus. At that time the Patient's neurovascular status was normal. A closed reduction was unsuccessful and an open reduction was performed two days later. Although the proper incision would have been

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Tarsem C. Garg, M.D.
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anteroilateral you made a posterior incision and after three hours in the operating room were able to obtain reduction and apply an orthopedic plate. Upon awakening from anesthesia Patient 2 had a radial nerve palsy and was unable to extend the wrist and fingers. Upon discharge you noted that the Patient was unable to contract his/her wrist or fingers.

On or about October 18, 1985 Patient 2 had exploratory surgery of the left wrist by another physician. The radial nerve was found to be underneath the upper portion of the plate you had previously inserted and one of the screws was actually piercing the nerve. At that time it was concluded that motor function to the radial nerve was lost.

- (3) On or about January 29, 1988 Patient 3, identified on the attached Patient Key (Key Confidential--to be withheld from public disclosure), presented to you for a scheduled flexor contracture release of the left fifth finger. You made your first incision in Patient 3's left palm believing him/her to be a different patient who was scheduled to undergo carpal tunnel surgery even though Patient 3 was scheduled for a contracture release of the left fifth finger. When you made the incision for the proper surgery, you made it in the wrong area. Further, you transected the ulnar nerve and failed to recognize it; thus, you neither repaired the nerve nor informed the patient.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) 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 (30) days of the time of mailing of this notice.

February 12, 1992

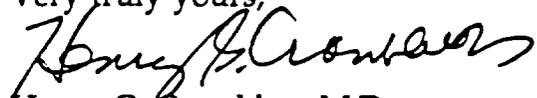
Tarsem C. Garg, M.D.
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You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, 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 (30) 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, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Henry G. Cramblett, M.D.
Secretary

HGC:jmb
Enclosures:

CERTIFIED MAIL #P 569 363 740
RETURN RECEIPT REQUESTED