State Medical Board of Ohio

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May 13, 1998

Edward Louis Woods, M.D.
#4 Poinciana Drive
Durham, NC 27707

Dear Doctor Woods:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 13, 1998, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal 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, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Anand G. Garg, M.D.
Secretary

AGG:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. Z 233 839 055
RETURN RECEIPT REQUESTED

Mailed 6/9/98

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 13, 1998, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Edward L. Woods, 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.

Anand G. Garg, M.D.
Secretary

(SEAL)

6/9/98
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

EDWARD LOUIS WOODS, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on May 13, 1998.

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

It is hereby ORDERED that:

1. The certificate of Edward Louis Woods, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Woods' certificate is SUSPENDED for an indefinite period of time, but not less than one (1) year.

2. The Board shall not consider reinstatement of Dr. Woods' certificate to practice unless all of the following minimum requirements have been met:

    a. Dr. Woods shall submit an application for reinstatement, accompanied by appropriate fees.

    b. Dr. Woods shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency. Dr. Woods must pass this examination prior to applying for reinstatement of his certificate.

3. Upon reinstatement, Dr. Woods' certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three (3) years:

   a. Dr. Woods shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

   b. Dr. Woods shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.

   c. Dr. Woods shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which the probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

   d. Dr. Woods shall appear in person for interviews before the full Board or its designated representative within three months of the reinstatement of his certificate and upon request for termination of the probationary period, or as otherwise requested by the Board.

   e. Dr. Woods shall notify the Board of any action in any state taken against a certificate to practice held by Dr. Woods in that state. Moreover, Dr. Woods shall provide acceptable documentation verifying the other state board's actions.

   f. Dr. Woods shall refrain from commencing practice in Ohio without prior written Board approval. Furthermore, prior to commencing practice in Ohio, the Board may require that Dr. Woods comply with additional terms, conditions, or limitations, including the following:

      i. Prior to commencement of practice in Ohio, Dr. Woods shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing

Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

ii. Prior to commencement of practice in Ohio, Dr. Woods shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Woods' activities will be directly supervised and overseen by a monitoring physician approved by the Board. The monitoring physician shall monitor Dr. Woods and his patient charts. The chart review may be done on a random basis, with the number of charts reviewed to be determined by the Board. The monitoring physician shall provide the Board with reports on Dr. Woods' progress and status and on the status of his patient charts on a quarterly basis. All monitoring physician reports required under this paragraph must be received in the Board's offices no later than the due date for Dr. Woods' quarterly declaration. It is Dr. Woods' responsibility to ensure that the reports are timely submitted.

Dr. Woods shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

In the event that the approved monitoring physician becomes unable or unwilling to serve, Dr. Woods shall immediately notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable. Dr. Woods shall refrain from practicing until such supervision is in place, unless otherwise determined by the Board. Dr. Woods shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

iii. Prior to commencement of practice in Ohio, Dr. Woods shall provide the Board with acceptable documentation evidencing his full and unrestricted licensure in the State of North Carolina.

iv. In the event that Dr. Woods has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to commencement of practice in Ohio, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

v. After commencement of practice in Ohio, Dr. Woods shall appear in person for interviews before the full Board or its designated representative within three months of the date in which probation becomes effective, at three (3) month intervals thereafter, and upon his request for termination of the probationary period, or as otherwise requested by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woods' responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Woods shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

vi. Within thirty (30) days of commencement of practice in Ohio, Dr. Woods shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Woods has privileges or appointments. Further, Dr. Woods shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Woods applies for or obtains privileges or appointments.

g. If Dr. Woods violates probation in any respect, the Board, after giving Dr. Woods notice and the opportunity to be hearing, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Woods' certificate.

4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Woods' certificate will be fully restored.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio.

Anand G. Garg, M.D.
Secretary

(SEAL)

6/9/93
Date

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REPORT AND RECOMMENDATION
IN THE MATTER OF EDWARD LOUIS WOODS, M.D.

The Matter of Edward Louis Woods, M.D., was heard by Sharon W. Murphy, Attorney Hearing Examiner for the State Medical Board of Ohio, on February 26, 1998.

INTRODUCTION

I. Basis for Hearing

A. By letter dated December 3, 1997, the State Medical Board of Ohio [Board] notified Edward Louis Woods, M.D., that the Board had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's action was based on one or more of the following reasons:

1. On or about February 26, 1996, the State of New York Department of Health Administrative Review Board for Professional Medical Conduct issued a Decision and Order revoking Dr. Woods' license to practice medicine and surgery in New York based on a finding of guilt of professional misconduct.

2. On or about May 1, 1996, Dr. Woods signed an application for renewal of his Ohio certificate to practice medicine and surgery, certifying that the information provided on the application was true and correct in every respect. In the application, Dr. Woods denied having had an action taken against him by another state licensing board. Nevertheless, on or about November 1, 1995, the New York Department of Health had issued a Determination and Order revoking Dr. Woods' license to practice based on professional misconduct. Moreover, on or about February 26, 1996, the Administrative Review Board for Professional Medical Conduct had issued its Decision and Order revoking his license to practice medicine and surgery in New York based on professional misconduct.

3. On or about December 6, 1996, the Commonwealth of Pennsylvania State Board of Medicine filed an Adjudication and Order which revoked Dr. Woods' Pennsylvania license to practice medicine and surgery based on the New York Order in paragraph (1), above.

The Board alleged that the action by the State of New York, referenced in paragraph (1), above, constitutes "'(t)he limitation, revocation, or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, the

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imposition of probation by that authority, or the issuance of an order of censure or other reprimand by that authority for any reason, other than nonpayment of fees,' as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect prior to March 6, 1996, to wit: Section 4731.22(B)(6), Ohio Revised Code."

The Board further alleged that Dr. Woods' conduct, as set forth in paragraph (2), above, constitutes "'fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the Board,' as that clause is used in Section 4731.22(A), Ohio Revised Code, [and] 'publishing a false, fraudulent, deceptive, or misleading statement,' as that clause is used in Section 4731.22(B)(5), Ohio Revised Code."

In addition, the Board alleged that the action by the State of Pennsylvania, referenced in paragraph (3), above, constitutes "(t)he limitation, revocation, or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, the imposition of probation by that authority, or the issuance of an order of censure or other reprimand by that authority for any reason, other than nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect on or after March 6, 1996.

Accordingly, the Board advised Dr. Woods of his right to request a hearing in this matter. (State's Exhibit 1).

B. On December 26, 1997, Dr. Woods submitted a written request for a hearing. (State's Exhibit 2).

II. Appearances

A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Anne Berry Strait, Assistant Attorney General.

B. On behalf of the Respondent: Although Dr. Woods had been advised of his right to be represented at hearing by counsel, Dr. Woods represented himself.

EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

The State presented no witnesses.

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B. Presented by the Respondent

1. Melvin E. Richardson

2. Betty Robinson Woods

3. Edward Louis Woods, M.D.

II. Exhibits Examined

In addition to State's Exhibits 1 and 2, noted above, the following exhibits were identified and admitted into evidence:

A. Presented by the State

1. State's Exhibits 3-6: Procedural exhibits.

2. State's Exhibit 7: Certified copies of documents from the State of New York Department of Health, Office of Professional Medical Conduct, regarding Dr. Woods. (59 pp.)

3. State's Exhibit 8: Certified copy of the Adjudication and Order issued in the matter of Edward Louis Woods, M.D., by the Commonwealth of Pennsylvania Department of State, Bureau of Professional and Occupational Affairs, State Board of Medicine. (10 pp.)

4. State's Exhibit 9: Certified copy of the application by Dr. Woods for renewal of his Ohio license for the 1996-1998 biennium. (2 pp.)

B. Presented by the Respondent

Respondent's Exhibit A: Copies of documents submitted by Dr. Woods, including licensure documents, Dr. Woods' curriculum vitae, and letters written in support of Dr. Woods. (59 pp.)

C. Post-Hearing Admissions to the Record

Upon motion of the Respondent, the following exhibits are admitted into evidence

Respondent's Exhibits B through H: Copies of medical records for Patients A through G, respectively. (Note: Exhibits have been sealed to protect patients' confidentiality)

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PROCEDURAL MATTERS

At hearing, Dr. Woods requested an opportunity to supplement the record with copies of the medical records for the patients at issue in this matter. The State did not object. The Attorney Hearing Examiner agreed to hold the record open for submission of the patient records. Dr. Woods supplied the records on March 13, 1998. Accordingly, the hearing record closed on that date.

SUMMARY OF THE EVIDENCE

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

1. Edward Louis Woods, M.D., received a Bachelor of Science degree in 1961. After serving several years in the United States Army, Dr. Woods received a Doctor of Medicine degree from the University of North Carolina at Chapel Hill in 1978. In 1983, Dr. Woods completed an internal medicine residency program at St. Elizabeth Hospital Medical Center in Youngstown, Ohio. Dr. Woods states that he is board eligible in internal medicine. (Respondent's Exhibit [Resp. Ex.] A at 3-5, 13). Dr. Woods' curriculum vitae advised that he has sixteen years experience in emergency medicine as locum tenens staff. He was certified as an Advanced Cardiac Life Support Provider in 1996. (Resp. Ex. A at 14, 15).

2. In Spring 1990, Dr. Woods contracted with CompHealth, a physician placement agency, in Salt Lake City, Utah. Pursuant to that contract, Dr. Woods served as locum tenens in the emergency department at the House of the Good Samaritan in Watertown, New York. The period for which he agreed to provide services was July 5 through August 30, 1990. (Transcript [Tr.] at 43-44; Resp. Ex. A at 37).

   Accordingly, Dr. Woods applied for a license to practice medicine in the State of New York. On March 29, 1990, the State of New York issued Dr. Woods a certificate of registration to practice as a physician in that state, for a registration period ending December 31, 1991. (Resp. Ex. A at 33).

3. On March 8, 1995, the New York Department of Health, State Board for Professional Medical Misconduct [New York Board], issued a notice of Hearing and Statement of Charges in the Matter of Edward Woods, M.D., based on the care Dr. Woods provided to seven patients at the House of the Good Samaritan in 1990. (State's Exhibit [St. Ex.] 7 at 19). On May 31, 1995, the New York Board issued an Amended Statement of Charges. Again, on June 29, 1995, the New York Board issued an Amended Factual Allegations. The Amended Statement of Charges alleged that Dr. Woods had practiced with gross negligence, gross

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incompetence, negligence and incompetence, and that he had failed to keep appropriate medical records, in his care and treatment of the seven patients. (St. Ex. 7 at 50-57).

Dr. Woods attended a hearing in that matter. He presented a written general denial and factual responses to the allegations. (St. Ex. 7 at 21; Resp. Ex. A at 42-45).

On or about November 1, 1995, subsequent to hearing, the New York Board of Professional Misconduct Hearing Committee [Hearing Committee] issued a Determination and Order revoking Dr. Woods' license to practice medicine. The Hearing Committee issued Findings of Fact and Conclusions regarding the seven patients at issue in that matter, as follows:

a. Patient A, a 24 year old female, presented to the emergency department [ED] after hitting her head when diving into a pool. She complained of pain in the posterior neck, shoulders, and upper chest. Because of the possibility of a cervical spine injury, a detailed neurologic examination should have been performed. Nevertheless, Dr. Woods did not document a neck examination, and merely indicated that grasps were good, extremities were moving, and the "neuro" was intact.

   Moreover, Dr. Woods ordered cervical and thoracic spine x-rays, which he interpreted as demonstrating "no obvious fracture." Dr. Woods missed "an obvious fracture" of the cervical spine.

   In addition, Dr. Woods did not consult an appropriate specialist.

   Patient A was discharged from the ED approximately 100 minutes after her arrival.

   The Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence, by "failing to perform and record an adequate physical examination of Patient A, failing to detect a fracture on Patient A's cervical spine x-rays and by inappropriately discharging Patient A."

   (St. Ex. 7 at 24-25, 35, 38, 40) (The medical records of Patient A were admitted to the hearing record as Resp. Ex. B).

b. Patient B, a 67 year old male, presented to the ED with a complaint of "'left nostril with clogging, had difficulty with passage of air and prior history of bronchitis." The nursing notes indicate that Patient B complained of "unusual shortness of breath," bilateral basilar rales, and inability to sleep in a supine position. Patient B had been taking various medications which had cardiopulmonary indications. Moreover, Patient B presented with a blood pressure of 220/180.

   Dr. Woods did not document his awareness of Patient B's hypertension or an investigation of its cause. Moreover, Dr. Woods did not take an adequate history, in

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light of Patient B's age and condition. In addition, Dr. Woods performed an inadequate physician examination, focusing on Patient B's nose and tympanic membranes. Dr. Woods' physical examination should have included a cardiorespiratory examination.

Dr. Woods diagnosed nasal congestion and sinusitis. He prescribed Dimetapp, which contains phenylephrine, "an alpha agonist which can cause acute elevation of blood pressure in hypertensive individuals."

Dr. Woods did not treat Patient B's hypertension.

Patient B was discharged from the ED forth-five minutes after his admission.

Later that day, Patient B returned to the ED. After a thorough examination and testing, another physician diagnosed mild congestive heart failure, COPD, bronchitis, left maxillary sinusitis, and diabetes mellitus.

The Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence "by failing to obtain and record an adequate physical examination of Patient B, to investigate and treat adequately Patient B's hypertension, failing to make a medically acceptable diagnosis, by inappropriately prescribing Dimetapp to Patient B and by inappropriately discharging Patient B."

(St. Ex. 7 at 26-28, 35-36, 38, 40) (The medical records of Patient B were admitted to the hearing record as Resp. Ex. C).

c. Patient C, a 72 year old male, presented to the ED with complaints of substernal pressure which had begun one hour prior to his arrival in the ED. Patient C had received two doses of sublingual nitroglycerin while in the ambulance, with complete relief of his chest pain. Upon arrival in the ED, however, he complained of "'non-radiating' chest pain with diaphoresis and pain in the teeth." An electrocardiogram indicated that Patient C was suffering from an acute anterior wall myocardial infarction.

Patient C experienced frequent episodes of chest pain. Dr. Woods failed to provide sufficient sublingual nitroglycerin. Moreover, Dr. Woods did not employ intravenous nitroglycerin or intravenous narcotics.

In addition, "[t]hrombolytic therapy could have minimized the damage to Patient C through intravenous drug administration to dissolve blood clots. The 1990 indications for the therapy were met by the ECG showing ST segment elevation in contiguous leads indicating one (1) area of the heart was having an infarction. [Thrombolytic therapy] should be administered two (2) to four (4) hours from the onset of symptoms. Patient C

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had no contraindications to thrombolytic therapy and would have been a good candidate for such." Nevertheless, Dr. Woods waited 1½ hours before contacting a cardiologist. Upon arrival in the ED, the cardiologist determined that too much time had passed for effective administration of thrombolytic therapy.

Patient C was diagnosed with a completed anterior wall myocardial infarction, congestive heart failure, and atrial fibrillation.

The Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence "by failing to treat adequately Patient C with nitroglycerin and failing to institute thrombolytic therapy in a timely manner."

(St. Ex. 7 at 28-30, 36, 38, 40, 47) (The medical records of Patient C were admitted to the hearing record as Resp. Ex. D).

d. Patient D, a 47 year old female, presented to the ED with complaints of right lower quadrant abdominal pain and slight abdominal distention.

Upon physical examination, Dr. Woods found "pain and tenderness to palpation in the right inguinal and lower inguinal abdominal area with a finding that bowel sounds were present and that there were no masses or hernias." Dr. Woods did not perform a pelvic or rectal examination. Dr. Woods did order blood tests which included amylase, a pregnancy test, a complete blood count, a chemistry profile, and a urinalysis.

Dr. Woods diagnosed "abdominal pain, rule out stone."

The Hearing Committee dismissed the charges against Dr. Woods regarding his opinion that the diagnostic studies had been inconclusive and his recommendation for further evaluation of Patient D. Nevertheless, the Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence "by failing to perform a rectal and a pelvic examination of Patient D."

(St. Ex. 7 at 30-31, 39, 41, 47-48) (The medical records of Patient D were admitted to the hearing record as Resp. Ex. E).

e. Patient E, a 15 year old male, presented to the ED after twisting his ankle while playing basketball. He complained of pain, swelling, and decreased motion. Dr. Woods recorded his physical examination only as "same."

Dr. Woods ordered x-rays of Patient E's ankle, which Dr. Woods interpreted to demonstrate "no obvious fracture." Dr. Woods diagnosed a left ankle sprain, and prescribed an Ace wrap, crutches, ice, elevation, and gradual weight bearing. Dr. Woods discharged Patient E from the ED seventy minutes after his arrival.

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Dr. Woods did not prescribe pain medication or refer Patient E to an orthopedic surgeon.

The following day, a radiologist reviewed the x-rays and diagnosed a fracture at the superiorlateral corner of the talus, and avulsion fracture fragments between the medial aspect of the talus and the medial malleolus. He also diagnosed probable ligament instability due to a widening of the mortise.

The Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence because he had "failed to perform and record an adequate physical examination and to interpret adequately the x-rays of Patient E's ankle as well as issuing inappropriate discharge instructions."

(St. Ex. 7 at 32-33, 37, 39, 41) (The medical records of Patient E were admitted to the hearing record as Resp. Ex. F).

f. Patient F, a 33 year old female, presented to the ED after having been involved in a motor vehicle accident. Patient F had been unconscious when found by the ambulance personnel. When she regained consciousness, she complained of pain in her head, neck, and right knee.

Dr. Woods did not perform physical examination of Patient F's neck. Moreover, he did not document a neurological examination, other than the word "'neuro.'"

Dr. Woods discharged Patient F approximately 2½ hours after her arrival in the ED.

The following day, Patient F was readmitted to the hospital with a diagnosis of a comminuted fracture of the lateral mass of C-2 of the cervical spine.

The Hearing Committee concluded that Dr. Woods had practiced with gross negligence "by failing to record and perform an adequate physical examination."

Nevertheless, the Hearing Committee dismissed the allegation that Dr. Woods' treatment of Patient F constituted gross incompetence. The Hearing Committee noted that Dr. Woods had provided adequate testimony at hearing to substantiate his neurological examination of Patient F.

(St. Ex. 7 at 33-34, 37, 39, 41) (The medical records of Patient F were admitted to the hearing record as Resp. Ex. G).

g. Patient G, a 23 year old male, complained that the had been bitten by a wild raccoon. Appropriate rabies prophylaxis includes the administration of human rabies immunoglobulin and a series of rabies vaccinations to be given over a three week period.

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> Dr. Woods did not administer human rabies immunoglobulin. In addition, although Dr. Woods administered the initial rabies vaccination, he did not advise Patient G to return for subsequent injections at the appropriate times.
>
> The Hearing Committee concluded that Dr. Woods had practiced with gross negligence and gross incompetence "by failing to administer human rabies immunoglobulin to Patient G and failing to have vaccine administered to Patient G on an appropriate schedule."
>
> (St. Ex. 7 at 34-35, 37, 39, 42, 48) (The medical records of Patient G were admitted to the hearing record as Resp. Ex. H).

The Hearing Committee further sustained the allegations that Dr. Woods had practiced with gross negligence and with gross incompetence on more than one occasion. In addition, the Hearing Committee found that Dr. Woods had failed to maintain adequate patient records for Patients A through G. (St. Ex. 7 at 42-43).

Finally, the Hearing Committee voted to revoke Dr. Woods' certificate to practice medicine in New York, based on the conclusion that Dr. Woods had been "practicing emergency medicine for about sixteen years. It can not be anticipated that he will change. His medical skill and judgment are both in question." (St. Ex. 7 at 48-49).

4. Dr. Woods appealed the decision of the Hearing Committee to the Administrative Review Board for Professional Medical Conduct. In his appeal, Dr. Woods argued that the allegations were not supported by the record, and that the penalty imposed was too harsh. (St. Ex. 7 at 7).

   On February 20, 1996, the Administrative Review Board issued a Decision and Order sustaining the decisions of the Hearing Committee. Moreover, the Decision and Order revoked Dr. Woods' license to practice medicine and surgery in New York based on a finding of guilt of professional misconduct, effective February 27, 1996. (St. Ex. 7 at 2-14). The Administrative Review Board based part of its decision to revoke Dr. Woods' certificate on its finding that:

   > [T]he Respondent fails to appreciate that he is not providing adequate care and he refused to acknowledge his mistakes. There is nothing in this record that indicates that the Respondent has the ability, insight, and motivation to correct his pattern of poor practice. The Board agrees with the Hearing Committee that the Respondent constitutes a danger to the public, especially in emergency medicine.

   (St. Ex. 7 at 9).

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5. Regarding his employment at the House of the Good Samaritan and the care he provided there, in general, Dr. Woods testified as follows:

   - Dr. Woods explained that the House of the Good Samaritan had approached CompHealth for locum tenens physicians because all of their emergency department physicians had resigned.

     Dr. Woods contracted to work three weeks at the House of the Good Samaritan. In the contract, it was specified that Dr. Woods would not see trauma patients and that he would not see more than 70 patients in a 24 hour period. Dr. Woods testified, however, that the hospital did not adhere to the terms of the contract.

     In addition, Dr. Woods testified that the ED was unkempt, staffing was inadequate, and construction was in process. Moreover, another ED in town had closed, so that all emergency patients were being transported to the House of the Good Samaritan. Furthermore, the Persian Gulf War had just begun, and members of the military stationed at a nearby base were frequenting the ED in hopes of receiving disability diagnoses.

     Dr. Woods testified that the House of the Good Samaritan was later cited by the JCAHO. He further testified that the believes that the hospital intended to make him the "scapegoat" for the hospital's deficiencies. (Tr. at 43-44).

   - Dr. Woods further testified that the House of the Good Samaritan does not provide radiologists or cardiologists to interpret x-rays and EKG's during the evening and night shifts. Therefore, x-rays and other tests were not interpreted by the appropriate discipline until the following day. (Tr. at 80-81).

   - Dr. Woods stated that no patient harm resulted from the care he provided. (Tr. at 9).

6. Regarding his care and treatment of Patient A, Dr. Woods testified that he had performed a neurological examination, but did not record the details. (Tr. at 50-51). When asked about his failure to observe the cervical fracture, Dr. Woods answered that:

   > The reported fracture that the radiologist read only showed up in one view. Now, normally, to any physician, that means it's a little questionable. It could be artifact, and especially in teenagers where you have cartilage and spine where the bone is not completely ossified and hard, so * * * you can see what appears to be a fracture, but it is not.

   (Tr. at 50). Dr. Woods stated that he told Patient A that she had suffered a whiplash injury and recommended that she follow-up with her family physician. Dr. Woods concluded that he did not deviate from the standard of care in his treatment of Patient A. (Resp. Ex. A at 43).

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The medical records for Patient A submitted for introduction into evidence contain only the radiologist's report of Patient A's cervical and thoracic spine x-rays. The radiologist described the cervical films as showing:

> a normal lordotic curvature with intact intervertebral disc spaces. However, there appears to be a 'tear drop' type fracture of the anterior aspect of the lower lip of the fourth cervical vertebra with minimal displacement of the fragment. Associated soft tissue swelling is difficult to evaluate in this region. The remainder of the study is unremarkable.

(Resp. Ex. B).

It should be noted that the radiologist specifically documented a finding on the thoracic films which could be seen only on one view. Nevertheless, his interpretation of the cervical spine films was not so limited, which raises questions regarding the credibility and reliability of Dr. Woods' testimony. (Resp. Ex. B).

Moreover, Dr. Woods' discussion of the difficulty recognizing fractures in teenagers is not relevant to Patient A, since Patient A was 24 at the time of her injury. (St. Ex. 7 at 24; Resp. Ex. B).

7. Regarding his care and treatment of Patient B, Dr. Woods explained that Patient B had admitted to Dr. Woods that he had used a Ventolin Inhaler excessively. From this statement, Dr. Woods concluded that Patient B's hypertension had been caused by excessive use of the inhaler. (Resp. Ex. A at 42).

   Dr. Woods further noted that he had ordered a dose of Dimetapp for Patient B, and fifteen minutes later Patient B's blood pressure had decreased from 220/120 to 180/110. This reasoning suggests that Dr. Woods attributes Patient B's drop in blood pressure to the dose of Dimetapp, and that he believes the decrease was significant enough to warrant no further attention. (Resp. Ex. A at 42; Resp. Ex. C).

8. Regarding his care and treatment of Patient C, Dr. Woods stated that Patient C had reported experiencing chest pain the previous day. Dr. Woods testified that thrombolytics are contraindicated in patients who have had chest pain of long duration. When questioned further regarding the onset of Patient C's pain, Dr. Woods testified that he did not get a clear answer from Patient C. Accordingly, Dr. Woods was not satisfied that he had obtained an adequate history to support giving the patient thrombolytics. (Tr. at 54-58).

   Moreover, Dr. Woods stated that the reason he waited so long before calling a cardiologist was because the hospital laboratory was very slow in reporting results. Nevertheless, Dr. Woods argued that thrombolytics could have been given by the

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cardiologist, because "the window for giving such therapy in 1990 had been extended." (Tr. at 54-58; Resp. Ex. A).

The medical records for Patient C indicate that, in his assessment of Patient C, Dr. Woods did not document the time of the onset of Patient C's chest pain. Nor did he document any discussion of that issue. However, in the consulting cardiologist's history and physical, it is definitively stated that the onset of Patient C's chest pain had been one hour before is admission to the ED. It is further indicated that Patient C had not experienced any previous episodes of chest pain. (Resp. Ex. D at 6).

Moreover, the medical records indicate that Patient C presented to the ED at 8:30 p.m. Patient C continued to complain of chest pain, but Maalox is the only medication recorded between 8:30 and 10:45 p.m. In addition, the cardiologist was not consulted until 10:10 p.m. (Resp. Ex. D at 3, 5).

9. Regarding his care and treatment of Patient D, Dr. Woods testified that he did not perform a pelvic examination because Patient D's history did not support a pelvic examination. Dr. Woods stated that he hadn't been impressed with the abdominal distention, and reasoned that her pain had been caused by exercise. (Tr. at 58-63). Moreover, Dr. Woods explained that Patient D had denied any symptoms other than "slight tenderness to heavy palpation. Dr. Woods stated that he had allowed her to go home so long as she followed up with her local physician within the week. (Resp. Ex. A at 44).

   Nevertheless, in his assessment of Patient D, Dr. Woods described the pain as "tender to palpation." There is no mention of "slight tenderness" or "heavy palpation." Moreover, the discharge instruction simply states "Force fluids, follow up with own M.D." (Resp. Ex. E).

10. Regarding his care and treatment of Patient E, Dr. Woods explained that it is not unusual for an orthopedic surgeon "to allow swelling to dissipate before cast application." (Resp. Ex. A at 43).

11. Regarding his care and treatment of Patient F, Dr. Woods explained that "the cervical spine x-rays did not show, clearly, any markers that would have suggested that the radiologist should have been call[ed] at that time. Only a CT scan made detection possible." (Resp. Ex. A at 45).

    The medical records for Patient F indicate that the radiologist reviewed the cervical spine x-rays and found that:

    > On the open mouth view there does not appear to be normal alignment of the lateral masses of C1 with that of C2 and the lateral masses of C1 appear laterally placed compared to C2. There is some soft tissue swelling anterior to C1-2.

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(Resp. Ex. G at 14). The impression was recorded as follows:

> Findings suspicious for a Jefferson type fracture of C1. I would recommend that the patient have a repeat open mouth view for further evaluation of this area. If there is high clinical suspicion or the abnormality is present again on the open mouth view than CT of the cervical spine is recommended.

(Resp. Ex. G at 14).

12. Regarding his care and treatment of Patient G, Dr. Woods stated that he had been told by a nurse that no rabies immune globulin was available in the hospital. Furthermore, Dr. Woods stated that he had not instructed Patient G to return to the ED in one week, but rather instructed him to see his family physician the following day. (Resp. Ex. A at 44).

    The medical records for Patient G do not reveal an order for rabies immune globulin, nor the fact that the medication was unavailable at the House of the Good Samaritan. Moreover, the record contains the notation "Referred to: Return in 7 days." (Resp. Ex. H at 4).

13. On March 1, 1996, the Ohio Board sent Dr. Woods an application for renewal of his certificate to practice medicine in Ohio. Dr. Woods returned the application on October 3, 1996. When he signed the application, Dr. Woods certified that the information provided on the application was true and correct in every respect. Nevertheless, in the application, Dr. Woods answered "No" to the question "Have you * * * [h]ad any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?" (St. Ex. 9).

14. Regarding his 1996 renewal application answer to the question "Have you * * * [h]ad any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio," Dr. Woods explained that he answered in the negative because:

    - He felt that he had not been treated fairly in New York. (Tr. at 71).
    - He had hoped to obtain further review by the New York Board. (Tr. at 71-72).
    - Dr. Woods did not believe he had ever obtained full licensure in New York. He stated that the license he obtained in New York was for temporary work and did not constitute a full licensure. Dr. Woods explained that the New York Board did not send him a license to hang on his wall. He received only a certificate which contained the statement "Registration Certificate - - - Not a License." (Tr. at 8-9, 21-23, 73) (Note:

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Dr. Woods' New York certificate contains the legend "Registration Certificate - - - Not a License." See Resp. Ex. A at 33).

- Dr. Woods believed that the appellate process had not been completed at the time he completed the renewal application. (Tr. at 9-10). Nevertheless, Dr. Woods later testified that he had been unable to initiate an appeal because he could not afford the attorney's fees. (Tr. at 70-71).

- Finally, Dr. Woods did not carefully read the question when he answered it. He admitted that, in hindsight, he should have answered affirmatively. (Tr. at 75-76, 91-92).

- Dr. Woods testified that he did not intend to defraud the Board. He has great respect for Ohio; he trained in Ohio and received his first license here. (Tr. at 67-68).

15. On or about December 6, 1996, the Commonwealth of Pennsylvania State Board of Medicine [Pennsylvania Board] filed an Adjudication and Order which revoked Dr. Woods' certificate to practice in that State. The Pennsylvania Board based it action on the action of the New York Board. Although the Pennsylvania Board held a hearing, Dr. Woods did not attend. (St. Ex. 8). Dr. Woods testified that he could not attend the hearing in Pennsylvania because he was ill at that time. He had suffered an automobile accident in 1990 in which his car had "flipped over." He incurred serious back injuries as a result. (Tr. at 24).

16. On August 5, 1997, William M. Libercci, Director, Health Care Administrative Sanctions, Office of Enforcement and Compliance, Department of Health & Human Services, advised Dr. Woods that an exclusion action had been initiated against his privilege to participate in the Medicare program. The exclusion action was based on the decision of the State of Pennsylvania to revoke Dr. Woods' certificate to practice medicine in that state.

    Mr. Libercci further advised, however, that after reviewing the evidence, the agency had determined that an exclusion was not warranted. (Resp. Ex. A at 50).

17. On October 15, 1997, the North Carolina Medical Board issued a Findings of Fact, Conclusions of Law, and Order, after a review of the New York Board's action against Dr. Woods. After a review of the evidence, the North Carolina Medical Board determined that no disciplinary action would be taken against Dr. Woods.

    In the Findings of Fact, the North Carolina Medical Board noted that "Dr. Woods [had] thoroughly and credibly testified as to his work at [the House of the Good Samaritan] seven years ago, and the circumstances and facts underlying the action of the New York Board." The North Carolina Medical Board further found that "[t]he facts that underlie the action of the New York Board are not sufficiently reflective of Dr. Woods' current competence to practice medicine for the [North Carolina Medical] Board to act against Dr. Woods' license." (Resp. Ex. A 51-53).

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18. Melvin Richardson testified on behalf of Dr. Woods. Mr. Richardson is a patient of Dr. Woods. Mr. Richardson testified that he has had training in investigative measures, and has been investigating the action of the New York Board against Dr. Woods. (Tr. at 14, 28-30). Mr. Richardson further testified that Dr. Woods could not have committed fraud, because Dr. Woods has not practiced in Ohio since 1991 and, thus, has not made any profit from his mistake on the renewal application. (Tr. at 18).

    More significantly, Mr. Richardson testified that Dr. Woods is an honest man, and Mr. Richardson has never known him to lie. (Tr. at 20).

19. In 1997, Obi C. Umesi, M.D., Medical Director of an Emergency Department in which Dr. Woods was employed, wrote that:

    > Dr. Woods' clinical evaluation and disposition ranks amongst the best. He has never had any untoward outcome during his two years in my ED. Although a very intelligent and clinically sound physician, he lacks an obstructive ego that would stand in the way of his seeking a second opinion when one is needed.

    (Resp. Ex. A at 25). Dr. Woods submitted additional letters of support from colleagues, allied health professionals, and patients. (Resp. Ex. A at 24-32).

20. Dr. Woods has not worked in Ohio since 1991. He is currently practicing family medicine in North Carolina. (Tr. at 69; Resp. Ex. A at 54).

FINDINGS OF FACT

1. On or about November 1, 1995, the New York Department of Health, State Board for Professional Medical Conduct, Hearing Committee, issued a Determination and Order revoking the certificate of Edward Louis Woods, M.D., to practice medicine and surgery in New York. The action was based on a finding that Dr. Woods had been guilty of professional misconduct, and had practiced with gross negligence, gross incompetence, negligence and/or incompetence, in his care and treatment of seven patients, and that he had failed to keep appropriate medical records.

    Dr. Woods challenged the decision of the Hearing Committee. On or about February 20, 1996, the New York Department of Health Administrative Review Board for Professional Medical Conduct issued a Decision and Order sustaining the decision of the Hearing Committee.

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2. On or about May 1, 1996, Dr. Woods signed an application for renewal of his Ohio certificate to practice medicine and surgery. In the application, despite the actions of the New York Board, Dr. Woods denied having had an action taken against him by another state licensing board.

3. On or about December 6, 1996, the Commonwealth of Pennsylvania State Board of Medicine filed an Adjudication and Order which revoked Dr. Woods' Pennsylvania license to practice medicine and surgery. The Pennsylvania action was based on the action by the New York Department of Health.

4. On October 15, 1997, the North Carolina Medical Board issued a Findings of Fact, Conclusions of Law, and Order, after a review of the New York Board's action against Dr. Woods. After a review of the evidence, the North Carolina Medical Board determined that no disciplinary action would be taken against Dr. Woods.

CONCLUSIONS OF LAW

1. The action by the State of New York against the certificate of Edward Louis Woods, M.D., to practice medicine and surgery in that state, as referenced in Findings of Fact 1, constitutes the "revocation * * * by another state of a license or certificate to practice issued by the proper licensing authority of that state * * * for any reason, other than nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect prior to March 6, 1996, to wit: Section 4731.22(B)(6), Ohio Revised Code.

2. Dr. Woods' conduct, as set forth in Findings of Fact 2, constitutes "fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the Board," as that clause is used in Section 4731.22(A), Ohio Revised Code.

3. The conduct of Dr. Woods, as set forth in Findings of Fact 2, constitutes "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

4. The action by the State of Pennsylvania, referenced in Findings of Fact 3, constitutes the "revocation * * * by another state of a license or certificate to practice issued by the proper licensing authority of that state * * * for any reason, other than nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect on or after March 6, 1996.

* * * *

Dr. Woods provided numerous arguments in support of his treatment of the patients at issue in the New York action. Many of these arguments are not supported by the patients' medical records.

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Moreover, at no time during the hearing did Dr. Woods acknowledge that he had, in fact, made some mistake in his treatment of these patients. Instead, he blamed all errors and omissions on the hospital, on other personnel, and on ancillary services. Dr. Woods' unwillingness to acknowledge his personal limitations was highlighted by the New York Administrative Review Board when it observed that Dr. Woods had not demonstrated "the ability, insight and motivation to correct his pattern of poor practice."

It is significant, also, that Dr. Woods employed the same imprudent reasoning when he falsely denied any action by another state board on his 1996 renewal application. Furthermore, in defending that action, Dr. Woods presented a long list of excuses for his failure to reveal the truth, before finally admitting that he should have read the question more carefully.

In mitigation, however, the conduct upon which the State of New York based its action occurred in 1990, nearly eight years ago. Dr. Woods testified that the conditions in the emergency department at the House of the Good Samaritan were appalling, and not conducive to the practice of quality medicine. In support of this argument, Dr. Woods has produced documentation suggesting that his treatment of these seven patients is not reflective of his current practice. Nevertheless, even if Dr. Woods' practice deficiencies were caused by conditions at the hospital, Dr. Woods failed to exercise good judgment in his failure to remove himself from a situation in which he was compelled to practice medicine in an unsafe manner.

In all, the evidence reveals that Dr. Woods has difficulty appropriately evaluating his own limitations, and may fail to exercise good judgment when under stress. Both of these issues raise concerns for the welfare of his patients.

PROPOSED ORDER

It is hereby ORDERED that:

1. The certificate of Edward Louis Woods, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of at least ninety (90) days.

2. The Board shall not consider reinstatement of Dr. Woods' certificate to practice unless all of the following minimum requirements have been met:

    a. Dr. Woods shall submit an application for reinstatement, accompanied by appropriate fees.

    b. Dr. Woods shall take and pass the SPEX examination or any similar written examination which the Board may deem appropriate to assess his clinical competency. Dr. Woods must pass this examination prior to applying for reinstatement of his certificate.

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3. Upon reinstatement, Dr. Woods' certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five (5) years:

   a. Dr. Woods shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

   b. Dr. Woods shall obey all federal, state, and local laws, and all rules governing the practice of medicine in the state in which he is practicing.

   c. Dr. Woods shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which the probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

   d. Dr. Woods shall appear in person for interviews before the full Board or its designated representative within three months of the reinstatement of his certificate and upon request for termination of the probationary period, or as otherwise requested by the Board.

   e. Dr. Woods shall notify the Board of any action in any state taken against a certificate to practice held by Dr. Woods in that state. Moreover, Dr. Woods shall provide acceptable documentation verifying the other state board's actions.

   f. Dr. Woods shall refrain from commencing practice in Ohio without prior written Board approval. Furthermore, prior to commencing practice in Ohio, the Board may require that Dr. Woods comply with additional terms, conditions, or limitations, including the following:

      i. Prior to commencement of practice in Ohio, Dr. Woods shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

      ii. Prior to commencement of practice in Ohio, Dr. Woods shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised

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structured environment in which Dr. Woods' activities will be directly supervised and overseen by a monitoring physician approved by the Board. The monitoring physician shall monitor Dr. Woods and his patient charts. The chart review may be done on a random basis, with the number of charts reviewed to be determined by the Board. The monitoring physician shall provide the Board with reports on Dr. Woods' progress and status and on the status of his patient charts on a quarterly basis. All monitoring physician reports required under this paragraph must be received in the Board's offices no later than the due date for Dr. Woods' quarterly declaration. It is Dr. Woods' responsibility to ensure that the reports are timely submitted.

Dr. Woods shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order..

In the event that the approved monitoring physician becomes unable or unwilling to serve, Dr. Woods shall immediately notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.
Dr. Woods shall refrain from practicing until such supervision is in place, unless otherwise determined by the Board. Dr. Woods shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

iii. Prior to commencement of practice in Ohio, Dr. Woods shall provide the Board with acceptable documentation evidencing his full and unrestricted licensure in the State of North Carolina.

iv. In the event that Dr. Woods has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to commencement of practice in Ohio, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

v. After commencement of practice in Ohio, Dr. Woods shall appear in person for interviews before the full Board or its designated representative within three months of the date in which probation becomes effective, at three (3) month intervals thereafter, and upon his request for termination of the probationary period, or as otherwise requested by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Woods' responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end

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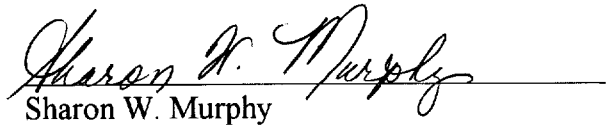
of the month in which the appearance should have occurred, Dr. Woods shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

vi. Within thirty (30) days of commencement of practice in Ohio, Dr. Woods shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Woods has privileges or appointments. Further, Dr. Woods shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Woods applies for or obtains privileges or appointments.

g. If Dr. Woods violates probation in any respect, the Board, after giving Dr. Woods notice and the opportunity to be hearing, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of Dr. Woods' certificate.

4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Woods' certificate will be fully restored.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio.



Sharon W. Murphy
Attorney Hearing Examiner

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website www.state.oh.us/med

EXCERPT FROM THE DRAFT MINUTES OF MAY 13, 1998

REPORTS AND RECOMMENDATIONS

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

Dr. Buchan 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: Saul I. Blecher, M.D.; Joel E. Burrell, M.D.; Hazem S. Garada, M.D.; James M. Magri, Jr., M.D.; Joe Wesley Morgan, D,O.; John D. Ott, D.O.; Reginald C. Phillips, M.D.; Clifford Sonnie, M.D.; Edward Louis Woods, M.D.; and Thomas A. Zoldowski, D.P.M. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Heidt	- aye
	Dr. Somani	- aye
	Mr. Sinnott	- aye
	Ms. Noble	- aye
	Dr. Stienecker	- aye
	Dr. Agresta	- aye
	Dr. Garg	- aye
	Dr. Buchan	- aye

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

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Heidt	- aye
	Dr. Somani	- aye
	Mr. Sinnott	- aye
	Ms. Noble	- aye
	Dr. Stienecker	- aye
	Dr. Agresta	- aye
	Dr. Garg	- aye
	Dr. Buchan	- aye

In accordance with the provision in Section 4731.22(C)(1), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

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

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

.....

Dr. Buchan asked Dr. Egner whether she had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Saul I. Blecher, M.D.; Joel E. Burrell, M.D.; Hazem S. Garada, M.D.; James M. Magri, Jr., M.D.; Joe Wesley Morgan, D.O.; John D. Ott, D.O.; Reginald C. Phillips, M.D.; Clifford Sonnie, M.D.; Edward Louis Woods, M.D.; and Thomas A. Zoldowski, D.P.M. Dr. Egner indicated that she had.

Dr. Buchan asked Dr. Egner whether she 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. Dr. Egner indicated that she understands.

.....

EDWARD LOUIS WOODS, M.D.

Dr. Buchan directed the Board's attention to the matter of Edward Louis Woods, M.D. He advised that objections were filed to Hearing Examiner Murphy's Report and Recommendation and were previously distributed to Board members.

DR. STIENECKER MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF EDWARD LOUIS WOODS, M.D. DR. AGRESTA SECONDED THE MOTION.

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

Dr. Stienecker stated that he believes that Dr. Woods got into problems and was on various occasions accused of gross incompetence, etc. Some of those allegations were reversed, others were left hanging. In any event, he takes issue with the following sentence on page 17 of the Report and Recommendation: "Nevertheless, even if Dr. Woods' practice deficiencies were caused by conditions at the hospital,

Dr. Woods failed to exercise good judgment in his failure to remove himself from a situation in which he was compelled to practice medicine in an unsafe manner." Dr. Stienecker stated that his problem with that conclusion is that it lays on the doctor the burden of circumstances beyond which he had no control. Dr. Stienecker stated that physicians are frequently forced by circumstances to practice in situations that might be unsafe. He has extricated people from farm equipment, the tops of silos, any number of places which probably were not the most safe places to practice medicine. To lay on physicians the judgment of poor practice based on circumstances over which they had no control is not right.

Dr. Stienecker stated that the proposed 90-day suspension is a little heavy. He wonders why the Board would suspend somebody after this length of time over this problem. He would be inclined to dismiss the case.

Dr. Egner stated that she reads this case very differently. This physician, in a seven-week period of time, made gross errors in his medical practice. She believes that he has fallen below minimal standards. He needs to improve his medical knowledge. He will do that with time off, and can prove it by taking and passing the SPEX. The other problem is that Dr. Woods lied about disciplinary action on his Ohio renewal application. As she has said previously, that is a serious problem. Lying on an application has consequences to it. She believes the questions are clearly written and that the answers should have been straightforward. She does not know that the hospital is at fault. She doesn't read anything in the record that says to her that he couldn't make an adequate diagnosis because of the hospital. Other people were able to read the x-rays. He was not a qualified physician and didn't have the knowledge that it took to work in the emergency room. Dr. Egner urged the Board to follow the disciplinary guidelines. He should have a stayed revocation with a minimum one-year suspension, and three-year probation. Dr. Egner stated that Dr. Woods still defends the actions that he took in the emergency room, and that is a frightening situation.

DR. EGNER MOVED TO AMEND THE PROPOSED ORDER TO PUT IN PLACE A STAYED REVOCATION, A ONE-YEAR SUSPENSION, FOLLOWED BY A THREE-YEAR PROBATIONARY PERIOD. DR. BHATI SECONDED THE MOTION.

Dr. Bhati reviewed Dr. Woods' treatment of Patients A, B, C, D, E, F, and G, indicating that Dr. Woods' treatment of these patients was as below minimal standards as one could get. There was a substantial question about his competency. He spoke in support of Dr. Egner's proposed amendment.

Dr. Garg stated that he must stress a couple of points. Dr. Woods indicates that he has been an emergency room physician for 16 years. He's not a newcomer. Anyone can make mistakes on x-rays, but the Board is not talking about x-rays of the ankle where the patient can hop around on it if the fracture is missed. This is a case of the physician missing cervical fractures, thoracic fractures, which are worse. If those are missed and nothing is done, the patient will probably become quadriplegic or paraplegic. This is a very serious problem. If the amendment passes with the one-year suspension, this physician is very lucky.

Dr. Somani stated that although the Board is considering suspending the physician's license, it is not ordering that he go back for some more training so that he does not remain as incompetent as he has been in the past. Also, in the Report and Recommendation there is a quoted statement from Obi C. Umesi, M.D., the medical director of the emergency room in which Dr. Woods worked, that states: "Dr. Woods clinical evaluation and disposition ranks amongst the best." Dr. Somani stated that he doesn't know what the Board can do with this type of testimony in light of the record showing long-standing problems in the emergency room. Dr. Somani suggested that the Board not only adopt the amendment, but also suggest that Dr. Woods go back for additional training.

Dr. Buchan stated that there is a notation that Dr. Woods will be monitored, which should put Dr. Somani's second concern somewhat to rest. There is no provision for C.M.E. or remedial education.

Dr. Somani stated that he wants Dr. Woods to go back for additional supervised training.

Dr. Heidt stated that this problem is one the Board faces all of the time. This may be the tip of the iceberg, but the iceberg is eight years old. The Board has received comments that this fellow has been practicing good medicine for quite a few years now. Now the Board is picking up items that occurred eight years ago, and the Board is suggesting that he get re-trained. Dr. Heidt stated that he's sure Dr. Woods has been re-trained on numerous times over the last eight years. He has also probably learned from his past experiences. A 90-day suspension is sufficient in this case.

Dr. Garg stated that he is surprised. All the Board knows is what it has in front of it. It must base its actions on those bases. There are two ways of correcting oneself. Either one keeps repeating the mistakes, and the Board has no idea whether he is or not, or he learns from his mistakes. The Board sees no evidence of the latter. For those reasons, he would support the amendment.

Dr. Egner stated that she would like to reiterate that this is what the Board has in front of it. In a previous case today the Board seemed to discuss the credibility of other observers with the two physicians who argued with each other. The Board discounted some of the credibility of the nurses and the people around them for the reason that maybe they would side more with one physician than the other. She added that she doesn't agree with that, but by the same token, she doesn't think that she can take Dr. Umesi's quote and put more weight on that than it truly deserves. Dr. Egner stated that she must consider the fact that these incidents occurred within a very short time frame. They did not occur over a three-year period of time, but in a seven-week period of time. In that amount of time this percentage of misdiagnosis is way too much. The Board needs to make sure that, if Dr. Woods is going to practice in an emergency room in Ohio, he is a better doctor now than he was then.

A vote was taken on Dr. Egner's amendment:

Vote:	Dr. Bhati	- aye
	Dr. Heidt	- nay

Dr. Somani	- aye
Dr. Egner	- aye
Mr. Sinnott	- aye
Ms. Noble	- aye
Dr. Stienecker	- nay
Dr. Agresta	- aye
Dr. Garg	- aye
Dr. Buchan	- aye

The motion carried.

DR. GARG MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF EDWARD LOUIS WOODS, M.D. DR. AGRESTA SECONDED THE MOTION. A vote was taken:

Vote:

Dr. Bhati	- aye
Dr. Heidt	- nay
Dr. Somani	- aye
Dr. Egner	- aye
Mr. Sinnott	- aye
Ms. Noble	- aye
Dr. Stienecker	- nay
Dr. Agresta	- aye
Dr. Garg	- aye
Dr. Buchan	- aye

The motion carried.

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

December 3, 1997

Edward Louis Woods, M.D.
#4 Poinciana Drive
Durham, NC 27707

Dear Doctor Woods:

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 February 26, 1996, the State of New York Department of Health Administrative Review Board (ARB) for Professional Medical Conduct issued its Decision and Order No. 95-257, revoking your license to practice medicine and surgery in New York and sustaining Determination and Order No. BMPC-95-257 of the State of New York Department of Health Board for Professional Medical Conduct Hearing Committee which found you guilty of professional misconduct. Copies of the ARB Decision and Order and the Hearing Committee Determination and Order are attached hereto and incorporated herein.

The Decision and Order as alleged in paragraph (1) above, constitutes"(t)he limitation, revocation, or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, the imposition of probation by that authority, or the issuance of an order of censure or other reprimand by that authority for any reason, other than nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect prior to March 6, 1996, to wit: Section 4731.22(B)(6), Ohio Revised Code.

(2) On or about May 1, 1996, you signed the application for renewal of your Ohio certificate to practice medicine and surgery, certifying that the information provided on the application was true and correct in every respect. In response to the question, "At any time since signing your last application for renewal of your certificate have you...(h)ad any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?" you answered, "No."

In fact, on or about November 1, 1995, The State of New York Department of Health issued Determination and Order No. BMPC-95-257 which revoked your license to practice finding you guilty of professional misconduct.

Mailed 12/4/97

In fact, on or about February 26, 1996, the State of New York Department of Health Administrative Review Board (ARB) for Professional Medical Conduct issued its Decision and Order No. 95-257, revoking your license to practice medicine and surgery in New York and sustaining Determination and Order No. BMPC-95-257 of the State of New York Department of Health Board for Professional Medical Conduct Hearing Committee which found you guilty of professional misconduct.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, constitute "fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, constitute "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

(3) On or about December 6, 1996, The Commonwealth of Pennsylvania State Board of Medicine filed Adjudication and Order No. 96-49-033322 which revoked your license to practice medicine and surgery in the Commonwealth of Pennsylvania. This disciplianry action was based on the New York Order in paragraph (1) above. Copies of the Adjudication and Order are attached hereto and fully incorporated herein.

The Adjudication and Order as alleged in paragraph (3) above, constitute "(t)he limitation, revocation, or suspension by another state of a license or certificate to practice issued by the proper licensing authority of that state, the refusal to license, register, or reinstate an applicant by that authority, the imposition of probation by that authority, or the issuance of an order of censure or other reprimand by that authority for any reason, other than nonpayment of fees," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code, as in effect on or after March 6, 1996.

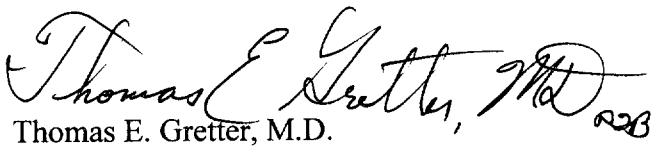
Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

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,



Thomas E. Gretter, M.D.
Secretary

TEG/par

Enclosures

CERTIFIED MAIL # P 152 984 518
RETURN RECEIPT REQUESTED

rev.2/15/95

STATE OF OHIO
97 OCT -1 AM 9:49

COPY

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

IN THE MATTER OF EDWARD WOODS, M.D.	ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 95-257

NEW YORK STATE DEPARTMENT OF HEALTH

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on January 26, 1996 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) November 1, 1995 Determination finding Dr. Edward Woods (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on November 20, 1995. James F. Horan served as Administrative Officer to the Review Board. The Respondent filed a brief on his own behalf which the Review Board received on December 21, 1995. Frederick Zimmer, Esq. submitted a reply brief for the Office of Professional Medical Conduct (Petitioner), which the Board received on January 2, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

[1]Sumner Shapiro did not participate in the deliberations in this case. Dr. Stewart participated in the deliberations by telephone.

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, and failing to maintain adequate records. The allegations concerned emergency medical care which the Respondent provided to seven persons, whom the record refers to as Patients A through G.

The Hearing Committee found the Respondent guilty of negligence on more than one occasion and gross negligence in his treatment for Patients A through G. The Committee found the Respondent guilty of gross incompetence and incompetence on more than one occasion in his treatment for Patients A through E and G. The Committee found the Respondent guilty of failure to maintain accurate records for Patients A through F.

The Committee found that the Respondent failed to detect an obvious cervical fracture and ordered a premature discharge for Patient A. In the case of Patient B, the Committee found that the Respondent failed to record an adequate history, failed to investigate adequately or treat the Patient's hypertension, failed to make a medically acceptable diagnosis, inappropriately prescribed medication that can elevate blood pressure and inappropriately discharged the Patient. In the case of Patient C, the Committee found that the Respondent failed to treat Patient C's continued pain with nitroglycerin and that the Respondent failed to treat the Patient with thrombolytic therapy to dissolve blood clots. In the case of Patient D, the Committee found that the Respondent failed to perform adequate pelvic or rectal examinations on the Patient, who was complaining of abdominal pain. In the case of Patient E, the Committee found that the Respondent failed to perform an adequate physical examination of the Patient's broken ankle, failed to interpret adequately an X-ray of the ankle and provided the Patient

NEW YORK STATE DEPARTMENT OF HEALTH 19

with inappropriate discharge instructions. In the case of Patient F, the Committee found that the Respondent failed to perform and record a neurological exam to detect damage or injuries to the Patient's spine and neck, following the Patient's injury in an automobile accident. In the case of Patient G, the Committee found that the Respondent failed to administer rabies immunoglobulin and to have vaccinations administered to the Patient, after the Patient was bitten by a wild raccoon.

The Committee found that the cases of three Patients, C, D and G stand out from the others, due to the dangers the Respondent's care posed to the Patients and because they document the Respondent's capabilities. In the case of Patient C, the Committee found that, even though the Respondent had diagnosed the Patient as suffering from acute myocardial infarction and even though the Patient was in pain, the Respondent did not treat the Patient with nitroglycerin and the Respondent did not use thrombolytic therapy. In the case of Patient D, the Committee found that the Respondent failed to perform a pelvic or rectal examination, for a patient with lower quadrant abdominal pain and slight abdominal distention. The Committee found that the pelvic exam would be routine for a patient with lower quadrant pain, to assess whether there were problems with her reproductive organs. The Committee found that the rectal examination was necessary to check for masses causing abdominal obstruction or blood in the stool. In the case of Patient G, the Committee found that the Respondent's failed treatment placed the Patient at risk of rabies. The Committee found that these three cases, and the other four that were subjects of the hearing, spoke to the Respondent's deviations from acceptable standards of care in emergency cases, with many patients at critical risk. The Committee concluded that the Respondent has practiced emergency medicine for about sixteen years, that his skill and judgement were both in question and that it can not be anticipated that the Respondent can change. The Committee voted to revoke the Respondent's license to practice medicine in New York State.

REQUESTS FOR REVIEW

RESPONDENT: The Respondent argues that the Petitioner's allegations are not supported by the record and that the Hearing Committee's penalty was harsh. The Respondent argues that there was inadequate staffing and poor conditions at the Good Samaritan Hospital in Watertown, New York, where the Respondent provided the care for Patients A through G. The Respondent alleges that he was denied due process because he did not receive requested adjournments to allow himself, or his prior counsel, time to prepare a defense. The Respondent's brief discusses each patient case and argues that the Respondent attempted to treat each patient as thoroughly as possible and care for the patient's needs to the highest degree. The Respondent states that he caused no additional morbidity.

In his Response to the Petitioner, the Respondent contends that the Petitioner's expert witness did not practice emergency medicine and the Respondent disputes some testimony by the Petitioner's expert concerning the Respondent's treatment for Patient C.

PETITIONER: The Petitioner contends that the Respondent had adequate time to prepare for his defense. The Petitioner argues further that the Committee's Determination is consistent with the findings of fact. The Petitioner contends that the Respondent may not relitigate this case before the Review Board. The Petitioner argues that revocation is the proper penalty in this case, because the Respondent's practice of medicine places patients at critical risk and because the Respondent is unlikely to change his practice at this point of his career.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes 4-0 to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence, gross incompetence, incompetence on more than one occasion, negligence on more than one occasion and failure to maintain adequate records. The Review Board

finds that the Committee's Determination is consistent with their findings and conclusions that the Respondent failed to perform adequate examinations or tests on seven patients, treated and discharged patients improperly and, in some cases, placed patients at critical risk.

The Review Board rejects the Respondent's contention that the Hearing Committee denied him due process by failing to grant him extensions of time to obtain counsel and prepare a defense. The Board finds that the Respondent did receive extensions of time from the Committee to allow a new attorney time to review his case and to allow the Respondent to prepare for his testimony. The Respondent contended in his brief that since the Petitioner had three years to prepare the charges in this case, the Respondent deserved equal time to prepare rebuttal testimony and expert witnesses. The Review Board finds no merit in that argument. The Respondent had notice of the charges from March 5, 1995, he had until July 11, 1995 to prepare his case and he had the opportunity to testify and to present evidence on his behalf at the hearing.

The Review Board finds no merit in the Respondent's challenge to the credibility of the Petitioner's witness Dr. Jastremski. The Respondent challenged Dr. Jastremski's expertise, because the Respondent did not concentrate all his efforts in practicing emergency medicine. There is, however, no requirement that an expert be a specialist in the same field of medicine as the Respondent. It is necessary only that the expert possess the requisite, skill, training, education, knowledge and experience from which it can be assumed that the opinion rendered is reliable, Matter of Enu v. Sobol, 208 AD2d 1123, 617 NYS2d 960 (Third Dept. 1994). The Hearing Committee as finder of fact has the best opportunity to assess the credibility of witnesses. In this case, the Committee credited the testimony by Dr. Jastremski and rejected conflicting testimony by the Respondent. Clearly, the Committee can consider the Respondent's stake in the outcome of this case as bias and can consider that bias as a ground for finding that the Respondent was not a credible witness.

The Review Board votes 4-0 to sustain the Hearing Committee's Determination to revoke the Respondent's license to practice medicine in New York State. The Respondent committed gross negligence and gross incompetence on repeated occasions. The Respondent placed patients at serious risk and continually failed to perform necessary tests and provide appropriate treatment. Despite his

NEW YORK STATE DEPARTMENT OF HEALTH

continued mistakes, the Respondent fails to appreciate that he is not providing adequate care and he refuses to acknowledge his mistakes. There is nothing in this record that indicates that the Respondent has the ability, insight and motivation to correct his pattern of poor practice. The Board agrees with the Hearing Committee that the Respondent constitutes a danger to the public, especially in emergency medicine. Repeated and severe misconduct warrants revocation of a physician's license. The Board agrees that the revocation of the Respondent's license is the appropriate penalty in this case.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **SUSTAINS** the Hearing Committee's November 1, 1995 Determination finding the Respondent guilty of professional misconduct.

2. The Review Board **SUSTAINS** the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

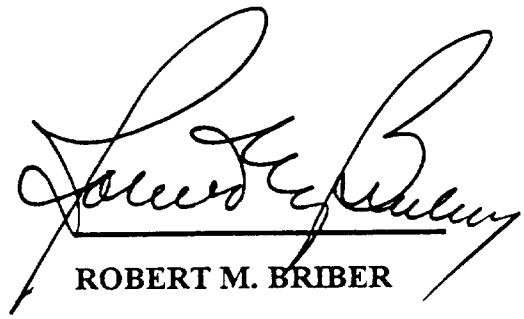
WILLIAM A. STEWART, M.D.

IN THE MATTER OF EDWARD L. WOODS, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Woods.

DATED: Schenectady, New York

2/14, **1995**



ROBERT M. BRIBER

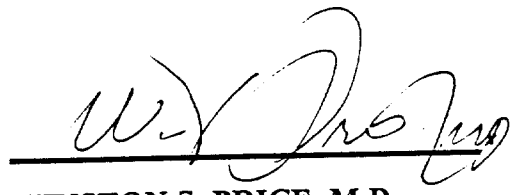
NEW YORK STATE DEPARTMENT OF HEALTH

IN THE MATTER OF EDWARD L. WOODS, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Woods.

DATED: Brooklyn, New York

2/16, **1995**



WINSTON S. PRICE, M.D.

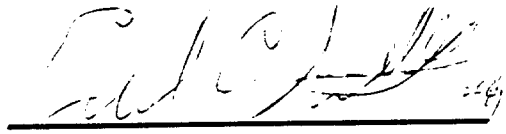
NEW YORK STATE DEPARTMENT OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH

IN THE MATTER OF EDWARD L. WOODS, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Woods.

DATED: Roslyn, New York
Feb 7, 1996



EDWARD C. SINNOTT, M.D.

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IN THE MATTER OF EDWARD L. WOODS, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Woods.

DATED: Syracuse, New York
5 Feb **, 1995**

WILLIAM A. STEWART, M.D.

NEW YORK STATE DEPARTMENT OF HEALTH 19

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

IN THE MATTER OF EDWARD WOODS, M.D.	DETERMINATION AND ORDER BPMC-95- 257

The undersigned Hearing Committee consisting of **IRVING S. CAPLAN, Chairperson, THERESE G. LYNCH, M.D.** and **ANDREW J. MERRITT, M.D.** was duly designated and appointed by the State Board for Professional Medical Conduct. **DAVID A. SOLOMON, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230, subdivision 10, of the New York Public Health Law and Sections 301-307 of the New York Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **EDWARD WOODS, M.D.** (hereinafter referred to as the "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Hearing Committee has considered the entire record in the above captioned matter and hereby renders its' decision with regard to the charges of medical misconduct.

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RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges dated March 8, 1994 (sic) served personally on Respondent on:	March 5, 1995
Amended Statement of Charges dated May 31, 1995 admitted on:	June 6, 1995
Amended Factual Allegations and Charges dated June 29, 1995 admitted on:	July 11, 1995
The State Board for Professional Medical Conduct appeared by:	Jerry Jasinski, Esq. Acting General Counsel NYS Dept. of Health BY: Frederick Zimmer, Esq. Assistant Counsel NYS Dept. of Health Corning Tower Albany, New York 12237
Respondent's representation:	Anne McKown, Esq. Durham, NC 27702 Withdrew on or about May 5, 1995
	Catherine A. Gale, Esq. Mackenzi, Smith, Lewis, Michell & Hughes P.O. Box 4967 Syracuse, NY 13221-4967 From on or about May 5, 1995 through May 23, 1995
Thereafter Respondent appeared pro se	
Locations and Dates of Hearing and Conferences:	
Pre-hearing Conference:	June 6, 1995 (10:10 am)
Hearing:	June 6, 1995 (12:30 pm)
Hearing	July 11, 1995 (9:15 am)
Deliberations:	August 12, 1995 (9:00 am)
All hearings and conferences held at:	Best Western Syracuse Airport Inn Hancock Airport Syracuse, New York

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Submission of Petitioner's Argument, Proposed Findings, Conclusions and Recommendation	August 4, 1995
The Respondent filed "Responses to Statement of Charges" denying the specifications of charges:	May 18, 1995
The Respondent filed an undated "Factual Responses to Allegations":	July 11, 1995
The Respondent filed a request to dismiss the charges:	August 10, 1995
Record Closed:	August 12, 1995

SUMMARY OF PROCEEDINGS

Several requests for adjournment of the hearing were received on behalf of the Respondent. The first was from the Respondent's North Carolina attorney, primarily for the purpose of retaining local counsel. After denial of the request, a local attorney in Syracuse was retained. An extension of time was granted for the new attorney to review the matter and to reschedule the Prehearing Conference. Prior to the Conference, the Syracuse attorney reported the Respondent was to represent himself; she withdrew. See, AO Ex. 1.

The Respondent was urged to consider professional representation. The Respondent chose to represent himself[1]. He filed a general denial and factual responses to the allegations. The Respondent also agreed to attend the second hearing day to testify before the Hearing Committee.

[1]NOTE: The Respondent made several requests for adjournments and objected to amendments to the charges and to factual allegations conforming the charges to the proof. The Department objected to each. The Administrative Officer denied the requests. See A.O. Exhibits 1, II, III: Attachment I.

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The Statement of Charges alleges the Respondent provided deficient emergency medical care to seven (7) patients during 1990 at the House of Good Samaritan (Hospital) in Watertown, New York. It is alleged that adequate physical examinations were not provided to five (5) of the patients and that two (2) were inappropriately discharged. A broad range of deficiencies in emergency medical care were also alleged: failure to detect a fracture in a cervical spine X-ray, failure to obtain or record an adequate medical history, failure to investigate or treat hypertension, failure to make a medically acceptable diagnosis, failure to appropriately prescribe Dimetapp, failure to prescribe nitroglycerine and thrombolytic treatments, failure to interpret diagnostic studies, and a failure to administer rabies immunoglobulin and vaccine. A final allegation was the Respondent's issuance of inappropriate discharge instructions.

The allegations are set forth more particularly in the Statement of Charges attached hereto as Appendix I. Dept. Ex, 1A, Amended Statement of Charges; Dept. Ex. 11, Additional Factual Allegations A.3, B.5 and E.3.

The State called the following witnesses:

Michael S. Jastremski, M.D.	Expert Witness
Judith S. Staffer, Department of Health	Fact Witness

The Respondent called the following witnesses:

Edward L. Woods, M.D., Respondent	Fact Witness
Betty R. Woods, R.N., Occupational Health Nurse	Fact Witness

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SIGNIFICANT LEGAL RULINGS

During the course of the hearing, the Hearing Committee had access to and consulted a memorandum dated February 5, 1992, entitled "Definitions of Professional Misconduct under the New York Education Law" prepared by the General Counsel for the Department of Health. The document contains suggested definitions for gross negligence and negligence on more than one occasion.

Negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, or deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that there be established that injury actually resulted from the deviation.

Gross Negligence has been defined by New York's highest court to be "...a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct." Roh v. Ambach, 74 NY2d 318, 322(1989). Egregious means conspicuously bad. Spero v. Board of Regents, 158 AD2d 763, 764 (3rd Dept. 1990).

Incompetence: A licensee who does not possess the requisite skill or knowledge to practice medicine is said to be incompetent. The incompetent physician lacks the ability to discharge the physician's required duty to the physician's patients because of a want of a skill or knowledge. Courts have defined incompetence or unskillfulness as meaning a lack of the learning or skill necessary to perform, day in or day out, the characteristic tasks of a given calling in at least a reasonably effective way.

Gross incompetence is when a practitioner shows a complete lack of ability necessary to perform an act in connection with the practice of the profession. Unlike ordinary incompetence, gross incompetence involves a total and flagrant lack of necessary knowledge or ability to practice.

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FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise. The findings and conclusions of the Petitioner and Respondent submitted herein were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings of fact were made after review of the entire record. Numbers following a finding refer to page numbers of the Transcript "(T. ____)". Numbers and/or letters following a finding preceded by a reference to exhibits refer to exhibits in evidence "(Ex. ___)". The citations represent evidence the Committee found persuasive in arriving at a particular finding. All findings of fact were established by at least a preponderance of the evidence. Evidence which conflicted with any findings of the Hearing Committee was considered and rejected. The extent of one expert or witness's opinion given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. Edward Woods, M.D., the Respondent, was served with a Notice of Hearing and Statement of Charges on April 5, 1995. (Dept.'s Ex. 1)

2. An Amended Statement of Charges was accepted into evidence at the June 6, 1995 hearing and three (3) additional Factual Allegations were accepted at the July 11, 1995 hearing. (Dept.'s Exs. 1A, 11; Prehearing Conference T. 9-10; T. 265)

3. Respondent was authorized to practice medicine in New York State on March 29, 1990 by the issuance of license number 181890. Respondent is not currently registered to practice medicine in New York State. (Dept.'s Ex. 2)

NEW YORK STATE DEPARTMENT OF HEALTH 19

FINDINGS OF FACT AS TO PATIENT A

4. Patient A, a 24 year old female, presented at the House of Good Samaritan emergency room (hereinafter "the emergency room") at 10:51 p.m. on July 22, 1990 and was provided emergency care by the Respondent. (T. 11-12; Dept.'s Ex. 3, pgs. 2-3)

5. Patient A hit her head diving into a pool. She complained of pain in the posterior neck, shoulders and upper chest. She was in a Philadelphia collar. (Dept.'s Ex. 3, pgs. 2-4; T. 12)

6. The Respondent diagnosed a "possible whiplash injury". (Dept.'s Ex. 3, pg. 3)

7. A patient who has hit her head diving into a shallow three (3) foot pool with resultant neck pain is at risk for spinal injury. In such a situation, accepted standards of medical care require that the emergency physician carefully examine the neck while it is stationary to determine if there is pain on palpation, deformity or other signs of injury. (T. 13)

8. With the main concern for Patient A's mechanism of injury being a possible cervical spine injury, a detailed neurological examination, testing all muscle groups; testing the dermatomes for sensation and testing reflexes, is needed to help assure the absence of a spinal cord injury. (T. 13-14)

9. Respondent's physical examination failed to meet acceptable standards of medical care in that he documented no neck examination and merely indicated that hand grasp was good, extremities are moving and the neuro is intact. Such is an inadequate neurologic examination of Patient A. (T. 13-14)

NEW YORK STATE DEPARTMENT OF HEALTH 19

10. Respondent ordered X-rays of Patient A's cervical and thoracic spine and interpreted these as showing no obvious fractures. (T. 14-15; Dept.'s Ex. 3, pg. 2)

11. Patient A was admitted to the emergency room at 10:51 p.m. on July 22, 1990 and discharged at 12:30 a.m. on July 23, 1990 with instructions that she not work for three (3) days, that she wear a soft cervical collar and return if any problems arose. (T. 11-12, 15; Dept.'s Ex. 3, pgs. 2-3, 7)

12. On July 23, 1990, a radiologist detected a fracture of the fourth cervical vertebrae of the neck. (T. 15-16; Dept.'s Ex. 3, pg. 6; Dept.'s Ex. 3f)

13. Respondent's reading of the cross table lateral X-ray of Patient A's cervical spine failed to meet acceptable standards of medical care in that Respondent missed an obvious fracture. The fracture was of a nature such that it should have been obvious to an emergency room physician. (T. 15-22, 141-141; Dept.'s Ex. 3f)

14. Respondent's discharge of Patient A about one (1) hour and forty minutes after admission to the emergency room failed to meet acceptable standards of medical care. While the fracture of Patient A's cervical spine was stable, Respondent failed to have Patient A evaluated by an appropriate specialist who could have determined upon examination whether a C.T. Scan of the spine was necessary to ensure that no unseen fractures were presenting a threat to her spinal cord. (T. 21, 23) * See Note p. 21.

NEW YORK STATE DEPARTMENT OF HEALTH 19

FINDINGS OF FACT AS TO PATIENT B

15. Patient B, a 67 year old male, presented at the emergency room at 4:18 a.m. on August 6, 1990 where he received emergency care from Respondent. (Dept.'s Ex. 4, pgs. 2-3; T. 23-24)

16. Respondent noted that Patient B had a subjective complaint of "left nostril with clogging, had difficulty with passage of air and prior history of bronchitis." (Dept.'s Ex. 4, pg. 2; T. 24)

17. The emergency department nursing flow sheet indicates that Patient B complained of unusual shortness of breath, had lung rales at the bases bilaterally, was unable to lie down and had to sleep in a sitting position. (Dept.'s Exs. 4 pg. 4, 4A pg. 17; T. 24-25)

18. Rales are indicative of extra fluid in the lungs. an inability to lie down is a common symptom of heart failure known as orthopnea which involves shortness of breath in the supine position caused by fluid accumulation in the lungs. (T. 25)

19. Respondent did not document that he was aware of Patient B's hypertension or that he investigated its' cause. Respondent's failure to do so deviated from accepted standards of medical care. (Dept.'s Ex. 4, pgs. 2-3; T. 30)

20. Patient B's blood pressure at 4:20 a.m. was 220/120. A blood pressure of 220/120 is indicative of hypertension requiring immediate treatment. (Dept.'s Ex. 4, pg. 4; T. 25-26)

21. At 4:50 a.m., Patient B's blood pressure was still quite high at 180/110 necessitating immediate treatment. (Dept.'s Ex. 4, pg. 4; T. 26, 32)

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22. Patient B was noted upon presentation to be taking medications including Coumadin, an anti-coagulent, and Choledyl and a Vancanese inhaler, both of which are used for obstructed airway disease. Patient B was also taking Lanoxin, used for heart failure or cardiac arrhythmia. (Dept.'s Ex. 4, pg. 2; T. 26-27)

23. Patient B's history recorded by Respondent failed to meet accepted standards of medical care given Patient B's age, condition and history of medication use indicating heart and lung disease. Respondent did not describe adequately Patient B's shortness of breath, that it was postural and whether there were associated symptoms such as fever, cough or chest pain. Respondent failed to document why Patient B was taking the various medications and whether he had previous myocardial infarctions, previous congestive heart failure or hypertension. (T. 27-29)

24. Respondent's physical examination of Patient B indicating the Patient was alert and in no respiratory distress, focused entirely on the Patient's nose and his ear tympanic membranes. The examination failed to meet accepted standards of medical care. Given his condition and medication history, his physical should have included a detailed cardiorespiratory examination focused on seeking a cardiac or lung related cause of patient B's shortness of breath and increased respiratory rate. (Dept.'s Ex. 3, pg. 2; T. 29-30)

25. Respondent diagnosed Patient B as having nasal congestion and sinusitis and prescribed medication including Dimetapp, an over the counter cold remedy.
(Dept.'s Ex. 4, pg. 3; T. 31)

26. Respondent's diagnosis of Patient B failed to meet accepted standards of medical care in that he failed to consider Patient B's hypertension or alternative causes of his breathing difficulties. (Dept.'s Ex. 4, pg. 2; T. 31)

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27. Respondent's instruction that Patient B take Dimetapp contravened accepted standards of medical care in that Dimetapp contains phenylephrine, an alpha agonist which can cause acute elevation of blood pressure in hypertensive individuals. (T. 31-32)

28. Respondent took no action to treat Patient B's hypertension. This failure contravened accepted standards of medical care. (Dept.'s Ex. 4, pgs. 2-3; T. 32)

29. Patient B was discharged at 5:02 a.m. on August 6, 1990. (Dept.'s Ex. 4, pg. 3)

30. Respondent's discharge of patient B failed to meet accepted standards of medical care in that Respondent failed to investigate adequately the cause of Patient B's shortness of breath or to treat his hypertension. (T. 33-34)

31. Patient B subsequently returned to the emergency room at 10:20 a.m. on the same day, August 6, 1990, when he was treated by another physician who noted that Patient B had had difficulty breathing for three (3) days. He subsequently receive a thorough examination including an electrocardiogram, chest X-ray and blood tests resulting in a diagnosis of mild congestive heart failure, chronic obstructive lung disease, bronchitis, left maxillary sinusitis and diabetes mellitus. (Dept.'s Ex. 4, pgs. 9-10; T. 33-34)

FINDINGS OF FACT AS TO PATIENT C

32. Patient C, a 72 year old male, presented at the emergency room at 8:34 p.m. on August 3, 1990. Respondent noted Patient C had substernal pressure which had been temporarily relieved by nitroglycerin and that the pressure was not associated with radiation, shortness of breath, diaphoresis, nausea, vomiting, headaches, chills, fever, cough, constipation, peptic

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ulcer disease or diarrhea. Respondent diagnosed acute myocardial infarction. (Dept.'s Ex. 5, pgs. 14-15; T. 36-37)

33. A patient with acute myocardial infarction with continued pain should receive nitroglycerin, unless the patient has contraindicating hypotension, both to limit the size of the infarction through restoration of coronary perfusion and to limit the secondary sympathetic effects of pain which can increase the work load and oxygen demands of the heart and cause the infarct to be larger. In the event the pain returns following the administration of nitroglycerin, further treatment with nitroglycerin should be administered.

34. Patient C received two (2) doses of sublingual nitroglycerin while in the ambulance en route to the hospital relieving his chest pain completely. On arrival at the emergency room at 8:34 p.m. he complained of "non-radiating" chest pain with diaphoresis and pain in the teeth. The initial pain had begun at 7:30 p.m. (Dept.'s Ex. 5, pgs. 3, 16; T. 39)

35. Pain in the back teeth of Patient C was a symptom of radiating pain. (Dept.'s Ex. 5, pgs. 14-16; T. 39, 51)

36. An electrocardiogram given when Patient C arrived at the emergency room indicated he was suffering from acute anterior wall myocardial infarction. (Dept.'s Ex. 5, pg. 64; T. 43)

37. Thrombolytic therapy could have minimized the damage to Patient C through intravenous drug administration to dissolve blood clots. The 1990 indications for the therapy were met by the ECG showing S.T. segment elevation and contiguous leads indicating one (1) area of the heart was having an infarction. It should be administered two (2) to four (4) hours from the onset of symptoms. Patient C had no contraindications to thrombolytic therapy and would have been a good candidate for such. Despite the potential the Respondent did not

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notify the attending cardiologist, Dr. DeBrown, until 10:10 p.m. Prior to such notice, the Patient complained of pain in the chest at 9:10 p.m., 9:17 p.m. and 10:00 p.m. (Dept.'s Ex. 5, pgs. 14-16; T. 39, 42-44, 50, 52, 147-148)

38. Dr. DeBrown arrived at the hospital at about 10:30 p.m. He treated Patient C with intravenous nitroglycerin and heparin to resolve the chest pain. Dr. DeBrown determined that Patient C had passed the effective period for administration of thrombolytic therapy. Patient C sustained a completed anterior wall myocardial infarction complicated by congestive heart failure and atrial fibrillation. (Dept.'s Ex. 5, pgs. 3-4, 16; T. 39-40, 47)

39. Respondent did not order thrombolytic therapy for Patient C. (Dept.'s Ex. 5, pg. 3, 14-15)

40. Respondent's treatment of Patient C failed to meet accepted standards of medical care in that he failed to treat adequately Patient C's chest pain by giving him sufficient sublingual nitroglycerin. In the event that sublingual nitroglycerin did not succeed in alleviating Patient C's pain, Respondent should have treated Patient C with intravenous nitroglycerine and/or intravenous narcotics. Respondent also failed to administer thrombolytic therapy thereby increasing the risk of cardiac damage to Patient C, damage which Patient C sustained due to a completed infarct. (T. 41, 42-47)

FINDINGS OF FACT AS TO PATIENT D

41. Patient D, a 47 year old female, presented at the emergency room at 12:17 a.m. on August 5, 1990 with right lower quadrant abdominal pain with slight abdominal distension. Patient D was treated by Respondent. (Dept.'s Ex. 6, pgs. 3-4; T. 52-53)

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42. Respondent's physical examination included a description of Patient D's abdomen indicating pain and tenderness to palpation in the right inguinal and lower inguinal abdominal area with a finding that bowel sounds were present and that there were no masses or hernias. Respondent did not perform a rectal or pelvic examination. (Dept.'s Ex. 6, pgs. 3-4; T. 54) * See Resp.'s Ex. C for his rationale; T. 213

43. A pelvic examination is routinely indicated for a female with lower quadrant pain presenting to an emergency room in order to assess adequately whether there are problems in the patient's reproductive organs. A rectal examination is similarly routinely indicated to determine if there are masses in the rectum causing abdominal obstruction and whether there is bleeding in the patient's stool. (T. 54-55)

44. Respondent's physical examination failed to meet accepted standards of medical care in that he did not perform rectal and pelvic examinations of Patient D. (T. 54)

45. Respondent ordered blood tests for Patient D consisting of an amylase, pregnancy test, a complete blood count, a chemical profile and a urinalysis which was repeated twice. (Dept.'s Ex. 6; T. 55)

46. Respondent diagnosed Patient D as having "abdominal pain, rule out stone." Respondent ordered the patient to push fluids, a standard treatment for kidney stones. (Dept.'s Ex. 6, pg. 4; T. 55-56)

47. Respondent evaluated the laboratory work as being inconclusive and recommended further evaluation of Patient D. (Dept.'s Ex. 5, pg. 59; T. 221-223)

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FINDINGS OF FACT AS TO PATIENT E

48. Patient E, a 15 year old male, presented at the emergency room on July 12, 1990 at 7:37 p.m. with a complaint that he had twisted his left ankle while playing basketball and that he was "now with pain, swelling and decreased motion." Respondent provided emergency room care to Patient E. (Dept.'s Ex. 7, pgs. 2, 4; T. 62)

49. With an ankle injury of this nature, Respondent should have evaluated Patient E's knee and physically described his ankle including the location of swelling and tenderness, performed an evaluation of ankle ligament stability including the Achilles tendon, range of motion and intactness of neurovascular function. (T. 63)

50. Respondent's physical examination of Patient E did not meet accepted standards of medical care in that he did not record a physical examination other than to note "same" for his objective findings. (Dept.'s Ex. 7, pg. 2; T. 62-63)

51. Respondent ordered X-rays of Patient E's ankle and interpreted them as showing "no obvious fracture." (Dept.'s Ex. 7, pg. 4, 6; T. 64)

52. Respondent diagnosed Patient E as having a sprained left ankle and discharged him at 8:50 p.m. He prescribed an Ace wrap, crutches, ice, elevation and gradual weight bearing. (Dept.'s Ex. 7, pgs. 4, 6; T. 64)

53. A fracture of Patient E's ankle involving the superiorlateral corner of the talus was detected on July 13, 1995 by the radiologist who also found avulsion fracture fragments present between the medical aspect of the talus and the medical malleolus. The mortise was found to appear widened indicating probable ligament instability. (Dept.'s Ex. 7, pg. 8; T. 64-69)

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54. Patient E's fracture was of a nature that it should have been obvious to an emergency room physician interpreting Patient E's X-rays. (T. 66-67, 71-72)

55. Patient E's discharge instructions failed to meet accepted standards of medical care in that Patient E suffered an injury which should not have been subject to weight bearing. In addition, they included no instructions or prescription for pain medication. (T. 70)

56. Respondent made a belated referral of Patient E to orthopedics on July 14, 1990. (T. 227)

FINDINGS OF FACT AS TO PATIENT F

57. Patient F, a 22 year old female, presented at the emergency room at 4:23 a.m. on September 1, 1990, after having been involved in a motor vehicle accident. Patient F, who was driving the vehicle without a seat belt complained of pain in her head, neck and right knee. She was unconscious when the ambulance reached her and may have undergone a prolonged period of unconsciousness. Patient F received emergency room care from the Respondent. (Dept.'s Ex. 8, pgs. 2-3, 6; T. 74-75)

58. Given the circumstances of Patient F's injury and her complaints of pain, acceptable medical standards require that Respondent should have examined Patient F's neck and performed a neurological examination to detect neurological damage or injuries to the spine or neck. (T. 74-75)

59. Respondent's physical examination of Patient F failed to meet accepted standards of medical care in that there is no evidence that he performed a physical examination of her neck. There is no evidence that he performed a neurological examination other than his notation of the

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word "neuro." Respondent's omissions risked his missing signs of serious injury. (Dept.'s Ex. 8, pg. 2; T. 74-75)

60. Respondent discharged Patient F at 6:45 a.m. (Dept.'s Ex. 8, pg. 3)

61. Patient F was ultimately readmitted to the House of Good Samaritan Hospital on September 2, 1990 with a comminuted fracture of the lateral mass of C-2 of the cervical spine. (Dept.'s Ex. 8, pgs. 17-21; T 77-78)

FINDINGS OF FACT AS TO PATIENT G

62. Patient G, a 23 year old male, presented to the emergency room at 10:34 p.m. on August 26, 1990, with a complaint that he had been bitten on his right index finger by a wild raccoon resulting in a small puncture wound. Patient G received emergency room care from the Respondent. (Dept.'s Ex. 9, pgs. 3-4, 6; T. 82)

63. For a raccoon bite of this nature, accepted standards of medical care require the administration of rabies prophylaxis to prevent the patient from catching rabies from a possibly rabid raccoon. Proper administration of rabies prophylaxis involves the administration of human rabies immunoglobulin containing the antibodies. The patient should also receive rabies vaccinations administered in a series of inoculations to stimulate the antibodies beginning on the day of injury followed by an inoculation two (2) or three (3) days later, then seven (7), fourteen and twenty days after the first vaccination. (T. 83-84, 238-239)

64. Patient G was never treated with human rabies immunoglobulin. (Dept.'s Ex. 9, pg. 13; T. 241)

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65. Respondent's treatment of Patient G failed to meet accepted standards of medical care in that he failed to treat Patient G with human rabies immunoglobulin. In addition, while Patient G received an initial rabies vaccination, he was advised to return seven (7) days later for his second vaccination, contravening the proper schedule. The failure to treat Patient G with immunoglobulin and administer rabies vaccination on an appropriate schedule risked that Patient G would contract rabies, a fatal disease. Such was a significant deviation from acceptable standards of medical care. (T. 85-86; Dept.'s Ex. 9, pgs. 4, 14)

66. Patient G was advised to return seven (7) days later for his second vaccination. This was a very significant deviation from acceptable standards of medical care. (Dept.'s Ex. 9, pg. 6)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

AS TO PATIENT A

Respondent provided emergency medical care on or about July 22, 1990 to Patient A, a 24 year old female, at Good Samaritan Hospital. She presented after hitting her head while diving into a swimming pool. Finding 4.

1. Respondent failed to perform and record an adequate physical examination. Findings 4, 5, 6, 7, 8, 9, 12, 13.
2. Respondent failed to detect a fracture on Patient A's cervical spine X-rays. Findings 4, 6, 7, 8, 10, 12, 13.
3. Respondent inappropriately discharged Patient A. Findings 4, 11, 12, 13, 14.

AS TO PATIENT B

Respondent provided emergency medical care to Patient B on or about August 6, 1990 at Good Samaritan Hospital. Patient B, a 67 year old male, presented to the Emergency Department with a complaint of difficulty in breathing and with abnormal vital signs. Findings 15, 16.

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4. Respondent failed to obtain and record an adequate history and perform and record an adequate physical examination of Patient B. Findings 17, 18, 19, 20, 21, 22, 23, 24.

5. Respondent failed to investigate and treat adequately Patient B's hypertension. Findings 19, 20, 21, 22, 23, 24, 28.

6. Respondent failed to make a medically acceptable diagnosis. Findings 25, 26.

7. Respondent inappropriately prescribed Dimetapp for Patient B. Findings 25, 27.

8. Respondent inappropriately discharged Patient B. Findings 29, 30, 21.

AS TO PATIENT C

Respondent provided emergency medical care to Good Samaritan Hospital to Patient C, a 72 year old male, who presented with chest pain on or about August 3, 1990. Finding 32.

9. Respondent failed to treat adequately Patient C with nitroglycerine. Findings 32, 33, 34, 35, 36, 38, 40.

10. Respondent failed to institute thrombolytic therapy in a timely manner to Patient C. Findings 37, 38, 39, 40.

AS TO PATIENT D

Respondent provided emergency medical care at Good Samaritan Hospital to Patient D, a 47 year old female, who presented with complaints of abdominal pain on or about August 5, 1990. Findings 41, 42.

11. Respondent evaluated the diagnostic laboratory studies ordered as being inconclusive and recommended further evaluation of Patient D. Findings 45, 47.

12. Respondent failed to perform a rectal or a pelvic examination, both accepted standards of Patient D's medical care. Findings 42, 43, 44.

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AS TO PATIENT E

Respondent provided emergency medical care on or about July 12, 1990 to Patient E, a 15 year old boy, at Good Samaritan Hospital. Patient E twisted his ankle while playing basketball. Finding 48.

13. Respondent failed to perform and record an adequate physical examination. Findings 49, 50.

14. Respondent failed to interpret adequately the X-rays of Patient E's ankle. Findings 51, 54.

15. Respondent issued inappropriate discharge instructions for Patient E. Findings 52, 53, 55.

AS TO PATIENT F

Respondent provided emergency medical care to Patient F, a 22 year old female, on or about September 1, 1990, at Good Samaritan Hospital, after she was involved in a motor vehicle accident. She complained of head and neck pain. Respondent failed to perform and record an adequate physical examination. Findings 57, 58, 59, 60, 61.

AS TO PATIENT G

Respondent provided emergency medical care to Patient G, a 23 year old male, on or about August 26, 1990, at Good Samaritan Hospital. Patient G had been bitten by a wild raccoon. Finding 62.

16. Respondent failed to initially administer human rabies immunoglobulin. Findings 63, 64, 65.

17. Respondent failed to have vaccine administered to Patient G on an appropriate schedule. Findings 63, 66.

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CONCLUSIONS WITH REGARD TO SPECIFICATION FIRST THROUGH SEVENTH

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE:

First Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs A, A.1 and A.2. Two (2) members of the Committee **SUSTAINED** the allegations set forth in Paragraph A.3. One (1) member, however, supported a contrary position, determining that Respondent's discharge directions to Patient A to continue use of the collar, to abstain from work for three (3) days and to return to the hospital should any problem arise, was reasonable based on the information the Respondent had at the time. The Committee concludes that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to perform and record an adequate physical examination of Patient A, failing to detect a fracture on Patient A's cervical spine X-rays and by inappropriately discharging Patient A.

Second Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs B, B.1., B.2., B.3., B.4. and B.5. The Committee concludes that Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to obtain and record an adequate physical examination of Patient B, to investigate and treat adequately Patient B's hypertension, failing to make a medically acceptable diagnosis, by inappropriately prescribing Dimetapp to Patient B and by inappropriately discharging Patient B.

Third Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs C, C.1. and C.2. The Committee concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to treat adequately Patient C with nitroglycerine and failing to institute thrombolytic therapy in a timely manner.

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Fourth Specification:

The Hearing Committee unanimously concludes that Allegation D.1. of the charges be **DISMISSED**, confirming the Respondent's evaluation of the diagnostic studies as being inconclusive and supporting his recommendation for further evaluation of Patient D. The Hearing Committee also unanimously concludes that the Allegations in Paragraphs D and D.2. be **SUSTAINED**, and that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to perform a rectal and a pelvic examination of Patient D.

Fifth Specification:

The Hearing Committee unanimously concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4), the Respondent having failed to perform and record an adequate physical examination and to interpret adequately the X-rays of Patient E's ankle as well as issuing inappropriate discharge instructions. The Allegations set forth in Paragraphs E, E.1., E.2. and E.3. are **SUSTAINED**.

Sixth Specification:

The Hearing Committee unanimously **SUSTAINED** the Allegations set forth in Paragraph F, concluding that the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to record and perform an adequate physical examination.

Seventh Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraph G , G.1. and G.2. The Committee concludes the Respondent practiced with gross negligence under New York Education Law Section 6530(4) by failing to administer human rabies immunoglobulin to Patient G and failing to have vaccine administered to Patient G on an appropriate schedule.

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CONCLUSIONS WITH REGARD TO SPECIFICATIONS EIGHTH THROUGH FOURTEENTH

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE:

Eighth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs A, A.1. and A.2. Two (2) members of the Committee sustained the allegations set forth in Paragraph A.3. One (1) members, however, for the reasons set forth in the First Specification, had a contrary position. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to perform and record an adequate physical examination of Patient A, failing to detect a fracture on Patient A's cervical spine X-rays and by inappropriately discharging Patient A.

Ninth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraphs B, B.1., B.2., B.3., B.4. and B.5. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to obtain and record an adequate physical examination of Patient B, to investigate and treat adequately Patient B's hypertension, to make a medically acceptable diagnosis, by inappropriately prescribing Dimetapp to Patient B and by inappropriately discharging Patient B.

Tenth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations in Paragraphs C, C.1. and C.2. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to treat adequately with nitroglycerine and by failing to institute thrombolytic therapy in a timely manner to Patient C.

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Eleventh Specification:

The Hearing Committee unanimously concludes that allegation D.1. of the charges be **DISMISSED**, confirming the Respondent's evaluation of the diagnostic studies as being inconclusive and supporting his recommendation for further evaluation of Patient D. The Committee also unanimously concludes that the allegations in Paragraphs D. and D.2. be **SUSTAINED**, and that the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to perform a rectal and a pelvic examination of Patient D.

Twelfth Specification:

The Hearing Committee unanimously concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6), the Respondent having failed to perform and record an adequate physical examination and to interpret adequately the X-rays of Patient E's ankle. The Respondent also issued inappropriate discharge instructions. The allegations set forth in Paragraphs E, E.1., E.2. and E.3. are **SUSTAINED.**

Thirteenth Specification:

Despite the Hearing Committee sustaining the Respondent's failure to record and perform an adequate physical examination, the Committee determined that such did not encompass the complete lack of ability, and the total and flagrant lack of necessary knowledge to perform such examination. The Respondent's description of his "three" examinations, in the collar, out of the collar and after viewing the X-rays, was introduced by his notation "neuro" in Patient F's record. (Finding 59; T. 236-237) The Committee concludes the charge of gross incompetence in this Specification should be **DISMISSED.**

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Fourteenth Specification:

The Hearing Committee unanimously **SUSTAINED** the allegations set forth in Paragraph G, G.1. and G.2. The Committee concludes the Respondent practiced with gross incompetence under New York Education Law Section 6530(6) by failing to administer human rabies immunoglobulin to Patient G and failing to have vaccine administered to Patient G on an appropriate schedule.

CONCLUSIONS WITH REGARD TO FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Fifteenth Specification:

The Hearing Committee, having determined that the Respondent practiced with gross negligence in the seven occasions set forth in the First through the Seventh Specifications, **SUSTAINED** the charge that the Respondent practiced with negligence on more than one occasion contrary to the provision of New York Education Law Section 6530(3).

CONCLUSIONS WITH REGARD TO SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Sixteenth Specification:

The Hearing Committee, having determined that the Respondent practiced with gross incompetence in the six[2] occasions set forth in the Eighth through Fourteenth Specifications, **SUSTAINED** the charge that the Respondent practiced with incompetence on more than one occasion contrary to the provision of New York Education Law Section 6530(5).

[2]The Committee dismissed the Thirteenth Specification

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CONCLUSIONS WITH REGARD TO SEVENTEENTH THROUGH TWENTIETH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Seventeenth Specification:

The Hearing Committee, having concluded in the first specification that the Respondent failed to obtain and record an adequate physical examination of Patient A, concludes that the Respondent did not fail to maintain a record for Patient A which accurately reflected his examination. New York Education Law Section 6530(32) requires that "the record for each patient accurately reflects the evaluation and treatment of the patient". The record for Patient A reflects the inadequate physical examination provided. The Committee concluded that the facts in Paragraphs A. and A.1., A.2. and A.3. spell out a violation of the failure to maintain accurate records of Patient A's examination. Therefore, this specification is **SUSTAINED**.

Eighteenth through Twentieth Specification:

The Committee further concludes that the Paragraphs B. and B.1., B.2., B.3., B.4., B.5., E., E.1., E.2., E.3. and F. encompass violations of failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Therefore, these specifications are **SUSTAINED**.

SUMMARY OF CONCLUSIONS

Patient A:

The Committee sustain the three (3) allegations against the Respondent. An injury frequently resulting in spinal damage was followed by an inadequate physical examination and a diagnosis of a "possible whiplash injury" (Finding 6). Respondent failed to detect an obvious cervical fracture (Finding 13). Respondent ordered a premature discharge of Patient A without a review by an appropriate specialist (Finding 14). The record of the Respondent and the testimony

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of the Department's expert witness, Dr. Jastremski, confirms the Committee's conclusions that gross negligence and gross incompetence need to be sustained.

Patient B:

The Committee sustained five allegations:

1. The failure to record an adequate medical history of Patient B, including the history of medications used, shortness of breath and previous heart treatment, among others, was of basic importance (Finding 23). Respondent performed a physical examination centered on the Patient's nose and ear tympanic membranes with no cardiorespiratory examination (Finding 24).

2. The Respondent failed to investigate adequately or treat Patient B's hypertension despite the history of cardiovascular symptoms and treatment and the acute hypertension that required immediate treatment (Findings 19, 20, 21, 28).

3. The Respondent failed to make a medically acceptable diagnosis (Finding 26). It should have included a detailed cardiorespiratory examination seeking a cardiac or lung related cause of Patient B's shortness of breath and increased respiratory rate (Finding 24).

4. The Respondent inappropriately prescribed Dimetapp (Finding 27). It can cause acute elevation of blood pressure in hypertensive individuals (Finding 25).

5. Respondent inappropriately discharged Patient B, without investigating the cause of Patient B's shortness of breath or treating his hypertension (Finding 30). Five and one-third hours later Patient B returned to the emergency room where he received a thorough examination (Finding 31).

Patient C:

The Hearing Committee sustained two (2) allegations. The first is an allegation that the Respondent failed to treat adequately Patient C with nitroglycerine. Sublingual nitroglycerine was needed to alleviate Patient C's continued pain from his acute myocardial infarction. If sublingual nitroglycerine did not resolve the pain, Patient C should have been treated with intravenous nitroglycerine (Finding 40).

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The second allegation was the Patient C should have been treated with thrombolytic therapy to dissolve blood clots during the limited time period available to the Respondent. Patient C was an acceptable candidate for the therapy (Findings 37, 40). By failing to utilize the therapy, and by delaying in calling the attending physician, the Respondent increased the risk of the additional cardiac damage that resulted in the acute myocardial infarction sustained by Patient C (Findings 37, 38, 39, 40). Sustained are gross negligence and gross incompetence.

Patient D:

The Department charged two (2) allegations against the Respondent concerning Patient D. The first allegation is the Respondent's failure to interpret adequately Patient D's diagnostic studies. The Respondent evaluated the laboratory work as being inconclusive and recommended further studies; the Committee agrees and does not sustain the allegation (Finding 47).

The second allegation charges a failure of the Respondent to perform rectal and pelvic examinations of Patient D. Both are routinely indicated for female patients to assess adequately potential problems in reproductive organs, abdominal obstructions of the rectum or bleeding in the patient's stool (Finding 43). The Hearing Committee sustains the second allegation as gross negligence only.

Patient E:

The Committee sustained the three (3) allegations charged against the Respondent. The first was a failure to perform or record an adequate physical examination. In lieu of a knee evaluation, a description of the ankle including the location of swelling and tenderness, ankle ligament an Achilles tendon stability, range of motion and intactness of neurovascular function, the Respondent's examination noted "same" as his findings (Findings 49, 50).

The second charge is a failure to interpret adequately the X-rays of Patient E's ankle. The Respondent's interpretation was "no obvious fracture" when the fracture should have been obvious to an emergency room physician (Findings 51, 54).

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The final charge was for inappropriate discharge instructions by the Respondent. They should have included an instruction not to subject the ankle to weight bearing and instructions or a prescription for pain medication (Finding 55). Respondent made a belated referral to orthopedics two (2) days later (Finding 56). Sustained are gross negligence and gross incompetence.

Patient F:

The Hearing Committee sustained the single charge of failure to perform and record an adequate physical examination. Patient F, who was driving a motor vehicle without a seat belt at the time of an accident, complained of pain in her head, neck and right knee and may have had a prolonged unconsciousness period (Finding 57). Under these circumstances, acceptable medical standards require that the Respondent should have examined Patient F's neck and performed a neurological examination to detect neurological damage or injuries to the spine or neck (Finding 58).

The only documentation of a neurological examination is the entry of the work (?) "neuro" by the Respondent in the patient record. The Committee concludes the failure to record a summary of any physical examination given does not indicate a complete lack of ability, or a total and flagrant lack of the necessary knowledge to perform the required examination. See, Thirteenth Specification, pg. 25, supra. The Committee concludes the allegation of gross negligence in the performance and recording of any examination is sustained. The allegation of gross incompetence is not sustained.

Patient G:

The Hearing Committee sustains the two (2) allegations of failure to initially administer human rabies immunoglobulin and failing to have vaccinations administered to Patient G on an appropriate schedule. Patient G suffered a small puncture wound from a wild raccoon bite. Findings 63, 64, 65.

The Committee sustains the allegations and the charges of gross negligence and gross incompetence in each allegation.

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Four allegations of a failure to maintain records for Patients A, B, E and F were dismissed because the Committee determined the records generally documented the Respondent's evaluation and treatment of the patients. In addition, four (4) dismissed allegations of gross negligence, gross incompetence, negligence on more than one (1) occasion and incompetence on more than one (1) occasion for Patient D were based on the Committee's conclusion that the Respondent had reason to determine the diagnostic studies at issue were inconclusive. The Respondent's recommendation for further evaluation was warranted. One (1) allegation of gross incompetence of patient F was dismissed as well.

The remaining allegations sustained by the Committee consisted of seventeen instances of gross negligence relating to all seven (7) patients, sixteen instances of gross incompetence relating to six (6) of the patients, seventeen instances of negligence on more than one (1) occasion relating to the seven (7) patients, and sixteen instances of incompetence on more than one (1) occasion relating to six (6) of the patients.

It is apparent that gross negligence and gross incompetence required a determination of egregious conduct in each of the seven (7) cases. However, three (3) of the cases are set forth from the others because of the dangers they pose to the patients and the documentation of the Respondent's capabilities:

1. **Patient C:** Shortly after arrival at the emergency room, the Respondent diagnosed Patient C as suffering an acute myocardial infarction confirmed by history and an electrocardiogram. The Patient was in pain. The Respondent did not treat with nitroglycerine. Nor did the Respondent take advantage of the hour or so that remained to use thrombolytic therapy to minimize permanent cardiac damage. Nor did the Respondent call the attending cardiologist until it was too late.

2. **Patient D:** This female patient was admitted with lower quadrant abdominal pain and a slight abdominal distention. The Respondent did not perform a pelvic or a rectal examination. The pelvic is routine for a female patient with lower quadrant pain to assess whether there are problems in her reproductive organs. The rectal is routine to determine

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if there are masses in the rectum causing abdominal obstructions and whether there is bleeding in the patient's stool.

3. **Patient G:** Patient G presented with a wild raccoon bite on a finger. Rabies prophylaxis starts with a prompt administration of human rabies immunoglobulin. It is followed by an initial rabies inoculation. Thereafter a series of rabies inoculations two (2) or three (3) days later, then seven (7), fourteen and twenty days after the first is given. The Patient did not receive the immunoglobulin. the Patient was given an initial inoculation by the Respondent. The Patient did not return to the hospital until seven (7) days later, in contravention of the schedule. The failed treatment risked rabies.

The three cases above, and the other four cases that are the subjects of the hearing, speak to the Respondent's deviations from acceptable standards of care in emergency cases. Many of the patients are at critical risk. The Respondent has been practicing emergency medicine for about sixteen years. It can not be anticipated that he will change. His medical skill and judgment are both in question.

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ORDER

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

In accordance with the provisions of Sections 230, Subdivision 10, Paragraph (g) and 230-a, Subdivision 4 of the Public Health Law, the Hearing Committee unanimously orders that license number 181809 to practice medicine in the State of New York of **EDWARD WOODS, M.D**. be and hereby is **REVOKED.**

DATED: **Albany, New York**
,1995

IRVING S. CAPLAN, Chairperson

THERESE G. LYNCH, M.D.
ANDREW J. MERRITT, M.D.

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EXHIBIT
Dept. INV
1A
MBB 6/6/95

ATTACHMENT I

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

IN THE MATTER OF EDWARD WOODS, M.D., Respondent	AMENDED STATEMENT OF CHARGES

EDWARD WOODS, M.D., the Respondent, was authorized to practice medicine in New York State on March 29, 1990, by the issuance of license number 181809 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine in New York State.

FACTUAL ALLEGATIONS

A. Respondent provided emergency medical care on or about July 22, 1990 to Patient A, a 24 year old female (all patients are identified in the attached Appendix), at House of the Good Samaritan, Watertown, New York (hereinafter "Good Samaritan Hospital"). Patient A presented after hitting her head while diving into a swimming pool. Respondent's care of Patient A was deficient in the following respects:

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1. Respondent failed to perform and/or record an adequate physical examination.

2. Respondent failed to detect a fracture on Patient A's cervical spine x-rays.

3. Respondent unappropriately discharged Patient A. (CS)

B. Respondent provided emergency medical care to Patient B on or about August 6, 1990 at Good Samaritan Hospital. Patient B, a 67 year old male, presented to the Emergency Department with a complaint of difficulty in breathing and with abnormal vital signs. Respondent's care of Patient B was deficient in the following respects:

1. Respondent failed to obtain and/or record an adequate history, and/or perform and/or record an adequate physical examination.

2. Respondent failed to adequately investigate and/or treat Patient B's hypertension.

3. Respondent failed to make a medically acceptable diagnosis.

4. Respondent inappropriately prescribed Dimetapp for this patient.

5. Respondent unappropriately discharged Patient B. (CS)

C. Respondent provided emergency medical care at Good Samaritan Hospital to Patient C, a 72 year old male, who presented with chest pain on or about August 3, 1990. Respondent's care of Patient C was deficient in the following respects:

1. Respondent failed to adequately treat this patient with nitroglycerin.

2. Respondent failed to institute thrombolytic therapy in a timely manner.

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D. Respondent provided emergency medical care at Good Samaritan Hospital to Patient D, a 47 year old female, who presented with complaints of abdominal pain on or about August 5, 1990. Respondent's care of Patient D was deficient in the following respects:

1. Respondent failed to adequately interpret diagnostic studies ordered for Patient D.

2. Respondent failed to perform a rectal and/or pelvic examination.

E. Respondent provided emergency medical care on or about July 12, 1990 to Patient E, a 15 year old boy, at Good Samaritan Hospital. Patient E presented after twisting his ankle while playing basketball. Respondent's care of Patient E was deficient in the following respects:

1. Respondent failed to perform and/or record an adequate physical examination.

2. Respondent failed to adequately interpret the x-rays of this patient's ankle.

3. Respondent inappropriately discharged Patient E. AS

F. Respondent provided emergency medical care to Patient F, a 22 year old, on or about September 1, 1990, at Good Samaritan Hospital. Patient F presented after being involved in a motor vehicle accident, with complaints of head and neck pain. Respondent's care of Patient F was deficient in that he failed to perform and/or record an

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adequate physical examination.

G. Respondent provided emergency medical care to Patient G, a 23 year old male, on or about August 26, 1990 at Good Samaritan Hospital. Patient G presented after having been bitten by a raccoon. Respondent's care of Patient G was deficient in the following respects:

1. Respondent failed to initially administer human rabies immunoglobulin.

2. Respondent failed to have vaccination administered to Patient G on an appropriate schedule.

SPECIFICATIONS

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (4) (McKinney Supp. 1995) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2.

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2. The facts in Paragraphs B and B.1, B.2, B.3 and/or B.4.

3. The facts in Paragraph C and C.1 and/or C.2.

4. The facts in Paragraph D and D.1 and/or D.2.

5. The facts in Paragraphs E and E.1 and/or E.2.

6. The facts in Paragraph F.

7. The facts in Paragraphs G and G.1 and/or G.2.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (6) (McKinney Supp. 1995) by reason of his having practiced the profession with gross incompetence, in that Petitioner charges;

8. The facts in Paragraphs A and A.1 and/or A.2.

9. The facts in Paragraphs B and B.1, B.2, B.3 and/or B.4.

10. The facts in Paragraph C and C.1 and/or C.2.

11. The facts in Paragraph D and D.1 and/or D.2.

12. The facts in Paragraphs E and E.1 and/or E.2.

13. The facts in Paragraph F.

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14. The facts in Paragraphs G and G.1 and/or G.2.

FIFTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (3) (McKinney's Supp. 1995) by reason of his having practiced the profession with negligence on more than one occasion, in that Petitioner charges that the Respondent committed at least two of the following:

15. The facts in Paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F, G and G.1 and/or G and G.2.

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SIXTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530 (5) (McKinney Supp. 1995) by reason of his having practiced the profession with incompetence on more than one occasion, in that the Petitioner charges that the Respondent committed at least two of the following:

16. The facts in Paragraphs A and A.1, A and A.2, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F, G and G.1 and/or G and G.2.

SEVENTEENTH THROUGH TWENTETH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with having committed professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) by reason of his having failed to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that the Petitioner charges:

17. The facts in Paragraphs A and A.1.
18. The facts in Paragraphs B and B.1.

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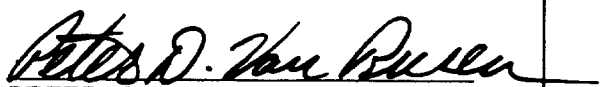
19. The facts in Paragraphs E and E.1.

20. The facts in Paragraph F.

DATED: May 31, 1995
Albany, New York



PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

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Rec. 7/1/95

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

June 29, 1995

EXHIBIT
Department
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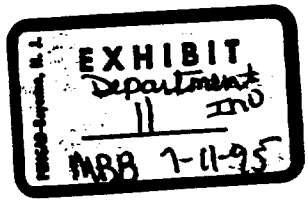

David Solomon, Esq.
Administrative Law Judge
2366 Algonquin Road
Schenectady, New York 12309

Re: Matter of Edward Woods, M.D.

Dear Judge Solomon:

By this letter, I am making an Application to add three Factual Allegations to the Statement of Charges in this matter. In your ruling on this application, I respectfully request that you consider that 10 NYCRR §51.6 allows any party to supplement a pleading at any time prior to the Hearing Committee' final Determination and Order if there is not substantial prejudice to any other party.

It is my understanding that Dr. Woods has obtained or has had the opportunity to obtain the transcript of the June 6, 1995 hearing date. The additional Factual Allegations are based on Dr. Jastermski's testimony at the June 6, 1995 hearing. Therefore, Dr. Woods will have had ample time to review the prior transcript and will have ample time prior to the next hearing date of July 11 to prepare for the additional charges. The Factual Allegations that I wish to add are as follows:

Factual Allegation A.3 (see transcript, pgs. 20-23)

Respondent inappropriately discharged Patient A. (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (first, eighth, fifteenth and sixteenth specifications).

Factual Allegation B.5 (see transcript, pgs. 34-35)

Respondent inappropriately discharged Patient B. (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (second, ninth, fifteenth and sixteenth specifications)).

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Factual Allegation E.3 (see transcript, pgs. 69-73)

Respondent issued inappropriate discharge instructions for Patient E (This allegation would be charged as gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion (fifth, twelfth, fifteenth and sixteenth specifications)).

Thank you for your attention to these matters.

Very truly yours,

Frederick Zimmer

Frederick Zimmer
Assistant Counsel
(518) 473-4282

FZ:ctt

Edward Woods, M.D.
#4 Poinciana Drive
Durham, North Carolina 27707

STATE BOARD OF OHIO
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NEW YORK STATE DEPARTMENT OF HEALTH 19

PROTHONOTARY

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BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs	:	
v.	:	Docket no. 0703-49-96 BPOA File no. 96-49-03322
Edward Louis Woods, M.D., Respondent	:	

ADJUDICATION AND ORDER

Frank C. Kahoe, Jr., Esquire
Hearing Examiner

Date of Hearing: December 5, 1996

HISTORY

This matter comes before the hearing examiner for the Bureau of Professional and Occupational Affairs (BPOA) on an order to show cause filed September 23, 1996, alleging that Edward Louis Woods, M.D. (Respondent) is subject to disciplinary action under the Medical Practice Act of 1985[1] (Act) at 63 P.S. § 422.41(4) by reason of disciplinary action taken against him by another state medical licensing board. Respondent did not file an answer.[2] A formal administrative hearing was held in Harrisburg December 5, 1996. Bernadette Paul, Esquire represented the Commonwealth as prosecuting attorney. Respondent did not attend. At the hearing, the Commonwealth moved to enter default and deem facts admitted in accordance with the General Rules of Administrative Practice and Procedure at 1 Pa. Code § 35.37.[3] The

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[1] Act of December 20, 1985, P.L. 457, No. 112, *as amended*, 63 P.S. § 422.1 *et seq*.

[2] On October 23, 1996, Respondent submitted to the BPOA Prothonotary a copy of a letter addressed to the Secretary of the United States Department of Health and Human Services and numerous other documents, none of which was responsive to the order to show cause in this matter.

[3] Section 35.37 of the General Rules of Administrative Practice and Procedure provides as follows:

> Any person upon whom, an order to show cause has been served . . . shall, if directed to do so, respond to the same by filing within the time specified in said order an answer in writing. . . . Mere general denials of the allegations of an order to show cause . . . will not be considered as complying with this section and may

hearing examiner granted the Commonwealth's motion and announced his decision from the bench.

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be deemed a basis for entry of a final order without hearing, unless otherwise required by statute, ... Any respondent failing to file an answer within the time allowed shall be deemed in default, and all relevant facts stated in the order to show cause may be deemed admitted.

FINDINGS OF FACT

1. Respondent holds a license to practice medicine and surgery in the Commonwealth of Pennsylvania, no. MD-032926-E. (Board records)

2. The Respondent's address on file with the Board is 4 Poinciana Drive, Durham, North Carolina 27707. (Board records)

3. On November 1, 1995, a hearing committee of the New York State Board for Professional Medical Conduct (New York board) issued an order revoking Respondent's license to practice medicine in that state for repeated deviations from the accepted standard of medical care to emergency patients which amounted to "gross negligence" and "gross incompetence" under New York law.[4] (Exhibit C-1)

4. The New York Department of Health Administrative Review Board sustained the New York board hearing committee's findings and order in February 1996. (Exhibit C-2)

5. Respondent was served with the order to show cause issued in this matter and all subsequent pleadings and orders filed of record in this proceeding. (Docket no. 0703-49-96)

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[4] The New York board made seven findings of gross negligence and six findings of gross incompetence relating to care rendered by Respondent to seven patients who presented at the House of the Good Samaritan Hospital in Watertown, New York in July and August 1990. (Exhibit C-1)

REHEARING AND/OR RECONSIDERATION BY HEARING EXAMINER

An application to the hearing examiner for rehearing or reconsideration may be filed by a party within 15 days after the mailing date of this adjudication and order. The application must be captioned "Application for Rehearing," "Application for Reconsideration," or "Application for Rehearing or Reconsideration." The application must state specifically and concisely, in numbered paragraphs, the grounds relied upon in seeking rehearing or reconsideration, including any alleged error in the adjudication. If the adjudication is sought to be vacated, reversed or modified by reason of matters that have arisen since the hearing and decision, the matters relied upon by the petitioner must be set forth in the application.

APPEAL TO BOARD

An application to the State Board of Medicine for review of the hearing examiner's adjudication and order may be filed by a party within 20 days after the mailing date of this adjudication and order. The application must be captioned "Application for Review." It must state specifically and concisely, in numbered paragraphs, the grounds relied upon in seeking the Board's review of the hearing examiner's decision, including any alleged error in the adjudication. Within an application for review a party may request that the Board hear additional argument and additional evidence.

An application to the Board to review the hearing examiner's decision may be filed irrespective of whether an application to the hearing examiner for rehearing or reconsideration is filed.

STAY OF HEARING EXAMINER'S ORDER

Neither the filing of an application for rehearing and/or reconsideration, nor the filing of an application for review operates as an automatic stay of the hearing examiner's order. If a party desires a stay of a hearing's examiner's order, he must file an application for stay directed to the hearing examiner. If the hearing examiner denies the stay, an application for stay directed to the Board may then be filed.

FILING AND SERVICE

An original and three copies of all applications must be filed with Deanna Walton, Prothonotary, 124 Pine Street, Suite 200, Harrisburg, Pennsylvania 17101. A copy of the application must also be served on all parties.

Applications must be received for filing by the prothonotary within the time limits specified herein. The date of receipt at the office of prothonotary, and not the date of deposit in the mail, is determinative. The filing of an application for rehearing and/or reconsideration does not extend, or in any other manner affect, the time period in which an application for review may be filed.

STATUTES AND REGULATIONS

Statutes and regulations relevant to post-hearing procedures are the Osteopathic Medical Practice Act at 63 P.S. §271.15(a)(3). Section 905 of the Health Care Services Malpractice Act, 40 P.S. §1301.905; and the General Rules of Administrative Practice and Procedure at 1 Pa. Code Part II to the extent they are not inconsistent with regulations promulgated by the Board or provisions of the Osteopathic Medical Practice Act or the Health Care Services Malpractice Act.

Not having an attorney will not be accepted as an excuse for failing to comply with the requirements contained in these notice provisions and relevant statutes and regulations.