Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Louis W. DeInnocentes, Jr., M.D.,	DATE: December 23, 1992
Petitioner,	Docket No. C-395
- v. -	Decision No. CR247
The Inspector General.	

DECISION

On May 7, 1991, the Inspector General (I.G.) advised Petitioner that he had determined to exclude him from participating in the Medicare program and in State health care programs for five years.[1] The I.G. told Petitioner that the exclusion was authorized by section 1156 of the Social Security Act (Act). The I.G. based his determination to exclude Petitioner on a recommendation made to the I.G. by the Arkansas Foundation for Medical Care, Inc., the peer review organization for Arkansas (Arkansas PRO).

The Arkansas PRO's recommendation that Petitioner be excluded derived from its findings that, in two separate hospital admissions of a patient, Petitioner had committed gross and flagrant violations of his statutory obligation to provide services of a quality that meets professionally recognized standards of health care. The I.G. advised Petitioner that he agreed with the Arkansas PRO's recommendation, and he enumerated 11 findings of gross and flagrant violations in his notice letter to

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[1] "State health care program" is defined by section 1128(h) of the Social Security Act to cover three types of federally-financed health care programs, including Medicaid. Unless the context indicates otherwise, I use the term "Medicaid" hereafter to represent all State health care programs from which Petitioner was excluded.

Petitioner. The I.G. found further that Petitioner demonstrated both an inability and an unwillingness to comply substantially with his statutory obligation to provide health care which meets professionally recognized standards of health care.

The I.G. advised Petitioner that he was entitled to a hearing concerning the I.G.'s exclusion determination. The I.G. further advised Petitioner, that, inasmuch as Petitioner practiced medicine in a county with a population of less than 70,000, he was entitled to a preliminary ruling by an administrative law judge as to whether his continued practice of medicine posed a serious risk to individuals to whom Petitioner provided health care. Petitioner requested a hearing, both as to the preliminary issue of serious risk and as to the issues of whether the I.G.'s exclusion determination was authorized and was reasonable.

The case originally was assigned to Administrative Law Judge Edward D. Steinman for a hearing and a decision. The parties agreed to waive their rights to present live testimony on the serious risk issue, but requested that Judge Steinman issue a ruling on that issue based on their respective documentary submissions. On April 20, 1992, Judge Steinman issued a ruling in which he found that Petitioner posed a serious risk to patients. His ruling permitted the I.G. to implement his exclusion of Petitioner, pending a final decision on the issues of the I.G.'s authority to exclude Petitioner and the reasonableness of the exclusion. Judge Steinman made no findings on these ultimate issues in his ruling.

The case subsequently was reassigned to me for a hearing and a decision on the merits of the I.G.'s exclusion determination. I held a hearing in Little Rock, Arkansas, on June 22 - 24, 1992. The parties then filed posthearing briefs and reply briefs.

I have carefully considered the applicable law, the evidence adduced at the June 1992 hearing, and the parties' arguments.[2] I conclude that the I.G. was authorized to exclude Petitioner pursuant to section 1156(b) of the Act. I further conclude that the five-

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[2] I have read Judge Steinman's ruling on the serious risk issue. I do not consider the ruling to be evidence or precedent, and I do not rely on it in reaching my decision in this case. My findings and my conclusions are based entirely on my independent review of the law, the evidence, and the parties' arguments.

year exclusion which the I.G. imposed in this case is reasonable, and I sustain the exclusion.

ISSUES

The issues in this case are whether:

1. The I.G. is authorized to exclude Petitioner pursuant to section 1156(b) of the Act.

2. The five-year exclusion which the I.G. imposed against Petitioner is reasonable.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Petitioner's education, training, work experience, and licensure as a physician[3]

1. Petitioner is a physician. Tr. at 92.[4]

2. Petitioner received his medical education at Georgetown University School of Medicine, graduating in 1957. P. Ex. 1/1; Tr. at 92.

3. Petitioner received residency training in general and thoracic surgery. P. Ex. 1/1; Tr. at 93.

4. Petitioner is not board certified in a medical specialty. Tr. at 94.

5. Petitioner has practiced general and thoracic surgery in several locations. P. Ex. 1/1 - 2; Tr. at 96 - 100.

6. From 1987 until 1989, Petitioner practiced medicine in Bull Shoals, Arkansas. P. Ex. 1/2; Tr. at 623.

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[3] As a convenience to the parties, I have divided my Findings of Fact and Conclusions of Law (Findings) into sections which are prefaced with descriptive captions. The captions are not Findings, and they are not intended to augment or substitute for my Findings in this case.

[4] I refer to the I.G.'s exhibits as "I.G. Ex. (number)/(page)." I refer to Petitioner's exhibits as "P. Ex. (number)/(page)." I refer to the transcript as "Tr. at (page)."

7. Since 1989, Petitioner has practiced medicine in Alabama. P. Ex. 1/2; Tr. at 102 - 103.

8. Petitioner presently practices in Scottsboro, Alabama, with his practice limited to emergency room practice. Tr. at 102 - 103, 623 - 624.

9. Petitioner's license to practice medicine in Alabama is limited, in that Petitioner is precluded from performing surgery, including elective surgery, in an operating room or suite. I.G. Ex. 24/5; Tr. at 625.

10. Petitioner's license to practice medicine in Alabama permits him to perform those procedures normally and customarily performed in an emergency room setting. I.G. Ex. 24/5; Tr. at 625.

II. Petitioner's treatment relationship with Barbara J. McCarty

11. In 1988, Petitioner had as a patient Barbara J. McCarty (Ms. McCarty). I.G. Ex. 1, 3, 5, 6, 10; Tr. at 632, 635.

12. In November 1985, Ms. McCarty was found to be entitled to Social Security disability benefits based on a determination that she suffered from chronic obstructive pulmonary disease (COPD). P. Ex. 22/2.

13. Ms. McCarty died at her home on December 30, 1988. I.G. Ex. 38/12.

14. Ms. McCarty was 43 years old on the date of her death. I.G. Ex. 1/1.

15. Petitioner treated Ms. McCarty in 1988 at the Bull Shoals Community Hospital and Clinic, Inc. (Bull Shoals Hospital), Bull Shoals, Arkansas, and at the Gascot Medical Clinic, a facility which was affiliated with the Bull Shoals Hospital. I.G. Ex. 1, 3, 5, 6, 10, 27/102; Tr. at 635.

16. Ms. McCarty was hospitalized at the Bull Shoals Hospital for stays beginning on May 9, September 19, November 2, November 21, and December 3, 1988. Petitioner was Ms. McCarty's attending physician for each of these hospitalizations. I.G. Ex. 1/2 - 5, 3/1 - 5, 5/1 - 6, 6/1 - 4, 10/1 - 4.

17. As Ms. McCarty's attending physician, Petitioner accepted responsibility for her welfare, for providing her with routine and ongoing health care, and for doing

the necessary paperwork associated with her hospitalizations. Tr. at 394; see I.G. Ex. 1/2 - 5, 3/1 - 5, 5/1 - 6, 6/1 - 4, 10/1 - 4.

18. During the dates of her hospitalizations in 1988, Ms. McCarty was a Medicare beneficiary. I.G. Ex. 1/1, 3/1, 6/1, 10/1; see P. Ex. 22/2.

19. Petitioner's diagnoses of Ms. McCarty's illnesses on the dates of her hospitalizations beginning on May 9, 1988, included: pneumonia, COPD, organic heart disease, arteriosclerotic heart disease, hypertension, congestive heart failure, secondary polycythemia, and anoxemia. I.G. Ex. 1/1, 2/1 - 3, 5/2, 6/1, 10/1 - 2.

20. Arteriosclerotic heart disease is the buildup of fatty material, or plaques, in the arteries of the heart itself. Tr. at 433 - 434.

21. Congestive heart failure is a condition in which a patient's heart does not pump with sufficient force to circulate his or her blood adequately, resulting in an accumulation of fluid in the patient's lungs. Tr. at 386.

22. Congestive heart failure may be manifested in a patient by shortness of breath and also by swelling in the patient's legs. Tr. at 391.

23. COPD is an ongoing condition affecting a patient's ability to breathe, which may cause the patient to experience: shortness of breath; difficulty in walking; and occasional lung infections which make the patient's breathing problems worse. Tr. at 491 - 495.

24. Polycythemia is a condition in which a patient has an excessive quantity of red blood cells in his or her bloodstream. Tr. at 392.

25. Polycythemia in a patient with breathing problems can place an increased work load on the patient's heart, which may exacerbate other conditions, including congestive heart failure and the accumulation of fluid in the patient's lungs. Tr. at 396.

III. Acts or omissions by Petitioner during Ms. McCarty's hospitalizations of November 21, 1988 through November 23, 1988, and December 3, 1988 through December 9, 1988, that are gross and flagrant violations of Petitioner's obligation to provide health care of a quality that meets professionally recognized standards of health care

26. A gross and flagrant violation by a physician of his or her obligation to provide services to a Medicare beneficiary which meets professionally recognized standards of health care is any act or omission which fails to meet professionally recognized standards of health care, by presenting an imminent danger to the health, safety, or well-being of the beneficiary, or which places the beneficiary unnecessarily in a high-risk situation. 42 C.F.R. § 1004.1(b); see Social Security Act, section 1156(b)(1)(B).

A. Petitioner's failure to order an electrocardiogram (EKG) of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988

27. Ms. McCarty was hospitalized at the Bull Shoals Hospital from November 21, 1988 through November 23, 1988, complaining of severe shortness of breath and severe swelling in her legs. I.G. Ex. 6/1, /4.

28. Petitioner observed Ms. McCarty to manifest severe leg swelling, with 3-4+ bilateral pitting edema. I.G. Ex. 6/4.

29. Ms. McCarty was diagnosed to be suffering from both COPD and congestive heart failure. I.G. Ex. 6/1 - 4.

30. The professionally recognized standard of health care to be followed in the case of an individual who is hospitalized with severe shortness of breath and associated congestive heart failure is to perform an EKG on that individual during the course of his or her hospitalization. Tr. at 407.

31. The purpose of performing an EKG in the case of a patient hospitalized with COPD and congestive heart failure is to document the extent of damage to the patient's heart, and also to determine whether the patient suffers from heart rhythm disturbances related to his or her intake of medications. Tr. at 406 - 407.

32. Given Ms. McCarty's complaints, Petitioner's findings, and the diagnoses of her conditions, an EKG

should have been administered to Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 39/4 - 5; Tr. at 406 - 407.

33. Petitioner did not order that an EKG be administered to Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 39/4; see I.G. Ex. 6.

34. Petitioner's failure to order that an EKG be administered to Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988, violated a professionally recognized standard of health care. Findings 30 - 33.

35. Petitioner's failure to order that an EKG be administered to Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988 presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. I.G. Ex. 39/4 - 5; Findings 26 - 34; 42 C.F.R. § 1004.1(b).

36. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to order that an EKG be administered to Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. Finding 35; Social Security Act, section 1156(b)(1)(B).

B. Petitioner's failure to order a chest x-ray of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988

37. The professionally recognized standard of health care to be followed in the case of an individual hospitalized with a diagnosis of congestive heart failure is to monitor that individual's status with chest x-rays of that individual during the course of his or her hospitalization. See I.G. Ex. 39/2 - 5.

38. Petitioner did not order a chest x-ray of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 39/2 - 5; see I.G. Ex. 6.

39. Petitioner's failure to order a chest x-ray of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988, violated a professionally recognized standard of health care. Findings 37 - 38.

40. Petitioner's failure to order a chest x-ray of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988 presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Findings 26, 37 - 39; 42 C.F.R. § 1004.1(b).

41. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to order a chest x-ray for Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. Findings 37 - 40; Social Security Act, section 1156(b)(1)(B).

C. Petitioner's failure to order arterial blood gas studies (ABGs) of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988

42. The diagnoses of Ms. McCarty's condition during her hospitalization from November 21, 1988 through November 23, 1988 included a diagnosis of secondary polycythemia. I.G. Ex. 6/1 - 4.

43. The professionally recognized standard of health care for an individual who is hospitalized for shortness of breath, congestive heart failure, and polycythemia, is to obtain ABGs on that individual. Tr. at 384, 398 - 399.

44. The purpose of obtaining ABGs of an individual who is hospitalized for shortness of breath, congestive heart failure, and polycythemia, is to determine that individual's need for oxygen. I.G. Ex. 39/3; see Tr. at 398.

45. Petitioner did not order ABGs of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. Tr. at 398; see I.G. Ex. 6.

46. Petitioner's failure to order ABGs of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988, presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Findings 26, 42 - 45; 42 C.F.R. § 1004.1(b).

47. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to order ABGs of Ms. McCarty during her hospitalization from November 21, 1988 through November

23, 1988. Findings 42 - 46; Social Security Act, section 1156(b)(1)(B).

D. Petitioner's failure to order that Ms. McCarty's electrolyte levels be monitored during her hospitalization from November 21, 1988 through November 23, 1988

48. Ms. McCarty was administered two diuretics, Bumex and Lasix, during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 6/6; Tr. at 409.

49. Bumex and Lasix are medications which are administered in order to reduce fluids in patients. Tr. at 410.

50. Ms. McCarty was administered Digoxin during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 6/6.

51. The medications Digoxin, Lanoxin, and digitalis are used interchangeably to treat patients. Tr. at 414 - 415.

52. Digitalis is generally used as a treatment for patients who suffer from congestive heart failure. Tr. at 386.

53. Bumex and Lasix have the potential, when administered to a patient, of reducing significantly that patient's potassium levels. Tr. at 410 - 411.

54. When potassium levels are depleted in a patient who is receiving digitalis or Digoxin, that patient is at risk for developing heart block, or complete arrest, or stoppage of his or her heart. Tr. at 410 - 411; see Tr. at 414 - 415.

55. The term "electrolytes" means certain chemicals present in an individual's blood, including sodium and potassium. Tr. at 411.

56. The professionally recognized standard of health care for a hospitalized patient who is receiving diuretics and digitalis or Digoxin is to monitor routinely that patient's blood electrolyte levels, in order to assure that the patient's potassium is at a safe or therapeutic level. Tr. at 411.

57. Petitioner failed to monitor Ms. McCarty's blood electrolyte levels during her hospitalization from

November 21, 1988 through November 23, 1988. I.G. Ex. 6, 39/5 - 6; Tr. at 411.

58. Petitioner's failure to monitor Ms. McCarty's blood electrolyte levels during her hospitalization from November 21, 1988 through November 23, 1988 presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high risk situation. I.G. Ex. 39/5 - 6; Tr. at 411 - 413; Findings 26, 48 - 57; 42 C.F.R. § 1004.1(b).

59. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to monitor Ms. McCarty's blood electrolyte levels during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 39/5 - 6; Tr. at 411 - 413; Findings 48 - 58; Social Security Act, section 1156(b)(1)(B).

E. Petitioner's failure to order BUN or creatinine testing of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988

60. The professionally recognized standard of health care for a hospitalized patient who is receiving diuretics and digitalis or Digoxin is to monitor that patient's kidney function by testing that patient for BUN and creatinine output. Tr. at 384 - 385, 416 - 417.

61. The term "BUN" means "blood urea nitrogen," which is a product formed by a patient's kidneys as they detoxify or break down substances. Tr. at 385.

62. BUN and creatinine output are an indicator of a patient's kidney function. Tr. at 416 - 417.

63. Patients whose kidney function is poor and who are receiving Digoxin are at a much greater risk of adverse cardiac consequences from the medication than are patients whose kidney function is satisfactory. Tr. at 416 - 417.

64. Petitioner failed to monitor Ms. McCarty's BUN or creatinine output during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 39/6; Tr. at 417; see I.G. Ex. 6.

65. Petitioner's failure to monitor Ms. McCarty's BUN or creatinine output during her hospitalization from November 21, 1988 through November 23, 1988 presented an imminent danger to Ms. McCarty's health, safety, and

well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Findings 26, 60 - 64; 42 C.F.R. § 1004.1(b).

66. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to monitor Ms. McCarty's BUN or creatinine output during her hospitalization from November 21, 1988 through November 23, 1988. Findings 60 - 65, Social Security Act, section 1156(b)(1)(B).

F. Petitioner's failure to order a follow-up chest x-ray of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988, despite a chest x-ray showing borderline cardiac decompensation

67. Ms. McCarty was hospitalized at the Bull Shoals Hospital from December 3, 1988 through December 9, 1988, complaining of severe shortness of breath. I.G. Ex. 10/1 - 2.

68. Petitioner's diagnoses of Ms. McCarty's conditions included secondary polycythemia, COPD, and congestive heart failure. I.G. Ex. 10/1 - 2.

69. A chest x-ray was taken of Ms. McCarty on December 3, 1988, which showed borderline cardiac decompensation. I.G. Ex. 10/21.

70. Petitioner ordered no follow-up chest x-rays of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988, although Ms. McCarty had been hospitalized for congestive heart failure, and her chest x-ray showed borderline cardiac decompensation. I.G. Ex. 39/5; Tr. at 401; see I.G. Ex. 10.

71. Petitioner's failure to monitor Ms. McCarty's congestive heart failure with follow-up chest x-rays during her hospitalization from December 3, 1988 through December 9, 1988, presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Findings 26, 67 - 70; see Findings 37 - 41; 42 C.F.R. § 1004.1(b).

72. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to monitor Ms. McCarty's congestive heart failure with follow-up chest x-rays during her hospitalization from December 3, 1988 through December 9,

1988. Findings 67 - 71; see Findings 37 - 41; Social Security Act, section 1156(b)(1)(B).

G. Petitioner's failure to order a chest x-ray of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988, to assess the consequences of a subclavian phlebotomy

73. Petitioner performed a subclavian phlebotomy on Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988. I.G. Ex. 10/2, 39/5; Tr. at 401 - 402, 531 - 532.

74. A "phlebotomy" is a procedure wherein a quantity of blood is withdrawn from a patient. Tr. at 531.

75. A "subclavian phlebotomy" is a procedure wherein blood is withdrawn from a patient's subclavian vein (which is a vein that lies under a patient's collar bone). Tr. at 401, 531.

76. The professionally recognized standard of health care for a patient who has had a subclavian phlebotomy is to perform a post-phlebotomy chest x-ray on the patient, to assure that the patient has not experienced a pneumothorax (a partial collapse of his or her lung). I.G. Ex. 39/5; Tr. at 401 - 402, 531 - 532.

77. Failure to perform a post-phlebotomy chest x-ray on a patient who has had a subclavian phlebotomy can place that patient at serious medical risk for the development of complications from a collapsed lung, unless the patient is monitored closely by other means for the presence of a collapsed lung. I.G. Ex. 39/5; Tr. at 402, 532.

78. Petitioner did not order a post-phlebotomy chest x-ray of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988. I.G. Ex. 39/5; Tr. at 401 - 402, 531 - 532; see I.G. Ex. 10.

79. Petitioner did not monitor Ms. McCarty closely by other means during her hospitalization from December 3, 1988 through December 9, 1988, to assure that she did not develop complications from a collapsed lung. Tr. at 402; see I.G. Ex. 10.

80. Petitioner's failure to order a post-phlebotomy chest x-ray of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988, presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a

high-risk situation. Findings 26, 73 - 79; 42 C.F.R. § 1004.1(b).

81. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to monitor Ms. McCarty with follow-up chest x-rays to assess the consequences of a subclavian phlebotomy done during her hospitalization from December 3, 1988 through December 9, 1988. Findings 73 - 80; Social Security Act, section 1156(b)(1)(B).

H. Petitioner's failure to order repeat electrolyte levels of Ms. McCarty during her hospitalization from December 3, 1988 through December 9, 1988

82. Blood electrolyte levels were ordered of Ms. McCarty on her admission to the Bull Shoals Hospital on December 3, 1988. Tr. at 415.

83. Although Petitioner diagnosed Ms. McCarty's conditions to include COPD and congestive heart failure, and despite the facts that Ms. McCarty was receiving aggressive diuretic therapy and her blood electrolyte levels showed low potassium levels, he did not order that Ms. McCarty's blood electrolyte levels be monitored with repeat tests during her hospitalization from December 3, 1988 through December 9, 1988. I.G. Ex. 39/6; Tr. at 416; see I.G. Ex. 10.

84. Petitioner's failure to order that Ms. McCarty's blood electrolyte levels be monitored with repeat tests during her hospitalization from December 3, 1988 through December 9, 1988 presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Findings 26, 82 - 83; see Findings 48 - 59; 42 C.F.R. § 1004.1(b).

85. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to order that Ms. McCarty's blood electrolyte levels be monitored with repeat tests during her hospitalization from December 3, 1988 through December 9, 1988. Findings 82 - 84; Social Security Act, section 1156(b)(1)(B).

I. Petitioner's failure to properly document his assessment of Ms. McCarty's condition, his orders, and Ms. McCarty's progress during her hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988

86. As Ms. McCarty's attending physician during her hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988, Petitioner was responsible for all paperwork associated with Ms. McCarty's hospitalizations. Tr. at 394; Findings 16 - 17.

87. The professionally recognized standard of health care to be followed by an attending physician for a hospitalized patient is to provide documentation of the physician's assessment of the patient, orders, and progress notes sufficient so that other providers can ascertain the patient's condition, treatment, and progress. Tr. at 402 - 403, 505 - 507.

88. The professionally recognized standard of health care to be followed by an attending physician for a patient hospitalized with a serious medical condition, such as Ms. McCarty, is to document the patient's condition with at least a daily progress note which details the physician's findings concerning the patient. Tr. at 402 - 403.

89. Petitioner's progress notes made during Ms. McCarty's hospitalization from November 21, 1988 through November 23, 1988, did not describe adequately Petitioner's findings concerning Ms. McCarty's condition. I.G. Ex. 6/6 - 8; Tr. at 402 - 404.

90. Petitioner's progress notes made during Ms. McCarty's hospitalization from December 3, 1988 through December 9, 1988, were not made daily and did not describe adequately Petitioner's findings concerning Ms. McCarty's condition. I.G. Ex. 10/24 - 28; Tr. at 402 - 406.

91. The records of Ms. McCarty's hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988, fail to document adequately multiple changes that were made in Ms. McCarty's medications, and did not document the reasons for these changes or the impact that the changes in medications may have had on Ms. McCarty's status. I.G. Ex. 38/10 - 11; Tr. at 545; see I.G. Ex. 6, 10.

92. The record of Ms. McCarty's hospitalization from November 21, 1988 through November 23, 1988, fails to document adequately the reason for, or Ms. McCarty's response to, a phlebotomy which Petitioner performed during this hospitalization. Tr. at 395 - 396; see I.G. Ex. 6.

93. The record of Ms. McCarty's hospitalization from December 3, 1988 through December 9, 1988, fails to document adequately the reason for, and Ms. McCarty's response to, the subclavian phlebotomy which Petitioner performed during this hospitalization. I.G. Ex. 39/3; Tr. at 404 - 406; see I.G. Ex. 10.

94. Petitioner's contention that the records of Ms. McCarty's hospitalizations which are in evidence omit progress notes that he prepared is not credible. See Tr. at 637 - 639.

95. Petitioner failed to maintain records of Ms. McCarty's hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988, which meets professionally recognized standards of health care. Finding 86 - 94.

96. Petitioner's failure to maintain records of Ms. McCarty's hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988, presented an imminent danger to Ms. McCarty's health, safety, and well-being, and placed Ms. McCarty unnecessarily in a high-risk situation. Tr. at 545 - 546; Findings 26, 86 - 95; 42 C.F.R. § 1004.1(b).

97. Petitioner committed a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care by failing to maintain records of Ms. McCarty's hospitalizations from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988. Findings 86 - 96; Social Security Act, section 1156(b)(1)(B).

IV. Additional acts or omissions by Petitioner related to his responsibility for Ms. McCarty's care which are not consistent with accepted medical practice

98. Ms. McCarty was hospitalized at the Bull Shoals Hospital from May 9, 1988 through May 13, 1988, complaining of respiratory distress. I.G. Ex. 1/1 - 2.

99. Petitioner's diagnoses of Ms. McCarty's condition during this hospitalization included pneumonia, COPD, and arteriosclerotic heart disease. I.G. Ex. 1/1 - 5.

100. Ms. McCarty was hospitalized at the Bull Shoals Hospital from September 19, 1988 through September 24, 1988, complaining of severe chest pain. I.G. Ex. 3/1 - 2.

101. Petitioner's diagnoses of Ms. McCarty's condition during this hospitalization included secondary polycythemia, congestive heart failure, and COPD. I.G. Ex. 3/1 - 5.

102. Ms. McCarty was hospitalized at the Bull Shoals Hospital from November 2, 1988 through November 5, 1988. I.G. Ex. 5/1 - 2.

103. Petitioner's diagnoses of Ms. McCarty's condition during this hospitalization included "intractable" congestive heart failure. I.G. Ex. 5/1 - 6.

A. Petitioner's failure to maintain adequate records of his treatment of Ms. McCarty during her hospitalization from May 9, 1988 through May 13, 1988

104. As Ms. McCarty's attending physician during her hospitalization from May 9, 1988 through May 13, 1988, Petitioner was responsible for preparing a discharge summary documenting Ms. McCarty's condition, treatment, and progress. Findings 16, 17; see I.G. Ex. 1/3.

105. A discharge summary serves as an information source for further care by a patient's attending physician and by other health care professionals who may treat that patient. I.G. Ex. 38/2.

106. Petitioner signed the discharge summary for Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988. I.G. Ex. 1/3.

107. The discharge summary for Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988, did not specifically describe her condition, her treatment and progress during her hospitalization, or Petitioner's plan for future treatment of Ms. McCarty. I.G. Ex. 1/3, 38/2, /4 - 5.

108. As Ms. McCarty's attending physician during her hospitalization from May 9, 1988 through May 13, 1988, Petitioner was responsible for preparing progress notes

concerning her condition. Findings 16, 17; see I.G. Ex. 1/17 - 20; Findings 87 - 90.

109. The only progress note prepared by Petitioner during Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988 is dated May 11, 1988. I.G. Ex. 1/19; see Finding 94.

110. Petitioner either failed to attend to Ms. McCarty on May 9, 10, and 12, 1988, or failed to prepare progress notes documenting his care of Ms. McCarty. See I.G. Ex. 1/17 - 20; Finding 94.

111. Petitioner's failure to provide a discharge summary documenting the course of Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988 and his failure to provide progress notes concerning his treatment of Ms. McCarty during this hospitalization violate professionally recognized standards of health care. Findings 87, 88, 104 - 110.

B. Petitioner's failure to treat adequately Ms. McCarty's lower respiratory infection during her hospitalization from May 9, 1988 through May 13, 1988

112. Ms. McCarty was diagnosed to be suffering from pneumonia when admitted to the hospital on May 9, 1988. I.G. Ex. 1/1 - 2.

113. A chest x-ray taken of Ms. McCarty on May 9, 1988 showed her to be suffering from COPD with mild changes of cardiac decompensation and pulmonary hypertension. I.G. Ex. 1/12.

114. Petitioner did not request or obtain prior x-rays of Ms. McCarty for comparison with the x-ray taken on May 9, 1988. I.G. Ex. 1/12.

115. Given the admitting diagnosis of pneumonia, and the x-ray evidence of pulmonary problems documented by the chest x-ray taken on May 9, 1988, Petitioner should have obtained prior chest x-rays of Ms. McCarty for comparison purposes. I.G. Ex. 38/2.

116. Petitioner's failure to obtain prior chest x-rays of Ms. McCarty for comparison with the May 9, 1988 chest x-ray constitutes a serious error in his management of Ms. McCarty's care. I.G. Ex. 38/2.

117. Ms. McCarty's pneumonia was treated with an antibiotic on May 9, 1988. I.G. Ex. 1/17, 38/4.

118. On May 10, 1988, Petitioner ordered that administration of the antibiotic to Ms. McCarty be stopped. I.G. Ex. 38/4.

119. Petitioner's discontinuation of antibiotic therapy on May 10, 1988, was a serious error in his management of Ms. McCarty's care. I.G. Ex. 38/4.

120. The medical records of Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988, do not document that Ms. McCarty's pneumonia had resolved itself prior to her discharge. I.G. Ex. 1; I.G. Ex. 38/5 - 6.

121. Petitioner failed to treat adequately Ms. McCarty's pneumonia during her hospitalization from May 9, 1988 through May 13, 1988. I.G. Ex. 38/5 - 6; Findings 112 - 120.

C. Petitioner's failure to manage adequately Ms. McCarty's oxygen therapy during her hospitalization from May 9, 1988 through May 13, 1988

122. ABGs were performed of Ms. McCarty on May 9, 1988, during her hospitalization from May 9, 1988 through May 13, 1988. I.G. Ex. 1/2, /8 - 9.

123. The results of these ABGs were significantly abnormal. I.G. Ex. 1/8 - 9, 38/3, /6.

124. Despite the abnormal ABGs, Petitioner did not order additional ABGs of Ms. McCarty during her hospitalization from May 9, 1988 through May 13, 1988. I.G. Ex. 38/6; see I.G. Ex. 1.

125. The physician who admitted Ms. McCarty to the Bull Shoals Hospital during her hospitalization from May 9, 1988 through May 13, 1988, ordered that she be administered oxygen. I.G. Ex. 1/17, 38/3.

126. Throughout Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988, Petitioner did not order tests to determine whether Ms. McCarty's oxygen therapy was adequate, nor did he order that the oxygen being administered to her be adjusted to address changes in her medical condition. I.G. Ex. 38/3; see I.G. Ex. 1.

127. Petitioner failed to provide orders for administration of oxygen to Ms. McCarty at her home when she was discharged from the hospital on May 13, 1988. I.G. Ex. 38/3; see I.G. Ex. 1.

128. Petitioner's failure to monitor Ms. McCarty's need for oxygen through continued ABGs, his failure to adjust or modify her oxygen therapy as was indicated by her condition, and his failure to prescribe orders for administration of oxygen to Ms. McCarty after her discharge, constitute serious errors in the management of Ms. McCarty during her hospitalization from May 9, 1988 through May 13, 1988. I.G. Ex. 38/3, /6; Findings 122 - 127; see I.G. Ex. 1.

D. Petitioner's inappropriate orders concerning administration of steroids to Ms. McCarty during her hospitalization from May 9, 1988 through May 13, 1988

129. The admission note generated by the physician who admitted Ms. McCarty to the Bull Shoals Hospital on May 9, 1988 observed that she was receiving Prednisone (an oral steroid) at home, "p.r.n." I.G. Ex. 1/21, 38/3 - 4.

130. The term "p.r.n." means "as needed." I.G. Ex. 38/3.

131. During her hospitalization from May 9, 1988 through May 13, 1988, Ms. McCarty was initially administered Solu-Medrol (a steroid) intravenously. I.G. Ex. 1/17, 38/3 - 4.

132. On May 11, 1988, while Ms. McCarty was under Petitioner's care, administration of Solu-Medrol to Ms. McCarty was ordered discontinued. I.G. Ex. 1/18.

133. On May 11, 1988, Petitioner was prescribed Prednisone 5 mg. twice daily. I.G. Ex. 1/18, 38/3 - 4.

134. Patients who require steroids to manage lung disease require variable doses of steroids appropriate to their condition. I.G. Ex. 38/4.

135. Patients who are converted from intravenous steroids to oral Prednisone are normally started on 20 to 40 mg. of Prednisone daily, and the medication is gradually tapered off. I.G. Ex. 38/4.

136. Petitioner's decision to administer 5 mg. of Prednisone twice daily to Ms. McCarty during her hospitalization from May 9, 1988 through May 13, 1988, after discontinuing administration of Solu-Medrol to Ms. McCarty, was inappropriate management of oral steroids to Ms. McCarty, and constituted inadequate medical care. I.G. Ex. 38/4.

E. Petitioner's premature discharge of Ms. McCarty from her hospitalization from May 9, 1988 through May 13, 1988

137. On May 12, 1988, during her hospitalization from May 9, 1988 through May 13, 1988, Ms. McCarty's blood pressure was recorded to be 64/42. I.G. Ex. 1/30.

138. On May 12, 1988, during her hospitalization from May 9, 1988 through May 13, 1988, Ms. McCarty's heart rate was recorded to be 120 beats per minute. I.G. Ex. 1/30.

139. No subsequent records were made of Ms. McCarty's blood pressure and pulse during her hospitalization from May 9, 1988 through May 13, 1988. See I.G. Ex. 1.

140. Ms. McCarty's blood pressure on May 12, 1988 was extremely low and her heart rate was elevated. I.G. Ex. 38/5.

141. As of May 12, 1988, Ms. McCarty was receiving a variety of medications that could have affected her blood pressure, including Vasotec, Verapamil, Nitro-Bid, and Lasix. I.G. Ex. 1/17, 38/5 - 6.

142. The readings of Ms. McCarty's blood pressure and pulse taken on May 12, 1988, showed Ms. McCarty's condition to be unstable medically, and Petitioner should not have discharged Ms. McCarty from the Bull Shoals Hospital on May 13, 1988. I.G. Ex. 38/5 - 6.

143. Petitioner's premature discharge of Ms. McCarty from the Bull Shoals Hospital on May 13, 1988, placed Ms. McCarty at serious risk from the effects of hypotension. I.G. Ex. 38/5 - 6.

F. Petitioner's failure to maintain adequate records of his treatment of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988

144. Petitioner signed the discharge summary for Ms. McCarty's hospitalization from September 19, 1988 through September 24, 1988. I.G. Ex. 3/3.

145. The discharge summary fails to contain information concerning the management of Ms. McCarty's medications, her respiratory therapy, or her home oxygen management. I.G. Ex. 3/3, 38/7.

146. The discharge summary fails to address Ms. McCarty's progress while in the hospital or to provide a plan for treatment of Ms. McCarty's illnesses. I.G. Ex. 3/3.

147. Petitioner's failure to provide a discharge summary documenting the course of Ms. McCarty's hospitalization from September 19, 1988 through September 24, 1988, violates professionally recognized standards of health care. Findings 87, 144 - 146.

G. Petitioner's failure to obtain ABGs of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988

148. Petitioner failed to order that ABGs be performed of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988, despite his diagnoses of Ms. McCarty's illnesses, which included congestive heart failure and COPD. I.G. Ex. 38/7; see I.G. Ex. 3.

149. Given Petitioner's diagnoses of Ms. McCarty's conditions as including congestive heart failure and COPD, his failure to order that ABGs be performed of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988, constituted a violation of a professionally recognized standard of health care. I.G. Ex. 38/7 - 8, /10; Findings 42 - 47, 148.

H. Petitioner's inappropriate administration of Demerol to Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988

150. On the evening of September 19, 1988, Petitioner ordered that Demerol be administered to Ms. McCarty. I.G. Ex. 3/12, 38/7 - 8.

151. Demerol is a narcotic drug which can cause respiratory failure in susceptible individuals. I.G. Ex. 38/8; Tr. at 437.

152. The quantity of Demerol that Petitioner ordered administered to Ms. McCarty on September 19, 1988, was potentially dangerous to her health and safety, in light of her significant COPD and congestive heart failure, and in the absence of ABGs that would document the seriousness of Ms. McCarty's condition. I.G. Ex. 38/7 - 8.

153. Given Ms. McCarty's condition, there existed a significant danger that administration of Demerol to her

on September 19, 1988, in the quantity prescribed by Petitioner, could have precipitated acute respiratory failure. I.G. Ex. 38/8; Tr. at 436.

154. Petitioner's directive on September 19, 1988, that Demerol be administered to Ms. McCarty in the quantity prescribed by Petitioner was, in light of her diagnosed condition and the absence of tests to determine the seriousness of her condition, an inappropriate directive. I.G. Ex. 38/7 - 8; Tr. at 436; Findings 150 - 153.

I. Petitioner's failure to prescribe bronchodilator therapy to Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988

155. Ms. McCarty's respiratory condition during her hospitalization from May 9, 1988 through May 13, 1988, was such as to require the administration of bronchodilator drugs. I.G. Ex. 1/17, 38/8.

156. Bronchodilator drugs, including Theophylline, are used to treat COPD. See I.G. Ex. 1/17, 38/8.

157. Ms. McCarty continued to suffer from COPD during her hospitalization from September 19, 1988 through September 24, 1988. I.G. Ex. 38/8; Finding 101.

158. COPD is a chronic condition that does not resolve itself spontaneously. Tr. at 492.

159. Notwithstanding that Ms. McCarty continued to suffer from COPD during her hospitalization from September 19, 1988 through September 24, 1988, Petitioner did not order that she be administered bronchodilator drugs during her hospitalization. I.G. Ex. 38/8; see I.G. Ex. 3.

160. Petitioner's failure to order that Ms. McCarty be administered bronchodilator drugs during her hospitalization from September 19, 1988 through September 24, 1988, constitutes a serious judgment error, because failure to administer bronchodilator drugs to Ms. McCarty placed her at significant risk for worsening of her condition. I.G. Ex. 38/8; Findings 156 - 159.

J. Petitioner's failure to order repeat chest x-rays of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988

161. A chest x-ray was taken of Ms. McCarty on her admission to the Bull Shoals Hospital on September 19, 1988. I.G. Ex. 3/10.

162. Petitioner did not order that follow-up chest x-rays be taken of Ms. McCarty during her hospitalization from September 19, 1988 through September 24, 1988. I.G. Ex. 38/8; see I.G. Ex. 3.

163. The chest x-ray taken of Ms. McCarty on her admission to the Bull Shoals Hospital on September 19, 1988, showed improvement in her condition as compared with a previous x-ray, but it also showed her to manifest basilar edema, more marked in the left lower lung field. I.G. Ex. 3/10, 38/8.

164. During her hospitalization from September 19, 1988 through September 24, 1988, Ms. McCarty gained three pounds, which could be a sign of worsening congestive heart failure. I.G. Ex. 3/21, 38/8.

165. Petitioner should have ordered a repeat chest x-ray of Ms. McCarty before discharging her from the Bull Shoals Hospital on September 24, 1988, given Ms. McCarty's diagnosis of congestive heart failure, her weight gain, and the findings on her admission chest x-ray. I.G. Ex. 38/8; Findings 161 - 164.

166. Petitioner's failure to order a repeat chest x-ray of Ms. McCarty before discharging her from the Bull Shoals Hospital on September, 24, 1988, was an error in medical judgment by Petitioner. I.G. Ex. 38/8; see Findings 67 - 72.

K. Petitioner's unjustified performance of a phlebotomy on Ms. McCarty on September 24, 1988

167. Petitioner performed a phlebotomy on Ms. McCarty on September 24, 1988. I.G. Ex. 3/14.

168. Ms. McCarty was discharged from the Bull Shoals Hospital on September 24, 1988. I.G. Ex. 3/1, /3 - 4, /14.

169. Removal of blood from a patient in Ms. McCarty's condition and in the quantity extracted from Ms. McCarty (500 cc) can have immediate adverse hemodynamic consequences for the patient. I.G. Ex. 38/9; see I.G. Ex. 3/14.

170. Petitioner provided no documentation concerning how the phlebotomy he performed on Ms. McCarty was performed, how Ms. McCarty tolerated the procedure, and what her vital signs were before and after the procedure. I.G. Ex. 38/9; see I.G. Ex. 3; Finding 94.

171. Petitioner provided no rationale in his progress notes or in other documentation for performing a phlebotomy on Ms. McCarty on September 24, 1988. I.G. Ex. 38/9; see I.G. Ex. 3.

172. There existed no clear medical need to perform a phlebotomy on Ms. McCarty on September 24, 1988, given her condition as of that date. I.G. Ex. 38/9.

173. Ms. McCarty should not have been discharged from the Bull Shoals Hospital on September 24, 1988, in view of the risks associated with performing a phlebotomy on her and the failure to monitor her condition after the phlebotomy was performed. I.G. Ex. 38/9; Findings 169 - 170.

174. Petitioner's performance of a phlebotomy on Ms. McCarty on September 24, 1988, unnecessarily placed her in a high-risk situation. I.G. Ex. 38/9.

175. Petitioner's performance of a phlebotomy on Ms. McCarty on September 24, 1988, was a gross and flagrant violation of his obligation to provide health care to Ms. McCarty which meets professionally recognized standards of health care.[5] I.G. Ex. 38/9.

L. Petitioner's premature discharge of Ms. McCarty from the Bull Shoals Hospital on November 23, 1988

176. On November 23, 1988, the day Ms. McCarty was discharged from her November 21, 1988 through November 23, 1988 hospitalization at the Bull Shoals Hospital, Ms. McCarty complained to a nurse that she was nauseous, that she was very short of breath, and that she was experiencing chest pain. I.G. Ex. 6/20.

177. Ms. McCarty experienced her chest pain while attempting to have a bowel movement. I.G. Ex. 6/20.

178. Chest pain during exertion (such as attempting to have a bowel movement) is inconsistent with COPD, but may be consistent with heart disease, including angina or a myocardial infarction. Tr. at 497 - 498.

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[5] Although Petitioner's conduct here meets the statutory test for a gross and flagrant violation, I am not relying on this violation as evidence supporting the I.G.'s determination to exclude Petitioner. Rather, the evidence of this violation is relevant only to the issue of remedy.

179. The nurse who was treating Ms. McCarty on November 23, 1988 observed her to be apprehensive. I.G. Ex. 6/20.

180. The symptoms complained of by Ms. McCarty on November 23, 1988 and her signs of apprehension could be indicative of cardiac disease, including angina or a myocardial infarction. Tr. at 497 - 499.

181. Petitioner failed to evaluate Ms. McCarty's complaints of nausea, chest pain, and shortness of breath, and her signs of apprehension, before discharging her from the Bull Shoals Hospital on November 23, 1988. See I.G. Ex. 3.

182. Petitioner could have ordered tests, such as an EKG and blood tests, to evaluate Ms. McCarty's symptoms and signs of apprehension prior to discharging her on November 23, 1988. Tr. at 499.

183. Petitioner's failure to order tests to evaluate Ms. McCarty's symptoms and signs of apprehension prior to discharging her on November 23, 1988, unnecessarily placed Ms. McCarty at risk. Tr. at 422, 496 - 499

M. Petitioner's inappropriate administration of Heparin to Ms. McCarty in conjunction with the subclavian phlebotomy he performed on her on December 5, 1988

184. On December 5, 1988, during Ms. McCarty's hospitalization at the Bull Shoals Hospital from December 3, 1988 through December 9, 1988, Petitioner ordered that she be administered 1000 units of Heparin. I.G. Ex. 10/25.

185. Petitioner's apparent purpose in ordering that 1000 units of Heparin be administered to Ms. McCarty was to make it easier to withdraw blood from her during a phlebotomy. I.G. Ex. 10/3.

186. Petitioner ordered that Heparin be administered to Ms. McCarty by injection into a muscle. I.G. Ex. 10/25; Tr. at 532.

187. Heparin is a drug which is administered to patients to prevent their blood from clotting. Tr. at 532.

188. The normal way to administer Heparin to a patient is by intravenous administration or by injection into a patient's fatty tissue. Tr. at 532.

189. It is dangerous to administer Heparin into a patient's muscle because Heparin can induce blood clots,

bleeding, or bruising in the patient's muscle. Tr. at 532 - 533.

190. The dose of Heparin which Petitioner ordered administered to Ms. McCarty is a subtherapeutic dose. Tr. at 532 - 533.

191. Administration of a subtherapeutic dose of Heparin to a patient exposes the patient to the risk of an adverse reaction to the drug, without conferring any benefit on the patient. Tr. at 532 - 533.

192. There is no medical justification to administer Heparin to a patient in conjunction with a phlebotomy, either in a subtherapeutic or a therapeutic dose. Tr. at 533.

193. Petitioner's directive that Heparin be administered to Ms. McCarty on December 5, 1988, by intramuscular injection and in a subtherapeutic dose, was medically unjustified and exposed Ms. McCarty to an unnecessary risk of injury. Findings 184 - 192.

V. The sufficiency of the Arkansas PRO's notice to Petitioner concerning its review of his treatment of Ms. McCarty and its recommendation that Petitioner be excluded

194. A peer review organization may recommend to the Secretary of the United States Department of Health and Human Services, or to his delegate, the I.G., that a party be excluded from participating in Medicare and Medicaid, if it: (1) determines that the party has grossly and flagrantly violated an obligation to provide health care that meets professionally recognized standards of health care in one or more instances; and (2) provides reasonable notice and opportunity for discussion with the concerned party (and where appropriate, provides the concerned party with the opportunity to enter into a corrective action plan). Social Security Act, section 1156(b)(1).

195. A peer review organization satisfies the requirement that it provide reasonable notice and opportunity for discussion with a party, prior to recommending that the party be excluded, based on a determination that the party has committed one or more gross or flagrant violations of that party's statutory obligation to provide health care, by sending to that party a written notice of its proposed determination and by providing that party with an opportunity to respond to

the determination. Social Security Act, section 1156(b)(1); 42 C.F.R. §§ 1004.40(a), 1004.50(a), (b).

196. A peer review organization satisfies the requirement that it provide written notice and opportunity for response to a party of a determination to recommend exclusion by sending the notice to that party's home or business mailing address, certified mail, return receipt requested. Finding 195; Social Security Act, section 1156(b)(1); 42 C.F.R. §§ 1004.40(a), 1004.50(a), (b).

197. The notice requirement of the Act and regulations does not require that a party obtain and read a notice that has been sent to that party by a peer review organization, so long as that party has been advised that a notice has been sent to that party via certified mail and that party has the opportunity to obtain and read the notice. Social Security Act, section 1156(b)(1); 42 C.F.R. §§ 1004.40(a), 1004.50(a), (b).

198. The Arkansas PRO sent notices to Petitioner, advising him of its initial determination that he had committed gross and flagrant violations of his obligation to provide health care to Ms. McCarty that meets professionally recognized standards of health care and of its decision to recommend exclusion. The notices also provided him with an opportunity to respond to the Arkansas PRO's determinations. I.G. Ex. 27/1 - 8, /45 - 49, /62 - 66, /77 - 81, /97; Tr. at 295 - 308.

199. The notices which the Arkansas PRO sent to Petitioner were dated January 23, 1990, March 15, 1990, July 31, 1990, and January 7, 1991. I.G. Ex. 27/6, /45, /62, /77.

200. The Arkansas PRO sent the notices to Petitioner's home address in Scottsboro, Alabama, by certified mail, return receipt requested. I.G. Ex. 27/6, /23, /45, /62, /77, /97; Tr. at 295 - 297.

201. The United States Postal Service notified Petitioner on each of the four occasions that he had been sent certified mail, but he failed to claim it. I.G. Ex. 27/2 - 3, /6, /9, /97; I.G. Ex. 27a; Tr. at 297.

202. The Arkansas PRO satisfied its obligation to Petitioner to provide him with written notice of its initial determination of gross and flagrant violations of his obligation to provide health care to Ms. McCarty that meets professionally recognized standards of health care and of its obligation to provide him with written notice

of its determination to recommend exclusion. The Arkansas PRO also provided Petitioner with an opportunity to respond to their determinations, by sending written notices to his home address in Scottsboro Alabama, certified mail, return receipt requested. Findings 194 - 201; Social Security Act, section 1156(b)(1); 42 C.F.R. §§ 1004.40(a), 1004.50(a), (b).

VI. Petitioner's inability or unwillingness substantially to comply with his obligation to provide health care of a quality which meets professionally recognized standards of health care

203. The Secretary or his delegate, the I.G., may exclude a party from participating in Medicare and Medicaid where, based on the recommendation of a peer review organization, he determines that the party has: (1) in one or more instances, grossly or flagrantly violated his obligation to provide health care of a quality which meets professionally recognized standards of health care; and (2) demonstrated an unwillingness or a lack of ability substantially to comply with such obligation. Social Security Act, section 1156(b)(1).

204. Petitioner committed gross and flagrant violations of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care. Findings 26 - 97.

205. The Arkansas PRO recommended to the I.G. that Petitioner be excluded based on his commission of gross and flagrant violations of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care. I.G. Ex. 27/1 - 5.

206. Based on the Arkansas PRO's recommendation, the I.G. determined that Petitioner had committed gross and flagrant violations of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care, and that he was unable or unwilling to meet his obligation to provide health care. I.G. Ex. 15.

A. Petitioner's inability to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care

207. The acts or omissions Petitioner committed during Ms. McCarty's hospitalizations from November 21, 1988 through November 23, 1988, and December 3, 1988 through

December 9, 1988, which constitute gross and flagrant violations of Petitioner's obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care, establish that Petitioner lacks a basic understanding of the pathophysiology of cardiovascular disease, respiratory disease, and polycythemia. Tr. at 423; Findings 26 - 97; see I.G. Ex. 6, 10.

208. Petitioner's treatment of Ms. McCarty during her hospitalizations from November 21, 1988 through November 23, 1988, and December 3, 1988 through December 9, 1988, demonstrates a total lack on Petitioner's part of a basic understanding of the essential elements of proper medical care of patients. Tr. at 538 - 539; Findings 26 - 97; see I.G. Ex. 6, 10.

209. The I.G. proved that Petitioner is unable to comply with his obligation to provide health care of a quality which meets professionally recognized standards of health care. Findings 26 - 97, 207 - 208; Social Security Act, section 1156(b)(1).

B. Petitioner's unwillingness to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care

210. Petitioner's management of Ms. McCarty's health care during her hospitalizations from November 21, 1988 through November 23, 1988, and December 3, 1988 through December 9, 1988, demonstrates a pattern of gross and flagrant violations by Petitioner of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care. Findings 26 - 97; see I.G. Ex. 6, 10.

211. The pattern of gross and flagrant violations by Petitioner of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care establishes Petitioner to be indifferent to his obligation to provide such health care. Findings 26 - 97, 210; see I.G. Ex. 6, 10.

212. Petitioner's indifference to his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care establishes him to be unwilling to meet his obligation to provide such health care. Findings 210 - 211.

213. The I.G. proved that Petitioner is unwilling to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care. Findings 210 - 212; Social Security Act, section 1156(b)(1).

VII. The remedial need for an exclusion

214. The remedial purpose of an exclusion imposed pursuant to section 1156 of the Act is to protect the welfare of program beneficiaries and recipients from parties who are untrustworthy to provide health care of the requisite quality. Social Security Act, section 1156(b)(1).

215. Petitioner's gross and flagrant violations of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care, and his other acts or omissions in the treatment of Ms. McCarty which are not consistent with accepted medical practice, constitute serious and repeated violations of Petitioner's duty as a physician to provide health care of a quality which meets accepted medical standards. Tr. at 538, 546; Findings 26 - 193; see 42 C.F.R. § 1004.90(d)(2), (3).

216. Petitioner's treatment of Ms. McCarty establishes that he lacks general medical understanding in a wide variety of areas, including basic, essential medical care. Tr. at 538; Findings 26 - 193; see 42 C.F.R. § 1004.90(d)(2), (3).

217. Petitioner's treatment of Ms. McCarty demonstrates him to be an untrustworthy provider of care. Findings 214 - 216.

218. Petitioner's completion of continuing medical education courses in advanced cardiac life support and advanced trauma life support does not establish that now or in the relatively near future he would be trustworthy to provide health care, because the materials taught in these courses do not address the basic deficiencies in Petitioner's knowledge of medicine, as demonstrated by his treatment of Ms. McCarty. Tr. at 546 - 547.

219. Petitioner's generally satisfactory performance as an emergency room physician subsequent to his treatment of Ms. McCarty does not establish that now or in the relatively near future he would be trustworthy to provide health care, because his current duties do not encompass the broad range of medical responsibilities inherent in

the practice of medicine. See I.G. Ex. 24; Tr. at 673 - 697, 706 - 717.

220. A five-year exclusion is reasonable in this case. Findings 26 - 193; 214 - 219.

ANALYSIS

There are two principal issues in this case. The first issue is whether, based on the Arkansas PRO's determination and recommendation to the I.G., the I.G. had authority to exclude Petitioner. The second issue is whether the five-year exclusion imposed and directed against Petitioner by the I.G. is a reasonable remedy.

The evidence strongly supports the Arkansas PRO's determination and recommendation to the I.G. that Petitioner be excluded pursuant to section 1156(b)(1). I therefore find that the I.G. has authority to exclude Petitioner pursuant to section 1156(b)(1) of the Act. There is overwhelming and essentially unrebutted evidence in this case that, in numerous instances, Petitioner grossly and flagrantly violated his obligation to provide health care to Ms. Barbara McCarty, a Medicare beneficiary, of a quality which meets professionally recognized standards of health care. Petitioner's gross and flagrant violations of his obligation establish that he is not competent to provide health care of a quality which meets professionally recognized standards of health care. He is thus unable to provide health care of a level required by the Act. Alternatively, Petitioner's conduct towards Ms. McCarty demonstrates indifference by Petitioner to his duty to fulfill his professional obligations. In that event, Petitioner is unwilling to provide health care of a level which meets professionally recognized standards of health care.

The evidence also proves that the five-year exclusion imposed and directed against Petitioner by the I.G. is reasonable. The evidence of Petitioner's gross and flagrant violations of his professional obligations, coupled with additional evidence of Petitioner's dereliction of his duty to provide health care to Ms. McCarty, establishes Petitioner to be a manifestly untrustworthy provider of health care. The evidence establishing Petitioner to be untrustworthy is not rebutted by evidence offered by Petitioner that, subsequent to his treatment of Ms. McCarty, he completed continuing medical education courses in advanced cardiac life support and advanced trauma life support. Nor is it rebutted by evidence that, subsequent to his treatment of

Ms. McCarty, Petitioner has performed in a generally satisfactory manner as an emergency room physician. A lengthy exclusion is justified in this case to protect program beneficiaries and recipients from the possibility that Petitioner might fail to treat them properly.

1. The I.G. had authority to exclude Petitioner under section 1156(b)(1) of the Act.

The I.G. excluded Petitioner pursuant to section 1156(b)(1) of the Act. The I.G.'s authority to impose an exclusion under section 1156(b)(1) derives from a peer review organization's determination and recommendation to him that a party be excluded. To be resolved in any hearing conducted under section 1156(b)(1), is: (1) whether evidence adduced by the peer review organization and relied upon by it in making its recommendation supports its recommendation to the I.G that a party be excluded; and (2) whether the peer review organization's recommendation is in accord with one of the statutory grounds on which an exclusion recommendation may be based.

Section 1156(a) of the Act defines three professional obligations of parties who provide items or services to program beneficiaries and recipients. These are that health care will be: (1) provided economically and only when, and to the extent, medically necessary; (2) of a quality which meets professionally recognized standards of health care; and (3) supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities. Section 1156(b)(1) provides that a peer review organization may recommend that a party be excluded if it determines that the party has either failed in a substantial number of cases to comply substantially with any of these three obligations, or if that party has grossly and flagrantly violated any of these obligations in one or more instances.

In this case, the Arkansas PRO based its exclusion recommendation to the I.G. on a conclusion that Petitioner had, on multiple occasions, engaged in gross and flagrant violations of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care.[6] The

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[6] The term "gross and flagrant violation" is defined by regulation to mean a violation of an

(continued...)

I.G. accepted the Arkansas PRO's finding. The I.G. found also that Petitioner was both unable and unwilling to provide health care of a quality which meets professionally recognized standards of health care.[7]

Section 1156(b)(4) of the Act provides that a party who is subject to an exclusion determination pursuant to section 1156(b)(1) is entitled to an administrative hearing. This section expressly confers on excluded parties those rights to a hearing which inure to parties under section 205(b) of the Act. Section 205(b) provides for a de novo hearing. Bernardo G. Bilang, M.D., DAB 1295 (1992); Eric Kranz, M.D., DAB 1286 (1991). My obligation in conducting a de novo hearing under sections 205(b) and 1156(b)(1) on the issue of the I.G.'s authority to exclude a party is to allow each party to the hearing the opportunity to offer evidence concerning the sufficiency of the facts on which a peer review organization's recommendation and the I.G.'s ultimate determination are based. Inasmuch as the I.G.'s authority to exclude under section 1156(b)(1) derives from a determination and a recommendation made by a peer review organization, I must limit the evidence I receive on the issue of authority to exclude to evidence which establishes whether there exists a basis in fact for: (1) the peer review organization's determination and recommendation to the I.G.; and (2) the I.G.'s finding that the excluded party is unable or unwilling to meet his statutory obligation to provide care.

In allowing the I.G. to offer proof on the issue of whether he has authority to exclude a party under section

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[6](...continued)
obligation to provide health care under section 1156, which violation presents an imminent danger to the health, safety, or well-being of a Medicare beneficiary, or which places the beneficiary unnecessarily in a high-risk situation. 42 C.F.R. § 1004.1(b).

[7] Section 1156(b)(1) provides that, in making a final determination whether to exclude a party based on a recommendation by a peer review organization, the Secretary, or his delegate, the I.G., must decide whether the party has demonstrated either an inability or an unwillingness to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care.

1156(b)(1) deriving from a peer review organization's recommendation, I may not permit him to offer evidence as to facts which were not considered by the peer review organization in making its determination and recommendation, even if those facts might support the I.G.'s ultimate determination to exclude a party. Also, I must permit the excluded party the opportunity to challenge and to rebut the factual basis for the peer review organization's determination and recommendation. However, I may not allow an excluded party to offer evidence proving facts which exceed the scope of the peer review organization's review, determination, and recommendation.

As I shall discuss infra, at Part 2 of this Analysis, the de novo hearing requirements of section 205(b) permit a broader evidentiary presentation under section 1156(b)(1) on the issue of whether an exclusion of a particular length is reasonable, than on the issue of whether the I.G. has the authority to exclude a party. On the remedy issue, I may accept evidence from either party which relates to an excluded party's trustworthiness to provide care, even if that evidence exceeds the boundaries of that which was considered by the peer review organization in making its determination and recommendation to the I.G.

My decision on the issue of whether the I.G. had authority to exclude Petitioner is therefore based on evidence which relates to the Arkansas PRO's findings of gross and flagrant violations by Petitioner of his obligation to provide health care to Ms. McCarty of a quality which meets professionally recognized standards of health care. On this issue, I have not considered evidence offered by the I.G. concerning other instances in which Petitioner is alleged to have engaged in unprofessional conduct. Nor have I considered as relevant to this issue evidence offered by Petitioner concerning his practice of medicine subsequent to the episodes which form the basis of the Arkansas PRO's recommendations to the I.G. However, I have considered such evidence as relevant to the issue of whether the five-year exclusion imposed by the I.G. is reasonable. On this latter issue, I have also considered as relevant evidence relating to the Arkansas PRO's findings of gross and flagrant abuses by Petitioner of his obligation to provide health care.[8]

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[8] Petitioner moved that first I should conduct a hearing on the issue of whether the I.G. had authority to

(continued...)

a. The Arkansas PRO gave notice to Petitioner of its initial determination in accordance with the requirements of the Act and regulations.

Petitioner raises the threshold question of whether the Arkansas PRO properly advised him of its intent to recommend an exclusion to the I.G., arguably which would have provided him with the required opportunity to respond to the Arkansas PRO's then-proposed determination. Petitioner argues that the Arkansas PRO failed to meet its obligation to provide him with notice of the proposed determination and opportunity to respond to it, because he did not obtain any of the notices which the Arkansas PRO sent to him. Therefore, according to Petitioner, he was denied due process guaranteed by the Act, and the Arkansas PRO's recommendation to the I.G. was defective. He asserts from that conclusion that the I.G. lacks authority to exclude him under section 1156(b)(1).

Section 1156(b)(1) provides that, before reaching a determination under the Act, a peer review organization must provide a party who is the subject of the determination with reasonable notice and opportunity for discussion of the proposed determination. The peer review organization's statutory obligation is defined further by regulations to mean giving written notice to a party of any proposed determination. 42 C.F.R. §§ 1004.40, 1004.50. The regulations do not specify the manner in which the written notice must be given to a party.

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[8](...continued)
exclude him, and should decide that issue before accepting evidence on the issue of whether the exclusion imposed by the I.G. is reasonable. Petitioner contended that my assessment of whether the I.G. had authority to exclude him might be tainted by evidence which related to the reasonableness of the remedy, but which exceeded the ambit of that which was relevant to the authority to exclude issue. I ruled against Petitioner, and I reaffirm that ruling here. Tr. at 63 - 67. It is good judicial administration not to split these hearings into segments, especially where, as in this case, evidence may be relevant to more than one issue. Furthermore, as a matter of routine, I conduct hearings in which issues of authority to exclude and reasonableness of remedy may involve separate relevancy standards for admission of evidence as to those issues, and I am capable of assigning evidence to those issues to which it may be relevant without tainting my judgment as to other issues.

The narrow question which I must resolve here is whether the Arkansas PRO discharged its notice obligation to Petitioner under section 1156(b)(1) and 42 C.F.R. §§ 1004.40, 1004.50, by mailing written notices, return receipt requested, to Petitioner's residence in Scottsboro, Alabama. I conclude that the Arkansas PRO discharged its notice obligation to Petitioner. The Arkansas PRO performed its duty notwithstanding the fact that Petitioner elected not to claim the certified notices from the Scottsboro, Alabama post office.

The facts relevant to this threshold issue are as follows. By early 1990, Petitioner no longer resided in or practiced medicine in Bull Shoals, Arkansas. He had relocated to Scottsboro, Alabama, and was practicing medicine in a local hospital's emergency room. However, Petitioner knew that the Arkansas PRO was concerned about his treatment of Ms. McCarty because, prior to his leaving Arkansas, he had received several notices from the Arkansas PRO concerning his treatment of Ms. McCarty, and had responded to at least one of them. On March 22, 1989, the Arkansas PRO advised Petitioner that it had discerned quality of care problems in his treatment of Ms. McCarty during her hospitalization from November 21, 1988 through November 23, 1988. I.G. Ex. 27/104 - 105. Petitioner responded to that notice with a letter dated March 29, 1989. I.G. Ex. 27/102 - 103. On April 13, 1989, the Arkansas PRO advised Petitioner that it had confirmed a quality of care problem in his treatment of Ms. McCarty and advised him that, as a consequence, his treatment of patients would be more intensively reviewed. I.G. Ex. 27/99. Thus, Petitioner knew when he left Arkansas that the Arkansas PRO was concerned about his treatment of patients and that it had not ceased reviewing the records of his treatments.

Petitioner left Arkansas without advising the Arkansas PRO of his move, and without providing the Arkansas PRO with an Alabama mailing address. An employee of the Arkansas PRO, Catherine Bain, ascertained from the Alabama Medical Board the residential address in Scottsboro, Alabama, that was being used by that agency as a mailing address for notices which it sent to Petitioner. Tr. at 349 - 350. Ms. Bain contacted the administrator of the Scottsboro hospital to verify that Petitioner practiced there. Tr. at 297. She confirmed with the Scottsboro, Alabama postmaster that the residential address in Scottsboro which the Alabama Medical Board used to mail notices to Petitioner was a valid mailing address for Petitioner. Tr. at 297 - 305.

The Arkansas PRO then sent three separate notices to Petitioner's Scottsboro, Alabama residential address, advising him of its likely determination and providing him with an opportunity to respond. The Arkansas PRO sent these notices to Petitioner on January 23, 1990, March 15, 1990, and July 31, 1990. The Arkansas PRO sent each of these notices to Petitioner by certified mail.[9] The Scottsboro, Alabama post office gave Petitioner written notification that each of these notices was available for him to claim. Petitioner did not claim any of the notices. On January 7, 1991, the Arkansas PRO sent Petitioner a copy of the determination and exclusion recommendation which it was making to the I.G. As with the three notices, this document was sent to Petitioner's Scottsboro, Alabama residence by certified mail. Again, the local post office advised Petitioner that the document was available for Petitioner to claim, and Petitioner failed to claim it. I.G. Ex. 27/6 - 12.

Petitioner does not dispute that the address in Scottsboro to which the Arkansas PRO sent the notices is in fact the address of his Scottsboro residence. Indeed, the I.G. sent his exclusion notice to that address and Petitioner received it there. Petitioner does not deny that he received notification from the Scottsboro, Alabama post office that certified letters had been sent to him and that they were available to be claimed by him. Petitioner does not argue that the three notices failed to contain the information required by law to be provided concerning the Arkansas PRO's determination. Petitioner does not contend that he was precluded from claiming the Arkansas PRO's notices by some event which was beyond his ability to control. Nor does Petitioner argue that, but for his failure to receive the Arkansas PRO's notices, he would have supplied the Arkansas PRO with exculpatory or explanatory information which would have affected the Arkansas PRO's determination.

Petitioner is arguing in effect that the Arkansas PRO was obliged to assure that he actually received the notice. He analogizes the Arkansas PRO's duty as being equivalent to that of a party serving a summons and complaint under the Federal Rules of Civil Procedure, noting that under those rules, a party must assure personal service of a summons and complaint if service is not effectuated by mail. See F.R.C.P. Rule 4.

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[9] The March 15, 1990 and July 31, 1990 notices were essentially copies of the notice which the Arkansas PRO sent to Petitioner on January 23, 1990, and which Petitioner failed to claim.

I disagree with Petitioner's analysis. The obligation of a peer review organization under section 1156(b)(1) of the Act and 42 C.F.R. §§ 1004.40, 1004.50 to provide a party with reasonable notice of its actions is not a service of process obligation. The language of both the Act and the regulations closely parallels the notice requirements of Rule 5 of the Federal Rules of Civil Procedure, a rule which pertains to notices between parties after process has been obtained in a civil action. See F.R.C.P. Rule 5(b). Under that rule, a party to a civil action discharges his or her duty to provide an adversary with "reasonable notice" of a pleading or other filing by mailing notice of that filing to the adverse party. The duty to provide notice under Rule 5(b) is discharged upon placing written notice in the mail to a party's last known address. Under Rule 5(b), sending a notice to a party by registered mail discharges the party's notice obligation, even if the addressee fails to claim the notice. Bourne, Inc. v. Romero, 23 F.R.D. 292, 296 (E.D. La. 1959).

Congress could have required peer review organizations to personally serve affected parties with notices of proposed actions. Petitioner's argument might be more persuasive had Congress opted to do so. However, Congress elected to impose on peer review organizations the less stringent duty to provide "reasonable notice" to affected parties. That congressional intent, which is evident from both the plain language of the Act and regulations, and from analogous language in the Federal Rules of Civil Procedure, defines the notice obligations of peer review organizations to affected parties.

There is a logical reason for Congress to have imposed a duty on peer review organizations of providing "reasonable notice" to affected parties rather than requiring them to serve affected parties in a manner consistent with the summons and complaint service requirements of the Federal Rules of Civil Procedure. The paramount purpose of section 1156 is to protect program beneficiaries and recipients from practitioners who have demonstrated a potential for engaging in harmful conduct. The rights of affected practitioners to be apprised of possible actions by peer review organizations have not been ignored by Congress. But, in setting the balance between protecting the welfare of beneficiaries and recipients and protecting the interests of affected practitioners, Congress opted to establish a notice standard which would be relatively easy for peer review organizations to comply with. Had Congress opted to impose a "service of process" obligation on peer review organizations, then some practitioners would be able to

evade service (and an exclusion), even as some parties to federal civil litigation may be able to evade service of process under the Federal Rules of Civil Procedure. In essence, that is what Petitioner is contending he should be able to do here. That result might benefit the clever or lucky practitioner, but potentially it would place in jeopardy the welfare of program beneficiaries and recipients.

Furthermore, the record in this case shows that the Arkansas PRO went beyond the requirements of the Act and regulations in sending notices to Petitioner. There is nothing in the Act or in the regulations which imposes on peer review organizations the duty to hunt for practitioners who move to other jurisdictions without leaving forwarding addresses. In this case, the Arkansas PRO went the extra mile of ascertaining Petitioner's Alabama residential address before sending notices to him at that address. That it did so is commendable, but it was not legally obligated to do so.[10] Nor does the Act or regulations impose a duty on peer review organizations to send more than one copy of a notice to a party's valid mailing address. Yet, in an effort to assure that Petitioner was notified of its potential actions in his case, the Arkansas PRO mailed notices to him concerning those potential actions by certified mail on three occasions.

Petitioner also contends that he was deprived of the opportunity to enter into a corrective action plan with the Arkansas PRO by virtue of his failure to obtain the notices which the Arkansas PRO sent to him. The Act provides that, in appropriate cases, a peer review organization should give a party the opportunity to enter into a corrective action plan (which may include remedial education), before recommending a sanction action to the I.G. The Act does not impose on peer review organizations any duty to assure that a party actually participate in or complete such a plan. The notices which the Arkansas PRO sent to Petitioner gave him the opportunity to discuss entering into a corrective action plan with the Arkansas PRO. Petitioner did not avail himself of that opportunity. However, to the extent that the Arkansas PRO had any duty to provide Petitioner with

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[10] Petitioner argues that Ms. Bain should have spoken directly with Petitioner at the Scottsboro, Alabama hospital to advise him that the Arkansas PRO was sending notices to him. Neither the Act nor the regulations impose this duty on a peer review organization.

the opportunity to enter into a corrective action plan, it discharged that duty by sending him the notices which informed him of his opportunity to discuss a corrective action plan with representatives of the Arkansas PRO.

b. Petitioner committed gross and flagrant violations of his obligation to provide health care of a quality which meets professionally recognized standards of health care.

The I.G. determined that, during two hospitalizations of Ms. McCarty, from November 21, 1988 through November 23, 1988, and from December 3, 1988 through December 9, 1988, Petitioner committed gross and flagrant violations of his obligation to provide health care of a quality which meets professionally recognized standards of health care. I.G. Ex. 15/3 - 4. The I.G. made his determination based on the Arkansas PRO's recommendation to him. The evidence in this case substantiates the I.G.'s determination with respect to nine instances of gross and flagrant violation by Petitioner of his obligation to provide health care. Findings 26 - 97.

The I.G.'s May 7, 1991 notice letter to Petitioner specified 11 instances of gross and flagrant violation by Petitioner of his obligation to provide health care to Ms. McCarty of a level which meets professionally recognized standards of health care. These are enumerated at pages 3 and 4 of the notice letter. I.G. Ex. 15/3 - 4. I conclude that the I.G. substantiated his determinations of gross and flagrant violations with respect to enumerated instances 1 and 3 - 10. Part III of my Findings addresses these enumerated instances in the following sequence: 7 (subheading A, Findings 27 - 36); 4 (subheading B, Findings 37 - 41); 3 (subheading C, Findings 42 - 47); 8 (subheading D, Findings 48 - 59); 10 (subheading E, Findings 60 - 66); 5 (subheading F, Findings 67 - 72); 6 (subheading G, Findings 73 - 81); 9 (subheading H, Findings 82 -85); and 1 (subheading I, Findings 86 - 97). I have organized my Findings in this manner because they follow the progression of Ms. McCarty's treatment during the two hospitalizations at issue.

The Act does not define the term "gross and flagrant violation." The term is defined by regulation to mean a violation of an obligation to provide health care which "presents an imminent danger to the health, safety, or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations." 42 C.F.R. § 1004.1(b).

In order to prove that a party has committed a gross and flagrant violation of an obligation to provide health care to a program beneficiary or recipient, the I.G. must prove the following. First, he must show that the party charged with the violation had an obligation to provide health care to a program beneficiary or recipient. Second, he must prove that there exists a professionally recognized standard of health care which the party violated in discharging his obligation to provide health care to the program beneficiary or recipient. Finally, he must prove that, in violating the professionally recognized standard of health care, the party presented an imminent danger to the health, safety, or well-being of the program beneficiary or recipient, or placed the program beneficiary or recipient unnecessarily in a high-risk situation.

There is no dispute that Ms. McCarty was a Medicare beneficiary. Nor is there any dispute that, by serving as Ms. McCarty's attending physician during her hospitalizations, Petitioner assumed an obligation to provide health care to her. That obligation included attending to Ms. McCarty's welfare, providing routine and ongoing care to her, and doing the necessary paperwork associated with her hospitalizations. Finding 17.

Nor is there any dispute that Petitioner's discharge of his obligation to provide health care to Ms. McCarty as her attending physician involved professionally recognized standards of health care. For example, Petitioner's obligation to do the necessary paperwork associated with Ms. McCarty's hospitalizations involved professionally recognized standards of health care. Petitioner was obligated to document Ms. McCarty's stay in sufficient detail so that other health care providers could comprehend his assessment of Ms. McCarty's condition, his treatment and medication orders, and his daily description of her progress while she was hospitalized. Findings 87, 88.

There is overwhelming evidence that, during the course of Ms. McCarty's November 21 through November 23, 1988 and December 3 through December 9, 1988 hospitalizations, Petitioner committed numerous violations of professionally recognized standards of health care in his treatment of Ms. McCarty. The evidence is also overwhelming that these violations by Petitioner of his treatment obligations to Ms. McCarty presented an imminent danger to her health, safety, or well-being, or

placed her unnecessarily in high-risk situations.[11] The I.G. offered the testimony and written statements of two board-certified physicians, along with the records of the two hospitalizations at issue, as evidence that Petitioner had committed violations of professionally recognized standards of health care in his treatment of Ms. McCarty, and that these violations constituted gross and flagrant violations of professionally recognized standards of health care. These two physicians are James David Busby, M.D., who is a diplomate of the American Board of Family Practice and the American Board of Quality Assurance and Utilization, and Joe V. Jones, M.D., who is certified by the American Board of Internal Medicine and the American Board of Quality Assurance and Utilization. Dr. Jones is also a diplomate in geriatrics. I.G. Ex. 18/1, 23/1, 38, 39; Tr. at 369 - 515, 519 - 610. I find both of these experts to be knowledgeable and their opinions to be credible. Their testimony was essentially unrebutted by Petitioner. Petitioner offered no expert testimony on the issue of whether he had been derelict in his treatment of Ms. McCarty, nor did Petitioner testify as to that issue.

Petitioner's violations of his obligation to provide health care which meets professionally recognized standards of health care included failure to perform routine tests and monitoring dictated by Ms. McCarty's medical condition, failure to perform requisite follow-up to procedures which he performed on Ms. McCarty while Ms. McCarty was hospitalized, and failure to maintain records of Ms. McCarty's stays in the hospital. For example, Petitioner's violations of his obligation to Ms. McCarty included failure to perform an EKG during Ms. McCarty's November 21, 1988 through November 23, 1988 hospitalization, despite the fact that Ms. McCarty had been hospitalized for severe shortness of breath and associated congestive heart failure. Findings 30 - 34. These violations by Petitioner also included failure to perform other routine testing and monitoring of Ms. McCarty's condition, such as monitoring her electrolyte levels, and performing ABG studies in order to determine the level of oxygen in her blood. They included failures

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[11] Although I have found nine instances in which Petitioner committed gross and flagrant violations of his obligation to provide health care in a manner which meets professionally recognized standards of health care, the Act requires that there be proof of only one such dereliction of duty to provide the I.G. with authority to impose and direct an exclusion against a party. Social Security Act, section 1156(b)(1).

to order chest x-rays. They also included failure to monitor medication levels in Ms. McCarty. And these violations also included a near-complete failure by Petitioner to document his assessment of Ms. McCarty's condition, her treatment, and her progress while in the hospital. Findings 86 - 97.

The uncontroverted evidence in this case establishes that Petitioner's violations of his obligation to provide health care presented an imminent danger to Ms. McCarty's health, safety, or well-being, or placed her unnecessarily in high-risk situations. Therefore, they are gross and flagrant violations within the meaning of the regulations and the Act. The dangers posed to Ms. McCarty by Petitioner's abdication of his responsibility to care for her included the risks that her medical condition would deteriorate and that complications resulting from the treatments Petitioner ordered or the medications Petitioner administered would go undetected. For example, one of Petitioner's derelictions of duty to Ms. McCarty consisted of failing to take a chest x-ray after performing a subclavian phlebotomy on her. Findings 73 - 81. The procedure performed by Petitioner involved withdrawing blood from Ms. McCarty by inserting a needle into a vein in Ms. McCarty's chest. The I.G.'s experts testified that there was a significant risk that this procedure could have resulted in a puncture of one of Ms. McCarty's lungs, which in turn would have gravely jeopardized her health, safety, or well-being. The accepted medical practice to be followed after having performed an invasive procedure of this nature would have been to monitor Ms. McCarty's condition with follow-up chest x-rays. Petitioner's failure to monitor Ms. McCarty's condition with chest x-rays meant that she could have developed serious undetected medical complications.

Another example of how Petitioner's dereliction of his obligation to provide health care to Ms. McCarty presented an imminent danger to her health, safety, or well-being, or placed her unnecessarily in a high risk situation, exists in Petitioner's failure to monitor her BUN and creatinine output during her hospitalization from November 21, 1988 through November 23, 1988. Findings 60 - 66. BUN (blood urea nitrogen) and creatinine output are indicators of kidney function. It is important to monitor kidney function in a patient who has cardiac problems, such as Ms. McCarty had, and who is receiving the medication digoxin, because such patients are at risk of experiencing toxic side effects from Digoxin, including cardiac problems, if their kidney function deteriorates. Petitioner's failure to monitor Ms.

McCarty's BUN or creatinine output meant that she could have developed serious undetected cardiac problems resulting from the toxic side effects of Digoxin.

Petitioner makes two arguments to rebut the evidence that he committed gross and flagrant violations of his obligation to provide health care. First, Petitioner contends that the opinions of the I.G.'s two experts are flawed because they confined their reviews to, and formed their opinions on, the medical records of Ms. McCarty's November 21 through November 23, 1988, and December 3, through December 9, 1988 hospitalizations. Petitioner argues that these experts should have considered other evidence pertaining to Ms. McCarty, including records generated in connection with her application for Social Security disability benefits and records of Petitioner's treatment of Ms. McCarty as an outpatient. Second, Petitioner contends that the hospital records which formed the basis for the I.G.'s experts' opinions are deficient in that they are missing vital documents, including progress notes which Petitioner prepared.

I find these two arguments to be without merit. Regarding Petitioner's first argument, while it is true that the experts did not review documents relating to Ms. McCarty's illness other than the records of Ms. McCarty's hospitalizations, other evidence concerning Ms. McCarty's condition would not have changed their opinions about Petitioner's dereliction of his duty to provide care. Tr. at 502, 548 - 549, 552 - 554, 560 - 561, 564. Moreover, Petitioner has not shown that medical evidence other than that reviewed by the experts ought to have changed their opinions of Petitioner's treatment of Ms. McCarty. For example, there is nothing of record in this case which would excuse Petitioner's failure to order routine chest x-rays, EKGs, or other tests during Ms. McCarty's hospitalizations. His failure to order these tests is certainly not excused by the fact that Ms. McCarty's medical problems predated her hospitalizations in November and December 1988.

At several junctures in his cross examination of Drs. Busby and Jones, counsel for Petitioner suggested the possibility that Ms. McCarty might have refused appropriate medical treatment or tests, or might have had herself discharged from the hospital against medical advice. See, e.g., Tr. at 499 - 500. Had Petitioner prescribed proper treatment to Ms. McCarty and had Ms. McCarty refused that treatment, those facts certainly would serve as a defense to allegations that Petitioner had violated his obligation to provide health care to Ms. McCarty, for those specific treatments which Petitioner

prescribed and which Ms. McCarty refused. There is no such evidence in the record of this case pertaining to the specific violations at issue. Petitioner makes general statements in some of the hospital discharge summaries and histories and physicals that are in evidence that Ms. McCarty was not a compliant patient. He specifically alludes in those records to Ms. McCarty's noncompliance with medical advice while an outpatient. But there is no evidence that, while Ms. McCarty was hospitalized, Petitioner ordered treatment and Ms. McCarty refused it.

I do not find credible Petitioner's assertion that missing from the records of Ms. McCarty's hospitalizations are documents which might change the picture of Petitioner's treatment of Ms. McCarty. Finding 94. Petitioner testified that he wrote progress notes on a form which was specifically designed for that purpose (according to Petitioner, on blue paper). He averred that these progress notes were deleted from all of the records of Ms. McCarty's hospitalization which were obtained by the Arkansas PRO. See Tr. at 637 - 639. Although it is not beyond the bounds of reasonable probability that some of these notes (if, in fact, Petitioner had created them) might be missing from Ms. McCarty's hospital records, I find it far-fetched that they would be excluded uniformly from all of her records. The more reasonable inference that I draw from their uniform absence is that they were never created to begin with.

My conclusion that Petitioner's contention that his progress notes were deleted from Ms. McCarty's hospital records is not credible is supported by the fact that there exist forms in each of Ms. McCarty's hospital records which are captioned "Physician's Order Sheet and Progress Notes," and on which Petitioner made some, albeit sketchy, entries. See, e.g., I.G. Ex. 10/24 - 28. I find it to be illogical, and therefore not likely, that the Bull Shoals Hospital would utilize two forms for recording progress notes in its cases, as Petitioner has contended. Also, I find it to be illogical, and therefore not likely, that Petitioner would record progress notes in a given case on both forms. Petitioner has offered no meaningful explanation as to why he would do that.

Furthermore, Petitioner's contention that there are missing documents is not corroborated by any documents which are in evidence and which might be expected to provide corroboration for Petitioner's contention. Had Petitioner ordered that a procedure be performed, that a

test be done, or that a medication be administered, and these orders were deleted from the records, one reasonably might expect that his orders would be documented elsewhere in the hospital record. For example, had Petitioner ordered that EKGs be performed on Ms. McCarty, and had his orders been deleted from the hospital record, the record should nevertheless contain EKG tracings, interpretations, and other documents discussing or at least mentioning the EKGs. Petitioner has not identified any situation where he allegedly ordered treatment, where the record of his orders was deleted, but where his orders were corroborated elsewhere in Ms. McCarty's hospital record.

Finally, Petitioner has not contended that the allegedly missing documents would prove that Petitioner provided health care to Ms. McCarty which meets professionally recognized standards of health care. His argument is merely that some records are missing.

c. Petitioner is unable or unwilling to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care.

The I.G. determined that Petitioner was both unable and unwilling to comply substantially with his obligation to provide health care of a quality which meets professionally recognized standards of health care. The I.G.'s determination was made in accordance with the Act, which requires as a prerequisite to the imposition of an exclusion against a party that the Secretary determine whether that party is able or willing to comply substantially with his obligation to provide health care as specified by the Act. Social Security Act, section 1156(b)(1).

There is ample evidence in this case to support the I.G.'s determination. First, the evidence demonstrates strongly that Petitioner substantially is unable to provide health care of a quality which meets professionally recognized standards of health care. Findings 207, 208. Petitioner's conduct during Ms. McCarty's hospitalizations from November 21 through November 23, 1988 and December 3 through December 9, 1988 demonstrates such fundamental flaws in his practice as to establish that Petitioner is incapable of providing care consistent with that which is required by the Act. Dr. Busby testified that Petitioner's acts and omissions during these hospitalizations showed that Petitioner lacks a basic understanding of the pathophysiology of cardiovascular disease, respiratory disease, and

polycythemia. Tr. at 423. Dr. Jones concurred in Dr. Busby's assessment of Petitioner's inadequacies. He concluded that Petitioner's treatment of Ms. McCarty demonstrates that Petitioner totally lacks a basic understanding of proper medical care of patients. Tr. at 538 - 539. These expert's opinions were supported and made credible by their citation to the medical records in evidence. Significantly, Petitioner neither denied nor rebutted the opinions.

Second, there is evidence here to support the I.G.'s determination that Petitioner is unwilling to provide health care of a quality which meets professionally recognized standards of health care.[12] In his May 7, 1991 notice letter to Petitioner, the I.G. inferred that Petitioner was unwilling to provide such care from Petitioner's lack of response to the several notices of proposed determination which the Arkansas PRO had sent to him. See I.G. Ex. 15/4 - 5. I do not agree with the I.G.'s analysis. There is no evidence to prove that Petitioner was aware that the certified letters which the Arkansas PRO sent to him in Scottsboro, Alabama, and which he failed to claim, were letters to him from the Arkansas PRO concerning his treatment of Ms. McCarty. For that reason, I cannot infer from Petitioner's failure to claim these letters that he was unwilling to comply with his obligation to provide health care.

On the other hand, unwillingness to comply can be inferred directly from the quality of health care Petitioner provided to Ms. McCarty during the November 21, 1988 through November 23, 1988 and the December 3, 1988 through December 9, 1988 hospitalizations. I am satisfied, from Drs. Busby's and Jones' testimony as to the poor quality of that health care, that Petitioner was either incompetent to provide health care, or, worse, that he was indifferent to the needs of his patient. If the former is true, then it supports the I.G.'s determination and my finding that Petitioner was unable

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[12] The Act does not require that the I.G. determine that a party is both unable and unwilling to provide health care of a quality which meets professionally recognized standards of health care, as a prerequisite to excluding that party. The Act's criteria for exclusion will be met if the I.G. determines either that a party is unable to provide health care of a quality which meets professionally recognized standards of health care, or that a party is unwilling to provide such health care. Social Security Act, section 1156(b)(1).

to provide health care of an acceptable quality level. If the latter is true, then it supports the conclusion that Petitioner is capable of ignoring the needs of his patients, and is, therefore, unwilling to provide health care of an acceptable level of quality. Finding 209.

The Act requires that, in deciding whether to exclude a party, the Secretary shall consider a party's willingness or lack of ability to enter into and successfully complete a corrective action plan during the period prior to the date when a peer review organization submits its recommendation to the I.G. Social Security Act, section 1156(b)(1).[13] This obligation has been satisfied in this case. The May 7, 1991 notice letter which the I.G. sent to Petitioner found Petitioner specifically unable to comply with his obligation to provide health care. I.G. Ex. 15/2. That finding naturally incorporates a conclusion that Petitioner's participation in a corrective action plan would have been to no avail.

2. The five-year exclusion which the I.G. imposed and directed against Petitioner is reasonable.

The final issue which I must resolve is whether the remedy which the I.G. imposed and directed against Petitioner -- a five-year exclusion from participating in federally-funded health care programs -- is reasonable. That question is not automatically answered by my conclusion that the I.G. had authority to exclude Petitioner under section 1156(b)(1), because the Act does not direct that an exclusion of any particular duration is per se reasonable in a given case.

Section 1156 is a remedial statute. As with other sections of the Act which authorize the imposition of an exclusion as a remedy, the purpose of an exclusion under section 1156 is not to punish a party for past wrongful conduct, but to provide a remedy against possible wrongful conduct by that party in the future. See Narinder Saini, M.D., DAB 1371, at 6 (1992) (Saini);

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[13] The Act does not require the Secretary to offer a party the opportunity to participate in a corrective action plan, nor does it suggest that the Secretary must, in effect, put a party "on probation" before excluding that party. The Act only requires the Secretary to consider a party's "willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan." Social Security Act, section 1156(b)(1).

Behrooz Bassim, M.D., DAB 1333, at 9 - 10 (1992). Evidence of past wrongful conduct by a party may serve as an important predictor of that party's propensity to engage in wrongful conduct in the future. For that reason, evidence about Petitioner's gross and flagrant violations of his obligation to provide health care to Ms. McCarty is highly relevant to the question of whether the exclusion imposed by the I.G. is reasonable. However, I may not limit legitimately the evidence which I receive on the remedy issue to that which was considered by the Arkansas PRO in making its determination that Petitioner had committed gross and flagrant violations. Nor may I limit the evidence to that which was considered by the I.G. in deciding to accept the Arkansas PRO's recommendation. Because section 1156 is remedial, and because of the de novo nature of the hearing which I conduct in a section 1156 case, I must consider evidence offered at the hearing either by the I.G. or by Petitioner concerning his propensity or lack of propensity to engage in wrongful conduct in the future. For that reason, I received evidence from the I.G. concerning derelictions of professional responsibility by Petitioner in his treatment of Ms. McCarty in instances other than those which formed the basis for the Arkansas PRO's recommendation.[14] For that reason, I received also evidence from Petitioner concerning continuing medical education courses which he had completed since 1988 and concerning his current practice as an emergency room physician in Alabama.

I am convinced from the weight of the evidence that the five-year exclusion which the I.G. imposed against

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[14] That evidence includes evidence relating to three hospitalizations of Ms. McCarty under Petitioner's care other than the two hospitalizations which are the basis for the Arkansas PRO's gross and flagrant violations determinations. Those hospitalizations were from May 9, 1988 through May 13, 1988 (I.G. Ex. 1), September 19, 1988 through September 21, 1988 (I.G. Ex. 3), and November 2, 1988 through November 5, 1988 (I.G. Ex. 5). I have considered also evidence concerning derelictions of duty by Petitioner which occurred during the November 21, 1988 through November 23, 1988, and December 3, 1988 through December 9, 1988 hospitalizations, which were not explicitly determined by the Arkansas PRO to constitute gross and flagrant violations of Petitioner's professional obligation. Findings 98 - 193 detail my findings as to these additional derelictions of duty by Petitioner.

Petitioner is a reasonable remedy. Petitioner's treatment of Ms. McCarty during her several hospitalizations in 1988 demonstrates a stunning degree of incompetence. I am persuaded by this evidence of incompetence, and by the opinions of Drs. Busby and Jones, that Petitioner is not capable of providing health care which comes close to meeting professionally recognized standards of health care. Findings 215 - 216. Petitioner is an untrustworthy provider of care. Finding 217. This exclusion is needed here to protect program beneficiaries and recipients from the possibility that Petitioner might render them the same kind of substandard care that he provided Ms. McCarty. My conclusion that Petitioner is untrustworthy and that the exclusion is justified is not shaken by the evidence which Petitioner offered to show that he has completed some continuing medical education courses or that he is now providing competent care in a limited setting.

The record of Ms. McCarty's 1988 hospitalizations is replete with instances in which Petitioner failed to provide her with even the most basic and elementary care which should have been provided to a person in Ms. McCarty's state. There exist numerous instances of failures by Petitioner to order requisite tests or to provide routine monitoring of Ms. McCarty's status. Findings 26 - 193. Petitioner's documentation of his treatments of Ms. McCarty and Ms. McCarty's progress as his patient was slipshod at best.

Furthermore, there is evidence that some of this documentation may have been generated after the fact and is not what Petitioner purported it to be. The record of Ms. McCarty's hospitalization from May 9, 1988 through May 13, 1988, contains an "Admission Note" which Petitioner purportedly dictated and had typed on May 9, the date of Ms. McCarty's admission to the hospital. I.G. Ex. 1/5. The "Admission Note" includes a report of a physical examination of Ms. McCarty which Petitioner purportedly performed on May 9. Id. However, the record of this hospitalization establishes that Ms. McCarty was admitted to the hospital on May 9, 1988 at 11:35 pm. I.G. Ex. 1/1. I find it to be highly unlikely that Petitioner examined Ms. McCarty between 11:35 pm and midnight on May 9, 1988, and dictated and had typed an admission note containing his findings on the same date. Moreover, the record of this hospitalization reflects no face-to-face contact between Petitioner and Ms. McCarty on May 9, 1988, and none until May 11, 1988. See I.G. Ex. 1/19. The inference which I draw from these inconsistencies in Ms. McCarty's May 9, 1988 through May 13, 1988 hospital record is that Petitioner did not, in

fact, examine Ms. McCarty on May 9, 1988, as his "Admission Note" states.

Petitioner's derelictions of duty to Ms. McCarty include instances where he ignored medical evidence that a responsible physician would have interpreted as suggestive of a potentially life-threatening condition. Findings 176 - 183. For example, Petitioner permitted Ms. McCarty to be discharged from the hospital on November 23, 1988. On that date, Ms. McCarty complained of chest pain and extreme shortness of breath, exacerbated by exertion (an attempted bowel movement). I.G. Ex. 6/20. She was observed to be apprehensive. Id. These signs and symptoms indicate a possible myocardial infarction or angina, which are serious and potentially life-threatening conditions. Yet, Petitioner approved Ms. McCarty's discharge from the hospital on November 23, 1988, without ordering an EKG or other tests which might have confirmed or refuted the possibility that Ms. McCarty had experienced a myocardial infarction or angina. Findings 176 - 183.

Petitioner's derelictions of duty to Ms. McCarty also include an instance where he administered medication to her which was of dubious or no medical benefit to her and which may have harmed her. Petitioner ordered that Ms. McCarty be administered the drug Heparin in conjunction with a phlebotomy (withdrawal of blood) which he attempted to perform on December 5, 1988. Findings 184 - 193. There existed no medical justification to administer Heparin to Ms. McCarty on that date. Finding 192. Furthermore, the dose administered to Ms. McCarty was subtherapeutic, and it was not properly administered to her. Findings 188 - 191. Administering Heparin to Ms. McCarty on this date thus had no medical benefit. Ms. McCarty could have been harmed by the drug because the quantity and manner in which it was administered could have induced bruising or other adverse side effects. Id.

Petitioner opted not to attempt to refute directly any of this evidence of his ineptitude. He chose not to testify in his own defense. He offered no evidence concerning his treatment of Ms. McCarty which changed the picture painted by the evidence offered by the I.G. He did not offer expert testimony to refute the opinions of the physicians who were called as experts by the I.G. I infer from Petitioner's failure to oppose directly the evidence which the I.G. offered as to his performance that he cannot refute that evidence credibly.

Petitioner's essential defense to the evidence of incompetence and lack of trustworthiness which the I.G. offered is to argue that, whatever his past level of performance, he is presently performing competently as a physician. Therefore, according to Petitioner, it would serve no legitimate remedial purpose to now exclude him. Petitioner offered evidence that, since 1988, he has completed two courses of continuing medical education. These are courses in advanced cardiac life support and advanced trauma life support. See Finding 218. Also, Petitioner offered evidence to prove that his present medical practice is limited to managing and staffing a hospital emergency room in Alabama. This practice is in accord with restrictions which have been placed on his license to practice medicine in Alabama. Findings 8 - 10. Petitioner offered the testimony of two physicians who are professional colleagues of Petitioner in Alabama, Boyde Jerome Harrison, M.D., and Johnny Elliott, M.D. These two physicians testified that Petitioner presently is performing competently in his capacity as an emergency room physician. Tr. at 673 - 694, 706 - 717.

I do not dispute the veracity of the evidence offered by Petitioner as to his current medical practice. However, this evidence does not detract from my conclusion that he is not a trustworthy provider of care. As Drs. Busby and Jones observed, the two continuing medical education courses completed by Petitioner do not address the fundamental deficiencies in Petitioner's practice of medicine established by his treatment of Ms. McCarty. Finding 218. Nor does Petitioner's generally satisfactory performance as an emergency room physician in Alabama prove to me that he is now competent to provide care generally. As Petitioner himself has admitted, the emergency room practice which he presently engages in is a limited practice. There is no evidence that this practice involves the kind of care which was involved in Petitioner's attendance on Ms. McCarty. The physicians who testified on Petitioner's behalf did not aver that, by virtue of Petitioner's satisfactory performance in the emergency room, Petitioner is now competent to deal with the general range of a physician's duties. Therefore, Petitioner's performance as an emergency room physician does not suggest that I should generalize from that performance to conclude that he is now a competent physician in other areas of practice.

Furthermore, there is a disturbing but certainly legitimate inference which I draw from contrasting Petitioner's assertions concerning his current medical practice with his failure to offer an explanation for his treatment of Ms. McCarty and to explain how his

performance could have improved in the period between 1988 and the present. A reasonable explanation for the otherwise inexplicable contrast, between what the evidence shows Petitioner's performance as a physician to have been and what Petitioner claims it is now, is that Petitioner's treatment of Ms. McCarty resulted from his indifference to her condition rather than incompetence. Such an explanation would be consistent with Petitioner's contention that he is now a competent physician and his failure to explain either his treatment of Ms. McCarty or how his performance could have improved in the subsequent period. Such an explanation is consistent also with the discharge summaries and histories that Petitioner signed in connection with Ms. McCarty's hospitalizations. These documents, individually and collectively, evidence that Petitioner concluded that meaningful intervention on Ms. McCarty's behalf was a lost cause. I.G. Ex. 5/1 - 2, 6/2 - 4, 10/2 - 4.

Whether Petitioner's treatment of Ms. McCarty constituted incompetence or malfeasance, it demonstrated such an appalling lack of professional skill as to establish Petitioner to be a manifestly untrustworthy provider. That evidence is not overcome by evidence which shows that Petitioner may now be practicing in a competent manner in a limited setting. A lengthy exclusion is justified in this case to protect the welfare of beneficiaries and recipients of federally-funded health care programs. I conclude, therefore, that the five-year exclusion is reasonable.

Petitioner has not requested that I modify the exclusion to permit him to claim reimbursement for beneficiaries and recipients whom he treats in an emergency room setting. However, had he done so, I would have concluded that I lacked the authority to modify the exclusion in that manner. The Secretary (and his delegates, administrative law judges) do not have authority to tailor an exclusion to permit an excluded party to claim reimbursement for particularized items or services. Saini at 9; Walter J. Mikolinski, Jr., DAB 1156 (1990).

CONCLUSION

I conclude that the I.G. had authority to impose and direct an exclusion against Petitioner pursuant to section 1156(b)(1) of the Act, based on the recommendation of the Arkansas PRO. The five-year exclusion imposed and directed against Petitioner by the I.G. is reasonable.

/s/

Steven T. Kessel
Administrative Law Judge