

State of Connecticut
Board of Examiners In Podiatry

In the Matter of:
Gary Fleischman, D.P.M.
Petition No. 880726-19-008

Memorandum Of Decision

The Department of Health Services presented the Connecticut Board of Examiners in Podiatry with a Statement of Charges, dated August 11, 1989, brought against Gary Fleischman, D.P.M., the Respondent. The Statement of Charges alleged violations of Conn. Gen. Stat. §§ 20-45 and 20-59.

A Notice of Hearing, dated September 13, 1989, was issued to the Respondent by the Board. The Department's Statement of Charges was attached to the Notice. On the initial hearing date, November 15, 1989, Gary Fleischman appeared before the Board and requested a continuance of the proceeding in order to obtain new legal counsel. The Board granted a continuance of the hearing until December 13, 1989 and advised the Respondent that he should be prepared to go forward on that date.

The hearing was held as scheduled on December 13, 1989. Neither the Respondent nor any representative of the Respondent appeared on that date. The Board, through its counsel, contacted the office of the Respondent on the date of the hearing and was advised that the Respondent was at a podiatry convention in Phoenix, Arizona.

All members of the Board involved in this decision attest that they were present throughout the course of the hearing. This decision is based entirely on the record presented and on the specialized professional knowledge and expertise of the Board in evaluating the evidence.

Findings of Fact

1. At all times pertinent to the Statement of Charges, Gary Fleischman was licensed to practice podiatry by the State of Connecticut Department of Health Services. Exhibit M.

2. Pursuant to Conn. Gen. Stat. § 4-182(c), Respondent was given an opportunity prior to the institution of agency action to show compliance with all the terms for retention of his license. Exhibit B.

3. The Respondent never filed an answer to the Statement of Charges.

4. On October 9, 1987, Gary Fleischman operated on the right foot of a patient named Joan Spoerndle to remove a bunion (bunionectomy) and reconstruct a joint in the great toe (arthroplasty). Exhibit J; Transcript of December 13, 1989 (hereinafter, "Tr.") pp. 21, 60.

5. During the course of the surgery performed by the Respondent on Joan Spoerndle, a surgical burr broke off inside the foot of the patient. Tr. pp. 25-26, Exhibit H. At the request of the patient, the Respondent thereafter surgically

removed the burr. Tr., pp. 25-26. Neither the breakage nor the removal of the burr was recorded in the Respondent's operative reports. Exhibit J.

6. The Respondent did not take an x-ray of Ms. Spoerndle's foot after he had removed the burr from her foot. Tr., pp. 38-39.

7. The Respondent's operative reports concerning Ms. Spoerndle's October 9, 1987 surgery consisted of pre-printed forms on which only the name of the patient, the date, and the designation of the foot operated on were filled in. Exhibit J. Both operative reports incorrectly indicate that the patient's left foot was operated on. Exhibit J.

8. The surgery performed by the Respondent on Ms. Spoerndle on October 9, 1987 resulted in destruction and interarticular damage to the patient's right first metatarsophalangeal joint. The surgery resulted in multiple fractures of the tibial sesamoid bone. Tr., pp. 59-69; Exhibits Q, R. The patient's tibial sesamoid bone should not have been involved in the procedures performed by the Respondent on Ms. Spoerndle on October 9, 1987. Tr., pp. 67-68, 74-75.

9. The Respondent did not wear a cap or mask while performing surgery on the patient Joan Spoerndle. Tr., p. 29.

10. The Respondent prepared Ms. Spoerndle's right foot for surgery by rubbing the foot for approximately twenty seconds with a cotton ball that had been saturated with some type of liquid. Tr., pp. 26-27.

11. After Ms. Spoerndle's foot had been prepared for surgery, she began to feel nauseous and was served food in the Respondent's operating room. Tr., pp. 24-25. After the patient had been served food in the operating room, no further scrubbing or washing of the operating room or of the patient's foot was done prior to the performance of surgery. Tr., pp. 27-28.

12. From the time of her surgery on October 9, 1987 until December, 1987, Ms. Spoerndle was examined by the Respondent on a weekly basis. Tr., p. 42. During this entire period, Ms. Spoerndle had an open, draining, warm wound and felt sharp pains in her foot. Tr., pp. 39-49.

13. During the course of Ms. Spoerndle's post-operative visits to the Respondent, he did not take a culture or x-ray of her right foot. Tr., pp. 47, 53. The Respondent did not prescribe an antibiotic for Ms. Spoerndle until mid-December, 1987. Tr., p. 47.

14. Proper treatment of a patient presenting with a draining, warm wound three weeks after surgery includes culturing the wound, x-raying the site and starting the patient on antibiotics Tr., pp. 78-79.

Discussion and Conclusions

It is the opinion of the Board that Section 3(d) of the Statement of Charges should be dismissed. The Board finds insufficient evidence to show that the Respondent failed to accurately inform the patient of the results of surgery.

The Respondent was charged with having violated Conn. Gen. Stat. § 20-59(3), and/or § 20-59(4), and/or § 20-59(10), and/or § 20-45. Conn. Gen. Stat. § 20-59 provides, in pertinent part, that:

The board may take any of the actions set forth in section 19a-17 for any of the following reasons: ... (3) fraudulent or deceptive conduct in the course of professional services or activities; (4) illegal or incompetent or negligent conduct in the practice of podiatry; ... (10) violation of any provision of this chapter or any regulation adopted hereunder.

Conn. Gen. Stat. § 20-45 lists the causes for which action may be taken against the license of a practitioner of the healing arts, and includes the specific causes stated in Conn. Gen. Stat. §§ 20-59(3), (4) and (10).

From October of 1987 until January of 1988, the Respondent Gary Fleischman undertook podiatric treatment of patient Joan Spoerndle. On October 9, 1987, the Respondent operated on the patient's right foot to remove a bunion (bunionectomy) and reconstruct a joint in the great toe (arthroplasty). The Respondent continued to treat Ms. Spoerndle on a post-operative basis until January of 1988. The Board concludes that the Respondent violated Conn. Gen. Stat. § 20-59(4), as well as the corresponding provisions of Conn. Gen. Stat. § 20-45, in his failure to provide proper podiatric care in undertaking treatment of Joan Spoerndle's foot.

The Respondent's operative reports pertaining to the surgery he performed on the patient Joan Spoerndle on October 9,

1987 were actually pre-printed forms on which only the name of the patient, the date of surgery, and the designation of which foot was being operated on were typed in. Both reports indicate that the left foot was operated on, when in fact the surgery was performed on the patient's right foot. Additionally, the operative reports do not indicate that a burr broke off inside the patient's foot or that the burr was subsequently surgically removed. Both of those events should have been noted in the reports.

The Board concludes that the Respondent failed to keep accurate or adequate medical records as alleged in Section 3(a) of the Statement of Charges and thereby violated Conn. Gen. Stat. §§ 20-59(4) and 20-45.

The Respondent operated on the patient Spoerndle's right foot to reconstruct her great toe joint (arthroplasty) and to remove a bunion (bunionectomy). Based on its review of the evidence, the Board concludes that the procedures performed by the Respondent resulted in joint destruction, with inadequate preservation of the first metatarsophalangeal joint. The procedures performed by the Respondent also resulted in fractures of the tibial sesamoid bone. The Board concludes that there was no reason for the Respondent to touch the tibial sesamoid bone in performing the type of surgery undertaken in his treatment of Joan Spoerndle.

The Board concludes that the Respondent failed to adequately preserve the first metatarsophalangeal joint and improperly fractured the tibial sesamoid, as alleged in Sections 3(b) and 3(g) of the Statement of Charges, and thereby violated Conn. Gen. Stat. §§ 20-59(4) and 20-45.

The Respondent failed to wear a surgical mask or cap while performing surgery on the patient Joan Spoerndle. The Respondent undertook a pre-operative "scrub" of the patient's right foot which consisted of rubbing the foot for approximately twenty seconds with a cotton ball that had been soaked in some type of liquid. The Board finds, on the basis of its own expertise, that this preparation of the site of surgery was inadequate for purposes of ensuring sterile conditions, which requires a mechanical cleaning for a period of several minutes. Additionally, the Respondent did not attempt to sterilize the foot or the operating environment after the patient had been served food in the room in which the surgery took place.

On the basis of the facts recited in the preceding paragraph, the Board concludes that the Respondent failed to ensure sterile conditions for the surgery on Ms. Spoerndle, as alleged in Section 3(c) of the Statement of Charges, and thereby violated Conn. Gen. Stat. §§ 20-59(4) and 20-45.

The Respondent did not take an x-ray of the patient's foot after he had retrieved the broken burr from inside the foot. On the basis of its own expertise, and as supported by the testimony

of Dr. Novicki, the Board concludes that minimum standards of podiatric care require the taking of an x-ray upon removal of a foreign body from the foot to confirm the removal of the entire foreign body. The failure of the Respondent to take an x-ray after removing a piece of broken burr violated Conn. Gen. Stat. §§ 20-59(4) and 20-45, as alleged in Section 3(e) of the Statement of Charges.

Subsequent to the surgery, the Respondent examined Ms. Spoerndle on a weekly basis until December, 1987. Throughout this period, the patient had an open, draining, warm wound and felt sharp pain in her foot. The Respondent never took a culture or x-ray of Ms. Spoerndle's right foot during the course of his post-operative treatment and did not prescribe an antibiotic for Ms. Spoerndle until mid-December.

Proper post-operative treatment of a patient presenting with a draining, warm wound includes culturing the wound and x-raying the site, as well as starting the patient on antibiotics sooner than was done in this case.

The Board concludes that the Respondent failed to render adequate post-operative treatment, and specifically failed to timely diagnose and treat a post-operative infection, as alleged in Sections 3(b) and 3(h) of the Statement of Charges, and thereby violated Conn. Gen. Stat. §§ 20-59(4) and 20-45.

ORDER

Pursuant to its authority under Conn. Gen. Stat. § 19a-17, the Board of Examiners in Podiatry hereby orders that:

The license of the Respondent, Gary Fleischman, to practice podiatry in the State of Connecticut be revoked, said revocation to be effective upon the issuance of this decision. The Board notes that the Respondent's license to practice podiatry in Connecticut is currently under suspension pursuant to the provisions of a prior Board order issued on September 27, 1989.

In determining an appropriate order in this case, the Board has considered previous decisions which resulted from disciplinary hearings involving this Respondent, i.e. Board decisions issued on December 11, 1985 (letter of reprimand), June 25, 1986 (six month suspension), July 22, 1987 (eighteen month suspension), September 9, 1988 (thirty day suspension), and September 27, 1989 (one year suspension).

Connecticut Board of
Examiners in Podiatry

David E. Ryan, DPM
Mark Mandell
Janis Kue, DPM

5/16/90
Date