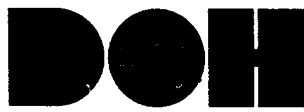
 STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

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

Dennis P. Whalen
Executive Deputy Commissioner

August 5, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Edward Zaino, M.D.
68 Washington Avenue
Garden City, New York 11530

Shawn P. Kelly, Esq.
Kelly, Rode & Kelly
410 Park Avenue
New York, New York 10022

RE: In the Matter of Edward Zaino, M.D.

Dear Mr. Smith, Mr. Kelly and Dr. Zaino:

Enclosed please find the Determination and Order (No. BPMC97-194) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

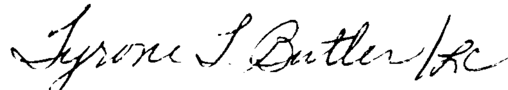
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

EDWARD ZAINO, M.D.

DETERMINATION

AND

ORDER

BPMC-97-194

A Notice of Hearing and a Statement of Charges, dated February 7, 1997, were served upon the Respondent, Edward Zaino, M.D. **ANTHONY SANTIAGO (Chair), THOMAS O. MULDOON, M.D. and NORTON SPRITZ, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by David W. Smith, Esq., Associate Counsel. The Respondent appeared by Kelly, Rode & Kelly, Shawn P. Kelly, Esq., of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	March 7, 1997
Answer to Statement of Charges:	April 7, 1997
Dates of Hearing:	April 18, 1997 May 9, 1997 June 3, 1997 June 4, 1997
Witnesses for Department of Health:	Harriet S. Gilbert, M.D. James Brown Teresa Habacker, M.D.
Witnesses for Respondent:	Stuart Lichtman, M.D. Leslie Lukash, M.D. Edward Zaino, M.D.
Deliberations Held:	June 25, 1997

STATEMENT OF CASE

The Statement of Charges alleged six specifications of professional misconduct, including allegations of negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence and failure to maintain accurate records. **During the course of the hearing the specifications of gross negligence and gross incompetence (the third and fourth specifications) were withdrawn.**

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all Findings and Conclusions herein are the unanimous determination of the Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence.

1. EDWARD ZAINO, M.D., (hereinafter "Respondent"), was authorized to practice medicine in New York State on September 15, 1944, by the issuance of license number 042864 by the New York State Education Department. (Petitioner's Exhibit 1 {hereinafter "Pet.Ex."})

PATIENT A:

2. Respondent saw Patient A in his office in October 1989 and February 1990 for respiratory complaints among other things. (T. 523, 554-560; Pet. Ex. 3)

3. In October, 1989, Respondent became aware of a mass in the right lung of Patient A. In February 1990, the Respondent once again received information noting a mass in the patient's right lung. (T. 542, 595; Pet. Exs. 3 & 4; Resp. Ex. D)

4. When a physician becomes aware of a mass in a patient's lung he should adequately inform the patient about it and the medical implications of this finding and follow up and treat the condition. Such should be noted in the patient's record. If the patient refuses treatment it should also be noted in the record. The Respondent did not do this. (T. 49-51, 55-59, 62, 449-450, 462-463, 465-467; Pet. Ex. 3, 5)

5. In February, 1990, the Respondent admitted Patient A to the hospital. (Pet. Ex. 5)

6. When a physician admits a patient to the hospital subsequent to finding a mass on her lung, he should indicate the existence of the mass in the hospital record, should further explore treatment of this condition with the patient and note such in the patient's record. The Respondent did not do this. (T. 122-123, 125-126, 464, 593-594; Pet. Ex. 5)

PATIENT B:

7. Respondent had treated Patient B in 1982 in his office for myeloproliferative disease. (T. 523,628-34; Pet. Ex. 7)

8. On September 19, 1989, Patient B was admitted to Mercy Hospital with symptoms of an abdominal problem. He was in unstable condition. (T. 482; Pet. Ex. 8)

9. Respondent was retained as hematological consultant for Patient B on September 23, 1989 because of his familiarity with Patient B's past medical condition of myeloproliferative disease. (Tr. 636-37, 668-69; Res. Ex. A)

10. On September 23, 1989, Respondent did a bone marrow biopsy of Patient B. When a physician performs a bone marrow biopsy he should note this in the record. The Respondent did this. (Pet. Ex. 8)

11. As the consultant, Respondent was responsible for managing Patient B's myeloproliferative disease. The Respondent did this. (T. 164, 642, 672, 678, 680; Pet. Ex. 8)

12. A consultant should identify himself in the hospital chart as such and note an evaluation or treatment plan and any presciptions for his patient. The Respondent did not do this. (Pet. Ex. 8)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support

each Factual Allegation:

Paragraph A: (2);

Paragraph A.1: (3,4,5&6);

Paragraph B: (7,8,&9);

Paragraph B.2: (12) with the exception of that part of the paragraph which alleges that Respondent failed to evaluate, follow-up or treat such condition.

The Hearing Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

FAILURE TO MAINTAIN RECORDS

Fifth Specification: (Paragraphs A.,A.1);

Sixth Specification: (Paragraphs B.,B.2)

The Hearing Committee voted to **not sustain** the first and **second** specifications.

DISCUSSION

Respondent was charged with three specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these charges, the

Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for negligence and incompetence in the practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Using the above-referenced definitions as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the fifth and sixth specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Harriet S. Gilbert, M.D. as its expert witness. Dr. Gilbert is a physician whose specialty is hematology. Dr. Gilbert is board certified in Internal Medicine and Hematology. There was no evidence of any bias on the part of Dr. Gilbert or her unsuitability as an expert witness. The Committee found her to be a credible witness. Dr. Gilbert's testimony was based solely on the records she was provided with. The Committee agreed with her assessment of the Respondent's substandard care of Patient A in that he failed to obtain a definitive diagnosis of the mass in the patient's lung or note his efforts to do so and if the patient refused medical care.

The Committee was not convinced that the Respondent fully informed the patient of her condition and options with respect to the x-ray findings from the October 1989 hospital admission. Respondent's own patient notes do not reflect any conversation with the patient nor

do the hospital records, including the hospital admission of Patient A in February, 1990, indicate in any way that Patient A knew of the lung mass. In particular the Committee noted in the latter hospital admission there was no mention of this previous finding. The Respondent's own expert testified that he had a duty to attempt to get the patient to agree to further exploration of the mass. Of particular significance to the Committee was the fact that the Respondent did not make any attempt to refer the patient to a specialist for assessment of the mass. Had the Respondent fully informed the patient the Committee would have accepted the right of the patient to refuse medical care. The Committee did not feel that the Respondent's explanation of his lack of action with respect to the x-ray finding was credible. This pattern of inadequate care with respect to Patient A was repeated when the Respondent instituted chelation therapy but did not follow through in its implementation.

With respect to Patient B, the Committee concluded that the Respondent's actions did not amount to negligence. Although the Respondent's role as a consultant was not clear from the record, the Respondent performed a bone marrow biopsy the report of which was in the hospital record. Although this may not have been the ideal mechanism for the Respondent to communicate his findings the Committee concluded it was adequate.

The Committee found that the Respondent's notes with respect to his treatment of the Patient B's myeloproliferative disorder were inadequate. However, in view of the overall management of the patient, the Respondent's contribution to the patient's care within his limited role as a consultant and the testimony of the Respondent regarding his communications to the patient's primary physician, the Committee determined that his treatment was appropriate. The Committee found that the care the Respondent provided Patient B was adequate.

Although negligent in the care of Patient A, the Committee did not find any evidence that the Respondent's care of either Patient A or B amounted to incompetence. Therefore, the second specification was not sustained. The record in this case clearly established that Respondent was negligent in the care of Patient A and failed to keep accurate medical records with respect to

both Patient A and B. However, since the Committee found only one incident of negligence the first specification was not sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent should be **censured and reprimanded**. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

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

1. The Fifth and Sixth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I) are **SUSTAINED**;

2. Respondent be and hereby is **CENSURED AND REPRIMANDED**.

DATED: Bronx, New York
July 29, 1997

ANTHONY SANTIAGO (CHAIR)

THOMAS O. MULDOON, M.D.
NORTON SPRITZ, M.D.

TO: David W. Smith, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Shawn P. Kelly, Esq.
Kelly, Rode & Kelly
410 Park Avenue
New York, New York 10022

Edward Zaino, M.D.
68 Washington Avenue
Garden City, New York 11530

ZAINO.DAO

APPENDIX I

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

IN THE MATTER OF EDWARD ZAINO, M.D.	STATEMENT OF CHARGES

EDWARD ZAINO, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 15, 1944, by the issuance of license number 042864 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A in or about October, 1989 and February, 1990 for respiratory complaints at his office at 68 Washing Avenue, Garden City, New York.

1. In October, 1989 and again in February, 1990 Respondent was aware that Patient A had a mass in her right lung. Nevertheless, Respondent failed to evaluate, follow-up or treat such condition or note such evaluation, follow-up or treatment, if any.

B. In or about 1982, Respondent treated Patient B for both leukocytosis and thrombocytosis at his office at 68 Washing Avenue, Garden City, New York. In or about September, 1988, Patient B was admitted to the hospital for an abdominal crisis in contemplation of surgery, and Respondent was called in as a consultant.

1. On or about September 23, 1988, Respondent performed a bone marrow biopsy on Patient B but failed to make any notes of his consultation before, on or after such date.

2. Despite the fact that the bone marrow indicated a myeloproliferative disorder and a high platelet count, Respondent inappropriately failed to evaluate, follow-up or treat such condition, or note such evaluation, follow-up or treatment, if any.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) (McKinney Supp. 1997) by practicing the profession with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1 and B and B1-2.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1997) by practicing the profession with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraghs A and A1 and B and B1-2.

THIRD SPECIFICATION

GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1997) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraphs B and B1-2.

FOURTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1997) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. Paragraphs B and B1-2.

FIFTH AND SIXTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

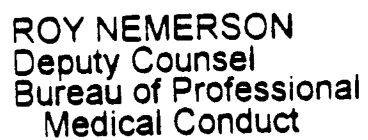
Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1997) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of such

patient as alleged in the facts of of the following:

5. Paragraphs A and A1.

6. Paragraphs B and B1-2.

DATED: February 7, 1997
New York, New York



ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct