STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

March 15, 2005

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

Yana M. Zukher, Esq.
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108 Main Street
Staten Island, New York 10307

William Blank, M.D.

REDACTED

RE: In the Matter of William Blank, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-44) 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.

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.

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,

REDACTED

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER

OF

WILLIAM BLANK, M.D.

DETERMINATION
AND
ORDER

BPMC 05-44

A Notice of hearing, dated April 9, 2004, and a Statement of Charges, dated April 9, 2004, were served upon the Respondent, **WILLIAM BLANK, M.D.** (Hereinafter "Respondent"). **DENISE BOLAN, P.A.**, Chairperson, **RICHARD KASULKE, M.D.** and **JAMES D. HAYES, II, M.D.**, are duly designated members of the State Board for Professional Medical Conduct. They served as the Hearing Committee ("the Committee") in this matter which was held pursuant to Section 230(10)(e) of the Public Health Law. **JONATHAN M. BRANDES**, Administrative Law Judge, served as the Administrative Officer.

The Department of Health ("the Department") appeared by DONALD P. BERENS, JR., ESQ., General Counsel, by **TIMOTHY J. MAHAR, ESQ.**, of Counsel. The Respondent appeared by DiJOSEPH & PORTEGELLO, P.C., **YANA M. ZUKHER, ESQ.**, and **ROBERT PORTEGELLO, ESQ.**, of Counsel.

Evidence was received and witnesses sworn and heard. Transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Answer Filed:	May 25, 2004
Pre-Hearing Conference Held:	May 25, 2004
Witness for Petitioner:	Richard D. Amelar, M.D. Expert Witness
Witnesses for Respondent	Respondent testified in his own behalf and called Peter N. Schlegel, M.D. as an expert.
Hearing Date(s)	May 25, June 29 and 30, 2004 and September 28, 2004.
Deliberation Date(s)	November 3, 2004

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct pursuant to §230 of the P.H.L. Respondent is charged with six violations of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). Specifically, Respondent is charged with:

1. Four counts of gross negligence as defined in §6350(4) of the Education Law (Specifications One through Four));
2. Four counts of gross incompetence as defined in §6350(6) of the Education Law (Specifications Five through Eight);
3. One count of negligence on more than one occasion as defined in §6350(3) of the Education Law (Specification Nine);
4. One count of incompetence on more than one occasion as defined in §6350(5) of the Education Law (Specification Ten);

5. Four counts of fraud in the practice of medicine as defined in §6350(2) of the Education Law (Specifications Eleven through Fourteen)

6. Four counts of failure to maintain records as defined in §6350(32) of the Education Law (Specifications Fifteen through Eighteen);

These charges arise from the treatment of four patients in 1998 and 1999. A copy of the Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

CONCLUSIONS REGARDING EXPERTS

The State offered Richard D. Amelar, M.D. as its expert witness. It was the opinion of Dr. Amelar that Respondent violated accepted standards of medicine by failing to perform tests studies and examinations which were essential to forming the basis of the diagnoses he put forward and the surgery he performed. Dr. Amelar concluded that the surgery performed by Respondent was either unwarranted or at least insufficiently supported by the medical record. The Committee found Dr. Amelar to be rather dogmatic in his approach to pre-operative patient examinations and studies under the facts and circumstances of this case. Dr. Amelar was at times less than completely forthcoming in answers to questions where the answer required by the question was not in direct support of his position. Dr. Amalar seemed confused and at times his testimony was inconsistent. In the course of his testifying, he obstinately clung to positions which favored the Department of Health, even when it was unreasonable to do so. Furthermore, when questioned about some of his opinions he appeared to not understand the allegations and raised the issue of infertility when the facts of the case did not involve that issue. His failure to answer questions directly undermined the weight given his opinions.

The Committee notes that each of the patients in this case had a primary care physician who referred the patient to Respondent. Respondent was therefore seen in the capacity of a specialist. A specialist is not in violation of accepted standards of medicine where he or she relies upon the primary care physician for in depth studies of the over all health of the patient. There is also no violation of accepted standards of medicine where a specialist does not repeat a study done by another even if

the test or study is directly pertinent to the specialty so long as the test or study was done sufficiently close in time to the specialist's examination. Hence, there was no violation of accepted standards when Respondent did not do full diabetic work ups on these patients nor was there a need for Respondent to perform in depth studies of each patient's thyroid or adrenal functions. There was no violation of accepted standards when Respondent did not refer each of these patients for psychological evaluations. Had Respondent performed all the tests and studies said to be required by Dr. Amelar, there would have been redundancy and more information than was necessary to meet accepted standards of medicine.

The Committee found Dr. Schlegel's approach to be reasonable and well considered. Dr. Schlegel appeared to have more experience in the specific area covered by the charges herein. Dr. Schlegel did not find Respondent's pre-operative examinations were exhaustive. However, Dr Schlegel held the opinion that Respondent had sufficient information upon which to base his diagnoses and perform the surgery. Dr. Schlegel added to his credibility by directly answering all questions asked of him. He did not deny weaknesses in Respondent's approach when questioned. Accordingly, Committee gave greater weight to the opinion of Dr. Schlegel.

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 set forth below are the unanimous determinations of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Committee hereby makes the following findings of fact:

FINDINGS OF FACT
REGARDING
PATIENT A

1. Patient A was a 46 year-old male who first saw Respondent on June 1, 1998 (T. 347; Ex. 3).
2. Respondent provided care to Patient A at his offices and at University Hospital, Syracuse, NY through 2001 (Exs. 3 & 4).
3. Patient A complained of a 2 to 3 year history of progressively worsening erectile dysfunction (T. 347; Ex. 3).
4. Patient A had months of normal erections and months of complete loss of erections (T. 21, 347; Ex. 3).
5. Three months prior to his examination, Patient A had no erections of any kind (T. 347).
6. Patient A denied morning erections and middle of the night erections (T. 347).
7. Respondent evaluated Patient A for psychological causes of erectile dysfunction by evaluating his psychological and psychosexual history, speaking to Patient A and generally getting to know him (T. 390).
8. Patient A's sexual history included:
    i. "high [level]" of sexual desire;
    ii. "a strong libido at all times throughout these periods"
    iii. Masturbating 7 to 8 times a week;
    iv. Ejaculating 7 to 8 times a week;
    v. Rare episodes of sexual intercourse;
    vi. Difficulty in obtaining erections (Ex. 3).
9. Patient A had difficulty obtaining an erection during intercourse with his spouse (T. 29-30).
10. He did not have difficulty obtaining an erection when masturbating (T. 29-30).
11. The examination performed by Respondent revealed atrophied testes measuring 3.2 by 1.2 cm on the left and 3.3 by 1.5 cm on the right (T. 349; Ex. 3).

12. Normal testis measure approximately 4.5 by 2-2.5 cm (T.351).

13. Both testes were slightly soft in consistency (Ex.3).

14. Atrophy of the testes always indicates hypogonadism (T. 243; 640).

15. Sperm forming cells in the testicles make up 75 percent of testicular volume (T. 38).

16. If there is testicular dysfunction, the volume and size of the testicles can be decreased due to lack of sperm production while the hormone production (Leydig cells) may be normal (T. 38).

17. A left varicocele was found and graded at 3. A right varicocele was found and was graded at 2+ (T. 350; Ex. 3).

18. Respondent performed a limited examination for retroperitoneal pathology (T. 351, 352, 611, 612).

19. A decompressing varicocele, whether on the right or left is sufficient to rule out retroperitoneal pathology (T. 351-352, 611-612).

20. If during examination in the supine position, nothing prominent or unusual is felt, there is no need for further analysis (T. 352).

21. Respondent found the varicocele was decompressed in the supine position (T. 415).

22. Respondent noted prominent filling and prominent pulse when describing Patient A's right and left varicoceles respectively (Ex. 3).

23. Nothing was written under "Noted supine" in Patient A's record which Respondent testified indicates "nothing of significance" was appreciated (T. 350; Ex. 3).

24. In Patient A's operative note, Respondent reported that during the varicocele ligation a "bulging varicocele" was found on the right side. The left varicocele was "much larger" [than on the right side] while Patient A was lying on the operating table (Exs. 3 & 4).

25. When in the supine position during surgery, blood naturally flows when the varicoceles are released from the area in which they are held. However, the varicocele nonetheless was decompressed (T. 415-416).

26. Respondent uses the word "bulging" to mean the varicoceles were very prominent (T. 415).

27. Respondent performed a physical examination upon Patient A's thyroid. No abnormalities of thyroid presented themselves. Therefore, there was no indication for any further analysis of the thyroid (T. 352-353, 612).

28. Testosterone and PSA are the only two tests required under the standard of care. Beyond these two analyses, all other tests were optional and are requested based upon the patient's history and presentation (T. 619).

29. Patient A had been referred by Dr. James Blangefield, an internist, who had ordered a urine analysis and CBC (T. 353; Ex. 3).

30. Where an analysis including urine and CBC had been conducted within the past year, absent symptoms or physical indications, such testing need not be repeated by Respondent, a specialized urologist (T. 353-354, 619 -621).

31. Patient A already had two testosterone analyses which could be considered below normal (T. 361; Ex. 3).

32. The free testosterone levels are an alternative way of looking at the testosterone. Hence, there were actually four levels with which the testosterone was measured (T. 361, Ex. 3).

33. Respondent assessed Patient A as having bilateral testes atrophy, erectile dysfunction, hypogonadism and testicular dysfunction (T. 23-24; Ex. 3).

34. Erectile dysfunction is the inability of a patient to attain erections satisfactory to accomplish a sexual act (T. 22, 618).

35. The causes of erectile dysfunction include physical deformity of the penis, psychological issues, neurological disease, hormonal deficiencies, or congenital defect (T. 22).

36. Hypogonadism can be defined in several ways:

    i. A state where testosterone levels are not consistently maintained at an adequate level (T. 319);

    ii. Abnormal function of the testicles (T. 601);

    iii. A failure of the androgen function of the testicles (T. 23).

37. Hypogonadism can be evidenced by any one of the following symptoms:

i. Low testosterone levels

ii. Varicoceles

iii. Atrophy of the testis

iv. Infertility

v. Erectile dysfunction

vi. Decreased libido

vii. Change in secondary sexual characteristics

viii. Change in energy level

ix. Decreased cognition
(T. 319-320, 601-602)

38. However, on physical examination, "beyond having soft testes, there may be no physical findings" of hypogonadism (T. 603).

39. Hypogonadism can be either primary or secondary (T. 24).

40. Primary hypogonadism is caused by a defect in the testicle resulting in insufficient production of testosterone (T. 24).

41. Testicles produce sperm and male hormones (testosterone). Testicular dysfunction can result in deficiencies in either sperm or testosterone production, or both (T. 25).

42. Secondary hypogonadism results from a defect in the pituitary gland, thyroid gland, or adrenal gland. It can be associated with illnesses such as diabetes (T. 24).

43. Hypogonadism is diagnosed by history, physical examination and laboratory testing (T. 106).

44. Respondent diagnosed Patient A with hypogonadism based on small, soft testes, a low testosterone level, bilateral varicoceles, Patient A's description of his clinical problems, and a standard penile examination (T. 356, 615).

45. Patient A had no fertility issues associated with his complaints (T. 355; Ex. 3).

46. It was not a deviation in the standard of care not to have ordered a semen analysis on Patient A as infertility was not a concern for him (T. 355, 614).

47. In July of 1997, approximately a year prior to being examined and treated by Respondent, Patient A underwent a testosterone analysis which revealed a testosterone level of 385 (T. 354; Ex. 3).

48. On June 1, 1998, after seeing Respondent, Patient A had his testosterone measured again and it revealed a level of 263 (T. 355; Ex. 3).

49. At Patient A's follow-up visit on June 15, 1998, his total testosterone level (taken June 1, 1998) of 263 and his free testosterone level of 54.4 were reviewed. These results are both considered low normal and the total testosterone level was lower that the one done approximately one year prior (T. 60-61, 613, 638-639; Ex. 3).

50. Normal testosterone levels could be considered 350 or higher or 400 and higher (T. 320, 602).

51. Low testosterone may interfere with erectile function (T. 62, 601-602).

52. A patient's libido is very subjective (T. 348-349, 609).

53. A man may have a testosterone level high enough to maintain libido, but not high enough to maintain erectile function (T. 348-349, 609).

54. It is not unusual for a hypogonadal man to have a normal or strong libido (T. 348-349, 609).

55. Respondent recommended and performed a varicocelectomy for Patient A based upon the following indications as set forth in Patient A's medical record:

    i. Patient A's testicular atrophy

    ii. The size of the varicoceles

    iii. Hypogonadism

    iv. Both Patient A and Patient A's wife wanted to proceed to try to improve his current status and to prevent further deterioration (Ex. 3).

56. Based upon the testing performed, the history given and the physical examination performed by Respondent, he had sufficient data and medical information in order to diagnose Patient A and recommend the varicocele ligation (T. 356).

57. A varicocele repair in Patient A could improve testosterone production, and because testosterone production is related to erectile function, that could improve erectile function (T. 615).

58. Varicoceles alone can be a cause of hypogonadism (T. 604).

59. Varicoceles are a contributing cause of testicular dysfunction (T. 604).

60. An untreated varicocele is generally thought to cause a progressive decrease in testicular function because of increased heat to the Leydig cells (T. 604).

61. Leydig cells are the predominant source of testosterone within the body (T. 605).

62. When a varicocele is repaired, the temperature and nutrient exchange are changed in the testicle and observational studies show that testosterone levels increase (T. 607).

63. A properly performed varicocele ligation is not a harmful procedure for a patient. All patients either benefit from the procedure or at least have prevention of progression of their testicular dysfunction. Varicocele ligation was performed on Patient A with the intention of preventing further deterioration of testicular function (T. 430, 607).

64. In 1998, varicocele ligation was an appropriate treatment for men with varicoceles with hypogonadism (T. 604-605).

65. Untreated hypogonadal men may be at risk of:

    i. Osteoporosis

    ii. Changes in muscle mass

    iii. Changes in bone mass

    iv. Decreased strength

    v. Decreased cognitive function

    vi. Lipid problems (T. 323-324, 603).

66. Patient A's condition appeared to improve following the ligation (T. 616).

67. He described a higher level of sexual thoughts, which is indicative of an increase in testosterone level (T. 369).

68. Patient A had an increased libido (T. 369).

69. Patient A was having successful relations with his wife and was pleased with the way his body was functioning (T. 369).

70. Viagra was prescribed to Patient A by Respondent at the June 1, 1998 visit to give Patient A immediate relief of his erectile dysfunction (T. 410; Ex. 3).

71. Viagra does not treat the cause of erectile dysfunction, only the symptom (T. 615).

72. It was not a deviation from the standard of care to prescribe Viagra prior to performing the varicocele ligation on Patient A (T. 614-615).

73. Respondent continued to prescribe Viagra to Patient A following surgery (Ex. 3).

74. On September 10, 1998, it was reported that Patient A continued to use Viagra without major change (Ex. 3).

75. In an office visit on October 26, 1998, Respondent reported that Patient A was using Viagra with good results (Ex. 3).

76. He noted an increase in the testosterone level to 287 from 263 pre-operatively (Ex. 3).

77. Respondent prescribed testosterone supplementation in October of 1998 for Patient A without stating his reason (Ex. 3).

78. Patient A was prescribed testosterone supplementation just when the positive effects of the varicocele ligation should have begun (T. 419).

79. T-gel was substituted for testosterone patches on February 1, 1999 without stating a reason (Ex. 3).

80. Patient A continued to receive Viagra and T-gel (replaced later by Androgel) until he discontinued seeing Respondent in June of 2001 (Ex. 3).

81. Respondent did not document in his record, nor adequately defend in his testimony, his reason(s) for continuing Patient A on Viagra and testosterone supplementation indefinitely (T. 435-437, 486-490; Ex. 3,).

82. Respondent did not document in Patient A's record, nor adequately in his testimony, his long term plans for Patient A (T. 435-438; Ex. 3).

CONCLUSIONS REGARDING FACTUAL ALLEGATIONS ARISING FROM PATIENT A

FACTUAL ALLEGATIONS A.1, A.2, AND A.3

In Factual Allegation A.1, Respondent is charged with failure to perform adequate pre-operative tests and evaluations. Factual Allegation A.2 alleges that Respondent diagnosed Patient A with hypogonadism to a degree requiring treatment without adequate medical indication. Factual Allegation A.3 is related in that it alleges that Respondent performed a varicocelectomy on Patient A without adequate medical indication. The Committee did not sustain these charges. As stated under the discussion of the experts, the Committee agrees with Respondent and his expert that there was sufficient information in the patient record upon which to perform the surgery. The Committee concludes that Respondent clearly set forth the reasons for the procedure in the patient record:

1. Patient A's testicular atrophy
2. The size of the varicoceles
3. Hypogonadism
4. Both Patient A and his wife "want to proceed to try to improve his current status and to prevent further deterioration".

Respondent found hypogonadism and the information upon which he based this diagnosis is found in the record. Tests that the Respondent ordered showed testosterone levels were low, and the patient's testicles were small in size and somewhat soft in consistency. Respondent performed a physical examination on Patient A, including his thyroid. He also obtained sexual information by speaking with the patient and his wife. A fairly extensive medical questionnaire was completed by the patient and contained in the record. It contains sexual, endocrinological, urological, psychosocial, and family history, as well as information related to medication use. All this combined to form a sufficient basis upon which to perform the treatment provided to Patient A by Respondent. It also provided, to the extent necessary, sufficient information regarding the etiology of the patient's condition.

By performing the varicocelectomy, Respondent would have reduced the size of the varicoceles, halted further testicular atrophy and prevented additional hypogonadism. The patient's testosterone level would be expected to rise. The rise in the level of testosterone plus the psychological aspect of taking action would be expected to improve this patient's erections. Hence, his "current status" would be improved and further deterioration would be halted. Given that Patient A sought Respondent's care due to unsatisfactory erections, it would be fair to say that the course of treatment would certainly provide a fair likelihood of a successful outcome.

Therefore:

Factual Allegation A.1 is **NOT SUSTAINED**
Factual Allegation A.2 is **NOT SUSTAINED**
Factual Allegation A.3 is **NOT SUSTAINED**

FACTUAL ALLEGATIONS A.4 AND A.5

In Factual Allegations A.4, and A.5, the State charges that performing varicocelectomies was the wrong treatment for the conditions presented by Patient A. The State bases its charges upon the premise that the varicocelectomies were performed to:

1. Address testicular atrophy;
2. Address bilateral varicoceles;
3. Address hypogonadism;
4. Improve Patient A's "current status;"
5. Prevent further deterioration.

The Committee finds that the evidence offered through the testimony of Respondent and Respondent's expert shows that varicocelectomy was an appropriate treatment for the listed conditions.

The Committee concludes that the evidence presented through Respondent and his expert show Patient A had soft, small testes, and bilateral varicoceles. The patient also had low testosterone levels and a history of unsatisfactory erections. The evidence further shows varicoceles alone can be a cause of hypogonadism. In addition, varicoceles are a contributing cause of testicular dysfunction, low testosterone levels and testicular atrophy.

It therefore follows that correction of the varicoceles would prevent further deterioration of the patient's testes. Additionally, testosterone levels would be expected to rise. Hence, the physical effects of the surgery combined with the psychological aspect of taking corrective action would lead to more satisfactory erections. In addition, Respondent recorded that both Patient A and his wife wanted to try this form of treatment. Ultimately, it was a history of less than satisfactory erections which caused Patient A to seek treatment from Respondent.

Therefore:

Factual Allegation A.4 is **NOT SUSTAINED**
Factual Allegation A.5 is **NOT SUSTAINED**

FACTUAL ALLEGATION A.6

In his operative reports, Respondent used the term "bulging" when describing the varicoceles. The State alleges that if the varicoceles were sufficiently large to make the term "bulging" accurate, Respondent had a duty to evaluate Patient A for retroperitoneal pathology. If the vessels were not sufficiently large to be accurately described as "bulging" then the term used by Respondent was misleading and inaccurate.

Respondent counters by asserting that his use of the term "bulging" simply means the varicoceles were very prominent. The Committee accepts this explanation and finds that the use of the word "bulging" is within the bounds of accepted standards of medicine.

Therefore:

Factual Allegation A.6 is **NOT SUSTAINED**

FACTUAL ALLEGATION A.7

In Factual Allegation A.7 the State asserts Respondent failed to perform an adequate post-operative evaluation of Patient A. The Committee agrees. In so finding, the Committee notes Respondent did examine Patient A to see that his surgery was healing properly. The Committee takes no issue with this part of Respondent's care. However, the Committee finds that Respondent continued to prescribe both testosterone and Viagra for this patient without any interruption.

Respondent noted improvements in Patient A's ability to obtain erections and higher testosterone levels but there is no way to know whether those results arise from the medication or the surgery. There was no post operative plan presented in the patient record. Respondent should have waited a reasonable period of time after the surgery before prescribing medication. If the patient had experienced improvement, then he would have known that the surgery had been fully successful. If the patient was still unable to obtain satisfactory erections, one or both of the medications could have been prescribed.

The failure to wait a reasonable period of time and perform testosterone level tests prior to prescribing medication was a violation of accepted standards of medicine. More troubling than the

simple violation of accepted standards of medicine is the beginning of the display of fraud on the part of Respondent. If Respondent actually expected the surgery to be successful, he would have given Patient A sufficient time without Testosterone and/or Viagra to witness the positive effects of the surgery.

Therefore:

Factual Allegation A.7 is **SUSTAINED**

FACTUAL ALLEGATION A.8

Factual Allegation A.8 alleges that Respondent did not assess Patient A adequately as to the cause of his erectile dysfunction. The Committee agrees with Respondent and his expert that Patient A's hypogonadism was the likely cause of Patient A's erectile dysfunction. As discussed under Factual Allegations A.1 and A.2, the Committee feels the evaluation for Patient A's hypogonadism was adequate. The Committee feels it is logical and reasonable for a physician to treat an identified problem that is an acceptable cause for Patient A's symptom/problem of erectile dysfunction, rather than looking for another cause that may or may not be present.

Therefore:

Factual Allegation A.8 is **NOT SUSTAINED**

FACTUAL ALLEGATION A.9

In Factual Allegation A.9, Respondent is charged with a failure to keep an adequate medical record for this patient. The Committee sustains this charge.

State law requires that all physicians keep an accurate record of the care and treatment of each patient. The standard is such that a medical record should be sufficient to allow a subsequent treating physician or reviewer to know what was done for the patient and what the physician was thinking when he or she performed the treatment described. The purpose of the standard is to provide continuity of care, avoid redundancy and prevent future treating professionals from taking

an action which would be deleterious to the patient when combined with what has already been done.

As stated above, there was no care plan provided by Respondent for this patient. Much of what Respondent did was set down in the record but a significant number of acts and findings were not written down. Respondent's description of a "bulging" varicocele obviously caused confusion in the minds of the experts, and Respondent himself admits it may not have been the best choice of words. Much of the information upon which Respondent's expert based his opinion came from Respondent's memory. Respondent stated it would take too much time to set down all the required information. The Committee does not accept this explanation. In order to meet accepted standards of medicine, practitioners are expected to record all significant information for each patient. Respondent's lack of a written plan post-operatively for this patient would pose a difficult, and perhaps dangerous, task for a subsequent treating physician.

The failure to keep adequate patient records is a violation of accepted standards of medicine. .

Therefore,

Factual Allegation A.9 is **SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT B

83. Dr. Blank saw Patient B for the first time on July 24, 1998 (T. 446; Ex. 5).

84. Patient B was referred to Respondent by Dr. Eric Daily, an internist (T. 446).

85. Patient B was a forty nine year old man who complained of progressively declining libido for approximately four (4) years:

    (1) Patient B expressed that his libido was at approximately fifteen (15%) to twenty five (25%) percent of normal (T.446)

(2) Patient B stated that he could get erections and that once in a while he would get morning erections.
(3) Patient B indicated that the last time he had sex was two months prior to the visit.
(4) Patient B denied any of the other causes for erectile dysfunction including diabetes;
(5) Patient B's history was negative for diabetes and he presented with no symptoms of diabetes.
(6) Patient B denied the use of exogenous steroids. He was not taking blood pressure medication and had nothing else in his history to suggest low testosterone.
(T. 446-447; Ex. 5)

86. His testosterone level was 216 (T. 447; Ex. 5).

87. Patient B had recently started taking Zyban in an attempt to quit smoking. Zyban would not have any affect on Patient B' complaints of erectile dysfunction (T. 447, 653).

88. Patient B had a history of cocaine and amphetamine use (Ex. 5).

89. Cocaine and amphetamines can cause changes in libido and cause impotence (T. 154, 155).

90. Respondent records the patient's history as "no" for drug use. Such a denial of use could only have been obtained directly from the patient during the initial visit (T. 156, 187).

91. Cocaine may suppress libido, however, Respondent testified that Patient B assured him that he hadn't used cocaine or amphetamines in a very long time (T. 495).

92. Patient B had been released from prison a few months prior (T. 495).

93. Since Patient B had only been released from prison several months prior to seeing Respondent, Respondent anticipated that Patient B's libido should have been much higher (T. 495, 659).

94. Respondent asked Patient B about his partners and relationships (T. 466).

95. Patient B did not provide any history that would link his erectile dysfunction to his sexual history or his relationship with his wife (T. 466).

96. Patient B did not present any obvious emotional factors that would have contributed to his erectile dysfunction (T. 447, 662-663).

97. Patient B' erectile dysfunction was organic in nature (T. 660-664).

98. Respondent conducted a physical examination upon Patient B (T. 448).

99. Respondent observed that Patient B was a thin, healthy looking man (Ex. 5).

100. Patient B had a full beard and adequate secondary sexual characteristics (T. 448).

101. Respondent checked for all of the items which were indicated on his office physical examination form and did not see any gynecomastia. This is a good indication regarding endocrine function (T. 448).

102. Respondent also examined Patient B's genitalia, measuring the testicles using calipers (Ex. 5).

103. This examination revealed both testicles present with a significant degree of atrophy in the left; measuring 3.6 by 1.5 cm and it was slightly soft in consistency (T. 448).

104. The right was measured at 3.9 by 1.9 cm and has a normal consistency (T. 448-449).

105. In addition, there were large bilateral varicoceles with the right being a grade 2+ to a 3 and the left was graded at 2+ (T 448-449).

106. Patient B's testicles were small in size with the left being slightly soft and flabby (T. 159).

107. Patient B's testicles were examined in the supine position. A"prominent filling and prominent pulse" were observed (T. 159 160).

108. Based upon Respondent's testimony and the record, the language indicated that Patient B's varicoceles decompressed in the supine position (T. 654).

109. The supine examination was conducted first and there was no evidence of a varicocele in that position (T. 449).

110. Both varicoceles very prominently filled in the upright position (T. 449, 654).

111. There was no indication for further retroperitoneal pathology evaluation (T. 654).

112. Respondent performed a thyroid examination upon Patient B by palpating his thyroid (Ex. 5).

113. No abnormalities were felt during his thyroid examination (T. 449).

114. Patient B did not present with any symptoms indicative of thyroid problems nor did he give any history indicative of thyroid problems (T. 449).

115. Prior to seeing Respondent, Dr. Daily, Patient B's internist, had sent him for a testosterone analysis which revealed a testosterone level of 216, a normal prolactin level, and a normal PSA (T. 447).

116. The normal prolactin levels indicate that patient B did not suffer from primary hypogonadism (T. 469).

117. Respondent diagnosed Patient B with hypogonadism based upon:

(1) his 4-year history of four year declining libido;
(2) other history which was indicative of a man who had low testosterone
(3) atrophied testis
(4) varicoceles
(5) Laboratory findings of low testosterone
(6) volume of Patient B' testes
(7) consistency of his testes
(8) low libido

(T. 452, 455-456, 657).

118. Patient B had no fertility issues (T. 15)

119. A specialist may rely upon examinations and laboratory results which have recently been performed by an internist, or any other referring physician (T. 655).

120. Patient B's internist previously performed the urine analysis. Therefore, further urine analysis was not necessary (T. 450, 655).

121. The varicocele ligation was not offered to Patient B as an alternative treatment for Viagra or the erectile dysfunction (T. 471-472).

122. The varicocele ligation was offered to halt any further deterioration of testicular function and try to improve his levels of testosterone production (T. 471-472).

123. As a result of the varicocele ligation, Patient B stated that he was having intercourse three times per week and that he was having good erections and ejaculations (T. 462-463).

124. Patient B indicated that he had only needed to use the Viagra one time since the ligation. Prior to the ligation he used viagra every time he engaged in sexual relations (T. 462-463)

125. Patient B's libido was increasing, he was having more sexual thoughts and his strength and endurance were improving (T. 462- 463).

126. Viagra will assist a man who is unable to attain an erection (T. 614).

127. A varicocele ligation treats the underlying disease (T. 607-608).

128. Patient B stated he did not want to have to take Viagra for the rest of his life. He wanted to fix the underlying problem (T. 453).

129. Patient B returned to see Respondent about a week following the ligation (T. 460).

130. At that time Patient B had no significant complaints (T. 460).

131. Respondent examined Patient B on this post operative visit and performed the same examination that he performed previously (T. 460).

132. The examination revealed that everything was healing well (T. 460).

133. Respondent checked for hydroceles and none were discovered (T. 460).

134. The patient record does not disclose why testosterone patches were prescribed for Patient B (T. 170).

135. There was no assessment in Respondent's medical record as to therapeutic benefits, if any, Patient B was receiving from the testosterone patches (T. 171).

136. In Patient B's pre-surgical history, it is indicated that the Viagra Respondent had prescribed worked but Patient B opted for surgical repair of varicoceles (T. 172-173).

137. Respondent recommended or offered a varicocelectomy to Patient B for the following indications as set forth in Patient B's medical record:

> *[Patient B] reports great concern about needing Viagra for the rest of his life. Patient B clearly states that he wants to correct the hypogonadism and low serum testosterone instead of treating it for the rest of his life. The link between untreated varicoceles and progressive testicular [sic] was discussed in detail and he wants to proceed to try to improve his current status and to prevent future damage (Ex. 5).*

138. Respondent wrote in Patient B's office record on August 14, 1998 that the

> *link between untreated varicoceles and progressive testicular [dysfunction] was discussed in detail and [Patient B] wants to proceed to try to improve his current status and to prevent future damage" (Ex. 5).*

139. During the post-operative period, the patient was prescribed testosterone patches on the first office visit, one week after the surgery (November 30, 1998) (T. 176-177).

140. The patient remained on testosterone patches until the prescription was changed to testosterone gel in April of 1999 (T. 177).

141. Testosterone gel is a more potent form of testosterone supplementation (T. 178).

142. The medical record indicates that in March of 1999, Patient B was using testosterone gel without major improvement (T. 179).

143. In April of 1999, Patient B reported increased energy levels and a strong libido (T. 179).

CONCLUSIONS REGARDING FACTUAL ALLEGATIONS ARISING FROM PATIENT B

FACTUAL ALLEGATIONS B.1, B.2, B.3, AND B.7

In Factual Allegations B.1 and B.2, Respondent is charged with failure to perform adequate pre-operative tests and evaluations and performing a varicocelectomy without adequate medical indications. Factual Allegation B.3 is related in that it alleges that Respondent performed a varicocele ligation on Patient B without adequate medical indication. In Factual Allegation B.7 Respondent is charged with the failure to adequately seek the etiology of this patient's erectile dysfunction. The Committee does not sustain these charges. As stated previously under the discussion of the experts and with regard to Patient A, the Committee agrees with Respondent and

his expert. There was sufficient information and research into the cause of the patient's complaint in the patient record upon which to perform the surgery.

Therefore:

Factual Allegation B.1 is **NOT SUSTAINED**
Factual Allegation B.2 is **NOT SUSTAINED**
Factual Allegation B.3 is **NOT SUSTAINED**
Factual Allegation B.7 is **NOT SUSTAINED**

FACTUAL ALLEGATIONS B.4 AND B.5

In Factual Allegations B.4 and B.5, Respondent is again charged with performing varicocelectomies when he knew or should have known the procedure was inappropriate to treat the conditions exhibited by his patients. As drafted, these charges cannot be sustained for reasons similar to those set forth under Factual Allegations A.4 and A.5 above. The reasons Respondent performed the varicocelectomies are set forth in his patient record:

1. To correct the hypogonadism
2. To raise serum testosterone;
3. To arrest progressive testicular atrophy
4. To improve his "current status;"
5. To prevent future damage;
6. To treat the underlying cause of his erectile dysfunction rather than the symptoms.

Respondent found hypogonadism and placed his measurements in the patient record. Respondent also found testicular atrophy. He ordered tests for testosterone levels which indicated low levels. He examined the patient's testicles and found them to be small in size with the left being slightly soft and flabby. In addition, Respondent performed a physical examination of Patient B, including examining his thyroid. He also obtained sexual information by speaking with the patient. All this combined to form a sufficient basis upon which to perform the treatment provided to Patient B by Respondent. It also provided, to the extent necessary sufficient information regarding the etiology of the patient's condition.

Performing the varicocelectomy, was expected to halt further testicular atrophy and prevented additional hypogonadism. The patient's testosterone level would be expected to rise. The rise in the level of testosterone would be expected to improve this patient's erections. Hence, his "current status" would be improved and further deterioration would be halted. Again, Patient B sought Respondent due to unsatisfactory erections. It would be fair to say that the course of treatment would certainly provide a fair likelihood of a successful outcome.

Therefore:

Factual Allegation B.4 is **NOT SUSTAINED**
Factual Allegation B.5 is **NOT SUSTAINED**

FACTUAL ALLEGATION B.6

Factual Allegation B.6 again takes issue with the use of the term "bulging." Respondent asserts that his use of the term "bulging" simply means the varicoceles were very prominent. The Committee accepts this explanation and finds that the use of the word "bulging" is within the bounds of accepted standards of medicine.

Therefore:

Factual Allegation B.6 is **NOT SUSTAINED**

FACTUAL ALLEGATION B.8

In Factual Allegation B.8, Respondent is charged with a failure to keep an adequate medical record for this patient. The Committee sustains this charge.

State law requires that all physicians keep an accurate record of the care and treatment of each patient. The standard is such that a medical record should be sufficient to allow a subsequent treating physician or reviewer to know what was done for the patient and what the physician was thinking when he or she performed the treatment described. The purpose of the standard is to provide continuity of care, avoid redundancy and prevent future treating professionals from taking

an action which would be deleterious to the patient when combined with what has already been done.

As stated above, there was no care plan provided by Respondent for this patient. Much of what Respondent did was set down in the record but a significant number of acts and findings were not written down. Much of the information upon which Respondent's expert based his opinion came from Respondent's memory. Respondent stated it would take too much time to set down all the required information. The Committee does not accept this explanation. In order to meet accepted standards of medicine, practitioners are expected to record all significant information for each patient.

The failure to keep adequate patient records is a violation of accepted standards of medicine.

Therefore:

Factual Allegation B.8 is **SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT C

144. Respondent first saw Patient C on March 2, 1998 (Ex. 7).

145. Patient C was referred to Respondent by a Dr. Onfell, a reproductive Endocrinologist (T. 497).

146. Patient C, was a thirty five (35) year old man who complained of a four to five year history of progressively worsening erectile dysfunction (Ex. 7).

147. Patient C's erectile function gradually decreased and at the time of the first visit, he reported having an erection only 50% of what he considered normal (T. 497-498).

148. It had been two years since Patient C had intercourse without any mechanical assistance (T. 497-498).

149. Patient C reported a normal libido and an adequate sexual drive (T. 497-498).

150. Patient C reported a previous evaluation by a general urologist with a showing of a venous leak and a failure to respond to Caverject (T 498).

151. Patient C indicated that he consumed minimal alcohol, did not smoke and took no medications of any kind (T. 498).

152. Respondent always asks a patient about his sexual history and his partners (T. 466).

153. Respondent was informed that Patient C would loose his erection during intercourse and would never reach a full erection even during foreplay (T. 520).

154. Respondent also notes that Patient C and his wife had been attempting to achieve pregnancy for approximately two years by the time of the initial visit. (T. 680; Ex. 7).

155. Hence, the erectile dysfunction began two to three years prior to the attempts to achieve pregnancy (T. 203, 206; Ex. 7).

156. Almost every patient has a psychological component to erectile dysfunction because it is traumatic to a male to have erectile dysfunction (T. 404).

157. The existence of a psychological component does not mean that the problem is entirely or substantially psychogenic (T. 404).

158. Respondent confined his physical examination to Patient C's genitalia, the area in which Respondent believed the problem existed (T. 499-500).

159. Respondent observed that Patient C was a young, healthy man (T. 499-500).

160. There were no obvious physical abnormalities observed by the Respondent (T. 499-500).

161. During Respondent's physical examination of Patient C he discovered significant atrophy of the testes; the left measuring 3.3 by 1.8 cm and the right measuring 3.3 by 1.5 cm (T. 500).

162. Both testicles were soft (T. 500, 676).

163. Patient C's testicles are approximately half the size of normal testicles (T. 212-213).

164. Respondent indicates that the consistency of the testicles is suggestive of a problem (T. 212- 213).

165. Patient C was also discovered to have grade 2 varicoceles which were palpable. (T. 212-213).

166. The words "prominent filling" and "prominent pulse" indicated that the varicoceles decompressed in the supine position (T. 500, 676).

167. When varicoceles decompress in the supine position there is no indication for further retroperitoneal evaluation (T. 351-352, 611-612, 717).

168. The record indicates that Patient C's primary concern was his erectile dysfunction not fertility (T. 355).

169. Respondent diagnosed Patient C with erectile dysfunction based upon:

1. his significant testicular atrophy;
2. his sexual history;
3. the presence of the varicoceles
4. the length of time which Patient C had been experiencing his dysfunction;
5. the failure to improve with conservative treatment. (T. 500, 507,676).

(Ex. 7)

170. Patient C's history did not indicate any blood abnormalities nor did Patient C present any symptoms of blood abnormalities; therefore there was no further laboratory work-up indicated (T. 619, 677).

171. There was no need for further examination of the thyroid since there were no symptoms that would have indicated the need for a work-up (T. 501, 677).

172. At the time he discussed varicocele surgery, Respondent told Patient C that his testosterone levels are "normal but clearly low normal" (T. 221, 510-511, 525; Ex. 7).

173. Respondent told Patient C that varicoceles are clearly linked to testicular dysfunction or low testosterone levels and erectile dysfunction (T. 525-528; Ex. 7).

174. Patient C's varicoceles, the progressive nature of the varicoceles and the atrophy of the testes would also be symptoms that indicate a varicocele ligation (T. 509).

175. Patient C was not diagnosed with hypogonadism (T. 510; Ex. 7).

176. Respondent testified that preserving Patient C's testicular function was essential (T. 509).

177. Varicocele ligation would help to improve Patient C's testicular function or at least prevent any further progression of testicular dysfunction (T. 677-678).

178. Following the varicocele ligation, Patient C's condition improved (T. 679).

179. After the varicocele ligation, Patient C was able to obtain normal erections without the use of erectile aids and without Viagra (T. 261).

180. Patient C exhibited significantly increased muscle development and acne. These developments are associated with an increase in testosterone production (T. 236-237, 265, 679).

181. Patient C was never prescribed testosterone supplementation (T. 510).

182. Respondent provided Patient C with Viagra for only a short time following the procedure. (T. 515-516; Ex. 7).

183. When Patient C informed Respondent that he had "almost normal erections without the Viagra", Respondent did not prescribe any further Viagra (T. 515-517; Ex. 7).

184. Patient C underwent the varicocele ligation on June 25, 1998 and was seen on July 2, 1998 (T. 514).

185. On July 2, 1998 Respondent examined Patient C and conducted the same post operative examination as on the other patients previously described (T. 514).

186. Respondent checked for hydrocele formation and testified that he did not see any indication of hydroceles. If there were hydroceles, Respondent would have noted them in the medical record (T. 514-515).

187. Respondent's examination revealed that Patient C was healing well (T. 514-515).

188. At no time following the procedure was there reoccurrence of varicoceles (Ex. 7).

CONCLUSIONS REGARDING FACTUAL ALLEGATIONS ARISING FROM PATIENT C

FACTUAL ALLEGATION C.1 and C.6

In Factual Allegations C.1 Respondent is charged with failure to obtain an adequate history pre-operative tests and evaluations and perform an adequate preoperative physical examination.

In Factual Allegation C.6, Respondent is cited for failing to adequately evaluate the etiology of Patient C's erectile dysfunction.

The Committee sustains Factual Allegation C. 1, in part. The Committee is satisfied that a sufficient history and preoperative laboratory work up was obtained. However, Respondent admits he did not perform a physical examination except for the genitalia. Respondent stated that this patient was a young, healthy man and therefore, no additional examination was warranted.

In the discussion of Patients A and B, Respondent stated he performed a "head to toe" examination. Both Patient A and Patient B were "healthy men". Therefore, Respondent's reason for failing to perform a more thorough examination on Patient C is inconsistent with his earlier pronouncements. It is a violation of accepted standards for a physician to perform surgery on a patient he or she has not fully examined. While recent tests, studies and notes from other practitioners can be relied upon, there is no substitute for at least a brief examination of all the major body systems where surgery is intended.

For the reasons set forth earlier under Patients A and B, the Committee does not sustain Factual Allegation C. 6. Respondent did all that was necessary to investigate this patient's erectile dysfunction.

Therefore:

Factual Allegation C.1 is **SUSTAINED** (in part)
Factual Allegation C.6 is **NOT SUSTAINED**

FACTUAL ALLEGATIONS C.2 and C.3

In Factual Allegations C.2 and C.3, Respondent is charged with recommending or offering (C.2) and performing (C.3) a varicocelectomy when he "knew or should have known it was an inappropriate therapy for the medical condition he describes in Patient C's medical record." Respondent made the following note in Patient C's record to justify the procedure:

A very lengthy discussion ensued [and] the following points were made to [Patient C]:

1) T [testosterone] levels are normal but clearly "low normal";
2) T [testosterone] plays a key role in normal sexual function;
3) Varicoceles are clearly linked to testicular function and sexual dysfunction;
4) Repair of varicoceles will halt further deterioration;
5) No guarantee was made or implied that repairing varicoceles will "cure" the impotence, however improvement to testicular function should improve sexual function. [Quotation re-formatted for clarity]; (Ex. 1)

In the cases of Patients A and B, Respondent performed the surgery:

1. To correct the hypogonadism
2. To raise serum testosterone;
3. To arrest progressive testicular atrophy
4. To improve "current status;"
5. To prevent future damage;

However, in the case of Patient C, the testosterone levels are normal. There is no mention of hypogonadism and no evidence of testicular dysfunction. The State charges that all the varicocelectomies were unwarranted. In the cases of Patients A and B, the Committee has accepted Respondent's universe of cause and effect. The Committee has found the surgeries to be not inconsistent with accepted standards. However, here, Respondent has acted outside of the universe he created. In other words, according to Respondent, low testosterone is related to hypogonadism and varicocelectomy is the cure. Patient C did not exhibit low testosterone therefore, there was no hypogonadism and therefore no basis for the surgery.

Given the very detailed nature of the pre-operative note, the Committee cannot accept any further explanation for the surgery given by Respondent or his expert. It is noteworthy that Respondent defended the paucity of information in his patient records for Patients A and B by saying he did not have the time to write detailed notes. It is therefore, somewhat paradoxical that he had the time to write a lengthy note regarding Patient C. It is also paradoxical that in a note as specific and all encompassing as the one in question, Respondent offered no legitimate

justification for the surgery. If Respondent had other reasons to perform the surgery, one would expect it to appear in such a detailed note. The evidence shows, there were no other reasons for performing the surgery. In fact, there were no valid reasons for performing the surgery.

Therefore:

Factual Allegation C.2 is **SUSTAINED**.
Factual Allegation C.3 is **SUSTAINED**.

FACTUAL ALLEGATION C.4

Factual Allegation C.4. again takes issue with the use of the term "bulging." Respondent asserts that his use of the term "bulging" simply means the varicoceles were very prominent. The Committee accepts this explanation and finds that the use of the word "bulging" is within the bounds of accepted standards of medicine.

Therefore:

Factual Allegation C.4 is **NOT SUSTAINED**

FACTUAL ALLEGATION C.5

In Factual Allegation C.5, the State asserts Respondent failed to perform an adequate post-operative evaluation of Patient C. The Committee does not agree. In so finding, the Committee notes Respondent did examine Patient C to see that his surgery was healing properly. Respondent noted improvements in Patient C's ability to obtain erections and higher testosterone levels of Respondent. The Committee believes this to be sufficient to meet accepted standards of medicine.

Therefore:

Factual Allegation C.5 is **NOT SUSTAINED**

[Factual Allegation C.6 was addressed in the first section of the conclusions regarding Patient C]

FACTUAL ALLEGATION C.7

In Factual Allegation C.7, Respondent is charged with a failure to keep an adequate medical record for this patient. The Committee sustains this charge.

State law requires that all physicians keep an accurate record of the care and treatment of each patient. The standard is such that a medical record should be sufficient to allow a subsequent treating physician or reviewer to know what was done for the patient and what the physician was thinking when he or she performed the treatment described. The purpose of the standard is to provide continuity of care, avoid redundancy and prevent future treating professionals from taking an action which would be deleterious to the patient when combined with what has already been done.

As stated above, there was no care plan provided by Respondent for this patient. Much of what Respondent did was set down in the record but a significant number of acts and findings were not written down. Much of the information upon which Respondent's expert based his opinion came from Respondent's memory. Respondent stated it would take too much time to set down all the required information. The Committee does not accept this explanation. In order to meet accepted standards of medicine, practitioners are expected to record all significant information for each patient.

The failure to keep adequate patient records is a violation of accepted standards of medicine.

Therefore:

Factual Allegation C.7 is **SUSTAINED**

PATIENT D

189. Respondent first saw Patient D. On July 27, 1998 (T 536, 537; Ex. 9).

190. Patient D was referred to Respondent from an internist from Watertown, New York. Respondent could not remember the referring doctor's name (T.536-537).

191. Patient D suffered from a five to ten year history of declining quality of erections to complete loss of erections (T. 538).

192. Patient D complained that he was unable to obtain a complete erection (T. 538).

193. Patient D stated that at times it would take him in excess of two hours to get a partial erection (T. 538).

194. On rare occasions he was able to obtain complete erections (T. 538).

195. Patient D stated his libido was adequate and that ejaculation was weak 70% of the time (T. 538-539).

196. Patient D reported to have masturbated ten times per week (T. 539).

197. Patient D further indicated to Respondent that he was using hair bands or rubber bands as erectile aids (T. 541; Ex. 10).

198. Patient D had no history or symptoms of diabetes (T. 539).

199. Patient D stopped drinking alcohol 13 years prior to his first visit with Respondent (T. 539).

200. Patient D smoked marijuana ten times per week and smoked two to three packs of cigarettes per day for twenty three years (T. 539).

201. Patient D informed Respondent that he had been having erectile dysfunction from the time that he was in his twenties. Respondent described this as an adult lifetime history (T. 539).

202. The chart for this patient indicated that Respondent advised Patient D to quit smoking and end his use of marijuana. The Respondent's expert, Dr. Schlegel, testified that Patient D had ceased smoking marijuana previously. He has not smoked marijuana in a few years. The medical record for Patient D and Respondent's testimony contradict this expert's testimony (T. 296, 539, 609; Ex. 9).

203. Marijuana use could have an effect on testosterone. However, it was the Respondent's opinion that to affect testosterone substantially, a patient would have to smoke "massive" amounts (T. 540).

204. Respondent took a psychological history and psychosexual history from Patient D (Ex. 10).

205. Respondent told Patient D that his habit of masturbating so frequently was not quite normal (T. 542).

206. Patient D had indicated on his questionnaire that he had been on Prozac, an antidepressant, for a 12 month period from 1993-1994, four years prior to his visit to Respondent (T. 299; Ex. 10).

207. During Patient D's first visit to Respondent he stated that he wasn't taking any antidepressants or depression medication (T. 299).

208. Patient D denied at that time having any depression issues (T. 299).

209. Patient D did not have problems with his libido. He reported a strong libido (T. 299; Ex. 10).

210. Patient D last had sex with a partner in 1997 (T. 303-304; Ex. 10).

211. Respondent performed the same examination upon Patient D that he testified performing previously on his patients (T. 542).

212. Respondent examined Patient D's thyroid and physical examination revealed no abnormalities (T. 543, 545).

213. No further thyroid analysis was indicated. (T. 704)

214. Respondent's examination of Patient D revealed normal genitalia except for atrophied testes (T. 543).

215. The left testis was measured at 3.4 by 1.4 cm and the right measured at 3.5 by 1.5 cm. (T. 543).

216. There were bilateral varicoceles (left side, grade 2 to 2 +; right side, grade 2) (T. 543).

217. Both varicoceles prominently filled when Patient D went from the supine to the upright position and there were no abnormalities noted in the supine position (T. 543).

218. There was no need for further retroperitoneal analysis as Patient D's varicoceles decompressed in the supine position (T. 717).

219. Patient D did not present with any history of blood diseases nor did he present with any symptoms of blood abnormalities (Ex. 9).

220. Patient D had two pre-operative testosterone levels taken 5 days apart which differed by 230 points, but both results were within normal values according to the laboratories at which the tests were done (Ex. 9).

221. It is not unusual that one testosterone analysis may differ from another as testosterone levels fluctuate (T. 546).

222. Respondent diagnosed Patient D with hypogonadism based on his complex history, his initial low testosterone level, the prominent size of his varicoceles and the significant degree of testicular atrophy (T. 548).

223. Libido is very subjective and a man may have a testosterone level high enough to maintain libido, but not high enough to maintain erectile function. It is not unusual that a hypogonadal man may have a normal or strong libido (T. 348-349).

224. Respondent offered and performed the varicocele ligation upon Patient D in an attempt to halt further testicular dysfunction (T. 552, 705).

225. The findings upon physical examination and his low testosterone level were indications for performing the varicocele ligation (T. 705).

226. Patient D underwent a varicocele ligation on August 17, 1998 and was seen by Respondent on August 21, 1998, four days later (T. 552).

227. Respondent performed an extensive postoperative examination which included examining the patient for hydroceles and recurrence of varicoceles. He performed the same examination that he testified to performing previously on his patients (T. 552-553, 567).

228. Patient D had no major complaints during the postoperative examination. Upon examination it was found that Patient D had some bruising and there was no indication of hydrocele formation or recurrence (T. 552-553, 556).

229. After the varicocele ligation, Patient D did report improved sexual function (T.555).

230. It should be noted that when Patient D described these improvements, he had not yet been prescribed Viagra (T. 715; Ex. 9).

231. At no time was Patient D ever prescribed testosterone supplementation (Ex. 9).

232. On October 26, 1998, at his post operative visit, Patient D's testosterone level was 466 (T. 546; Ex. 9).

233. This level was lower than his preoperative testosterone level of 510. Both levels were within normal range. There were no subsequent testosterone levels ordered (T. 292).

234. Patient D's pre-operative testosterone level of 510 was adequate to support erectile function (T. 292).

235. Respondent believed both pre-operatively and postoperatively that in addition to the psychological component, there was an organic component to Patient D's disorder (T. 580).

236. Patient D indicated he had gone to see a therapist only postoperatively. The first mention of qualified sex therapist or psychotherapist takes place in the medical record on 10/26/98. The date of operation on the varicoceles was 8/17/98 (T. 562-567; Ex. 9).

237. Respondent informed him that it would be best to resolve his psychological dysfunction before continuing further with the treatment for his physical dysfunction (T. 562).

CONCLUSIONS REGARDING FACTUAL ALLEGATIONS ARISING FROM PATIENT D

FACTUAL ALLEGATION D.1

In Factual Allegations D.1 Respondent is charged with failure to obtain an adequate history, pre-operative tests and evaluations, and perform an adequate preoperative physical examination. The

Committee is satisfied that a sufficient history and preoperative laboratory work up was obtained. For the reasons set forth earlier under Patients A and B, the Committee does not sustain Factual Allegation D.1.

Therefore:

Factual Allegation D.1 is **NOT SUSTAINED**

FACTUAL ALLEGATIONS D.2 and D.3

In Factual Allegations D.2 and D.3 Respondent is cited for finding hypogonadism warranting treatment (D.2) and performing a varicocelectomy (D.3) without adequate medical justification. The Committee sustains these charges.

Patient D exhibited adequate testosterone levels in two pre-operative laboratory result and one post-operative test. His preoperative Testosterone levels were 272 on July 22 1998, and 510 on July 27. At his post operative visit, his testosterone was 466. All of these were within the "normal" range for the laboratory which performed the test. These lab results lead to several conclusions: First, Patient D had normal testosterone levels prior to the surgery. Second, the surgery had no effect on his production of testosterone.

Throughout this proceeding, the basis for Respondent's finding of hypogonadism have been low testosterone levels. In the case of Patient D, respondent said he performed the surgery because the patient had hypogonadism. However, given the normal level of testosterone, Respondent was forced to make his hypogonadism findings based upon the "complex history of Patient D, his initial low testosterone level, the prominent size of his varicoceles and the significant degree of testicular atrophy." In addition, Respondent's findings that Patient D had "small soft testes" and therefore needed the varicocelectomy contradicts his findings for Patient C who also had "small soft testes" but was not a candidate for surgery based upon that finding. Respondent's records do not support the reason Respondent gave for performing varicocelectomies.

Therefore:

Factual Allegation D.2 is **SUSTAINED**
Factual Allegation D.3 is **SUSTAINED**

FACTUAL ALLEGATIONS D.4 and D.5

Factual Allegations D 2 and D.3 directed the Committee to decide if there was an objective basis for the varicocelectomies. Based upon Respondent's records, the Committee could find no objective basis for the procedure. However, in Factual Allegations D.4 and D.5, the Committee is asked to review an office note which purports to be the basis for the procedure. As the charges are drafted, the Committee cannot sustain them.

> *The repeat [testosterone] level [510] is clearly higher than the 272 initially reported. These wide fluctuations are not clear at this time. However, [Patient D's] history and physical clearly confirm the hypogonadism and the initial T-level confirms this. [Patient D] very clearly requests varicocele ligations because of all these factors.* (Ex. 10)

Respondent's note is an accurate recitation of the facts and circumstances surrounding Patient D. It is not a violation of accepted standards of medicine for Respondent to accede to what appears to be an informed consent from Patient D. Both experts agreed that a varicocelectomy is virtually an elective form of surgery. Testimony was received to the effect that there are those that have the procedure because they are unsatisfied with the way their scrotum looks as a result of a varicocele. Accordingly, based upon the note above, Respondent was not outside the bounds of elective medicine in performing the surgery. Whether or not reasonable minds would find the reasons given to be sufficient was dealt with above. However, the note submitted indicates Respondent usedhis clinical judgment and performed a procedure that he could have believed would help the patient. Hence, the Committee cannot sustain the allegation as posed.

Therefore:

Factual Allegation D.4 is **NOT SUSTAINED**;

Factual Allegation D.5 is **NOT SUSTAINED**

FACTUAL ALLEGATION D.6 WAS WITHDRAWN BY THE STATE

FACTUAL ALLEGATION D.7

In Factual Allegation D.7 Respondent is charged with the failure to perform an adequate post-operative evaluation on this patient. When the post operative testosterone study came back at a lower level than those done pre-operatively, Respondent had a duty to continue to treat this patient. At a minimum, the testosterone test should have been repeated. It is possible that the surgery simply failed. In that case, other avenues should have been explored to fully treat the patient's complaint.

Therefore:

Factual Allegation D.7 is **SUSTAINED**

FACTUAL ALLEGATION D.8

In Factual Allegation D.8 Respondent is cited for failing to adequately evaluate this patient's erectile dysfunction. There can be no doubt that this patient had psychological and perhaps substance abuse problems. Either could have led to erectile dysfunction. It is not sufficient for Respondent to have testified that he tried to have Patient D see a therapist. Respondent had a duty to send Patient D for an evaluation. Surely, the incident of acting out in Respondent's office plus the fact that a middle aged man is reporting he masturbates ten times per week and has not had a sexual relationship in years would require the prudent practitioner to take direct and decisive steps to see that this patient received the treatment he needed. Respondent made no such preoperative effort. Therefore, he was not in compliance with accepted standards of medicine.

Therefore:

Factual Allegation D.8 is **SUSTAINED**

FACTUAL ALLEGATION D.9

In Factual Allegation D.9 Respondent is charged with the failure to maintain an adequate patient record. This patient record was of the same quality as those previously reviewed. Once again there was no treatment plan. Once again, had it not been for Respondent's explanations, vital parts of the treatment of this patient would have been unknown. This is a violation of accepted standards of medicine.

Therefore:

Factual Allegation D.9 is **SUSTAINED**

CONCLUSIONS REGARDING SPECIFICATIONS

FIRST THROUGH FOURTH SPECIFICATION
(Gross Negligence)

The Committee was instructed that negligence is the failure to exhibit that level of care and diligence expected of a physician in this state. Gross negligence is either an egregious violation of that standard of a series of acts which in their sum constitute an egregious violation of the standard.

The Committee found that none of the acts established under Patients A, B, and C constituted egregious violations of accepted standards of medicine which would amount to gross negligence.

However, the Committee found that the care rendered to Patient D was profoundly flawed. Patient D was obviously a very troubled individual. His problems, while no doubt effecting his ability to achieve satisfactory erections, were not physical in nature. He clearly had psychological and substance abuse problems. To perform surgery on such a patient is problematic to begin with. Worse however, Respondent had no substantial justification for performing the surgery. Hence, an individual with a myriad of social adjustment disorders was subjected to surgery. Furthermore, the surgery had no real association with the patient's problems. The fact is that his testosterone levels were normal.

To perform a varicocelectomy on someone like Patient D shows a cavalier disregard for the facts and the well being of that particular individual. It is an egregious violation of accepted standards and, as such constitutes gross negligence.

Therefore:

The First Specification is **NOT SUSTAINED**;
The Second Specification is **NOT SUSTAINED**;
The Third Specification is **NOT SUSTAINED**;
The Fourth Specification is **SUSTAINED**;

FIFTH THROUGH EIGHTH SPECIFICATION
(Gross Incompetence)

The Committee was instructed that incompetence is the failure to exhibit that level of skill and expertise expected of a physician in this state. Gross incompetence is either an egregiousviolation of that standard of a series of acts which in their sum constitute an egregious violation of the standard.

The Committee found that none of the acts established under Patients A, B, and C constituted egregious violations of accepted standards of medicine which would amount to gross incompetence.

However, the Committee found that the care rendered to Patient D was profoundly flawed. For essentially the same reasons set forth under the analysis of gross negligence, the Committee finds gross incompetence. Regardless of what Respondent knew based upon his training and experience, his actions in reference to this patient were those of someone who does not know how to appropriately manage a patient as troubled as Patient D.

To perform a varicocelectomy on someone like Patient D exemplifies an ignorance of the standards for treating erectile dysfunction in a person who is suffering from psychological and possibly substance abuse problems. It is an egregious violation of accepted standards and, as such, constitutes gross incompetence.

Therefore:

The Fifth Specification is **NOT SUSTAINED**;
The Sixth Specification is **NOT SUSTAINED**;
The Seventh Specification is **NOT SUSTAINED**;

The Eighth Specification is **SUSTAINED**;

THE NINTH SPECIFICATION
(Negligence on more than one occasion)

The Committee now turns its attention to the remaining charges to see if any of the facts which were sustained rise to the level of negligence. To begin with, since negligence is a lesser included offense under gross negligence, the Ninth Specification is sustained based upon the facts in allegations D.2, D.3, D.7, D.8 and D.9. In addition, the Committee has sustained Factual Allegations A.7, A.9, B.8, C.1(in part), C.2, C.3, C.5, and C.7. The Committee finds that in each of the acts established Respondent failed to show that level of care and diligence expected of a physician in this state.

Therefore:

The Ninth Specification is **SUSTAINED**

THE TENTH SPECIFICATION
(Incompetence on more than one occasion)

The Committee now turns its attention to the remaining charges to see if any of the facts which were sustained rise to the level of incompetence. Since incompetence is a lesser included offense under gross incompetence, the Tenth Specification is sustained based upon the facts in allegations B.8, C.1 (in part), D.2, D.3, D.7, D.8 and D.9. In addition, the Committee has sustained Factual Allegations A.7, A.9, C.2, C.3, and C.7. The Committee finds that in each of the acts established Respondent failed to show that level of skill and expertise expected of a physician in this state.

Therefore:

The Tenth Specification is **SUSTAINED**

THE ELEVENTH THROUGH FOURTEENTH SPECIFICATION
(FRAUD)

To prove fraud requires proof of a false representation by the respondent, which the respondent knew to be false, and which was made with the intent to mislead (Sherman v. Board of Regents, 24AD2d 315 affd. 19NY2d 679). A respondent's knowledge of his misrepresentation and intention to deceive may be inferred by the Hearing Committee from other evidence found by the Hearing Committee (Saldanha v. DeBuono, 256 AD2d 935)

The fraudulent practice of medicine can be sustained when it is proven that Respondent made an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. The fraudulent practice of medicine is present when:

a.) In the practice of medicine, a false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;

b.) Respondent knew the representation was false;

and

c.) Respondent intended to mislead through the false representation.

Where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences and the basis for the inference.

Therefore:

The Eleventh Specification is **NOT SUSTAINED**
The Twelfth Specification is **NOT SUSTAINED**
The Thirteenth Specification is **SUSTAINED**
The Fourteenth Specification is **NOT SUSTAINED**

THE FIFTEENTH THROUGH THE EIGHTEENTH SPECIFICATION
(Failure to keep adequate records)

Under the discussions of Patients A, B, C, and D, the Committee has found that Respondent kept substandard records. The New York State Education Law, Section 6530, subdivision (32) requires a physician to "maintain a record for each patient which accurately reflects the evaluation and treatment of the patient...." The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given entry or set of entries and be able to understand a practitioner's course of treatment and the basis for same.

The Committee has already stated repeatedly that the Respondent's records did not meet this standard. Indeed, much of the information in this proceeding used by the Committee and Respondent's expert came from Respondent's memory rather than his records. This is a serious violation of accepted standards of medicine. Accordingly, the Committee finds that the facts established under Factual Allegations A.9, B.8, C.7, and D.9 Respondent has failed to keep adequate patient records.

Therefore:

The Fifteenth Specification is **SUSTAINED**
The Sixteenth Specification is **SUSTAINED**
The Seventeenth Specification is **SUSTAINED**
The Eighteenth Specification is **SUSTAINED**

SPECIFICATIONS SUMMARY

The Committee found Dr. Blank guilty of the Fourth Specification of gross negligence. This was based on Patient D. Of the Specifications 5 through 8, alleging gross incompetence, the Committee did not find Specification 5, 6 or 7, but did sustain the Eighth Specification of gross incompetence. Both gross negligence and gross incompetence requires only one event that demonstrates gross negligence or gross incompetence.

The Ninth Specification was sustained based on multiple events listed in the Conclusions regarding Specifications. This establishes negligence.

Incompetence was established also on the basis of multiple events listed in the Conclusions.

The Eleventh through Fourteenth Specification alleged fraud. The Committee did sustain allegations C.2 which establishes fraud.

Under the charge of failure to keep adequate records, the Fifteenth thru Eighteenth Specifications were sustained.

Based on these Specifications, the Committee sustains the allegation that the Respondent, William Blank, M.D., has committed gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraud and inadequate records on more than one occasion.

DISCUSSION OF PENALTY

The Committee was informed, at the end of the hearing, of Dr. Blank's previous encounter with OPMC. The Committee did not find credible, Dr. Blank's statement, that it was a mere lapse in his memory that he did not list a conviction for a felony even though that felony was a number of years ago. The knowledge of this previous encounter, which involved a fraudulent act, and the not fully credible explanation of how it came about, did influence the Committee's penalty deliberations.

The Committee was well educated and aware of the full scope of penalties that could be assigned to this case. While Dr. Blank's actions did not produce life threatening danger to the patients, the multiple occasions on which they occurred did convince the Committee that Dr. Blank should be placed on probation for 5 years as a means of assuring the Committee and the public health at large that the acts which led to these charges will not continue as a part of his practice pattern.

The Committee deliberated at length over the issue of a practice monitor. It was the Committee's unanimous feeling that Dr. Blank did not commit so egregious an act that he requires a supervisor for prospective monitoring, but it was the Committee's strong feeling that a practice monitor should carefully look at the frequency of Dr. Blank's performance of varicocele ligation and report that to the probation officials that are monitoring Dr. Blank's probation. The practice monitor should have full retrospective review capabilities and periodically review the full scope of Dr. Blank's work to recognize early any continued patterns of incompetence, negligence, gross

incompetence, gross negligence, fraud, or inadequate records. We recommend a practice monitor for a term of 5 years.

We further recommend that Dr. Blank be limited to conducting both his outpatient and hospital practice in a hospital system. His current venue, the Veteran's Administration System, is adequate for this purpose. The Committee orders that before relocating, Dr. Blank clear the relocation to the probation officials, who could then determine the quality and scope of a quality assurance system to function as an independent check on the quality of Dr. Blank's practice. The Committee desires that this restriction be present for 5 years.

ORDER

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

1. The Fourth, Eighth, Ninth, Tenth, Thirteenth and Fifteenth through Eighteenth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED**;

2. . Respondent is placed on **PROBATION FOR 5 (FIVE) YEARS**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

3. A fine in the amount of **Thirty Thousand Dollars ($30,000)** be and hereby is imposed against Respondent.

DATED: Troy, New York
March 15, 2005

REDACTED

DENISE BOLAN, P.A.
Chairperson

RICHARD KASULKE, M.D.
JAMES D. HAYES, II M.D.

TO: Timothy J. Mahar, Esq.
Associate Counsel
New York State Department of Health

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Staten Island, New York 10307

William Blank, M.D.

REDACTED

APPENDIX I

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

IN THE MATTER OF WILLIAM BLANK, M.D.	STATEMENT OF CHARGES

William Blank, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 11, 1981, by the issuance of license number 148813 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified by name in Appendix A, hereto) during the period including June 1, 1998 through 1999 at his offices, then located at 725 Irving Avenue, Syracuse, New York and University Hospital, Syracuse, New York. Respondent assessed Patient A on June 1, 1998 as having "bilateral testes atrophy, erectile dysfunction, hypogonadism [and] testicular dysfunction". On July 23, 1998, Respondent performed right and left varicocele ligations on Patient A. Respondent's medical care of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient A prior to surgery, including, but not limited to the failure to do one or more of the following: obtain an adequate history, perform an adequate physical examination, order indicated laboratory studies, and adequately evaluate a pre-operative trial of Viagara.

2. Respondent diagnosed Patient A with hypogonadism to a degree requiring treatment without adequate medical indications.

3. Respondent performed a varicocelectomy on Patient A without adequate medical indication.

4. Respondent recommended or offered a varicocelectomy to Patient A for the following indications as set forth in Patient A's medical record:

> [Patient A's] testicular atrophy and size of the varicoceles plus his documented hypogonadism make the bilateral varicoceles an indicated procedure. Both [Patient A] and [Patient A's wife] agree with this and want to proceed to try to improve his current status and to prevent further deterioration.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical conditions Respondent describes in Patient A's medical record as the indications for the surgery.

5. Respondent performed a varicocelectomy on Patient A for the following indications as set forth by Respondent in Patient A's medical record:

> [Patient A's] testicular atrophy and size of the varicoceles plus this documented hypogonadism make the bilateral varicocele ligation an indicated procedure. Both [Patient A] and [Patient A's wife] agree with this and want to proceed to try to improve his current status and to prevent further deterioration.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical conditions Respondent describes in Patient A's medical record as the indications for the surgery.

6. Respondent in his operative report of Patient A's bilateral varicocelectomy described the varicocele on the right side as "bulging" and the varicocele on the left side as "much larger [than on the right side]". Respondent's description of the size of the varicoceles at surgery was inaccurate and/or misleading. In the alternative, if Respondent's description of the size of the varicoceles as seen at surgery is accurate, then Respondent failed to evaluate Patient A for retroperitoneal pathology.

7. Respondent failed to perform an adequate post-operative evaluation of Patient A.

8. Respondent failed to adequately evaluate Patient A as to the etiology of his erectile dysfunction.

9. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent provided medical care to Patient B during the period including July 24, 1998 through May 20, 1999 at his office and University Hospital. Respondent assessed Patient B on July 24, 1998 as having "erectile

dysfunction, hypogonadism, bilateral varicoceles, [and] bilateral testes atrophy". On November 23, 1998, Respondent performed right and left varicocele ligations on Patient B. Respondent's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient B prior to surgery, including, but not limited to the failure to do one or more of the following: obtain an adequate history, order adequate lab studies, and adequately evaluate any therapeutic benefit of testosterone supplementation to Patient B.

2. Respondent diagnosed hypogonadism in Patient B to a degree requiring treatment without adequate medical indications.

3. Respondent performed a varicocelectomy on Patient B without adequate medical indications.

4. Respondent recommended or offered a varicocelectomy to Patient B for the following indications as set forth in Patient B's medical record:

> [Patient B] reports great concern about needing Viagra for the rest of his life. Patient B clearly states that he wants to correct the hypogonadism and low serum testosterone instead of treating it for the rest of his life. The link between untreated varicoceles and progressive testicular [sic] was discussed in detail and he wants to proceed to try to improve his current status and to prevent future damage.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical condition Respondent describes in Patient B's medical record.

5. Respondent performed a varicocelectomy on Patient B for the following indications as set forth by Respondent in Patient B's medical record:

> [Patient B] reports great concern about needing Viagra for the rest of his life. Patient B clearly states that he wants to correct the hypogonadism and low serum testosterone instead of treating it for the rest of his life. The link between untreated varicoceles and progressive testicular [sic] was discussed in detail and he wants to proceed to try to improve his current status and to prevent future damage.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical condition Respondent describes in Patient B's medical record.

6. Respondent in his operative report of Patient B's bilateral varicocelectomy described a "bulging varicocele" on the right side and "varicosities in the tunica vaginalis which were extremely dilated and quite noteworthy" on the left side. Respondent's description of the size of the varicoceles was inaccurate and/or misleading. In the alternative, if Respondent's description of the size of the varicoceles as seen at surgery was accurate, then Respondent failed to evaluate Patient B for retroperitoneal pathology.

7. Respondent failed to adequately evaluate Patient B as to the etiology of his erectile dysfunction.

8. Respondent failed to maintain an adequate medical record for Patient B.

C. Respondent provided medical care to Patient C during the period including March 2, 1998 through 1998 at his offices and University Hospital. Respondent assessed Patient C on March 2, 1998 as having "erectile dysfunction, bilateral varicoceles [and] testicular dysfunction". On June 25, 1998, Respondent performed right and left varicocele ligations on Patient C. Respondent's medical care deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient C prior to surgery, including, but not limited to one or more of the following: obtain an adequate history, perform an adequate physical examination, and order appropriate laboratory studies.

2. Respondent recommended or offered the varicocelectomy to Patient C for the following indications as set forth in Patient C's medical record:

> A very lengthy discussion ensued [and] the following points were made to [Patient C]:1) T [testosterone] levels are normal but clearly "low normal"; 2. T [testosterone] plays a key role in normal sexual function; 3. Varicoceles are clearly linked to testicular function and sexual dysfunction; 4. Repair of varicoceles will halt further deterioration; 5. No guarantee was made or implied that repairing varicoceles will "cure" the impotence, however improvement to testicular function should improve sexual function.

Respondent knew or should have known that a varicocelectomy was an inappropriate therapy for the medical condition Respondent describes in Patient C's medical record, as the indications for surgery.

3. Respondent performed a varicocelectomy on Patient C for the following indications as set forth by Respondent in Patient C's medical record:

> A very lengthy discussion ensued [and] the following points were made to [Patient C]: 1) T levels are normal but clearly "low normal"; 2. T [testosterone] plays a key role in normal sexual function; 3. Varicoceles are clearly linked to testicular function and sexual dysfunction; 4. Repair of varicoceles will halt further deterioration; 5. No guarantee was made or implied that repairing varicoceles will "cure" the impotence, however improvement to testicular function should improve sexual function.

Respondent knew or should have known that a varicocelectomy was an inappropriate therapy for the medical condition Respondent describes in Patient C's medical record, as the indications for surgery.

4. Respondent described a "bulging varicocele" on Patient C's left side in his operative report. Respondent's description of the size of the varicocele at surgery was inaccurate and/or misleading. In the alternative, if Respondent's description of the varicocele's size was accurate, then Respondent failed to evaluate Patient C for retroperitoneal pathology.

5. Respondent failed to perform an adequate post-operative evaluation.

6. Respondent failed to adequately evaluate Patient C as to the etiology of his erectile dysfunction.

7. Respondent failed to maintain an adequate and/or accurate medical record for Patient C.

D. Respondent provided medical care to Patient D during the period including July 27, 1998 through 1998, at his office and University Hospital. Respondent assessed Patient D on July 27, 1998 as having "bilateral testes atrophy, bilateral varicocele, hypogonadism, [and] testicular dysfunction". On August 17, 1998, Respondent performed right and left varicocele ligations on Patient D. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately evaluate Patient D prior to surgery, including, but not limited to the failure to do one or more of the following: obtain an adequate history and order adequate lab studies.

2. Respondent diagnosed Patient D with hypogonadism to a degree requiring treatment without adequate medical indications.

3. Respondent performed a varicocelectomy on Patient D without adequate medical indications.

4. Respondent recommended or offered the varicocelectomy to Patient D for the following reasons as set forth in Patient D's medical record:

> The repeat [testosterone] level [510] is clearly higher than the 272 initially reported. These wide fluctuations are not clear at this time. However, [Patient D's] history and physical clearly confirm the hypogonadism and the initial T-level confirms this. [Patient D] very clearly requests varicocele ligation because of all these factors.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical condition Respondent describes in Patient D's medical record.

5. Respondent performed a varicocelectomy on Patient D for the following indications as set forth by Respondent in Patient D's medical record:

> The repeat [testosterone] level [510] is clearly higher than the 272 initially reported. These wide fluctuations are not clear at this time. However, [Patient D's] history and physical clearly confirm the hypogonadism and the initial T-level confirms this. [Patient D] very clearly requests varicocele ligation because of all these factors.

Respondent knew or should have known that a varicocelectomy was an inappropriate treatment for the medical condition Respondent describes in Patient D's medical record.

6. Respondent described in the operative report a "massively dilated varicocele" on Patient D's left side and "massively dilated veins" on Patient D's right side. Respondent's description of the size of the varicoceles and veins at surgery was inaccurate and/or misleading. In the alternative, if Respondent's description of the varicocele and vein sizes were accurate, then Respondent failed to evaluate Patient D for retroperitoneal pathology.

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7. Respondent failed to perform an adequate post-operative evaluation of Patient D.

8. Respondent failed to adequately evaluate Patient D as to the etiology of his erectile dysfunction.

9. Respondent failed to maintain an adequate medical record for Patient D.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(4) by reason of his having practiced medicine with gross negligence, in that Petitioner charges:

1. The facts set forth in factual allegation A and A.1, A and A.3, A and A.4, A and A.5.
2. The facts set forth in factual allegation B and B.1, B and B.3, B and B.4, B and B.5.
3. The facts set forth in factual allegation C and C.1, C and C.2, C and C.3.
4. The facts set forth in factual allegation D and D.1, D and D.3, D and D.4, D and D.5.

FIFTH THROUGH EIGHTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(5) by reason of his having practiced medicine with gross incompetence, in that Petitioner charges:

5. The facts set forth in factual allegation A and A.1, A and A.3, A and A.4, A and A.5.
6. The facts set forth in factual allegation B and B.1, B and B.3, B and B.4, B and B.5.
7. The facts set forth in factual allegation C and C.1, C and C.2, C and C.3.
8. The facts set forth in factual allegation D and D.1, D and D.3, D and D.4, D and D.5.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(3) by reason of his having practiced medicine with negligence on more than one occasion, in that Petitioner charges:

9. The facts set forth in two or more of the following factual allegations: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, and/or D and D.9.

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law § 6530(4) by reason of his having practiced medicine with incompetence on more than one occasion, in that Petitioner charges:

10. The facts set forth in two or more of the following factual allegations: A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6, D and D.7, D and D.8, and/or D and D.9.

ELEVENTH THROUGH FOURTEENTH SPECIFICATION

FRAUD IN THE PRACTICE OF MEDICINE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) by reason of his having practiced the profession of medicine fraudulently in that Petitioner charges the following:

11. The facts set forth in factual allegation A and A.4 and/or A and A.6.

12. The facts set forth in factual allegation B and B.4 and/or B and B.6.

13. The facts set forth in factual allegation C and C.2 and/or C and C.4.

14. The facts set forth in factual allegation D and D.4 and/or D and D.6.

FIFTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in the Petitioner charges the following:

15. The facts set forth in factual allegation A and A.6 and/or A and A.9.

16. The facts set forth in factual allegation B and B.6 and/or B and B.8.

17. The facts set forth in factual allegation C and C.4 and/or C and C.7.

18. The facts set forth in factual allegation D and D.6 and/or D and D.9.

DATED: April 9, 2004
Albany, New York

REDACTED

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

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. The Respondent, William Blank, M.D., shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records, which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall work only in a supervised setting, such as a facility licensed by New York State or a U.S. government regulated facility, where close practice oversight is available on a daily basis and where quality assurance and risk management protocols are in effect.

Respondent shall not practice medicine until the supervised setting proposed by Respondent is approved, in writing, by the Director of OPMC.

a. Respondent shall propose an appropriate supervisor or administrator in all practice settings, who shall be subject to the written approval of the Director of OPMC. Respondent shall cause the supervisor or administrator to submit reports, as requested (or quarterly), regarding Respondent's overall quality of medical practice.

b. Respondent shall provide the supervisor/administrator in all settings with the Order and Terms of Probation and shall cause the supervisor/administrator, in writing, to comply with OPMC schedules and requests for information.

c. Respondent shall submit semi-annually a signed Compliance Declaration to the Director of OPMC which truthfully attests whether Respondent has been in compliance with the employment setting and required supervision.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.