Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

March 24, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Claudia M. Bloch, Esq.
NYS Department of Health
145 Huguenot Street
New Rochelle, New York 10801-5228

Steve Song-Shan Ho, M.D.
Redacted Address

Steve Song-Shan Ho, M.D.
Redacted Address

RE: In the Matter of Steve Song-Shan Ho, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-49) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent 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 Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER	DETERMINATION
OF	AND
STEVE SONG-SHAN HO, M.D.	ORDER

BPMC #10-49

A Notice of Hearing and Statement of Charges, dated January 20, 2010, were served upon the Respondent, Steve Song-Shan Ho, M.D. **WILLIAM M. BISORDI, M.D., (Chair), IFFATH ABBASI HOSKINS, M.D. JACQUELINE GROGAN,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(Executive) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Claudia M. Bloch, Esq., Associate Counsel. The Respondent failed to appear in person and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	February 9, 2010
Answer Filed:	None Filed
Pre-Hearing Conference:	March 2, 2010
Hearing Date:	March 8, 2010
Witnesses for Petitioner:	None
Witnesses for Respondent:	None
Deliberations Held:	March 8, 2010

STATEMENT OF CASE

Petitioner has charged Respondent, an obstetrician/gynecologist (OB/GYN), with eleven specifications of professional misconduct. The charges relate to the care and treatment rendered to seven patients. The charges include allegations of gross negligence, in violation of N.Y. Education Law §6530(4), negligence on more than one occasion, in violation of N.Y. Education Law §6530(3), incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5), fraudulent practice of the profession, in violation of N.Y. Education Law §6530(2), and failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32).

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

The Petitioner attempted, unsuccessfully, to personally serve Respondent with the Notice of Hearing and Statement of Charges. The record established that Respondent has apparently left the country and moved to Taiwan without leaving a forwarding address. Pursuant to the provisions of Public Health Law §230(10)(d)(i), the Petitioner then served the papers by certified mail to Respondent's last known address. Accordingly, the Administrative Law Judge ruled that the Board had achieved proper jurisdiction over Respondent.

Respondent failed to file an Answer to the Statement of Charges no later than ten days prior to the hearing, as required by Public Health Law §230(10)(c). Upon motion by the Petitioner, the Administrative Law Judge further ruled that all allegations and charges be deemed admitted.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

Respondent

1. Steve Song-Shan Ho, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 126132 on or about January 12, 1976. (Ex. #10).

Patient A

2. On or about March 6, 2007, Respondent performed a termination of pregnancy (TOP) on Patient A at 16 weeks of gestational age and under sedation, at his office located at 3907 Prince Street, Flushing, New York ("his office"). In the course of the procedure, Respondent perforated the anterior wall of the uterus in two places, as well as caused an aperture in the omentum, which required extensive surgical intervention. (Ex. #12, 13, 28).

3. Respondent failed to obtain and/or note an adequate and complete medical history from Patient A. (Ex. #12, 28).

4. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient A. (Ex. #12, 28).

5. Respondent failed to obtain and/or note significant laboratory tests, including: Rh factor, antibody screen and a complete blood count. (Ex. #12, 28).

6. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. #12, 13, 28).

7. Respondent failed to maintain an anesthesia record for Patient A. (Ex. #12, 28).

8. Respondent falsely informed the Office of Professional Medical Conduct (OPMC) and, with intent to deceive, entered a note in his chart stating that he had performed the TOP on Patient A at the Queens Surgical Center, located in a different suite at the same address as his office, when in fact, Respondent wrongfully performed the procedure in his own office. (Ex. #12, 14, 15, 28).

9. Respondent failed to appropriately maintain his office for the performance of office based procedures, in that he failed to have available adequate equipment for the performance of a second trimester TOP, and failed to have available resuscitation equipment, appropriately trained personnel and established plans to transfer the patient to an acute care facility. (Ex. #28).

10. Respondent falsely informed OPMC that when the perforation occurred, he called 911 and that the patient was transported to Flushing Hospital Medical Center by ambulance. In fact, Respondent did not call 911 and instead,

inappropriately transported Patient A to the hospital in his car. (Ex. #12, 14, 15, 28).

11. Respondent knowingly and willfully created a medical record for Patient A which did not accurately reflect the care and treatment rendered to the patient. (Ex. #12, 14, 15).

12. Respondent failed to maintain a medical record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. #12, 28).

Patient B

13. On or about April 23, 2004, Respondent performed a TOP procedure on Patient B at a Surgical Center located at 81 Willoughby Street, Brooklyn, New York at 12-13 weeks of gestational age and under sedation. In the course of the procedure, Respondent perforated the uterus, which required extensive surgical intervention and a hysterectomy. The TOP began at or about 10:45 a.m. and concluded at or about 11:00 a.m. Patient B began complaining of severe abdominal pain when awakened at or about 11:15 a.m., which intensified over time, along with the patient becoming hypotensive. Upon arrival at The Brooklyn Hospital Center at or about 2:10 p.m., Patient B was in hypotensive shock and delirious. Findings on

exploratory laparotomy revealed about 2000cc of blood present within the abdomen, a large rent in the uterus at the level of the internal cervical os and large hematomas in both the right and left broad ligaments. (Ex. # 16, 17, 28).

14. Respondent failed to obtain and/or note an adequate and complete medical history from Patient B. (Ex. # 16, 28).

15. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient B. (Ex. # 16, 28).

16. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 16, 17, 28).

17. Respondent failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs. (Ex. # 16, 17, 28).

18. Respondent failed to appropriately monitor and evaluate the patient after the TOP and failed to appropriately recognize and/or consider that a uterine perforation had occurred. (Ex. # 16, 17, 28).

19. Respondent inappropriately and with wanton disregard for the welfare of the patient, sought to induce her to leave the Surgical Center, despite the patient's continued

complaints of severe abdominal pain and requests to be brought to the hospital, by offering her $20.00 to take a taxi home. (Ex. # 16, 28).

20. Respondent failed to transfer the patient to an acute care medical facility in a timely manner. (Ex. # 16, 17, 28).

21. Respondent failed to write progress notes contemporaneously with his care and treatment of the patient. (Ex. # 16,28).

22. Respondent failed to maintain a medical record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 16. 28).

Patient C

23. On or about August 17, 2001, Respondent performed a TOP procedure on Patient C at the Ambulatory Surgery Center of Brooklyn, (ASCB) 313 43rd Street, Brooklyn, New York, at 16+ weeks of age and general anesthesia. In the course of the procedure, Respondent caused a 4 cm perforation at the fundus of the uterus with bowel pulled through and noted to be coming from the cervix. Patient C required extensive surgical intervention, which included bowel resection and a colostomy. (Ex. # 18, 19, 28).

24. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 18, 28).

25. Respondent failed to recognize that a perforation had occurred in a timely and appropriate manner. (Ex. # 18, 28).

26. Respondent performed the procedure with inappropriate rapidity and lack of attention. (Ex. # 18, 28).

27. Respondent failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs. (Ex. # 18, 19, 28).

28. Respondent failed to appreciate and/or recognize the significant damage caused in a timely manner. (Ex. # 18, 28).

29. Respondent failed to maintain a medical record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 18, 28).

Patient D

30. Respondent undertook the care and treatment of Patient D from on or about January 18, 2002 through on or about January 25, 2002. On or about January 18, 2002, Respondent performed a TOP on Patient D at the ASCB, at 15+

weeks gestation and under general anesthesia. Respondent took approximately 4 minutes to perform the TOP. During the course of the procedure, Respondent perforated the patient's uterus. An exploratory laparotomy, performed on January 25, 2002, at Franklin Hospital Medical Center, revealed a 3 x 4 cm uterine perforation and an abdominal pregnancy located in the "right gutter just lateral to the ascending colon, and fixed to the abdominal wall." The pathology report of the fetus revealed a macerated male, with arms missing, the lower extremities distorted and with the thoracic and abdominal organs present. (Ex. # 20, 21, 28).

31. Respondent failed to obtain and/or note an adequate and complete medical history from Patient D. (Ex. # 20, 28).

32. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient D. (Ex. # 20, 28).

33. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 20, 28).

34. Respondent performed the procedure with inappropriate rapidity and lack of attention. (Ex. # 20, 28).

35. Respondent failed to inspect the products of conception and tissue removed in an appropriate and acceptable

manner and to appropriately account for removal of all the fetal major organ systems and limbs. (Ex. # 20, 21, 28).

36. Respondent failed to appropriately monitor, evaluate and follow the patient after the TOP and failed to appropriately recognize and/or consider that a uterine perforation had occurred. (Ex. # 20, 28).

37. The pathology report contained in the medical record for Patient D is dated January 29, 2002 and states that the specimen was collected on January 17, 2002 and received on January 18, 2002. The report further concludes that the evaluated specimen was "placental tissue and/or fetal parts". Respondent failed to send the products of conception from the TOP performed on Patient D for pathological review and/or failed to read, question and/or appreciate the inadequacy, and/or validity of the report received. (Ex. # 20, 28).

38. Respondent failed to maintain a medical record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 20, 28).

Patient E

39. On or about January 25, 2002, Respondent performed a TOP procedure on Patient E at ASCB, at approximately 14-15 weeks of gestational age and under general

anesthesia. Respondent discharged the patient from ASCB approximately 40 minutes after completion of the TOP despite her complaint of abdominal pain. Approximately 8 hours after discharge, Patient E presented at the emergency department of Staten Island University Hospital and underwent an emergency exploratory laparotomy, with findings of a 6 cm perforation at the fundus of the uterus and an 8 cm perforation of the sigmoid. Patient E required extensive surgical intervention, which included bowel resection and a colostomy. The fetal head was found to the left of the uterus within the posterior cul de sac. (Ex. # 22, 23, 28).

40. Respondent failed to obtain and/or note an adequate and complete medical history from Patient E. (Ex. # 22, 28).

41. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient E. (Ex. # 22, 28).

42. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 22, 23, 28).

43. Respondent performed the procedure with inappropriate rapidity and lack of attention. (Ex. # 22, 28).

44. Respondent failed to inspect the products of conception and tissue removed in an appropriate and acceptable

manner and to appropriately account for removal of all the fetal major organ systems and limbs. (Ex. # 22, 23, 28).

45. Respondent failed to appropriately monitor, evaluate and follow the patient after the TOP, and failed to appropriately recognize and/or consider that a uterine perforation had occurred. (Ex. # 22, 28).

46. Respondent inappropriately discharged the patient home after completing the procedure, in that the patient had complaints of abdominal pain. (Ex. # 22, 28).

47. Respondent failed to maintain a medical record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 22, 28).

Patient F

48. On or about September 28, 2003, Respondent performed a TOP on Patient F at his office, at approximately 14-15 weeks of gestational age and under sedation. On or about October 3, 2003, Patient F presented at the emergency department of Mt. Sinai Hospital of Queens with complaints of severe and worsening abdominal pain. An exploratory laparotomy was performed revealing a 2 cm fundal uterine perforation; a large mass in the area of the left flank, which pathology reported as "blood clot admixed with products of

conception", and small bowel serosal lacerations. (Ex. # 24, 25, 28).

49. Respondent failed to obtain and/or note an adequate and complete medical history from Patient F. (Ex. # 24, 28).

50. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient F. (Ex. # 24, 28).

51. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 24, 25, 28).

52. Respondent wrongfully performed the procedure in his office, in that he failed to have available adequate equipment for the performance of a second trimester TOP, and failed to have available resuscitation equipment, appropriately trained personnel and established plans to transfer the patient to an acute care facility. (Ex. # 24, 28).

53. Respondent performed the procedure with inappropriate rapidity and lack of attention. (Ex. # 24, 28).

54. Respondent failed to inspect the products of conception and tissue removed and/or to do so in an appropriate and acceptable manner, and to appropriately

account for removal of all the fetal major organ systems and limbs. (Ex. # 24, 25, 28).

55. Respondent failed to appropriately monitor, evaluate and follow the patent after the TOP and failed to appropriately recognize and/or consider that a uterine perforation had occurred. (Ex. # 24, 28).

56. Respondent failed to send the products of conception for pathological review. (Ex. # 24, 28).

57. Respondent failed to maintain a medical record for Patient F in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 24, 28).

Patient G

58. Respondent undertook the care and treatment of Patient G on or about August 24, 2006 and on or about August 25, 2006, performed a TOP procedure on her at his office, at 17-18 weeks of gestational age and under sedation. In the course of the procedure, and without any fetal parts removed, Respondent caused a 3 x 3 cm midline posterior uterine wall perforation and pulled bowel through the perforation with the forceps. Patient G required extensive surgical intervention, which included bowel resection and a colostomy. A free

floating, intact fetus was identified and removed from the abdominal cavity. (Ex. # 26, 27, 28).

59. Respondent failed to obtain and/or note an adequate and complete medical history from Patient G. (Ex. # 26, 28).

60. Respondent failed to perform and/or note a complete and appropriate physical examination of Patient G. (Ex. # 26, 28).

61. Respondent failed to perform the TOP in an appropriate and acceptable manner. (Ex. # 26, 28).

62. Respondent failed to recognize that a perforation had occurred in a timely and appropriate manner. (Ex. # 26, 28).

63. Respondent wrongfully performed the procedure in his office, in that he failed to have available adequate equipment for the performance of a second trimester TOP, and failed to have available resuscitation equipment, appropriately trained personnel and established plans to transfer the patient to an acute care facility. (Ex. # 26, 28).

64. Respondent performed the procedure with inappropriate rapidity and lack of attention. (Ex. # 26, 27, 28).

65. Respondent failed to appreciate and/or recognize the significant damage caused in a timely manner. (Ex. # 26, 28).

66. Respondent failed to maintain a medical record for Patient G in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient. (Ex. # 26, 28).

CONCLUSIONS OF LAW

Respondent is charged with eleven specifications of professional misconduct. The charges relate to the care and treatment rendered to seven patients. The charges include allegations of gross negligence, in violation of N.Y. Education Law §6530(4), negligence on more than one occasion, in violation of N.Y. Education Law §6530(3) incompetence on more than one occasion, in violation of N.Y. Education Law §6530(5), fraudulent practice of the profession, in violation of N.Y. Education Law §6530(2), and failure to maintain accurate medical records, in violation of N.Y. Education Law §6530(32).

The Education Law sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel

for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Incompetence is a lack of the requisite knowledge or skill necessary to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209, 213 (3rd Dept. 1996).

Fraudulent Practice

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (3rd Dept. 1991), citing Brestin v. Commissioner of Education, 116 A.D.2d 357, 501 N.Y.S.2d 923 (3rd Dept. 1986). In order to sustain a charge that a licensee was engaged in the fraudulent practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D,2d 315, 266 N.Y.S.2d 39 (3rd Dept. 1966), aff'd 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). The licensee's knowledge and intent may properly be inferred from facts found by the hearing committee, but the committee must specifically state the inferences it is drawing regarding knowledge and intent. Choudhry, at 894 citing Brestin.

The other charged specifications of misconduct allege the failure to maintain records which accurately reflect the care and treatment of the patient, in violation of N.Y. Education Law §6530(32). The Hearing Committee interpreted this statute in light of the usual and commonly understood meaning of the underlying language. (*See*, New York Statutes, §232).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee takes note of the fact that the charges were deemed admitted, following Respondent's failure to file the statutorily required Answer. Moreover, the medical records received into evidence, combined with the affidavit submitted by Jay Stephen Lupin, M.D., the Department's expert witness, provide an ample basis upon which to sustain the charges. Accordingly, the Hearing Committee voted to sustain all factual allegations, as well as the First through Eleventh Specifications of professional misconduct set forth in the Statement of Charges.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's license to practice medicine should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent has essentially abandoned his right to a medical license by closing his practice, and leaving the country without informing the state of his whereabouts. The charges which were deemed admitted demonstrate serious deficiencies in surgical technique, case management, and lack of attention to possible surgical complications. In addition, Respondent is guilty of fraud in his dealings with the OPMC. Respondent presented no evidence to either refute the charges, or mitigate the penalty. Under the circumstances, revocation is the only sanction which will adequately protect the public, should Respondent ever return to New York.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First through Eleventh Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice medicine in the State of New York is REVOKED;

3. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Larchmont, New York
March 23, 2010

Redacted Signature

WILLIAM M. BISORDI, M.D. (CHAIR)

IFFATH ABBASI HOSKINS, M.D.
JACQUELINE GROGAN

TO: Claudia M. Bloch, Esq.
Associate Counsel
New York State Department of Health
145 Huguenot Street
New Rochelle, New York 10801-5228

Steve Song-Shan Ho, M.D.
Redacted Address

Steve Song-Shan Ho, M.D.
Redacted Address

APPENDIX I

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

STEVE SONG-SHAN HO, M.D.

STATEMENT

OF

CHARGES

STEVE SONG-SHAN HO, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 12, 1976, by the issuance of license number 126132 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about March 6, 2007, Respondent performed a termination of pregnancy (TOP) procedure on Patient A (the identity of all patients is set forth in the annexed Appendix) at 16 weeks of gestational age and under sedation, at his office, located at 3907 Prince Street, Flushing, N.Y ("his office"). In the course of the procedure, Respondent perforated the anterior wall of the uterus in two places, as well as caused an aperture in the omentum, which required extensive surgical intervention. In the care and treatment of Patient A, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient A;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient A;
3. Failed to obtain and/or note significant laboratory tests, including: Rh factor, antibody screen and a complete blood count;

4. Failed to perform the TOP in an appropriate and acceptable manner;

5. Failed to maintain an anesthesia record for Patient A;

6. Falsely informed the Office of Professional Medical Conduct (OPMC) and, with intent to deceive, entered a note in his chart stating he had performed the TOP on Patient A at the Queens Surgical Center, located in a different suite at the same address as his office, when in fact, Respondent wrongfully performed the procedure in own his office.

7. Failed to appropriately maintain his office for the performance of office based procedures, in that Respondent:

   a. Failed to have available adequate equipment and set up for the performance of a second trimester TOP;

   b. Failed to have available resuscitation equipment, appropriately trained personnel and established plans to transfer the patient to an acute care facility.

8. Falsely informed OPMC that when the perforation occurred, he called 911 and the Patient A was transported to Flushing Hospital Medical Center by ambulance. Respondent did not call 911 and, instead, acted inappropriately by transporting the patient to the Hospital in his car;

9. Knowingly and willfully created a medical record for Patient A which did not accurately reflect the care and treatment rendered to the patient;

10. Failed to maintain a medical record for Patient A in accordance with accepted medical standards and in a manner which

accurately reflects his care and treatment of the patient.

B. On or about April 23, 2004, Respondent performed a TOP procedure on Patient B at a Surgical Center located at 81 Willoughby Street, Brooklyn, N.Y., at 12-13 weeks of gestational age and under sedation. In the course of the procedure, Respondent perforated the uterus, which required extensive surgical intervention and a hysterectomy. The TOP began at or about 10:45am and concluded at or about 11:00 am. Patient B began complaining of severe abdominal pain when awakened, at or about 11:15 am, which intensified over time, along with the patient becoming hypotensive. Upon arrival at The Brooklyn Hospital Center at or about 2:10pm, Patient B was in hypotensive shock and delirious. Findings on exploratory laparotomy revealed about 2000cc of blood present within the abdomen, a large rent in the uterus at the level of the internal cervical os and large hematomas in both the right and left broad ligaments. In the care and treatment of Patient B, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient B;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient B;
3. Failed to perform the TOP in an appropriate and acceptable manner;
4. Failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs;
5. Failed to appropriately monitor and evaluate the patient after the TOP and failed to appropriately recognize and/or consider that a

uterine perforation had occurred;

6. Inappropriately and with wanton disregard for the welfare of the patient, sought to induce her to leave the Surgical Center, despite the patient's continued complaints of severe abdominal pain and requests to be brought to the hospital, by offering her $20.00 to take a taxi home;
7. Failed to transfer the patient to an acute care medical facility in a timely manner;
8. Failed to write progress notes contemporaneously with his care and treatment of the patient;
9. Failed to maintain a medical record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

C. On or about August 17, 2001, Respondent performed a termination of TOP procedure on Patient C at the Ambulatory Surgery Center of Brooklyn, 313 43rd Street, Brooklyn, N.Y. (ASCB) at 16 + weeks of gestational age and under general anesthesia. In the course of the procedure, Respondent caused a 4 cm perforation at the fundus of the uterus with bowel pulled through and noted to be coming from the cervix. Patient C required extensive surgical intervention, which included bowel resection and a colostomy. In the care and treatment of Patient C, Respondent:

1. Failed to perform the TOP in an appropriate and acceptable manner;
2. Failed to recognize that a perforation had occurred in a timely and appropriate manner;
3. Performed the procedure with inappropriate rapidity and lack of attention;

4. Failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs;
5. Failed to appreciate and/or recognize the significant damage caused in a timely manner;
6. Failed to maintain a medical record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Respondent undertook the care and treatment of Patient D from on or about January 18, 2002 through on or about January 25, 2002. On or about January 18, 2002, Respondent performed a TOP on Patient D, at the ASCB, at 15 + weeks gestation and under general anesthesia. Respondent took approximately 4 minutes to perform the TOP. During the course of the procedure, Respondent perforated the patient's uterus. An exploratory laparotomy, performed on January 25, 2002, at Franklin Hospital Medical Center, revealed a 3 x 4 cm uterine perforation and an abdominal pregnancy located in the "right gutter just lateral to the ascending colon, and fixed to the abdominal wall." The pathology report of the fetus revealed a macerated male, with arms missing, the lower extremities distorted and with the thoracic and abdominal organs present." In his care and treatment of Patient D, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient D;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient D;
3. Failed to perform the TOP in an appropriate and acceptable

manner;

4. Performed the procedure with inappropriate rapidity and lack of attention;
5. Failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs;
6. Failed to appropriately monitor, evaluate and follow the patient after the TOP and failed to appropriate recognize and/or consider that a uterine perforation had occurred;
7. The pathology report contained in the medical record for Patient D is dated January 29, 2002 and states that the specimen was collected on January 17, 2002 and received on January 18, 2002. The report further concludes that the evaluated specimen was "placental tissue and/or fetal parts. Respondent failed to send the products of conception from the TOP performed on Patient D for pathological review and/or failed to read, question and/or appreciate the inadequacy, inaccuracy and/or validity of the report received;
8. Failed to maintain a medical record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

E. On or about January 25, 2002, Respondent performed a TOP procedure on Patient C at ASCB, at approximately 14 -15 weeks of gestational age and under general anesthesia. Respondent discharged the patient from ASCB approximately 40 minutes after completion of the TOP despite her complaint of abdominal pain. Approximately 8 hours after discharge, Patient E

presented at the emergency department of Staten Island University Hospital and underwent an emergency exploratory laparotomy, with findings of a 6 cm perforation at the fundus of the uterus and a 8 cm perforation of the sigmoid. Patient E required extensive surgical intervention, which included bowel resection and a colostomy. The fetal head was found to the left of the uterus within the posterior cul de sac. In the care and treatment of Patient E, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient E;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient E;
3. Failed to perform the TOP in an appropriate and acceptable manner;
4. Performed the procedure with inappropriate rapidity and lack of attention;
5. Failed to inspect the products of conception and tissue removed in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs;
6. Failed to appropriately monitor, evaluate and follow the patient after the TOP, and failed to appropriately recognize and/or consider that a uterine perforation had occurred;
7. Inappropriately discharged the patient home after completing the procedure, in that the patient had complaints of abdominal pain;
8. Failed to maintain a medical record for Patient E in accordance with accepted medical standards and in a manner which

accurately reflects his care and treatment of the patient.

F. On or about September 28, 2003, Respondent performed a TOP on Patient F at his office, at approximately 14 -15 weeks of gestational age and under sedation. On or about October 3, 2003, Patient F presented at the emergency department of Mt. Sinai Hospital of Queens with complaints of severe and worsening abdominal pain. An exploratory laparotomy was performed revealing a 2 cm fundal uterine perforation; a large mass in the area of the left flank, which, pathology reported as "blood clot admixed with products of conception," and small bowel serosal lacerations. In his care and treatment of Patient F, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient F;
2. Failed to perform and/or note a complete and appropriate physical examination of Patient F;
3. Failed to perform the TOP in an appropriate and acceptable manner;
4. Wrongfully performed the procedure in his office, as alleged in paragraph A.7, A.7.a and A.7.b, supra;
5. Performed the procedure with inappropriate rapidity and lack of attention;
6. Failed to inspect the products of conception and tissue removed and/or to do so in an appropriate and acceptable manner and to appropriately account for removal of all the fetal major organ systems and limbs;
7. Failed to appropriately monitor, evaluate and follow the patient after the TOP and failed to appropriately recognize and/or consider that a uterine perforation had occurred;

8. Failed to send the products of conception for pathological review;

9. Failed to maintain a medical record for Patient F in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

G. Respondent undertook the care and treatment of Patient G on or about August 24, 2006 and, on or about August 25, 2006, performed TOP procedure on her at his office, at 17 - 18 weeks of gestational age and under sedation. In the course of the procedure, and without any fetal parts removed, Respondent caused a 3 x 3 cm midline posterior uterine wall perforation and pulled bowel through the perforation with the forceps. Patient G required extensive surgical intervention, which included bowel resection and a colostomy. A free floating, intact fetus was identified and removed from the abdominal cavity. In the care and treatment of Patient G, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history from Patient G;

2. Failed to perform and/or note a complete and appropriate physical examination of Patient G;

3. Failed to perform the TOP in an appropriate and acceptable manner;

4. Failed to recognize that a perforation had occurred in a timely and appropriate manner;

5. Wrongfully performed the procedure in his office, as alleged in paragraph A.7, A.7.a and A.7.b, supra;

6. Performed the procedure with inappropriate rapidity and lack of attention;

7. Failed appreciate and/or recognize the significant damage caused in a timely manner;

8. Failed to maintain a medical record for Patient G in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

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

1. Paragraphs A, A.1 through A.6, A.7.a, A.7.b, A.8, A.9, A.10, B, B.1 through B.9, C. C.1 through C.6, D, D.1 through D.8, E, E.1 through E.8, F, F.1 through F.9, G, G.1 through G.8.

SECOND SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

2. Paragraphs A, A.1 through A.6, A.7.a, A.7.b, A.8, A.9, A.10, B, B.1 through B.9, C. C.1 through C.6, D, D.1 through D.8, E, E.1 through E.8, F, F.1 through F.9, G, G.1 through G.8.

THIRD SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

3. Paragraphs A, A.1 through A.6, A.7.a, A.7.b, A.8, A.9, A.10, B, B.1 through B.9, C. C.1 through C.6, D, D.1 through D.8, E, E.1 through E.8, F, F.1 through F.9, G, G.1 through G.8.

FOURTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional medical conduct as defined in N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

4. Paragraphs A.6, A.8, A.9

FIFTH THROUGH ELEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of the following:

5. Paragraphs A.1, A.2, A.3, A.5, A.9, A.10
6. Paragraphs B.1, B.2, B.8, B.9
7. Paragraph C.6
8. Paragraphs D.1, D.2, D.8

9. Paragraphs E.1, E.2, E.8

10. Paragraphs F.1, F.2, F.9

11. Paragraphs G.1, G.2, G.8

DATE: January 20, 2010
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct