NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 2, 2019

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ayman Shahine, MD
334 86th Street
Brooklyn, New York 10024

Douglas M. Nadjari, Esq.
Ruskin, Moscou, Faltischek PC
1425 RXR Plaza
Uniondale, New York 11579

Christine Radman, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007

RE: In the Matter of Ayman Shahine, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 19-002) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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

noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

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

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IN THE MATTER	DETERMINATION
OF	AND
AYMAN SHAHINE, M.D.	ORDER
----------X	19-002

A Notice of Hearing[1] and Statement of Charges were served upon AYMAN SHAHINE, M.D. ("Respondent"). Pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("PHL"), STEVEN M. LAPIDUS, M.D., Chairperson, WILLIAM DILLON, M.D., and CURTIS HART, M. DIV., Lay Member, duly designated members of the State Board for Professional Medical Conduct ("Board"), served as the Hearing Committee ("Committee")[2] in this matter. KIMBERLY A. O'BRIEN, served as the Administrative Law Judge.

The Department of Health, Office of Professional Medical Conduct ("Department") appeared by RICHARD J. ZAHNLEUTER, General Counsel, by CHRISTINE RADMAN, Associate Counsel. The Respondent was represented by DOUGLAS NADJARI, Esq. Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made. After full consideration of the entire record, the Committee issues this Determination and Order. The

1 The hearing was scheduled to begin on August 4, 2017 [Ex. 1]. Mr. Nadjari requested an adjournment stating that he had longstanding personal plans and that he had been recently retained by Respondent. The Department opposed the request stating that Mr. Nadjari had been Respondent's counsel during the Department's investigation and was aware of the hearing date and the charges well before he made the request. After considering the reasons for the request and the opposition, the Committee granted the adjournment of the first day of hearing. The hearing began in September 2017 and ended in March 2018; Respondent waived the "120-day requirement" to complete the hearing [ALJ Ex. 7].

2 The original committee included Dr. Lapidus, Rev. Hart, and Ronald Uva, M.D. The original committee, including Dr. Uva, did not anticipate that the initial hearing day would be adjourned for one month or that once the hearing began that its duration would exceed 120 days. Dr. Uva had a lengthy and longstanding European vacation planned to occur in the fall of 2017; and his property in the [redacted] was damaged in hurricane Maria, and he needed to spend significant time there. In both instances, Dr. Uva did not have reliable access to phone and internet services, and he became incapable of serving on the Committee. Pursuant to PHL § 230, the Board Chair replaced Dr. Uva with Dr. Dillon; both specialize in Obstetrics and Gynecology [ALJ Ex. 8].

Committee unanimously sustained sixteen of the twenty–eight specifications of professional misconduct. After full consideration of the penalties available, the Committee has determined that to protect the people of the State of New York the Respondent's license to practice medicine shall be revoked.

PROCEDURAL HISTORY

Pre-Hearing Conference:	September 7, 2017
Hearing Dates:	September 8, 2017 October 24, 2017 October 27, 2017 December 5, 2017 December 6, 2017 January 29, 2018 January 30, 2018 March 23, 2018
Witnesses for Petitioner:	William Koenig, MD Kenneth Baker, MD Martha Quizphi, Senior Investigator Kirby Pyle, IT Director
Witnesses for Respondent:	Nadia Mustafa, Respondent's Employee David Durso, Esq. Ayman Shahine, MD
Written Submissions:	May 18, 2018
Deliberations Held:	May 31, 2018 June 1, 2018 October 10, 2018 November 9, 2018

STATEMENT OF CASE

The Department charged the Respondent with committing professional misconduct as defined in New York Education Law ("NY Educ. Law") including the following: Practicing medicine fraudulently, NY Educ. Law § 6530(2); Practicing medicine with negligence on more than one occasion, NY Educ. Law § 6530(3); Practicing medicine with gross negligence on a particular occasion, NY Educ. Law § 6530(4); Practicing medicine with incompetence on more than one occasion, NY Educ. Law § 6530(5); Practicing medicine with gross incompetence, NY Educ. Law § 6530(6); Willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, NY Educ. Law § 6530(21); Failing to respond within thirty days to written communications from the Department and making relevant records available, NY Educ. Law § 6530(28); and Failing to maintain an adequate medical record, NY Educ. Law§ 6530(32).[3] The charges involve nine patients treated in either Respondent's cosmetic surgery practice or his OB/GYN practice [Ex. 1A]. Respondent "denies each and every factual allegation contained in Factual Allegations paragraphs to the Statement of Charges" and "denies Specifications of Misconduct designated as 1-29 (sic 1-28)" [Ex. A1]. A copy of the Amended Statement of Charges is attached to this Determination and Order as Appendix A. [4]

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3 The General Counsel of the Department of Health has prepared a memorandum of law, "*Definitions of Professional Misconduct under the New York State Education Law*", on the definitions of professional misconduct set forth in New York Education Law § 6530 for the guidance of the hearing committees and the Administrative Law Judge ("memorandum"). Some modifications suggested by Mr. Nadjari and Ms. Radman ("modified memorandum") were made to the memorandum, and it was admitted into the record on October 23, 2018 [ALJ Ex. 2]. The Committee in reaching its determination used the definitions of misconduct provided in NY Educ. Law § 6530 and the explanations contained in the modified memorandum [ALJ Ex. 2].

4 On October 24, 2017, the Department's Amended Statement of Charges was admitted into the record [Ex. 1A].

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Numbers below in parentheses refer to exhibits ("Ex.") or transcript page numbers ("Tr."). The Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on March 8, 1993, by the issuance of license number 191635 ("physician" or "licensee"). In 1996, after Respondent completed his residency in obstetrics and gynecology, at Lutheran Medical Center, Brooklyn, New York, and after passing board examinations, he became board certified in obstetrics and gynecology and was accepted as a fellow, and granted the designation "*Fellow of The American Congress of Obstetricians and Gynecologists*" ("FACOG") [Ex. 2, Ex. B; Tr. 718-721].

2. A physician must maintain a medical record that accurately reflects the care and treatment provided to each patient, this ensures continuity of care. A physician is required to obtain and record vital signs; obtain and record appropriate history; conduct appropriate physical examination(s) and record findings; order appropriate lab work/tests and obtain and record findings ("information"). A physician must consider this information and document indications for treatment, prescribing medications, and performing invasive procedures and surgery [Tr. 23-25, 214-216, 246-264, 376-379, 420-429, 469-470].

3. A physician who performs a procedure/surgery must make or cause to be made a patient operative report/ notes that is made a part of the patient medical record. The operative report/notes should include indications for the procedure/surgery; description of the procedure/surgery; procedure/surgery site(s) and details about the area(s) being treated; vital signs during surgery; type and amount of anesthesia used and how and where it was administered; if indicated, pre-operative

IV access and amount of IV fluids administered, if any; and the outcome of the surgery [Tr. 408 - 409, 415-416, 476-479, 507, 513, 525-528].

4. A physician treating a female patient of child bearing age must obtain and record the patient's menstrual history and pregnancy status before performing invasive medical procedures, surgery and or prescribing medications that are contraindicated during pregnancy. Pregnancy tests are routinely conducted during a patient's visit to a medical office ("office visit") by testing a sample of the patient's urine; the test results can be obtained and considered during the office visit. Pregnancy tests can also be conducted using a sample of a patient's blood, which is sent out to a lab for testing the level/presence of a hormone, "HCG," which is produced in the body during pregnancy [Tr. 25, 212-216, 240-241, 411-414, 427].

Office-based Surgery

5. Office-based surgery means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital"; "excluding minor procedures and procedures requiring minimal sedation". A physician may only perform office-based surgery in an accredited surgery center/ medical office that has obtained and maintains full accredited status ("accredited surgery center") [ALJ Ex. 5 - PHL § 230-d (1)(h), (2) & (3)].

6. A physician may perform "minor procedures" in a medical office that is not accredited ("minor procedures exception"). "Minor procedures means (i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii) procedures performed with local or topical anesthesia; or (iii)

liposuction with the removal of less than 500 cc of fat under un supplemented local anesthesia" ("minor liposuction procedures") [ALJ Ex.5 - PHL § 230-d (1) (g)].

Respondent's Cosmetic Surgery Practice

7. Respondent operates a private solo cosmetic surgery practice known as "NEWYORKBEAUTYSURGEON", "NY Laser Cosmetic Center," and "The Pavilion for Cosmetic Surgery," located at 1 West 34th Street, New York, New York ("cosmetic surgery office"). Respondent performed surgery on Patient A, Patient B, Patient C, and Patient D in his cosmetic surgery office [Ex. 1, Ex. 3A, Ex. 3B, Ex.4, Ex. 5, Ex. 6].

8. Respondent's "NY Laser Cosmetic Center Authorization to Release Records and Assignment of Benefits Form" states that Respondent is "Triple Board Certified FACS, FACOG, FICS" ("benefits form") [Ex. 3A, Ex. 5, Ex. 6].

9. Respondent is not "Triple Board Certified." Respondent has not been accepted as a fellow and has not been granted the designation *Fellow of the International College of Surgeons* ("FICS") or the designation *Fellow, American College of Surgeons* ("FACS") [Ex. 2, Ex. B, Ex. P].

10. Respondent testified that he does "only small simple procedures" ("small cases") in his cosmetic surgery office, using local anesthesia, Klein/tumescent solution [Tr. 741-747, 749, 763-764, 773-765, 882, 1158].

11. Respondent testified that he does not employ any medical staff, nurses or physician assistants, because he does not perform any procedures in his cosmetic surgery office that require surgical assistance or use of general anesthesia/ deep sedation [Tr. 744, 749-750, 751, 757, 771-773, 946-948, 1158-1159].

12. Respondent testified that he refers patients for "big procedures that need multiple things are not done in the office." "I send them to other doctors where they need to be done, you know the appropriate setting" [Tr. 946].

13. Respondent's patient medical records contain little or no patient history; indication of a physical examination; description of surgery/procedure; operative notes; and description of patient outcomes [Ex. 3A, Ex. 4, Ex. 5, Ex. 6].

14. Respondent's patient medical records contain patient receipts and billing history, and documents signed by his patients that insure that Respondent is paid and limit Respondent's liability including: benefits form; photographic consent form; procedure consent form; "Binding Arbitration Agreement"; and "Patient Privacy Notice" [Ex. 3A, Ex. 4, Ex. 5, Ex. 6].

Patient A

15. On November 15, 2013, Patient A, a 65-year-old woman, presented at Respondent's cosmetic surgery practice with a complaint of "rock hard breasts," which made it difficult for her to obtain a mammogram ("initial visit"). Patient A had 37-year-old silicone breast implants that had become encapsulated, and she was seeking to have them removed and replaced. [Ex. 3A at p. 3, 10-11, 13, 21-25, 33-37; Tr. 55].

16. Respondent's medical record for Patient A contains a benefits form, wherein Respondent represents he is "Triple Board Certified;" Patient A signed the form at the initial visit [Ex. 3A].

17. Respondent's medical record for Patient A also contains a signed photographic consent form; a procedure consent form; "Binding Arbitration Agreement;" and "Patient Privacy Notice," all dated November 21, 2013, the day of the surgery [Ex. 3A].

18. Surgery to remove 37-year old encapsulated silicone breast implants is a "long, difficult" and painful operation requiring "good sedation." The implants "are almost always ruptured, so there is free silicone floating everywhere." There is a significant risk for complications and blood loss is to be expected; the scar tissue is "highly vascularized" and it requires "meticulous dissection to protect the surrounding tissue." The surgery should only be performed at a hospital or accredited surgery center, where there is a high degree of sterility, good monitoring of vital signs with IV access and fluids, surgical assistance and appropriate anesthesia [Ex. 3A, Ex. 3B; Tr. 25-30, 44, 55-57, 61-65, 81, 107-111, 185-187, 511].

19. On or about November 21, 2013, at almost midnight and without medical assistance, Respondent operated on Patient A in his cosmetic surgery office using local anesthesia. Respondent removed Patient A's silicone breast implants and replaced them with saline implants. Respondent's operative report for Patient A did not contain any indication that pre-operative IV access was established; a description of the surgical site; a description of the condition of the silicone implants removed by Respondent; location of the new saline implants; size and amount of saline Respondent used to fill the new implants; amount/volume of anesthesia Respondent used and where it was injected; and any indication that during the surgery Patient A was connected to a pulse oximeter, blood pressure cuff, or cardiac monitor [Ex. 3A].

20. Respondent's medical record for Patient A does not contain any preoperative or postoperative photographs of the surgical site or photographs of the silicone implants that were removed [Tr. 63-65; Ex. 3A].

21. Respondent's medical record for Patient A states that her preoperative bloodwork shows that her hemoglobin was 12. 1 and her hematocrit was 38, normal [Ex. 3A at p. 28; 877].

22. Respondent testified that Patient A's surgery was "bloodless;" there was no presence of free silicone; and he placed the saline implants "under muscle" and filled the implants after closing the incision [Tr. 881-882, 838, 859, 875, 877, 901, 915, 939-940, 942].

23. On the morning of November 22, 2013, at approximately 8:42am, Patient A was taken by ambulance to Bellevue Hospital ("hospital") [Ex. 3A; Ex. 3B at p. 84, 102].

Patient A Admitted to the Hospital on November 22, 2013

24. Patient A arrived at the hospital at approximately 9:27am, she was admitted, and the hospital took over her care and treatment. On or about 9:46am, Patient A's hematocrit was 29.7, and at approximately 12:00 noon it was 30.2. Patient A was "clearly on her way to hemodynamic shock" resulting from blood loss experienced from the surgery that Respondent performed on Patient A in his cosmetic surgery office [Ex. 3B at p. 60, 81, 87, 106-111; Tr. 79-81, 169-170, 185-187].

25. Under general anesthesia, Patient A had surgery for an evacuation of a hematoma, approximately 300ccs, that had formed in her left breast; removal of the left saline implant with no replacement, due to a muscle tear and infection risk; debridement and a complex layered closure of her left breast; and cauterization of an arterial bleeder at the skin edge of the lateral skin flap [Ex. 3B at p. 57-61, 66-70, 86-88, 106-111].

Liposuction Surgery

26. Liposuction is elective cosmetic contouring surgery to produce a patient's desired aesthetic effect ("Liposuction or Liposuction surgery"). Subcutaneous fat ("fat") is removed from a patient in a specific area(s) ("problem area(s)") by introducing fluid into the subcutaneous tissue. The type and volume of fluid used must be closely monitored and documented. The operation requires a physician to make small incisions in the skin into which a cannula is inserted and the

cannula is connected to a suction machine where the fluid, which contains the fat, is collected. The fat can be processed and transferred to another area of the body [Tr. 23].

27. Liposuction surgery is not intended for weight loss. No more than 5 liters or 5000ccs, approximately twelve pounds, of fat should be removed from a patient at any one time. When treating more than one problem area, such as the "abdomen and flanks", "the average amount of fat removed is between 3500 to 4000ccs" ("debulking") [Tr. 32, 37].

28. Liposuction surgery is performed in a hospital or an accredited surgery center/ medical office. The common risks associated with liposuction include bleeding and infection of surgical site(s), adverse reactions to anesthesia/medications and need for fluid resuscitation. Liposuction procedures require careful monitoring of patient vital signs; established IV access and monitoring of IV fluids; and in "some instances a urinary catheter may be indicated to regulate a patient's fluid status during surgery." A resuscitation/crash cart should be available in the event of an emergency [Tr. 23, 26-27, 37].

29. Respondent testified that he performs minor liposuction surgery/ "sculpting" in his cosmetic surgery office, and that he does not do "debulking" because it is a "big procedure and needs to be done with a team, not an individual doctor" [Tr. 773]

30. Respondent testified that he was trained in "cosmetic surgery procedures that I felt were easy," "simple," "low risk," and "safe" ("small cases") [Tr. 724, 730-736, 763-765, 1158-1159; Ex. P].

31. Respondent performed liposuction surgery on Patient B, Patient C, and Patient D in his office [Ex. 4, Ex. 5, Ex. 6].

Patient B

32. On or about March 23, 2014, Patient B, a 34-year-old woman, 5' 9" and 212-pounds, presented to Respondent's office. Respondent ordered bloodwork for Patient B, and the results showed an elevated HCG level, indicating pregnancy [Ex. 4 at p. 32-33; Tr. 412-414].

33. Respondent's medical record for Patient B contains signed and initialed consent for "tumescent liposuction" surgery, consent for "fat transfer", photographic consent, "Binding Arbitration Agreement", and "A Client Questionnaire Form" [Ex. 4 at p. 1-3, 13-17, 19-21, 23-28].

34. On April 11, 2014, Respondent performed liposuction surgery on Patient B in his office, without ruling out pregnancy. Respondent's medical record for Patient B does not contain a history and physical examination, surgery sites, and volume of tumescent fluid used during the surgery and sites where it was injected [Ex. 4].

35. Respondent documented in his medical record for Patient B that he removed 320ccs of fat, less than 1 pound. Respondent issued a receipt for payment for the surgery of $3,000.00 identifying treatment areas as "front, inner thigh and back" [Ex. 4 at p. 22, 24, 30; Tr. 414-415].

36. Removal of 320ccs of fat from front, inner thigh and back "would make no appreciable difference in Patient B's appearance" [Tr. 414-415].

Patient C

37. On or about June 21, 2014, at his cosmetic surgery office, Respondent performed a liposuction procedure on Patient C, a 53-year-old woman, 5'11" tall, and weighing 264-pounds. Respondent's medical record for Patient C includes three pages of an unsigned and undated "Binding Arbitration Agreement"; Two pages of "A Client Questionnaire Form," dated March 27, 2014, without a signature page; signed and initialed consents for tumescent liposuction surgery and for fat transfer. Respondent's medical record for Patient C contains photographs of Patient C's

naked body, with three large problem areas marked. The record does not contain a signed photographic consent form [Ex. 5 at p. 12-13, 17-22, 23-25, 30-33].

38. Respondent's medical record for Patient C contains a surgery receipt indicating that the surgery Respondent performed was "belt lipo," liposuction performed around the waist or belt line. The heading on Respondent's operative report for Patient C states "anterior abdomen and sides" ("problem areas"). The body of Respondent's operative report for Patient C does not include a description of the problem areas where the fat was removed and transferred, and the amount of tumescent anesthesia/ fluid used and sites where it was injected [Ex. 5 at p.27, 29-30; Tr. 513].

39. Respondent documented in his medical record for Patient C that he removed a total of 460ccs of fat, less than 1 pound, from these problem areas [Ex. 5].

40. Respondent's medical record for Patient C includes a handwritten surgery receipt from "NY LASER COSMETIC CENTER" ("receipt") which identifies Patient C, the date of her surgery and the procedure, "Surgery: Belt lipo." The receipt notes a $12,000.00 surgery fee; a "$4,500.00 deposit" paid 3 days before the surgery; and a patient balance of $1,000.00, paid on the day of the surgery [Ex. 5 at p. 27, 29-30].

Patient D

41. On or about March 18, 2014, Respondent performed a liposuction procedure on Patient D, a 47-year-old female, 5' 2" tall, and weighing 134-pounds, at his cosmetic surgery office. Respondent did not document the volume of fat removed, how the fat was treated/processed prior to transfer, procedure areas where the fat was removed and where it was transferred; and the amount of anesthesia/fluid used and where it was injected [Ex. 6; Tr. 525-527, 1142-1143].

42. Respondent's medical record for Patient D contains two different receipts for "Procedure Date March 18, 2014." One receipt lists: "Procedure: Brazilian Butt; Total: 6000; Paid

3000;" and "Balance: 0." The other receipt lists "Procedure: Lower Back Sides Ft to butt & hips & Ankle; Total: $6000; Paid $2000; and Balance: $3000" [Ex. 6 at p. 5, 14].

43. The term "Brazilian Butt lift" is a common name for a liposuction surgery where fat is added to the buttocks to lift it. Brazilian Butt lift surgery is a painful and difficult operation associated with significant risk of complications that include developing fat embolism syndrome, which can lead to death. The surgery should only be performed at a hospital or accredited surgery center, where there is a high degree of sterility, good monitoring of vital signs with IV access and fluids, surgical assistance, and appropriate anesthesia [Tr. 530-531].

44. Respondent's medical record for Patient D contains a signed "Procedure Consent Form" and "Permission for Invasive Procedures and/or Treatment;" both are dated March 18, 2014, the day of the procedure. The form does not specifically describe the grave risks associated with Brazilian Butt lift surgery [Ex. 6 at p. 16-17, 19-27; Tr. 530-531].

45. Respondent's medical record for Patient D does not contain a signed photographic consent, but contains a photograph of Patient D's naked body, with marks identifying large problem areas [Ex. 6 at p. 00017].

46. Respondent testified that Patient D "blackmailed" him into doing another "procedure" for "free," and he remembers that he "gave her a touch up for her stomach, another one for free, just to please her, shut her down, so she doesn't keep banding on me." Respondent's medical record for Patient D does not contain information about another procedure [Tr. 1154; Ex. 6].

Respondent's OBGYN Practice

47. Respondent operates a private solo obstetrics & gynecology practice known as both "WOMEN'S HEALTH CENTER - AYMAN A. SHAHINE, MD" and "WOMEN'S MEDICAL HEALTH CHECKUP P.C./AYMAN A. SHAHINE, MD," located at 334 86th Street, Brooklyn,

New York ("Respondent's OBGYN office"). Patient E, Patient F, Patient G and Patient H were treated in Respondent's OBGYN office [Ex. 6, Ex. 7, Ex. 8, Ex. 9].

48. On or about 2010, Respondent employed Seema Hashmi, MD, who treated Patient F, Patient G and Patient H, at Respondent's OBGYN office [Tr. 721-722; Ex. 1, Ex. 7, Ex. 8, Ex. 9].

49. A woman generally has two fallopian tubes, one on the left and one on the right, and each fallopian tube carries eggs to a woman's uterus. An egg is fertilized in the fallopian tube ("pregnancy"), and the fertilized egg travels down the tube into the uterus where it continues to grow and develop ("intrauterine pregnancy") [Tr. 264].

50. An ectopic pregnancy is growth and development of a fertilized egg outside the uterus, which usually occurs in a fallopian tube ("ectopic or tubal pregnancy"), it is a life-threatening condition and surgery must be performed to evacuate the contents of the tube and sometimes requires that the fallopian tube be removed, salpingectomy ("ectopic surgery"). Once a woman has had an ectopic pregnancy it increases the likelihood of another ectopic pregnancy [Tr. 265].

51. A salpingogram is a procedure that is used to view the inside of the uterus and fallopian tubes. The test results can reveal whether either or both two fallopian tubes are "patent"/ open or "occluded"/blocked [Tr. 288-292].

52. A sonogram is a non-invasive procedure which is used to, among other things, see the growth and development of a pregnancy. A sonogram alone cannot rule out a pregnancy in its earliest stages [Tr. 207-208, 212-213, 261].

Patient E

53. Patient E is a woman of child bearing age, who Respondent treated in his OBGYN office from on or about September 27, 2002, when Patient E was 18 years-old, through on or about August 5, 2008, when she was about 24 years old [Ex. 7].

54. On or about January 7, April 15, May 9, May 27, June 17, June 21, July 2, July 9 and August 18, 2003 ("nine visits"). On eight visits Patient E presented at Respondent's OBGYN office with a complaint of pelvic pain, and on the May 27th, visit she presented with a complaint of a missed period. Respondent did not conduct or order a pregnancy test to determine Patient E's pregnancy status [Ex. 7 at p. 71-80, 154-175; Tr. 212-213, 261].

55. Provera is a medication used to induce a woman's menstrual period. Provera is contraindicated for women in the early stages of pregnancy because it can be harmful to a developing fetus [Ex. 7 at p. 75, 124; Tr. 262-264, 338].

56. On May 27, 2003, Patient E presented with a complaint of a missed period, and reported that her last menstrual period occurred on April 21, 2003. Respondent did not conduct or order a pregnancy test to determine Patient E's pregnancy status. Respondent prescribed 10 milligrams of Provera for 15 days [Ex. 7 at p. 76; Tr. 262].

57. On June 21, 2003, Patient E presented with a complaint of pelvic pain and reported that her last menstrual period was in April. Respondent ordered a pregnancy test that revealed that Patient E was 6 to 8 weeks pregnant. Patient E's sonogram did not reveal an intrauterine pregnancy, and Respondent documented "rule-out ectopic" [Ex. 7 at p. 74, 76, 162; Tr. 1266].

58. On June 23, 2003, Respondent operated on Patient E, at Lutheran Medical Center in Brooklyn, New York, to evacuate the contents of a left sided tubal pregnancy [Ex. 7 at p. 111; Tr. 265].

59. On January 23, 2004, Respondent again performed surgery on Patient E for a left sided tubal pregnancy, at Lutheran Medical Center, Brooklyn, New York ("second ectopic surgery"). Respondent's medical record for Patient E does not contain information about the second ectopic surgery he performed or the outcome, and it shows no post-surgery/follow-up visit to Respondent's OBGYN office; Patient E did not visit at any time in 2004 [Ex. 7 at p. 166-177; Tr. 266-269].

60. Patient E next visited Respondent's office on April 13, 2005, and had four more visits to Respondent's OBGYN office in 2005 [Ex. 7 at p. 58-70, 106-107, 109-110, 119, 236-237; Tr. 269-275].

61. In 2007, Respondent saw Patient E four times at his OBGYN office, April 30, July 20, November 16 and December 21, 2007, and each time Patient E received a sonogram. A November 16, 2007 pap smear was positive for trichomonas vaginalis, which is treated with antibiotics. Respondent's medical record for Patient E does not contain a prescription for antibiotics [Ex. 7 pp 18-46, 92-94; Tr. 281-282].

62. Respondent ordered a salpingogram, and the July 13, 2007 test report states that Patient E's right tube was "patent"/ open, and the left tube was "occluded"/ blocked [Ex.7 at p. 95; Tr. 288-292].

63. On May 6, 2008, Patient E presented to Respondent's OBGYN office with a complaint of pelvic pain and pressure, and reported that March 29, 2008 was the first day of her last menstrual period. Respondent ordered an HCG test and ruled out a pregnancy [Ex. 7 at13-17, 89-91; Tr. 293-293].

64. On July 28, 2008, Patient E presented at Respondent's OBGYN office with a complaint of a heavy painful period, and she reported that her last menstrual period began on June

22, 2008. Respondent did not obtain the results of a pregnancy test during the visit or include an order for an HCG test with the blood work he ordered for Patient E [Tr. 1259, 1281, 1293-1295].

65. On July 28, 2008, after leaving Respondent's OBGYN office, Patient E presented to the Emergency Department at Downstate Hospital, Brooklyn, New York ("Hospital"). Patient E was admitted to the Hospital where she underwent a third ectopic surgery including removal of a fallopian tube [Tr. 306-308, 1298].

Urodynamic Testing

66. Urinary frequency is common in early pregnancy due to the enlarging uterus putting pressure on the bladder [Tr. 201-221, 605, 607].

67. Urinary urgency and burning upon urination are common symptoms of a urinary tract infection ("UTI") [Tr. 201-221, 605, 607].

68. Urodynamic testing is used to determine the cause of undiagnosed complaints of involuntary loss of urine. Urodynamic testing is an invasive procedure that is performed by introducing a catheter into the urinary tract and bladder imposing a risk for infection. Urodynamic testing is contraindicated during pregnancy or a urinary tract infection ("UTI") [Tr. 201-221, 369-370, 605, 607].

Patient F

69. On August 30, 2010, Patient F, a 32year-old woman, presented to Respondent's OBGYN office for an initial visit ("initial visit"). Patient F presented with a complaint of pelvic pain for one week, and she reported that she had three live children and a history of one ectopic pregnancy, and her last menstrual period was July 28, 2010. Patient F was seen by Respondent's physician employee, Seema Hashmi, M.D., who ordered a pap smear, and performed a sonogram

which showed a possible physiologic right ovarian cyst. No pregnancy test was ordered [Ex. 8 at p. 30-39; Tr. 342-346].

70. On August 31, 2010, the day after Patient F's initial visit to Respondent's OBGYN office, Respondent's medical record for Patient F indicates that she returned to Respondent's OBGYN office and underwent urodynamic testing for "involuntary loss of urine." Patient F made no urinary complaints at her initial visit on August 30, 2010. Dr. Hashmi did not rule out pregnancy, and Patient F did not sign a consent for the urodynamic procedure. [Ex. 8 at p.10, 26-30; Tr. 349, 356, 381-382].

71. On November 30, 2010, Patient F was seen by the Respondent and she presented with a complaint of post-coital bleeding and reported that her last menstrual period occurred on October 4, 2010. Respondent did not order a pregnancy test to determine Patient F's pregnancy status [Ex. 8 at p.19-20; Tr. 213-216, 356-359].

Patient G

72. On April 27, 2011, Patient G, a 27-year-old woman, with three live children presented to Respondent's OBGYN office with a complaint of a missed period, nausea without vomiting, pelvic pain and urinary frequency, and reported that her last menstrual cycle occurred on February 19, 2011. Patient G was seen by Respondent's physician employee, Seema Hashmi, M.D. [Ex. 9 at p. 6, 26-27].

73. During Patient G's April 27, 2011 visit, Dr. Hashmi ordered a pap smear and bloodwork including an HCG test, and performed a sonogram that revealed an intrauterine pregnancy at over nine weeks, which was later confirmed by the HCG test. Patient G made no urinary complaints [Ex. 9 at p. 6, 15, 26-27].

74. The handwritten date on the Patient G's bill for the services reads "2/27/11" ("bill"). There is no documentation in Patient G's medical record that she visited Respondent's OBGYN office on "2/27/11." The diagnostic codes and the number of weeks pregnant on the bill, as well as the dates on Patient G's blood work, pap smear and signed authorization all correspond to Patient G's April 27th visit to Respondent's OBGYN office ("initial visit") [Ex. 9 at p. 4, 6, 15, 26-27].

75. On April 28, 2011, the day after Patient G's initial visit to Respondent's OBGYN office, it is documented in her medical record that she returned to Respondent's OBGYN office and underwent urodynamic testing for "involuntary loss of urine." Patient G's medical record does not contain a signed consent for urodynamic testing, which is contraindicated during pregnancy [Ex. 9 at p. 5, 28-33].

76. Respondent's bill for the April 28, 2011 urodynamic testing cites the "cystocele" diagnostic code. The medical record for Patient G's April 27, 2011 visit states that Patient G's vaginal, bladder and pelvic support were "normal" and there is no indication of suspected cystocele [Ex. 9 at p. 4-5, 26-27; Tr. 380-382].

Patient H

77. On October 7, 2011, Patient H presented at Respondent's OBGYN practice with a complaint of pelvic pain for one-week, heavy periods for five months and burning on urination for five days ("initial visit"). Patient H reported that she had two live children and a history of one ectopic pregnancy. Respondent's employee, Seema Hashmi, M.D., saw Patient H. She performed a sonogram, and ordered blood work, a urine culture and a pap smear. The urine culture later confirmed that Patient H had a UTI [Ex. 10 at p. 28-37; Tr. 641-642].

78. On October 8, 2011, the day after the initial visit, Patient H's medical record indicates that she underwent urodynamic testing for pelvic pressure and involuntary loss of urine. Patient H had not complained of involuntary loss of urine during the initial visit. Patient H's medical record does not contain a signed consent for the procedure [Ex. 10 at 9, 23-27].

79. Respondent's bill for the October 8, 2011 urodynamic testing cites the "cystocele" diagnostic/ billing code. The medical record for Patient G's October 7, 2011 visit states that Patient H's vaginal, bladder and pelvic support exams were "normal" and there is no indication of suspected cystocele [Ex. 10 at p. 7, 9, 28-29].

Patient I

80. On April 18, 2017, an OPMC investigator sent a letter, by certified mail, to Respondent's counsel of record, demanding a copy of the complete medical record of Patient I. Respondent was charged without being provided with an opportunity for an interview [Ex. 1A; Ex. 13; Tr. 548-555].

DISCUSSION & CONCLUSIONS

The burden of proof is on the Department, PHL § 2803-d(6)(d); 10 NYCRR 81.6. The Department must prove the charges by a preponderance of the evidence, Miller v. DeBuono, 89 N.Y.2d 815 (1997). The Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not, PHL § 230(10)(f). When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department [*See* Prince, Richardson on Evidence § 3-206].

The Department presented two expert witnesses, Dr. Koenig [5] and Dr. Baker, who each provided testimony about whether Respondent met minimum acceptable standards of care. Dr. Koenig is board certified in plastic surgery with 25 years of experience in private practice, and for the last 13 years his practice consists of performing liposuction and body contouring, and cosmetic breast surgeries [Ex. 11]. Dr. Baker is board certified in obstetrics and gynecology, with over 20 years-experience in general hospital based OBGYN practice [Tr. 203-205]. Dr. Baker provided testimony about the care provided in Respondent's OBGYN practice. The Committee found that both these witnesses have the required training and experience to provide an opinion about whether Respondent met minimum acceptable standards of care. The Committee found that they both provided credible testimony and relied on it in reaching its determination.

Respondent testified on his own behalf about both his cosmetic surgery practice and his OB/GYN practice, and the care that he provided to his patients. At the hearing, years after he had provided care to these patients, Respondent testified about details that were not contained in his patient records including: patient histories, surgery/procedure he performed, patient pregnancy status, and tests ordered and results. The Committee found that it strained the bounds of credulity that Respondent could recall these details about the care he provided so long ago, and that it was no coincidence that the details Respondent provided tended to absolve him of misconduct.

5 After the hearing on December 5, 2017, Dr. Koenig and a Committee Member, Reverend Hart, pastor and medical ethicist, had a conversation that lasted approximately five minutes; Dr. Koenig confided in Reverend Hart about issues of a pastoral nature. At the hearing on December 7, 2017, Reverend Hart affirmed that his conversation with Dr. Koenig would not affect his ability to assess Dr. Koenig's credibility and his testimony. During an intra-hearing conference on January 29, 2018, Dr. Koenig provided testimony about the sum and substance of the conversation and affirmed that he had initiated the conversation and had not had any further conversations with Reverend Hart, and that he would not have any further conversations with him or other members of the Committee.

Respondent's Cosmetic Surgery Practice

Dr. Koenig's Testimony

Dr. Koenig testified that Respondent failed to meet acceptable standards of care in the treatment he provided in his cosmetic surgery office to patients A, B, C & D. Respondent does not employ any trained medical staff, and he does not have any hospital affiliations/ admitting privileges. Respondent's medical records do not accurately reflect the care and treatment provided to these patients including that they contain little or no patient history, vital signs, description of surgery/ procedure, surgical report/operative notes, and outcome. Respondent's patient records were all missing important information that would assist subsequent treating physicians in providing continuity of care [Tr. 476-479].

Respondent used the same local anesthesia procedure on all these patients, and it was clearly not appropriate for Patient A [Tr. 60]. While, Respondent documented in his medical record for Patient A that her blood loss during the surgery was "nil," this is "simply not possible" [Tr. 81, 185-187]. It is "common sense" that Patient A's surgery to remove 37-year-old encapsulated breast implants presented significant risk of complications including blood loss and Respondent should not have performed this surgery in his cosmetic surgery office. Patient A developed serious complications because of the surgery Respondent performed in his office; and Patient A was hospitalized and required surgery. Respondent's medical record for Patient D contains a receipt describing the surgery he performed as "Brazillian Butt," which is a risky procedure that can have grave consequences. Respondent should not have performed the surgery on Patient D in his cosmetic surgery office.

Patient B, Patient C & Patient D, are all women of childbearing years, and pregnancy should be ruled out before performing surgery. Respondent performed surgery on Patient B

without ruling out pregnancy and this is a "severe" deviation from the standard of care [Tr. 412-414]. Respondent's medical records for patients B, C & D contain little detail about the liposuction surgery he performed on each of these patients. However, Respondent documented in each medical record the exact amount of fat he removed, which was always less than 500ccs ("minor liposuction surgery"). Respondent also noted in each of these patient records that he addressed multiple problem areas such as abdomen, back, and inner thighs ("multiple problem areas"). Liposuction procedures where a physician is treating multiple problem areas involves the removal of significantly more fat than 500ccs, and these liposuction/debulking surgeries are always performed in a hospital or accredited surgery center. Respondent either performed minor liposuction surgery on these patients that would be of no benefit, or he performed liposuction/ debulking surgery on these patients exposing them to serious risk of infection and complications [Tr. 431].

Respondent's Testimony

Respondent testified that he has a "niche" cosmetic surgery practice where he performs small "low risk" procedures including breast implants, and minor liposuction procedures [Tr. 947]. Since about 2010 Respondent has been focusing on his cosmetic surgery practice. Because he actively practiced as an OBGYN he often performs cosmetic surgery at night. For "20 years as an OB-GYN I never slept a single night." "I can't sleep at night so I work in the afternoon to evenings, late evenings" [Tr. 946]. Many of his patients are "big" women who want to remain "big" and want to enhance their "curves," for instance around the bra line to remove "little fat, little bumps," "500 ccs of fat or less" [Tr. 730-736, 741-47, 1158]. Respondent realized that he does not need to be accredited to perform surgery in his office because he only performs small surgeries/ procedures using local anesthesia [Tr. 677-682]. He does not need medical assistance, but he

usually has an office employee on hand during surgery, to provide comfort to the patient and hand him items he may need [Tr.1060-1061].

Respondent testified that he was authorized to perform surgery on Patient A, and during the surgery he continually monitored Patient A's pulse oximetry, blood pressure and heart rate, and established IV access and administered fluids; he just did not document it [Tr. 891-893]. When Patient A complained of being dizzy, Respondent made sure she was "fine," called 911 and accompanied her in the ambulance to the hospital [Tr. 879, 944]. Because he used tumescent anesthesia, the surgery he performed on Patient A was "bloodless," and any hematoma resulting from the surgery he performed in his office would have resolved without surgery [Tr. 838, 859, 901, 915]. Patient A's hematocrit readings at the hospital were artificially low because she was given a lot of IV fluids, "hemo-dilution," and the blood loss occurred during Patient A's surgery at the hospital [Tr. 677-679]

Respondent testified that before he performed surgery on Patient B, he obtained the results of a pregnancy test that showed Patient B had an HCG level of 34, and Patient B reported to him that she had recently had an abortion. While he did not note the abortion in his medical record for Patient B, he considered it along with the HCG level in ruling out pregnancy [Tr. 1025-1027]. Respondent conceded that his recordkeeping could be better, and he intends to hire a "scribe" to ensure that contemporaneous notes are created and included in his patient records [Tr.1143, 1157].

Respondent's OBGYN Practice

Dr. Baker's Testimony

Dr. Baker testified about the care provided to Patient E, Patient F, Patient G & Patient H, at Respondent's OBGYN practice. When treating women of childbearing age, a physician must determine pregnancy status and rule out pregnancy before prescribing medications, performing

invasive procedures, and surgery. Respondent failed to determine the pregnancy status of Patient E and Patient F.

Ectopic pregnancy is a life-threatening condition, and must be treated immediately. Once a woman has one ectopic pregnancy it is likely to happen again. Respondent's medical record for Patient E shows that he treated her over a long period of time, she has a history of ectopic pregnancy and Respondent performed ectopic surgery on Patient E. Respondent repeatedly failed to rule out pregnancy, and when Patient E presented to his office on July 28, 2012, with a complaint of pelvic pain and missed period, he should have obtained both a urine and HCG pregnancy test; this is a serious deviation from the standard of care.

Urodynamic testing is sometimes ordered if there is an undiagnosed patient complaint of involuntary loss of urine. The patient medical records reflect that Dr. Hashmi saw patients E, F, G & H at Respondent's OBGYN office; that Dr. Hashmi saw each of these patients the day before she ordered/billed for urodynamic testing; and that there is no indication for urodynamic testing.

Respondent's Testimony

Respondent testified that while he is the sole shareholder in his OBGYN practice, during 2010, he was transitioning out of his OBGYN practice to concentrate on his cosmetic surgery practice [Tr. 1183-1184]. Dr. Hashmi was hired to take over his OBGYN practice and she had oversight over clinical matters, staff, and billing [Tr. 1184-1186]. Dr. Hashmi treated Patient E, Patient F, Patient G and Patient H, she ordered urodynamic testing for these patients, and she alone is responsible for the care she provided to these patients [Tr. 1184].

Respondent testified that he treated Patient E over many years, and was aware of her history and performed ectopic surgery on Patient E. When Patient E came to his OBGYN office on July

28, 2012, with a complaint of pelvic pain and missed period, he noted "rule out pregnancy" in his medical record for Patient E [Ex. 7]. He treated Patient F only once and he never saw Patient G or Patient H [Tr. 1184].

THE COMMITTEE'S DISCUSSION & CONCLUSIONS

Specifications First through Fourth – Gross Negligence **Sustained First Specification*

The Department alleged in its first through fourth specifications of misconduct that Respondent is guilty of practicing the profession of medicine with gross negligence on a particular occasion as it relates to the care and treatment he provided to Patient A and Patient B in his cosmetic surgery practice; and Patient E in his OBGYN practice. The Department was required to show that Respondent failed to "exercise the care that would be exercised by a reasonably prudent licensee under the circumstances and that Respondent's deviation from the standard of care in treating Patient A, Patient B and or Patient E was egregious [Ex. 1A, ALJ Ex. 2]. The Committee found that Respondent put Patient A at significant risk in performing surgery in his office with no medical assistance and no provisions in the event of an emergency, that Respondent did not inform Patient A of the risks, and that Respondent misrepresented the amount of blood loss and failed to treat and/or document the care and treatment he provided to Patient A. The Department has met its burden to show that Respondent is guilty of gross negligence in his care and treatment of Patient A. Accordingly, the Committee sustained the first specification of gross negligence.

Fifth Specification - Negligence on More Than One Occasion **Sustained Fifth Specification*

The Department alleged in its fifth specification of misconduct that Respondent practiced medicine with negligence on more than one occasion in the care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E and Patient F. The Department was required to show that on

more than one occasion Respondent failed to "exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and deviated from acceptable medical standards in the treatment of a patient" [Ex. 1A, ALJ Ex. 2]. The Committee found that Respondent clearly deviated from acceptable standards of care in treating these patients including his failure to provide care and/or document in his patient medical records the treatment he provided to each of his patients; and his repeated and pervasive failure to order and obtain the results of pregnancy tests and other tests to inform his treatment decisions. The Committee also found that Respondent failed to inform Patient A and Patient D of the significant risks/complications associated with the surgery he performed, and that Respondent should not have performed these surgeries in his cosmetic surgery office [See Discussion & Conclusions – First through Fourth Specification Gross Negligence]. The Department has met its burden to show that Respondent is guilty of negligence in his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E and Patient F. Accordingly, the Committee sustained the fifth specification of misconduct.

Sixth Specification - Gross Incompetence * *Sustained Sixth Specification*

The Department alleged in its sixth specification of misconduct that Respondent is guilty of gross incompetence in the practice of medicine as it relates to Patient A, Patient B, & Patient E [Ex. 1A, ALJ Ex. 2]. For the Committee to sustain a charge of gross incompetence, the Department needs to show that Respondent lacked the requisite skill, knowledge and training to practice, and that the incompetence can be characterized as significant or serious and has potentially grave consequences. The Committee found that Respondent should not have treated Patient A in his office, he should not have performed surgery on Patient B before obtaining the results of a pregnancy test, and he showed little understanding or insight about the serious nature of his deviations from the standard of care [See Discussion & Conclusions – First through Fourth

Specification - Gross Negligence & Fifth Specification - Negligence on More Than One Occasion]. The Department has met its burden to show that Respondent is guilty of gross incompetence in his care and treatment Patient A and Patient B. Accordingly, the Committee sustained the sixth specification of misconduct.

Seventh Specification - Incompetence on more than one occasion **Sustained Seventh Specification*

The Department alleged in its seventh specification of misconduct that Respondent is guilty of incompetence in the practice of medicine as it relates to patients A, B, C, D, E & F [Ex. 1A, ALJ Ex. 2]. For the Committee to sustain a charge of incompetence, the Department would need to show that Respondent lacked the requisite skill, knowledge and training in his treatment of more than one of these patients. The Committee found that Respondent did not possess the requisite skill, knowledge and training to meet the minimum standard of care in his treatment of Patient A and Patient D [See Discussion & Conclusions, Specifications First through Fourth – Gross Negligence, Fifth Specification – Negligence on More Than One Occasion, and Sixth Specification - Gross Incompetence]. The Department has met its burden to show that Respondent is guilty of incompetence in his care and treatment of Patient A, Patient B, Patient C and Patient D. Accordingly, the Committee sustained the seventh specification of misconduct.

Eighth through Thirteenth Specifications - Fraudulent Practice **Sustained Eighth, Ninth and Tenth Specifications*

The Department alleged in its eighth through thirteenth specifications of misconduct that Respondent is guilty of fraudulent practice, which includes "intentional misrepresentation or concealment of a known fact which is made with the intent to deceive" as it relates to patient A, B, C, F, G, H [Ex. 1A, ALJ Ex. 2]. The Department was required to show that Respondent

knowingly and intentionally concealed Patient A's blood loss during the office surgery; concealed the actual amount of subcutaneous fat removed during Patient B and Patient C's office surgery; and knowingly and intentionally billed for urodynamic testing for Patient F, Patient G, and Patient H that was never performed. The Committee found that Respondent was aware of Patient A's blood loss as a result of surgery, but concealed it; and he knowingly and intentionally reported that he removed less than 500 ccs of fat from Patient B and Patient C to fall within the minor procedures exception [See Discussion & Conclusions – First through Fourth Specification - Gross Negligence, Fifth Specification - Negligence on More Than One Occasion, Sixth Specification - Gross Incompetence, Seventh Specification - Incompetence on more than one occasion]. The Department has met its burden to show that Respondent is guilty of fraudulent practice in his care and treatment of Patient A, Patient B, and Patient C. Accordingly, the Committee sustains the Eighth, Ninth and Tenth Specifications of misconduct.

Fourteenth through Nineteenth Specifications – False Report **Sustained Fourteenth, Fifteenth & Sixteenth Specifications*

The Department alleged in its fourteenth through nineteenth specifications of misconduct that Respondent is guilty of filing a false report as it relates to patient A, B, C, F, G, H [Ex. 1A, ALJ Ex. 2]. The Department must show not only that the report was false, it must show that Respondent made the report with "intent or knowledge of the falsity" [ALJ Ex. 2]. The Department has met its burden in showing that Respondent is guilty of false reporting as it relates to Respondent's cosmetic surgery patients, A, B & C [See Discussion & Conclusions, Specifications Eighth through Thirteenth Specifications-Fraudulent Practice]. Accordingly, the Committee sustains the fourteenth, fifteenth and sixteenth specifications of misconduct. 6

6 The Committee found that Respondent was likely aware of and may have caused urodynamic testing to be ordered/ billed for Patient F, Patient G and Patient H. However, the Committee could not ignore that the patient records show

Twentieth through Twenty-Seventh Specifications – Failure to Maintain Records **Sustained Twentieth through Twenty-Fifth Specifications*

The Department alleged in its twentieth through twenty-seventh specifications of misconduct that Respondent is guilty of failing to maintain a record that accurately reflects the care and treatment of the patient as it relates to patient A, B, C, D, E, F, G, H [Ex. 1; ALJ Ex. 2]. The Committee found that Respondent failed to maintain a record that accurately reflects the care and treatment of the patient as it relates to patient A, B, C, D, E & F [See Discussion & Conclusions, First through Fourth Specification Gross Negligence & Fifth Specification - Negligence on More Than One Occasion]. Accordingly, the Committee sustains the twentieth through twenty fifth specifications of misconduct.

Twenty-Eighth Specification – Failure to respond within thirty days to written communications from DOH and to make available relevant records **NOT SUSTAINED/NOT CONSIDERED**

The Department alleged in its twentieth-eighth specification of misconduct that Respondent is guilty of failing to respond and failing to make relevant records available to the Department [Ex. 1A, ALJ Ex. 2]. The Department did not send the request to the Respondent and it did not provide the Respondent with an opportunity to be interviewed about this allegation. The Committee found that on its face the Department has failed to meet its burden. Accordingly, the Committee did not sustain the twenty-eighth specification of misconduct or consider it in reaching a determination about the other allegations of misconduct.

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that Dr. Hashmi treated patient F, G & H the day before the urodynamic testing was ordered/billed, and her name is listed as the provider on the orders for urodynamic testing services.

PENALTY

The Committee considered the full spectrum of penalties available pursuant to statute including censure and reprimand, suspension, probation, imposition of civil penalties and revocation of Respondent's medical license. It was deeply troubling to the Committee that Respondent, by his own design, has isolated himself from the medical community, and he practices with virtually no oversight. Respondent has no hospital affiliations; he operates two solo practices in different disciplines, cosmetic surgery and obstetrics & gynecology, at two separate locations; he does not participate in regular cosmetic surgery training and uses the same techniques regardless of the circumstances; and he undertook major surgeries/ procedures in his cosmetic surgery office without the assistance of trained medical staff and appropriate equipment/ safeguards. Respondent has also repeatedly failed to accurately document, by omission and intentional misrepresentation, the care and treatment he provided to his patients. While, Respondent testified that he wanted to improve his recordkeeping and that he was going to hire a scribe, the Committee took note that Respondent had long been aware of charges made against him, which included several recordkeeping charges, and at the time of his testimony Respondent had not hired anyone.

The Committee sustained sixteen specifications of misconduct including gross negligence, gross incompetence, negligence, incompetence, fraudulent practice, false reporting, and failure to maintain records. The facts underlying each of the sustained specifications constitute serious misconduct. The evidence shows that Respondent repeatedly and pervasively failed to meet the standard of care in his treatment of his patients. The Department requested that the Committee revoke Respondent's license to practice medicine.

The Committee is keenly aware of the dire impact that revocation of Respondent's license to practice medicine would have on both Respondent and his family, and they struggled to identify

terms where Respondent could receive retraining and oversight to allow him to continue to practice medicine. However, Respondent's repeated intentional misrepresentations, lack of remorse, and his apparent lack of interest in seeking training and improving his practices, lead the Committee to conclude that under the circumstances revocation is the only appropriate sanction available to protect the public.

ORDER

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

1. The First, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, Fourteenth, Fifteenth, Sixteenth, and Twentieth through Twenty-Fifth Specifications of professional misconduct, as set forth in the Amended Statement of Charges, are **SUSTAINED**;

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

3. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail or upon the Respondent at his 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: , **New York**
Dec. 28 , 2018

[redacted]

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APPENDIX A

Depts
Ex 1A
10/24/19 KSO

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

IN THE MATTER

OF

AYMAN SHAHINE, M.D.

AMENDED

STATEMENT

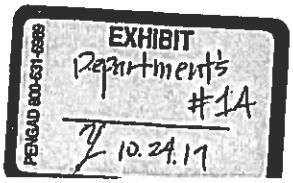
OF CHARGES

AYMAN SHAHINE, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 8, 1993, by the issuance of license number 191635 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about January 6, 2013 through on or about December 17, 2013, Respondent evaluated and treated Patient A, a then 65-year-old woman with 37-year-old breast implants, at his office at 1 West 34th Street, New York, New York, identified alternately under the titles NYBEAUTYSURGEON and NY Laser Cosmetic Center. Respondent deviated from the standard of care in that he exposed Patient A to grave risk as he:

1. On November 21, 2013, performed an extensive surgery involving the removal of Patient A's encapsulated implants and the placing of new saline implants, outside of a hospital operating room or approved office based surgery facility.
2. Failed to provide IV access and/or fluids during Patient A's surgery.
3. Failed to appropriately monitor Patient A's vital signs during the surgery.
4. Failed to document Patient A's blood loss as a result of the surgery.
   a. Respondent did so with intent to deceive.
5. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient A.



B. From on or about January 10, 2014 through on or about April 11, 2014, Respondent evaluated and treated Patient B, a then 5' 9", 212 pound 34-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to follow-up on a March 24, 2014 pre-operative blood result indicating that Patient B was in an early stage of pregnancy before proceeding to perform liposuction on April 11, 2014, on Patient B's abdomen, back and inner thighs with a fat transfer to her buttocks.
2. Failed to obtain a history and physical examination of Patient B at any time before the April 11, 2014 surgical procedure.
3. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient B.
4. Failed to document in his operative report the areas on which he surgically treated Patient B.
5. Falsely documented that he removed only 320 cc of subcutaneous fat combined from all the areas on which he surgically treated Patient B.
   a. Respondent did so with intent to deceive.
6. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient B.

C. From on or about March 27, 2014 through on or about June 25, 2014, Respondent evaluated and treated Patient C, a then 5' 11", 264 pound 53-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient C.
2. Failed to document in his operative report the areas on which he surgically treated Patient C.
3. Falsely documented that he removed only 460 cc of subcutaneous fat combined from all the areas on which he surgically treated Patient C.
   a. Respondent did so with intent to deceive.

4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient C.

D. From on or about February 26, 2014 through on or about March 18, 2014, Respondent evaluated and treated Patient D, a then 5' 2", 143 pound 47-year-woman at his office at 1 West 34th Street, New York, New York. Respondent deviated from the standard of care in that he:

1. Failed to document in his operative report the amount of lidocaine-filled tumescent fluid he injected into Patient D.
2. Failed to document in his operative report the areas on which he surgically treated Patient D.
3. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient D.

E. From on or about September 27, 2002, when Patient E was 18 years-old, through on or about August 5, 2008, Respondent evaluated and treated her within his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Failed to obtain the results of Patient E's May 6, 2008 pap smear, which report on May 12, 2008 revealed normal findings, before performing a medically unnecessary colposcopy on Patient E on May 9, 2008.
2. Operated on Patient E, both in 2003 and 2004, at Lutheran Medical Center in Brooklyn, New York, for the removal of two respective ectopic pregnancies, yet despite this history, failed to obtain a urine test and/or order blood work to rule out pregnancy in Patient E on July 28, 2008, exposing her to great risk.
3. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient E.

F. From on or about August 30, 2010 through on or about January 7, 2011, Respondent evaluated and treated Patient F, a then 32-year-old woman, within

his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Failed to rule out pregnancy in Patient F on November 30, 2010, after Patient F reported a prior surgery for an ectopic pregnancy.
2. Documented that he performed or caused to be performed urodynamic testing on Patient F and billed for such service but, in fact, no such service was provided.
   a. Respondent did so with intent to deceive.
3. Failed to follow-up on Patient F's alleged urologic complaints after the purported August 31, 2010 urodynamic testing.
4. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient F.

G. From on or about February 27, 2011 through on or about April 28, 2011, Respondent evaluated and treated Patient G, a then 27-year-old woman, within his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Documented that he performed or caused to be performed urodynamic testing on Patient G, when she was almost ten weeks pregnant, and billed for such service but, in fact, no such service was provided.
   a. Respondent did so with intent to deceive.
2. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient G.

H. From on or about October 7, 2011 through on or about December 16, 2011, Respondent evaluated and treated Patient H, a then 31-year-old woman, within his OB/GYN practice in Brooklyn, New York. Respondent deviated from the standard of care in that he:

1. Documented that he performed or caused to be performed urodynamic testing on Patient H and billed for such service but, in fact, no such service was provided.

a. Respondent did so with intent to deceive.

2. Failed to maintain a record that accurately reflects the evaluation and treatment of Patient H.

I. On April 18, 2017, an OPMC investigator sent a demand letter for a copy of the complete medical record of Patient I, by certified mail. A signed return receipt was received by OPMC prior to May 12, 2017. To this date, no such record has been received by OPMC from Respondent.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

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 on a particular occasion as alleged in the facts of the following:

1. Paragraph A and each of its subparagraphs, except 4(a).
2. Paragraph B and each of its subparagraphs, except 5 and 5(a).
3. Paragraphs E and E (1).
4. Paragraphs E and E (2).

FIFTH 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:

5. Paragraph A and each of its subparagraphs, except 4(a); Paragraph B and each of its subparagraphs, except 5 and 5(a); Paragraphs C, C (1), C (2) and C (4); Paragraph D and each of its subparagraphs; Paragraph E and each of its subparagraphs and Paragraph F and each of its subparagraphs, except 2 and 2(a).

SIXTH SPECIFICATION

GROSS INCOMPETENCE

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

6. Paragraph A and each of its subparagraphs, except 4(a); Paragraph B and each of its subparagraphs except 5 and 5(a) and Paragraphs E, E (1) and E (2).

SEVENTH 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:

7. Paragraph A and each of its subparagraphs, except 4(a); Paragraph B and each of its subparagraphs, except 5 and 5(a); Paragraphs C, C (1), C (2) and C (4); Paragraph D and each of its subparagraphs; Paragraph E and each of its subparagraphs and Paragraph F and each of its subparagraphs, except 2 and 2(a).

EIGHTH THROUGH THIRTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

8. Paragraphs A and A(4)(a).
9. Paragraphs B, B(5) and B(5)(a).
10. Paragraphs C, C(3) and C(3)(a).
11. Paragraphs F, F(2) and F(2)(a).
12. Paragraphs G, G(1) and G(1)(a).
13. Paragraphs H and H(1) and H(1)(a).

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

FOURTEENTH THROUGH NINTEENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

14. Paragraphs A and A (4).

15. Paragraphs B and B (5).

16. Paragraphs C and C (3).

17. Paragraphs F and F (2).

18. Paragraphs G and G (1).

19. Paragraphs H and H (1).

TWENTIETH THROUGH TWENTY-SEVENTH 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 evaluation and treatment of the patient, as alleged in the facts of:

20. Paragraphs A and A (5).

21. Paragraphs B and B (6).

22. Paragraphs C and C (4).

23. Paragraphs D and D (3).

24. Paragraphs E and E (3).

25. Paragraphs F and F (4).

26. Paragraphs G and G (2).

27. Paragraphs H and H (2).

TWENTY-EIGHTH SPECIFICATION

FAILURE TO RESPOND WITHIN THRITY DAYS TO

WRITTEN COMMUNICATIONS FROM DOH AND

TO MAKE AVAILABLE RELEVANT RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(28) by failing to comply as directed therein, as alleged in the facts of:

28. Paragraph I.

DATE: October , 2017
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct