STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Dennis P. Whalen
*Executive Deputy Commissioner*

April 1, 1999

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Marcia Kaplan, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Michael H. Sussman, Esq.
Sussman Law Offices
25 Main Street
Goshen, New York 10924

James Thomas Horne, M.D.
77 Pondfield Road
Bronxville, New York 10708

RE: In the Matter of James Thomas Horne, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-62) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of □230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER
OF
JAMES THOMAS HORNE, M.D.

DETERMINATION
AND
ORDER

BPMC - 99-62

PATRICK F. CARONE, M.D., Chairperson, RUTH HOROWITZ, PH.D., and ARTHUR J. WISE, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230 (10) (e) and 230 (12) of the Public Health Law. ELLEN B. SIMON, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this Determination.

## AMENDED STATEMENT OF CHARGES

The Amended Statement of Charges essentially charges the Respondent with professional misconduct by reason of having a psychiatric condition that impairs his ability to practice, by practicing while impaired, by practicing with negligence on more than one occasion, and by failure to maintain records.

The charges are more specifically set forth in the Amended Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

## SUMMARY OF THE PROCEEDINGS

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|---|---|
| Statement of Charges Dated: | June 10, 1998 |
| Amended Statement of Charges Dated: | August 26, 1998 |
| Prehearing Conference: | July 7, 1998 |
| Hearing Dates: | July 14, 1998<br>August 18, 1998<br>August 26, 1998<br>September 11, 1998<br>October 27, 1998<br>October 28, 1998<br>November 3, 1998<br>December 8, 1998<br>December 15, 1998 |
| Deliberation Date: | January 27, 1999 |
| Place of Hearing: | NYS Department of Health<br>5 Penn Plaza<br>New York, New York |

Petitioner Appeared By:

Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
By: Marcia E. Kaplan, Esq.
Associate Counsel

Respondent Appeared By:

Sussman Law Offices
25 Main Street
Goshen, New York 10924
By: Michael H. Sussman, Esq.

WITNESSES

For the Department:

Stephen B. Billick, M.D.
Paul R. Weiss, M.D.
Wilfred G. van Gorp, Ph.D.

For the Respondent:

Respondent
Francis Hayden, M.D.
Thomas E. Brown, Ph.D.
Steven Mattis, Ph.D.

## FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or exhibits and denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

1. JAMES THOMAS HORNE, M.D., the Respondent, was authorized to practice medicine in New York State on October 22, 1962, by the issuance of license number 089644 by the New York State Education Department [Dept.'s Exhibit (hereafter "Ex.") 2].

2. On June 3, 1998, Respondent temporarily surrendered his license, without any admission of wrongdoing or of disability relevant to this action, pending the issuance of the final administrative determination in this matter [Stipulation, Transcript pages (hereafter "T.") 17-18, Pre-hearing Conference, July 7, 1998].

3. An Amended Statement of Charges, superseding the original Statement of Charges that was served upon Respondent, was admitted in evidence as Ex. 1C on August 26, 1998 (Exs. 1A, 1B, 1C; T. 571-574).

## FIRST SPECIFICATION: HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE ABILITY TO PRACTICE

4. Respondent has a psychiatric condition that impairs his ability to practice medicine.

5. Stephen Billick, M.D., a psychiatrist and one of the Department's experts who evaluated Respondent, testified that Respondent is suffering from a form of dementia, primarily focused in the frontal lobes of his brain, that is severe enough to impair his judgment and make it difficult for him to practice medicine. Dr. Billick further characterized that dementia as "gradual, insidious, and progressive" (T. 41-42).

6. Wilfred G. van Gorp, Ph.D., the second of the Department's experts, who administered various psychometric tests to Respondent, noted *inter alia* that Respondent's performance on, for example, the Wisconsin Card Sorting Test indicated clinical impairment and frontal lobe dysfunction. Dr. van Gorp testified that someone

performing at Respondent's level would have difficulty adapting to novel situations and rapid changes in his environment, so that a surgeon performing at that level could not be trusted to practice safely (T. 775-782, 878-879).

7. Thomas E. Brown, Ph.D., one of Respondent's experts, testified that Respondent has severe attention deficit disorder (ADD) that, *inter alia*, interferes with his reading and writing and social relationships (T. 1818, 1819, 1872, lines 9-14, 1894). Dr. Brown also said that that disorder would not become less severe over time (T. 1864).

8. Steven Mattis, Ph.D., another of Respondent's experts, testified that Respondent's attentional difficulties are not severe but, rather, are mild (T. 1996).

9. Francis Hayden, M.D., Respondent's treating psychiatrist, noted that during therapy sessions, which began in November 1997, Respondent had difficulty in communicating, and Dr. Hayden was concerned about his ability to function (T. 1703-1704).

The Hearing Committee found these five experts all to be well qualified and credible witnesses, although they offered conflicting or inconsistent testimony on Respondent's impairment. Accordingly, there is not a preponderance of credible evidence that permits the Hearing Committee to determine whether Respondent's impairment is a frontal lobe disorder, attention deficit disorder, or another disorder. In any case, the Committee finds that such impairment is either not adequately in remission or not adequately controlled. The Committee further cites to its more specific **findings of fact** below as to Respondent's behavior and demeanor during the hearing.

## SECOND SPECIFICATION: PRACTICING WHILE IMPAIRED

10. Respondent practiced the profession of medicine while impaired by mental and/or physical disability from in or before 1996 until he temporarily surrendered his license in 1998. During that time, Respondent's impairment was evidenced by his formulating an inappropriate plan of treatment and/or rendering inappropriate care and treatment to Patients A-G, his inadequate and disorganized recordkeeping as to those patients, his failure to maintain an appropriate narcotics log documenting drugs dispensed as against drugs purchased during 1996 and 1997, his writing prescriptions inappropriately in his own name for his wife and for Patient F, and his exhibiting rage and other inappropriate behavior in demanding medicines for his office use and for his wife from pharmacists at two hospitals and at other pharmacies (Exs. 4, 5, 6; T. 145-147, 152-154, 192-193, 706-709).

The Committee further cites to its more specific findings of fact below as to Respondent's departures from the minimally acceptable standard of care in his treatment of Patients A through G.

11. Respondent's recordkeeping and patient care fail to meet the standard of care and evidence his impairment. His medical records, including operative reports, contain incorrect anatomical terms and are missing words that cannot accurately be supplied from the context; they also are often incoherent. Respondent's failure to review his records and his admitted inability to correct them reflect his impairment. In addition, Respondent's explanation of his inability to obtain narcotics for his practice from suppliers when plastic surgeons can obtain such drugs simply by ordering them--together with the unorthodox way in which Respondent sought to get them--reflect his impairment. Moreover, Respondent has demonstrated a lack of insight and an inability to appreciate both the gravity of particular medical situations and his own limitations in managing them (Exs. 6-K, 6-M, 6-O, 6-P, 6-W, 6-X; T. 125-130, 146-147, 657-660, 826-828, 943-944).

12. Respondent's practice put his patients at risk and may have caused actual harm to Patients F and G (T. 661-664).

**CHARGE B.2.F.: FAILING TO MAINTAIN AN APPROPRIATE NARCOTICS LOG DOCUMENTING DRUGS DISPENSED AS AGAINST DRUGS PURCHASED DURING 1996-1997**

13. Respondent's recordkeeping was inadequate and disorganized; he failed to maintain an appropriate narcotics log documenting drugs dispensed as against drugs purchased during 1996-1997 (Ex. 6-R; T. 152-154, 632-635, 643-645).

14. A reasonably prudent plastic surgeon keeps a log that notes the purchases of various narcotics, by date and amount, and how those drugs were dispensed, by date and amount, in order both to adjudicate how much of each was purchased and how much was used and to ensure that the drugs, which are controlled substances, are used in the manner intended. If any of the medicine is drawn but not used and is discarded, the log must record that as well (T. 632-637, 645-646).

15. Respondent's narcotics log deviated from minimally accepted standards. Its first page records the dispensation of drugs but that dispensation is not adjudicated against their purchase. Its second page has so many cross-outs and improperly logged entries that it is unusable (T. 633-635).

**CHARGE B.3.: WRITING PRESCRIPTIONS INAPPROPRIATELY FOR PSYCHOTROPIC AND ADDICTIVE DRUGS IN HIS OWN NAME, FOR HIS WIFE AND FOR PATIENT F DURING THE PERIOD 1994-1996**

16. Respondent's impairment was evidenced by his poor judgment in inappropriately writing prescriptions for psychotropic and addictive drugs in his own name, for his wife, and for Patient F between 1994 and 1996 (Ex. ALJ 4; T. 153-154).

17. Reasonably prudent plastic surgeons do not appropriately prescribe psychotropic or addictive drugs for themselves or their spouses except in case of dire emergency. When a plastic surgeon or his spouse has a legitimate medical condition requiring the prescription of psychotropic and addictive drugs, the physician managing that condition should prescribe those drugs, in order objectively to monitor their administration and to prevent addiction or dependency (Ex. 6-X; T. 648-650, 654-655). Respondent showed poor judgment, in evidence of his impairment, by prescribing controlled substances for his wife (Ex. ALJ 4).

18. Respondent inappropriately prescribed narcotic analgesics Percocet and Roxicet to Patient F from January 1994 through July 1995 after performing surgery to insert calf implants. A reasonably prudent plastic surgeon would have refused to prescribe more Percocet for Patient F after about six weeks after surgery and would have made a progress note in the patient's file of each time that he had prescribed Percocet or a similar drug. Respondent failed to do so. Instead of addressing the source of Patient F's continuing pain by other means, Respondent furthered the patient's drug dependence (Exs. 12, 16, G; T. 418-421, 441, 450).

**THIRD SPECIFICATION: PRACTICING THE PROFESSION OF MEDICINE WITH NEGLIGENCE ON MORE THAN ONE OCCASION**

**STANDARDS OF PRACTICE AS TO PREOPERATIVE MONITORING AND MONITORING DURING SURGERY**

19. STANDARD OF CARE OF PREOPERATIVE MONITORING A reasonably prudent plastic surgeon, practicing within minimally acceptable standards of practice, assesses a patient's vital signs before performing surgery. That permits the physician to evaluate

the patient's condition both before administering any medication, as a baseline, and during the course of treatment, to ensure that the patient's pulse, blood pressure, and oxygen saturation are good. Such information is important in protecting the patient's safety during the surgery and while the patient is exposed to all of its ramifications. Before surgery, a reasonably prudent plastic surgeon would have measured and recorded blood pressure and identified and recorded the medication being taken before the start of the procedure. When a doctor takes vital signs, it is a standard of care to record them (T. 372-374, 376, 526-527, 576).

20. STANDARD OF CARE AS TO MONITORING DURING SURGERY The monitoring a reasonably prudent plastic surgeon would provide for a patient during surgery would include, at a minimum, watching blood pressure and pulse, and oxygen saturation by pulse oximetry. When a physician takes vital signs, it is a standard of care to record them. The surgeon could appropriately either have an assistant take the blood pressure and pulse manually or use an automated system to monitor them. A machine could be set to monitor vital signs at any interval, but standard recording of such signs on an anesthesia record occurs every 15 minutes, unless a dramatic change in vital signs requires notation at another interval.

During surgery, the surgeon has a pulse oximeter that provides continuous monitoring and that changes briefly every few minutes, with an alarm usually set at 90 percent. If the patient's oxygen saturation falls below 90 percent, the alarm goes off, signalling the surgeon either to ask the patient to breathe deeper or, if the patient is being sedated, to slow the sedation or otherwise alter the treatment. The pulse oximeter provides early warning of any deterioration the patient may suffer as result of any untoward event during surgery (T. 374, 376, 394-395, 398-399, 526-527, 576).

21. IMPORTANCE OF MONITORING DURING SURGERY The standard of care for treating patients is the same in an office as it is in a hospital, except that a surgeon has greater responsibility during surgery in an office because that setting does not provide the ancillary personnel and backup available in a hospital.

During surgery, oxygen saturation must be maintained to ensure that the brain is getting enough oxygen. Proper blood pressure must also be maintained to protect vital organs. Careful monitoring gives a surgeon early warning of changes in vital signs that can indicate possible harm to the patient, so that the surgeon can act quickly to prevent or arrest it (T. 374-375, 377-378, 399-401, 409-411, 526-527).

22. RISKS OF FAILURE TO MONITOR AND OF INADEQUATE RECORDKEEPING WITH RESPECT TO MONITORING The unnecessary risks to which a patient may be subjected by inadequate or no monitoring before and during surgery include cardiovascular collapse which, if not remedied, could result in myocardial infarction or even death. Low oxygen saturation, if unchecked, could cause brain damage. Unnecessary risks of vital signs' not being recorded include that a subsequent treating physician or other person reviewing Respondent's records could not know whether the patient's vital signs had been seriously adverse during the prior surgery--a condition that a subsequent treating physician would need to know in order, for example, to avoid problems with a particular medication or procedure (T. 396-397, 410-412, 526-527, 576).

**CHARGE B.1.a.: FAILING TO MONITOR PATIENT E APPROPRIATELY BEFORE AND DURING SURGERY IN OR ABOUT APRIL 1997, AND FAILING TO TAKE OR RECORD VITAL SIGNS**

23. Respondent failed in his practice to meet minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient E by failing to monitor the patient appropriately before and during surgery in or about April 1997, and by failing to take or record vital signs (Ex. 11A, pp. 4-7; Ex. 11B, pp. 3-8; T. 371).

24. Respondent performed on Patient E abdominal liposuction/removal lipodystrophy surgery, which involves removing fat from beneath the skin with a suction technique and a blunt-tipped instrument (Ex. 11A, pp. 4-7; Ex. 11B, pp. 3-8; T. 371-372).

25. The anesthesia that Respondent administered included a tumescent solution of Lidocaine and epinephrine, as well as other medications given intramuscularly (Ex. 11A, pp. 4-7; Ex. 11B, pp. 3-8; T. 372).

26. Respondent left blanks in his operative note, failing to identify the exact amount of medication administered. The note reads "Two hours before surgery she had taken--*blank*--one milligram. She arrived in the office nervous, therefore 100 milligrams Demerol and 5 milligrams Versed were given IM in two separate sites in the deltoid on each side" (i.e., on the shoulder). "She was still not sedated enough and still nervous about the operation. Therefore the remaining--blank--was placed into a sink and entry into vein done and 21 butterfly drawn back into tube, and slow injection was done until nystagmus was seen and slurring of speech. This resulted in giving an additional 5 milligrams" (Ex. 11A, p. 5; T. 372-373).

27. The general minimally acceptable standard of care and findings of fact regarding preoperative and operative monitoring, set forth in findings of fact (FOFs) 19-22 at pages 4-5 above, apply in the circumstances of this surgery (T. 373-378).

28. Respondent failed in April 1997 to provide any monitoring for Patient E and to take Patient E's vital signs before or during surgery (T. 375-376).

29. Failure to take the patient's vital signs before or during surgery creates an unnecessary risk to the patient's general well-being (T. 374-378).

30. Respondent's monitoring of Patient E before and during surgery deviated from minimally acceptable standards of care (T. 378).

31. Respondent's failure to take or record Patient E's vital signs before or during surgery deviated from minimally acceptable standards of care (T. 378-379).

32. Respondent failed to formulate an appropriate plan of treatment for Patient E. An appropriate plan would have included the monitoring of the patient (T. 378).

**CHARGE B.1.b.: FAILING TO TAKE PATIENT A'S VITAL SIGNS PRIOR TO THE ADMINISTRATION OF SEDATIVES AND HYPNOTICS AND/OR DELAYING UNREASONABLY IN PROCEEDING WITH SURGERY AFTER THE ADMINISTRATION OF ANESTHESIA IN OR ABOUT APRIL 1997**

33. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient A by failing to take Patient A's vital signs before administering sedatives and hypnotics and/or by delaying unreasonably in proceeding with surgery after the administration of anesthesia in or about April 1997 (Ex. 7; T. 525-532, 576-577).

**B.1.b.: Failing to take Patient A's vital signs prior to the administration of sedatives and hypnotics in or about April 1997**

34. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient A by failing to take Patient A's vital signs before the administration of sedatives and hypnotics (Ex. 7, p. 13; T. 525).

35. In April 1997, Respondent performed on Patient A touch-up liposuction or lipodystrophy of small areas remaining after liposuction (Ex. 7, p. 13; T. 525).

36. Before surgery, Respondent administered sedatives and hypnotics to Patient A: 10 milligrams of Valium and 100 milligrams of meperidine (Demerol) (Ex. 7; T. 525-526).

37. Respondent failed to take Patient A's vital signs before administering sedatives and hypnotics in April 1997 (Ex. 7; T. 526).

38. The general minimally acceptable standard of care and findings of fact regarding preoperative and operative monitoring, set forth in FOFs 19 and 22 at pages 4 and 5 above, apply in the circumstances of this surgery (T. 526-527, 576).

39. Respondent's administration of sedatives and hypnotics without first taking Patient A's vital signs deviated from minimally acceptable standards of care (T. 528, 576).

40. Respondent failed to formulate an appropriate plan of treatment for Patient A. It was inappropriate to attempt to do surgery on a patient with sedation of this nature without first determining what her vital signs were (T. 528, 576).

**B.1.b.: Delaying unreasonably in proceeding with surgery after the administration of anesthesia in or about April 1997**

41. Respondent failed to practice according to minimally acceptable standards by delaying unreasonably in proceeding with surgery after administering anesthesia in or about April 1997 (Ex. 7, p. 13; T. 528-532).

42. Respondent's operative report establishes that he administered anesthesia to Patient A including, first, the intramuscular medication discussed above and, a long time later, intravenous medication. The record fails to indicate what medication was administered. As to how much time elapsed between Respondent's initial anesthesia of Patient A and the beginning of surgery, the record states that "while she was waiting, two patients' surgery was performed and therefore it was approximately three hours after this that she came to the OR" (Ex. 7, p. 13; T. 528-530).

43. A reasonably prudent plastic surgeon would not administer the anesthesia that Respondent gave to Patient A and then delay three hours in starting surgery. The effects of the medication would peak long before three hours had elapsed, so that additional intravenous medication--which would otherwise have been unnecessary--would be required. The delay renders the initial dosage superfluous and adds to the needless risk of any complications that might arise from sedating the patient and leaving her unobserved for three hours (T. 530).

44. In fact, one reason for the three-hour delay is that Respondent ran out of drugs that he needed for the surgery and then tried to obtain them while Patient A was already under sedation (T. 953-956, 989-991, 1170-1174).

45. Respondent failed to monitor the patient after his initial administration of anesthesia (T. 530).

46. Respondent's delay, in or about April 1997, in starting to operate on Patient A after she had been sedated deviated from minimally acceptable standards of care (T. 531-532).

47. Respondent failed to anticipate that the surgery he had planned to perform on Patient A could not be accomplished without intravenous sedation (T. 532).

48. Respondent failed to formulate an appropriate plan of treatment for Patient A (T. 532).

**CHARGE B.1.c.: FORMULATING AN INAPPROPRIATE PLAN IN OR ABOUT FEBRUARY 1997 TO PERFORM LIPOSUCTION ON PATIENT A ON MULTIPLE SITES WITH LOCAL ANESTHESIA ALONE, AND/OR ADMINISTERING SEDATION WITHOUT PROPER MONITORING**

49. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and/or rendering inappropriate care and treatment to patients by formulating an inappropriate plan in or about February 1997 to perform liposuction on Patient A on multiple sites with local anesthesia alone (Ex. 7, pp. 7-8; T. 516-521).

50. Respondent next undertook to operate on Patient A on or about February 18, 1997. Two notes in the record indicate that Respondent planned to perform liposuction at multiple sites including areas of the upper thigh, hips, under the arms, pelvic rim, and medial thighs (Ex. 7, pp. 7-8; T. 516-517).

51. At the start of the procedure, Respondent administered to Patient A intramuscularly 5 milligrams of Versed and 75 milligrams of Demerol. The local anesthesia that Respondent planned to use was tumescent fluid, but because of the patient's discomfort, the procedure was terminated, so that not all the fluid was instilled (T. 506, 517-518).

52. A reasonably prudent plastic surgeon would not have planned to perform liposuction on Patient A at multiple sites with local anesthesia alone. With such a minimal amount of sedation it would be very difficult for a patient to tolerate liposuction at that many sites, because of both the discomfort at each initial site and the amount of time needed to perform adequate liposuction (T. 518-519).

53. An average liposuction for this many sites could take a minimum of about two hours (T. 519).

54. Respondent's plan for surgery subjected Patient A to needless risk. To have attempted to operate on so many sites without adequate sedation was imprudent (see FOFs 50 and 51 above), and to give enough medication intramuscularly to provide adequate sedation would have put the patient at risk of being oversedated. Respondent's plan could have caused cardiovascular problems and undue anxiety that might have precipitated such other problems as myocardial infarction, although in a healthy patient like Patient A such problems would be relatively unlikely. Finally, if carried out, Respondent's plan would have subjected Patient A to unnecessary pain (T. 519-520).

55. To perform liposuction on so many sites involving so many areas of the body, a reasonably prudent plastic surgeon would have planned to use either general anesthesia or intravenous sedation and monitoring. That would ensure that the patient would be deeply enough sedated to avoid discomfort during instillation of tumescent fluid and subsequent liposuction. In addition, a reasonably prudent plastic surgeon who undertook a similar procedure with either general anesthesia or IV sedation would be assisted by either an anesthesiologist or a nurse anesthetist (T. 520-521).

56. There was no such person present in the operating room while Respondent operated on Patient A (Ex. 7, pp. 7-8; T. 521).

57. Respondent's plan to perform liposuction on Patient A at multiple sites with local anesthesia alone, the IM sedation and then the tumescent fluid, deviated from minimally acceptable standards of care (T. 521).

**B.1.c.: Administering sedation without proper monitoring**

58. Respondent failed to practice according to minimally acceptable standards by administering sedation without proper monitoring (T. 522-524).

59. Respondent attempted to execute his plan and administered intramuscular sedation, i.e., Versed and Demerol, to Patient A before starting to operate (Ex. 7, pp. 7-8; T. 522).

60. The general minimally acceptable standards of care and findings of fact as to preoperative and operative monitoring, set forth in FOFs 19-22 at pages 4-5 above, apply in the circumstances of this surgery (T. 522-523).

61. Respondent failed to provide adequate monitoring, or even any monitoring, for Patient A after administering sedation to her (T. 523-524).

62. Respondent's administration of sedation without proper monitoring was a deviation from minimally acceptable standards of care (T. 524).

63. Respondent failed to formulate an appropriate plan of treatment for Patient A (T. 524).

**CHARGE B.1.d.: MISDIAGNOSING A HEMATOMA, WHICH WAS HIS NOTED INDICATION FOR RE-OPERATION ON PATIENT B'S BREAST IN FEBRUARY 1997, AND/OR RENDERING INAPPROPIATE TREATMENT FOR A HEMATOMA**

**B.1.d.: Misdiagnosing a hematoma, which was his noted indication for re-operation on Patient B's breast in February 1997**

64. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient B by misdiagnosing a hematoma, which was his noted indication, in February 1997, for re-operation on Patient B's breast (Ex. 8A, p. 10; Ex. 8B, pp. 2, 17).

65. On February 18, 1997, Respondent first operated on Patient B's breast. He performed a bilateral augmentation mammoplasty, i.e., placement of breast implants into both breasts (Ex. 8A, pp. 8-9; Ex. 8B, pp. 56, 59; T. 264).

66. On February 25, 1997, Respondent re-operated on Patient B's breast. The procedure appears in the operative record as a removal of implant, exploration, and ligation of bleeders. According to Respondent's record, what happened between the two operations was swelling of the breasts and deformity and a question of formation of the hematoma, and so the patient was returned to the operating room for exploration of a hematoma. Respondent's preoperative diagnosis on the operative report and his noted indication for reoperating on Patient B's breast, is a "sudden swelling of breasts over lower zygoma; rule out hemorrhage." Under Procedure and Finding in his operative report, Respondent noted "Some bleed remaining, some hematoma present" (Ex. 8A, p. 11; Ex. 8B, p. 2; T. 264-266).

67. The zygoma is a bone in the cheek (T. 266, 275).

68. A hematoma is a collection of blood. A reasonably prudent plastic surgeon usually diagnoses hematoma by physical examination of the patient. A severe hematoma may result in a drop in the hemoglobin or blood count; that would be another indication. If drains are left in place at the time of surgery, a significant volume of blood coming out of the drain would perhaps indicate a bleeding problem. Or one might see bruising on the chest wall in the area of a hematoma. The area would probably be tender, and the deformity created by the hematoma would be unilateral. It would be very unusual for a hematoma to occur bilaterally (T. 268).

69. A reasonably prudent plastic surgeon would not have diagnosed a hematoma in the case of Patient B. *First*, the physical examination described is not consistent with a hematoma. There is no indication of an asymmetric swelling of the chest, which would likely be the best indication of a hematoma. Although the record does not specify that the swelling was symmetric, it is implied in the narrative description. *Second*, it is significant that Patient B's admission for her second hospitalization was almost a week after the first surgery. Respondent diagnosed a sudden swelling. Although it is conceivable that a hematoma could occur after five days following surgery, it is unlikely that it would be diagnosed then. A hematoma would usually be apparent within the first 48 hours after surgery. There is no indication in the record of a problem within that time. *Third*, the discharge summary after the second surgery does not document a clinical picture of a hematoma. Although a re-exploration of the patient would be indicated if a hematoma were present, the surgery that Respondent performed was not indicated and appropriate to treat a hematoma. The findings at surgery were of minimal hematoma, and the procedure done was to replace the original breast implants with larger ones. That necessitates creating a larger pocket, additional surgery that would be contraindicated if a hematoma were present (Ex. 8B, p. 20; Ex. K, p. 27, paragraph 3; T. 268-272).

70. Patient B did not have a hematoma on February 25, 1997. Respondent misdiagnosed her condition as a hematoma; the narrative description of his findings before and during surgery are inconsistent with that diagnosis (T. 314-315).

71. On February 25th, under Present Illness, Respondent noted "sudden swelling" and "rule out bleeding." Although the standard of care, when there is a rapidly expanding or sudden mass at the chest wall seven days after surgery, is to rule out the possibility of hematoma, generalized swelling is not necessarily an indication of a hematoma, and Patient B's record does not note lateralization or localization of the swelling. Respondent's description fails to state which breast is involved. A reasonably prudent physician would not have done exploratory surgery in the absence of lateralization of the swelling. Furthermore, noninvasive, safe means such as an ultrasound test may be used to rule out hematoma (Ex. 8B, p. 18; T. 301-304).

72. Examination of the chest wall would tell a surgeon whether there was malposition of an implant, whether the breast was larger or smaller than it had been, and whether the right or left side was involved. Bilateral or hematoma mass of both breasts would occur only when there was some bleeding disorder (T. 305-306).

73. When a doctor says rule out something, that represents his differential diagnosis (T. 308-309).

74. When a surgeon states, as Respondent did in his operative note for Patient B's second surgery, "some blood remaining, some hematoma present", that means that there was a little blood in the pocket; it is not the description of a significant hematoma (Ex. 8A, p. 11; T. 309-311).

75. In the second surgery, on February 25, 1997, Respondent expanded the site of the implants and then increased the size of the implants. Respondent's admission diagnosis should have been inadequate-volume implants, not hematoma. His representation

deviated from accepted medical practice. The intent of the second surgery was simply to replace the implants with larger ones (T. 311-312, 1297-1336).

76. The diagnosis that a reasonably prudent plastic surgeon would have made in this case is that of displaced or malpositioned breast implants (T. 272).

77. The volume of the implants is significant. The original ones were more than 100 cc or more than three ounces smaller than the replacement implants. That difference indicates that the original implants were too small to produce a satisfactory aesthetic result (Ex. K, p. 27; T. 272).

78. Respondent did not render appropriate treatment to Patient B with respect to the replacement of implants and a hematoma. It was a misdiagnosis to consider that Patient B had a hematoma, and appropriate treatment would include making a reasonable diagnosis. There was nothing to indicate that Patient B had a hematoma (T. 273).

79. Respondent's misdiagnosis of a hematoma put Patient B at needless risk by subjecting her to an unnecessary second surgical procedure (T. 273-274).

80. Respondent's diagnosis of a hematoma, which was his noted indication for reoperating on Patient B's breast in February 1997, deviated from minimally acceptable standards of care. Respondent deviated from the standard of care and failed to exercise appropriate medical judgment in using the diagnosis of hematoma as the indication for reoperation when, in fact, the real indication was to increase the patient's breast size with larger implants (T. 272, 274).

**B.1.d.: Rendering inappropriate treatment to Patient B for a hematoma**

81. Respondent failed to practice according to minimally acceptable standards by rendering inappropriate treatment to Patient B for a hematoma (Ex. 8B, p. 20; T. 332-335).

82. A reasonably prudent surgeon would not treat a patient with a hematoma of a breast by removing the original implants, dissecting some more tissue, and inserting double the size implants, as Respondent did. Dissecting a second pocket in a patient with a hematoma increases the risk of further bleeding. The usual procedure for re-exploring someone with hematoma of the breast is to open the previous surgical incision, remove the implant, treat with a ligature or cautery, replace the implant, and insert a drain to evacuate blood or other fluid that would accumulate in the breast pocket. When a breast implant is replaced, a surgical resection is made on top of or underneath, as in this case, the pectoralis muscle, and in creating that space the surgeon obviously cuts tissue that has blood vessels; that is how bleeding can occur. It is especially important, when inserting an implant, to ensure that hemostasis exists before insertion. Doubling the size of the implant is not a treatment for a hematoma (Ex. 8B, p. 20; T. 332-335).

**CHARGE B.1.e.: FAILING TO TAKE OR NOTE ADEQUATE MEDICAL HISTORIES AND/OR TO PERFORM OR NOTE ADEQUATE PHYSICAL EXAMINATIONS OF PATIENT A IN OR ABOUT JUNE 1996, PATIENT B IN OR ABOUT JUNE 1996 AND FEBRUARY 1997, PATIENT C IN OR ABOUT OCTOBER 1996, AND/OR PATIENT E IN OR ABOUT JANUARY 1997**

**STANDARDS OF PRACTICE AS TO THE TAKING AND NOTING OF PREOPERATIVE HISTORY**

83. STANDARD OF CARE AS TO PREOPERATIVE HISTORY The medical history that a reasonably prudent physician would take would include a review of systems in

which he would ask the patient about organ system problems such as cardiovascular problems, high blood pressure, thyroid disorder, past myocardial infarction, pulmonary problems, endocrine disorders, kidney dysfunctions, and gastrointestinal problems. He would ask the patient about any personal and family history as to other diseases, allergies, medicines currently taken, and any previous hospitalizations or surgical procedures. He would obtain a history of use of drugs, alcohol, and cigarettes or tobacco products (T. 340-341).

84. IMPORTANCE OF TAKING A HISTORY The importance of taking a medical history is that it alerts the treating physician to the need for certain precautions, such as those related to specific problems like hypertension, which is a common one, for example. Hypertension could be adversely affected by certain medications. For example, epinephrine, which is used in local anesthetics, routinely can cause increased heart rate and blood pressure. Someone with labile hypertension would be a very bad candidate for local anesthetics unless certain precautions were taken. A reasonably prudent plastic surgeon would specifically caution the patient particularly to take his medication on the day of surgery since patients go without food beginning at midnight before surgery. There are numerous other problems, such as the need to address diabetes or management of insulin. It is important to be aware of thyroid diseases because that would alert the physician to other potential problems. It would be important to ask the patient about previous surgery and whether he had had an adverse effect or outcome from that surgery. For example, a bleeding disorder might have been noted at a previous hospitalization or surgery. A history of unexplained bleeding would alert the physician to the need for additional preoperative workup to ensure that the clotting profile or clotting factors were normal. It is important for a physician to know whether the patient is a smoker. Excessive alcohol use would have many implications, not the least of which is the effect it might have on the patient's response to sedatives. It is important to inquire about known allergies. A patient who was allergic to penicillin before is always allergic to it, and if a physician fails to determine that fact and administers penicillin, there might be severe complications (T. 342-346).

85. IMPORTANCE OF WRITING DOWN HISTORY The importance of noting a medical history in a patient's chart is to permit the physician himself or other treating physicians to know what that history is, particularly in an emergency. For the treating physician, when the patient later returns on the day of surgery, it is important to have access to that information. In cases involving an anesthesiologist, a documented history provides the same important information to allow that person appropriately to plan the procedure and/or that person's part of it before the patient even arrives. In addition, if anything were to occur after the surgery and the physician familiar with the patient was not available, any other, subsequent treating physician would have access to the patient's history. The implication for physicians other than the treating physician is the same; if information is not documented in the chart, there is no way for a subsequent or other treating physician to know what was going on (T. 344-347, 496).

86. RISKS OF FAILURE TO NOTE HISTORY The unnecessary risk to the patient of his physician's failure to note his medical history is essentially the same as the risk of the physician's failure to take that history (T. 346).

**B.1.e.: Patient A**
**Failing to take or note adequate medical histories**

87. Respondent failed to comply with minimally acceptable standards of practice by failing to take and note an adequate medical history of Patient A (Ex. 7, p. 5; T. 495-505).

88. Respondent saw Patient A in June 1996. There is an operative record in her chart, dated June 12, 1996, but no other notation (Ex. 7, p. 5; T. 495).

89. The general minimally accepted standard of care and findings of fact as to the taking of a patient's history before performing plastic surgery, set forth in FOFs 83-86 at pages 12-13 above, apply in the circumstances of this surgery (T. 495-497).

90. Respondent failed to note any medical history in Patient A's chart in June 1996 (T. 495).

91. It is a deviation from minimally acceptable standards of care to fail to take a medical history (T. 497).

92. It is a deviation from minimally acceptable standards of care to fail to note a medical history in a patient's chart (T. 497).

93. It is a deviation from minimally acceptable standards of recordkeeping to fail to enter a medical history in a patient's chart (T. 497).

94. Respondent took and noted an inadequate medical history of Patient A in June 1996 (T. 497-498).

95. That inadequate medical history constituted a deviation from minimally acceptable standards of care for recordkeeping (T. 498).

**B.1.e.: Patient A**
**Failure to perform or note an adequate physical examination**

96. Respondent failed to comply with minimally acceptable standards of practice by failing to perform and note an adequate physical examination of Patient A in or about June 1996 (T. 498-505).

97. The physical examination that a reasonably prudent plastic surgeon would have performed in this circumstance would have included examination of, at a bare minimum, the sites that were planned for surgical treatment at the time (T. 498-499).

98. There is a connection between the medical history taken and the physical examination that a reasonably prudent physician would do. The documentation should be of both the medical history and the physical examination, particularly as it pertains to the planned surgical sites (T. 499-501).

99. The importance of performing a physical examination in general and in this specific circumstance is to identify and document conditions that affect the patient's candidacy for surgery from a medical standpoint; from a physical standpoint, the areas that are planned for surgical treatment must be addressed carefully in order to avoid incorrect treatment. If the area designated for liposuction, for example, were one that did not require liposuction because of a contour problem or the absence of one, it would be important for the surgeon to ascertain that for himself and to document it in the chart in order to plan adequately how much liposuction, if any, is needed and to determine issues related to anesthesia (T. 500-501).

100. A reasonably prudent plastic surgeon would have entered in the patient's chart all physical findings that he made at the examination (T. 501-502).

101. The importance of noting the findings on physical exam in a patient's chart in general and in this particular circumstance is to enable the physician and other treating health professionals to know and document what was found at the examination (T. 502).

102. The absence of an interim history and the absence of a physical examination of the surgical area in question fails to meet minimally accepted standards of care (T. 502-504).

103. There was an inadequate documentation of a physical examination. Respondent noted and performed an inadequate examination of Patient A in or about June 1996 (T. 504-505).

**B.1.e.: Patient B**
**Failing to perform or note an adequate physical examination of Patient B in June 1996**

104. Respondent failed to comply with minimally acceptable standards of practice by failing to perform and note an adequate physical examination of Patient B in or about June 1996 (Ex. 8A, p. 2; T. 325-326).

105. A reasonably prudent surgeon would have performed and noted a physical examination of Patient B, on whom he planned to to operate, including measurements of blood pressure, weight, and height, because that information affects how much medication is safe and reasonable to give during surgery. Midazolam and morphine sulfate IM are dangerous drugs, and their effect when given intramuscularly is not as predictable as when they are given intravenously. It is important to document vital signs and height, weight, etc. in the consultation note because that information is needed in order to determine whether the patient is a suitable candidate for liposuction (T. 325-327).

**B.1.e.: Patient B**
**Failing to take or note an adequate medical history in February 1997**

106. Respondent failed to comply with minimally acceptable standards of practice by failing to take and note an adequate medical history of Patient B in or about February 1997 (Ex. 8A; T. 330-331).

107. The general findings of fact and minimally acceptable standards of care as to taking and noting an adequate history, set forth in FOFs 83-86 at pages 12-13 above, apply in the circumstances of this surgery.

108. In addition to the general minimally acceptable standard of care as to the need to record the information obtained through a history, set forth in FOF 84 at page 12 above, the history that a reasonable plastic surgeon takes when he is going to operate and enlarge a breast includes existing breast history and previous breast cancer. The surgeon screens for breast cancer. He performs a physical examination to determine whether there are any lumps or bumps in the breast. Respondent's records for Patient B do not reflect any such examination, and the Committee finds that none was performed.

It is important that the surgeon both ascertain that there are no preexisting conditions in the breast that might be difficult to diagnose after insertion of breast implants and be aware of any reason that the patient may not be a good candidate for implants, such as a strong family history of breast cancer (Ex. 8A; T. 330-331).

**B.1.e.: Patient C**
**Failure to take and note a medical history in October 1966**

109. Respondent failed to comply with minimally acceptable standards of practice by failing to take and note an adequate medical history of Patient C and, by that omission, deviated from minimally acceptable standards of care (Ex. 9A, p. 3; T. 340-347).

110. The only medical history that Respondent noted in Patient C's chart on or about October 31, 1996 is: "He is having more difficulty seeing upward things and his eyes get tired during the afternoon and it is harder to work." There is no medical history in the chart concerning anything other than the patient's eyes (Ex. 9A, p. 3; T. 340-341).

111. The general findings of fact and minimally acceptable standards of care as to taking and noting an adequate history, set forth in FOFs 83-86 at pages 12-13 above, apply in the circumstances of this surgery.

112. The importance of taking a medical history in Patient C's particular case is that the surgeon must know whether there is any history of ocular disease (T. 344).

**B.1.e.: Patient E**
**Failure to take and note an adequate medical history**

113. Respondent failed to comply with minimally acceptable standards of practice by failing to take and note an adequate medical history of Patient E (Ex. 11A, p. 3; Ex. 11B, p. 2; T. 366-371).

114. The medical history that Respondent noted in Patient E's chart in January 1997 was that the patient came in because she had some fat layer on her abdomen that she did not want and that she had no other medical problems (Ex. 11A, p. 3; Ex. 11B, p. 2; T. 366-367).

115. The general findings of fact and minimally acceptable standards of care as to taking and noting an adequate history, set forth in FOFs 83-86 at pages 12-13 above, apply in the circumstances of this surgery.

116. Respondent's failure to take and note an adequate medical history of Patient E in January 1997, including his failure to note pertinent negatives, deviated from minimally acceptable standards of care (Ex. 11A, p. 3; T. 370-371).

**CHARGE B.1.f.: FAILING TO ENTER AN OPERATIVE REPORT IN THE RECORDS OF PATIENT A IN OR ABOUT JANUARY 1996, PATIENT C IN OR ABOUT FEBRUARY 1997, AND PATIENT D IN OR ABOUT JULY 1996, FOR SURGERY PERFORMED**

**STANDARDS OF PRACTICE WITH RESPECT TO RECORDING AN OPERATIVE NOTE**

117. STANDARD OF CARE AS TO CONTENT OF THE OPERATIVE NOTE A reasonably prudent plastic surgeon complying with minimally acceptable standards of care and recordkeeping enters an operative report for all surgery performed. The information that a reasonably prudent plastic surgeon enters in each such report includes the date of surgery; the type of anesthesia administered and the time of its administration; the name of the operating surgeon and the assistant, if any; the pre- and postoperative diagnoses; a narrative of the operative report; the operative procedure itself; a narrative detailing the operative procedure, including the incisions, markings for

those incisions, what tissue was removed and how, how the wounds were closed, how much blood loss may have occurred during the procedure, indications about the placement of drains and whether drains were left in place at the time of the surgery, complications, type of sutures used, whether the sponge and instrument counts were correct, and whether there were any abnormal complications or findings or any other deviations from what would normally be expected for the type of surgery performed (T. 284-285, 348-350, 491).

118. STANDARD OF CARE AS TO THE IMPORTANCE OF KEEPING AN OPERATIVE NOTE It is an accepted medical standard of practice in recordkeeping to enter an operative report, or note, in a patient's chart. The necessity and importance of doing so is to document the care rendered so that that information will be available to the original treating physician or those who subsequently treat the patient. An adequate operative record enables such health care providers to determine the type of surgery and any problems that may have occurred as a result of the procedure and that might influence treatment management (T. 350, 492).

119. STATEMENT AS TO THE RISK OF FAILURE TO KEEP AN OPERATIVE NOTE The needless risk to a patient created by failure to enter an appropriate operative report includes, for example, that some untoward effect that occurred but was not noted could be permitted or caused to occur in a subsequent treatment (T. 492-493).

**B.1.f.: Patient A**
**B.2.b.: Patient A**
**Negligent practice--Failure to enter an operative report**
**Recordkeeping violation--Failure to enter an operative report**

120. Respondent failed to practice according to minimally acceptable standards by rendering inappropriate care and treatment to Patient A by failing to enter an operative report in her records in or about January 1996 (Ex. 7, pp. 2, 4; T. 490-494).

121. Patient A first presented to Respondent on or about January 10, 1996, requesting liposuction of her buttock and thigh areas. Respondent's plan was to perform liposuction on those areas (Ex. 7, p. 2; T. 490).

122. Respondent noted in Patient A's chart that the patient was two months post-liposuction, which implies that Respondent performed surgery on that patient in January 1996 (Ex. 7, p. 4).

123. Respondent failed to enter any operative report in Patient A's chart for the surgery that he performed in January 1996 (T. 491-493).

124. Respondent admitted during his interview at OPMC on November 19, 1997 that the undated operative report for a patient named Helga that is included in the medical record of Patient A did not belong in that record and does not refer to Patient A. The Committee rejects Respondent's testimony that it was, in fact, the operative report for Patient A's surgery in January 1996 (Ex. 6-B, p. 3; Ex. 7, p. 3; T. 576-577).

125. The general findings of fact and minimally acceptable standards of care as to recording an adequate operative note after performing plastic surgery, set forth in FOFs 117-119 at page 16 above, apply in the circumstances of this surgery.

126. Regarding liposuction, as performed on Patient A, the minimally acceptable standard of care requires documentation of which areas were treated and what result was achieved. If, for example, a surgeon should not achieve the result desired, the

report must indicate what problem occurred that might be avoided in a subsequent treatment (T. 493).

127. Respondent deviated from minimally acceptable standards of care by failing to enter an operative report in Patient A's chart (T. 492).

128. Respondent deviated from minimally acceptable standards of recordkeeping by failing to enter an operative report in Patient A's chart (T. 492).

129. Respondent's note in the record on the surgery performed on Patient A in January 1996 is insufficient. It discusses the results of the surgery and not the actual procedure. Respondent noted only the patient's reaction and his examination of the patient following the liposuction (Ex. 7, p. 4; T. 493-495).

**B.1.f.: Patient C**
**B.2.b.: Patient C**
**Negligent practice--Failure to enter an operative report**
**Recordkeeping violation--Failure to enter an operative report**

130. Respondent failed to practice according to minimally acceptable standards by rendering inappropriate care and treatment to Patient C by failing to enter an operative report in Patient C's chart in or about February 1997 (Ex. 9B, p. 17; T. 347-351).

131. In February 1997, Respondent performed upper and lower eyelid blepharoplasty on Patient C (Ex. 9B, p. 17; T. 347-348).

132. Respondent failed to enter an operative report for that surgery in Patient C's chart. Other than a bill, Respondent entered no information concerning the operative procedure (T. 348).

133. The general findings of fact and minimally acceptable standards of care as to recording an adequate operative note after performing plastic surgery, set forth in FOFs 117-119 at page 16 above, apply in the circumstances of this surgery.

134. Respondent failed to enter an adequate operative note in Patient C's record in or about February 1997. That failure was a deviation from minimally acceptable standards of care and recordkeeping (T. 351).

**B.1.f.: Patient D**
**B.2.b.: Patient D**
**Negligent practice--Failure to enter an operative report**
**Recordkeeping violation--Failure to enter an operative report**

135. Respondent failed to practice according to minimally acceptable standards by rendering inappropriate care and treatment to Patient D by failing to enter an operative report in Patient D's chart in or about July 1996 (Ex. 10B, pp. 16-17; T. 361-365).

136. Patient D's chart includes a note dated July 9, 1996 that a vertical mastopexy and reshaping of the breast tissue was to be performed on July 10th. The chart further includes a note, dated July 15th, that documents the postoperative condition of the patient (Ex. 10B, pp. 16-17; T. 361-363).

137. Respondent performed a mastopexy on Patient D in July 1996 (T. 363).

138. Respondent failed to record and maintain an operative note for the mastopexy that he performed; Patient D's chart contains no information about the procedure, and the pre- and postoperative notes are not sufficient to document the surgical procedure itself (T. 361-364).

139. The general findings of fact and minimally acceptable standards of care as to recording an adequate operative note after performing plastic surgery, set forth in FOFs 117-119 at page 16 above, apply in the circumstances of this surgery.

**CHARGE B.1.g.: PREPPING THE OPERATIVE FIELD AFTER RATHER THAN BEFORE ADMINISTERING LOCAL ANESTHESIA IN CONNECTION WITH LIPOSUCTION PERFORMED ON PATIENT A IN OR ABOUT JUNE 1996; i.e., OUT OF APPROPRIATE CHRONOLOGICAL ORDER**

140. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient A by prepping the operative field after rather than before administering tumescent fluid in connection with liposuction that he performed on Patient A in or about June 1996, i.e., out of appropriate chronological order (Ex. 7, p. 5; T. 505-510).

141. Respondent performed liposuction on Patient A in June 1996 (Ex. 7, p. 5; T. 505).

142. Liposuction is a procedure in which, by means of vacuum suction, fat is removed from areas of the body. The areas treated in the June 1996 surgery on Patient A were the trochanteric (hip) areas on both the right and left sides (T. 505).

143. Respondent's operative note indicates that he administered a local anesthesia, referred to as the tumescent fluid, which is a diluted solution of anesthesia used for liposuction, in connection with his surgery on Patient A on June 12, 1996 (T. 505-506).

144. In using tumescent fluid, the surgeon makes an incision through which the liposuction ultimately will be performed. He then places a blunt-tipped needle through that incision and infuses the areas to be treated with the tumescent solution. That procedure reduces the amount of blood loss, provides local anesthesia, and permits a more complete liposuction of the area (T. 506-507).

145. A reasonably prudent plastic surgeon who was to perform liposuction would usually prep the operative field while the patient is standing. Generally, the entire area is prepped and the patient is placed on a sterile sheet on the operating table. Then the anesthetic is administered and the surgery is performed. It can also be performed while the patient is in a supine position on the table, but it is more difficult to do an adequate prep with the patient in that position (T. 507).

146. A reasonably prudent plastic surgeon would prep the operative field *before* making the incisions and administering the tumescent solution, in order to prevent contamination of the wound by bacteria present on the skin. In operating on Patient A in June 1996, Respondent prepped the operative field *after* making the incisions. By that action, Respondent put the patient at needless increased risk of serious infection and deviated from minimally acceptable standards of care (T. 507-510).

**CHARGE B.1.h.: FAILING TO MONITOR PATIENT F APPROPRIATELY AFTER THE ADMINISTRATION OF SEDATION AND DURING AN OPERATIVE PROCEDURE IN OR ABOUT JANUARY 1994 WITH THE PATIENT IN A PRONE POSITION, AND/OR GIVING ANTIBIOTICS AFTER, NOT BEFORE, SURGERY,**

**i.e., OUT OF APPROPRIATE CHRONOLOGICAL ORDER, AND/OR FAILING TO EVALUATE AND TREAT PATIENT F APPROPRIATELY FOR CHRONIC PAIN AFTER THE SURGERY, INCLUDING INAPPROPRIATELY PRESCRIBING NARCOTICS, INCLUDING PERCOCET, UNTIL IN OR ABOUT OCTOBER 1995**

**B.1.h.: Failing to monitor Patient F appropriately in January 1994**

147. Respondent failed in or about January 1994 to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient F by failing to monitor the patient appropriately after administering sedatives and during surgery with the patient in a prone position (Ex. 12, pp. 4-5; T. 405-412).

148. In January 1994, Respondent performed surgery on each of Patient F's legs to insert a calf implant (a silicone rubber device placed under the skin and fascia of the calf to increase its size) (Ex. 12, pp. 4-5; T. 406).

149. Respondent administered a local anesthetic and a sedative: midazolam (Versed) and Toradol (Ex. 12, pp. 4-5; T. 406).

150. Respondent appropriately placed Patient F in a prone position during the surgery (Ex. 12, pp. 4-5; T. 406, 425).

151. Placing an unmonitored patient in a prone position (i.e., face down) during surgery entails more risk than placing him in a supine position. With the patient in a prone position, the work of respiration is increased, it would be difficult to administer oxygen or evaluate or maintain an airway should that be necessary, and there is the risk, *inter alia*, of cardiovascular collapse. When operating on a patient who is prone, the surgeon has a greater obligation to have monitoring available than when operating on a patient who is supine. Failure to protect the patient through adequate monitoring and maintaining a proper airway constitutes an inappropriate risk (T. 406-407, 412, 429-432).

152. Respondent failed to provide any monitoring of Patient F during surgery and failed to assess Patient F's vital signs before or during surgery in January 1994 (T. 408-409).

153. The general findings of fact and minimally acceptable standards of care as to preoperative and operative monitoring and the nature and extent of such monitoring, set forth in FOFs 19-22 at pages 4-5 above, apply in the circumstances of this surgery (T. 407-411).

154. Respondent's monitoring of Patient F before and during the surgery deviated from minimally acceptable standards of care (T. 411-412).

**B.1.h.: Giving antibiotics after, not before, surgery, i.e., out of appropriate chronological order**

155. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient F by giving antibiotics after, not before, surgery, i.e., out of chronological order (Ex. 12, pp. 4-5; T. 412-418).

156. Respondent gave Patient F Keflex, an antibiotic, only after the surgery (the transcript incorrectly reads "not until half" instead of "not until after") (Ex. 12, pp. 4-5; T. 412-413).

157. The minimally acceptable standard of care with which a reasonably prudent plastic surgeon would have complied requires that the antibiotic be administered before surgery. Compliance with that standard would give the patient a blood level of antibiotic at the time of the surgery, which is when contamination could lead to infection. All calf implant surgery, as with insertion of any foreign body, should be done with preoperative antibiotics because infection is best prevented with a blood level of such medication at that time. Such prevention is better ensured by giving the antibiotics intravenously just at the beginning of surgery, rather than by relying on the patient's taking it orally, when his gastric function may be compromised by anxiety or other problems (T. 413-415, 427-428).

158. Respondent's giving antibiotics to Patient F after and not before surgery in or about January 1994 deviated from minimally acceptable standards of care (T. 417-418).

**B.1.h.: Failing to evaluate and treat Patient F appropriately for chronic pain after surgery**

159. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment to Patient F by failing to evaluate and treat Patient F appropriately for chronic pain after the surgery, including inappropriately prescribing narcotics, including Percocet, from just after the January 1994 surgery until about October 1995 (Ex. 12; Ex. 16; Ex. G; T. 418-421, 441, 444-450).

160. Respondent operated on Patient F to insert bilateral calf implants on January 26, 1994. The two notes in the patient's chart following that surgery record telephone calls, not visits, on February 7 and 22, 1994. The next time that the patient was seen in Respondent's office was May 3, 1994, more than three months later (T. 444).

161. There are complications specific to surgery to insert calf implants: infection; seroma, or a collection of fluid around the implants; displacement of an implant, making the legs asymmetrical; nerve injury as a result of creating the pockets for the implants; and muscle necrosis and pulmonary emboli, which could occur usually within two weeks after surgery (T. 445-446).

162. If a patient still needs narcotics more than ten to fourteen days after surgery, the surgeon should see and evaluate the patient to rule out a possible complication. In May 1994, Respondent looked at Patient F's wound from the January surgery and thought that everything looked all right except that the scar was a little dark, but the patient still complained of chronic pain. Respondent ought to have investigated that complaint instead of prescribing Percocet (T. 446).

163. The physical examination that a prudent plastic surgeon would do and note to evaluate the pain and its cause would include ensuring that the pulses were intact in the extremity; evaluating the appearance of the skin and the size of the calf after the implant surgery; determining whether something else was causing chronic swelling that might cause pain; checking for deep vein thrombosis, including looking for signs of swelling or discoloration of the skin; looking into the inguinal area of the groin to see if there were large lymph nodes, although that would be a fairly remote sequela of the surgery; and checking whether a nerve compression was causing pain (T. 446-448).

164. When a patient still has chronic pain five months after surgery, one can diagnose the cause of that pain. Careful physical examination and nerve studies, such as an MRI, can determine whether the patient has a chronic compartment syndrome that is rendering him unable to straighten out his leg (T. 449-450).

165. Respondent should have examined Patient F after not longer than four to six weeks after surgery to determine the cause of his pain and, if no cause could be found, Respondent should have referred the patient to a pain clinic. Instead, Respondent inappropriately prescribed narcotic analgesics Percocet and Roxicet to Patient F from January 1994 through July 1995, or about a year and a half after surgery. By continuing to prescribe narcotics, Respondent failed to address the primary problem and furthered the patient's drug dependence (Ex. 12; Ex. 16; Ex. G; T. 418-421, 435, 441, 450).

**CHARGE B.1.i: INAPPROPRIATELY ELECTING TO DO A SECONDARY CLOSURE OF A DEBRIDED NECROTIC WOUND IN PATIENT G'S BREAST IN OR ABOUT AUGUST 24, 1992**

166. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate care and treatment ot Patient G by inappropriately electing to do a secondary closure, on or about August 24, 1992, of a debrided necrotic wound in Patient G's breast (Ex. 13, pp. 44-45; T. 595-599).

167. Patient G's operative record lists as the patient's diagnosis bilateral necrosis of reduction mammoplasty, which indicates that there was dead tissue in both breasts (Ex. 13, pp. 44-45; T. 595-596).

168. With that diagnosis, the procedure that a reasonably prudent plastic surgeon would perform is a debridement (T. 596).

169. The procedure that Respondent performed was a debridement and secondary wound closure with VY local arrangement of tissue closure; area closed 20 to 30 centimeters. That is, he first removed devitalized tissue and then used a VY advance, or rearrangement of the tissue, to close the wound (T. 596).

170. "Secondary closure" implies that a wound that was initially opened was closed at a later time, as opposed to a primary closure, which would be done at the time of the initial reduction mammoplasty (T. 596-597).

171. Respondent's secondary closure of a debrided necrotic wound in Patient G's breast deviated from minimally acceptable medical standards. Established surgical principals dictate that if one enters an open wound with necrotic tissue, the wound has bacterial contamination, even if it is clean, and induration, swelling, and hardness of the tissue that interfere with the surgeon's ability to rearrange the tissue or close the wound. To perform a secondary closure of such a wound risks potential further necrosis and infection because one is closing a contaminated wound. Such a wound would appropriately be debrided and then closed secondarily or, if it were large enough, closed with a skin graft (T. 597-598).

172. Respondent's plan of treatment was inappropriate. He subjected Patient G to needless risks. If there were devitalized or necrotic tissue, to perform the manipulation of the tissue that Respondent planned, and did, could lead to further necrosis and a much higher risk of infection that could result in further deformity and infection (T. 598-599).

**CHARGE B.1.j.: FAILING TO MONITOR PATIENT B APPROPRIATELY DURING SURGERY IN OR ABOUT JUNE 1996**

173. Respondent failed to practice according to minimally acceptable standards by formulating an inappropriate plan of treatment and rendering inappropriate treatment

to Patient B by failing to monitor Patient B appropriately during surgery in or about June 1996 (Ex. 8A, pp. 2-3; T. 324-329).

174. The general minimally acceptable standards of care as to preoperative and operative monitoring and the findings of fact as to the nature, extent, and importance of monitoring during anesthesia and surgery and the needless risk to which a patient is exposed by a physician's failure to comply with the stated standards, set forth in FOFs 19-22 at pages 4-5 above, all apply in the circumstances of this surgery (Ex. 8A, pp. 2-3; T. 324-329).

175. The standard of care is that pulse oximetry and blood pressure recordings should be made in patients undergoing surgery with IV sedation to monitor the sedatives (T. 328-329).

176. The importance of complying with the general minimally acceptable standards for monitoring a surgical patient and the needless risks associated with failure to comply with them are even more acute in the circumstances of Patient B's case and in view of Respondent's poor plan for the surgery, as set forth below (T. 324-329).

177. During the consultation with a patient on whom the surgeon is planning to operate, the surgeon should do a physical examination, including taking and recording blood pressure, weight, and height, to help in judging whether the patient is a suitable candidate for liposuction and what amounts of medication would be safe and reasonable to administer during the surgery (Ex. 8A, pp. 2-3; T. 325-326).

178. Midazolam, 5 milligrams, and morphine sulfate, 7.5 milligrams, given intramuscularly, are very potent drugs that can affect cardiopulmonary stability. Therefore, vital signs must be monitored. Respondent ought to have had an assistant helping him to monitor Patient B while he was performing surgery on her (T. 325-328).

179. The standard of care is to have an IV running while one administers midazolam and morphine sulfate. The most important reason for having an IV is that if there arose such an emergency as a significant drop in blood pressure, pulse, or respiration, the surgeon could give medications to treat the problem immediately. There is no note in Respondent's records that an IV was running while he was operating on Patient B. (T. 328-329).

## FOURTH SPECIFICATION; FAILURE TO MAINTAIN RECORDS FOR EACH PATIENT WHICH ACCURATELY REFLECT THE CARE AND TREATMENT OF THE PATIENT

### CHARGE B(2)(a): USING WRONG ANATOMICAL TERMS, e.g., "ZYGOMA" AND "PLATYSMA," WITH RESPECT TO PATIENT B'S BREAST AUGMENTATION SURGERY IN OR ABOUT FEBRUARY 1997

180. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. As to Patient B, Respondent's recordkeeping was inadequate and disorganized because Respondent repeatedly used incorrect anatomical terms, e.g., "zygoma" and "platysma," with respect both to Patient B's breast augmentation mammoplasty in or about February 1997 and to Respondent's aftercare (Ex. 8A, pp. 7-8, 10-11; Ex. 8B, pp. 2, 18, 20, 56; T. 275-284).

181. The anatomical term "zygoma" refers to the prominent bone in the cheek just below the eye (T. 275).

182. The anatomical term "platysma" refers to a band of muscle in the neck that begins at the jawline and ends just above the clavicle (T. 275).

183. In Respondent's note under the subheading "Objective," he included the following entry: "Some elevation zygoma but breast implants well-fixed and symmetrical; placed circumferential around nipple bilateral center zygoma attached lower upper; still some swelling and elevation but minor." That is an incorrect use of the term zygoma (Ex. 8A, p. 7; T. 275).

184. In the operative report for the bilateral augmentation mammoplasty that Respondent performed on Patient B on February 28, 1997, the second paragraph of the entry describing the procedure refers to the "platysma muscle" when the proper reference would have been to the pectoralis muscle. Respondent never corrected the error. In the same report, Respondent also referred incorrectly to the alveolar, which is the shelf of tissue from which the teeth arise (Ex. 8A, p. 8; Ex. 8B, p. 56; T. 276-277).

185. In his discharge summary for Patient B's admission of February 25-26, 1997 at Community Hospital at Dobbs Ferry, Respondent entered the following note under "Present Illness": "The patient was done here approximately eight days ago and was doing well postoperatively when suddenly there was a swelling over the zygomatic area. The etiology is unclear. The possibility of a hematoma was raised. The patient was admitted for exploration and controlling of bleeding." That is an incorrect use of the anatomical term "zygomatic area" (Ex. 8A, p. 10; T. 277-278).

186. A reasonably prudent plastic surgeon would have used the correct term "xiphoid" in order to communicate accurately the nature of the procedure (T. 277-278).

187. That is an incorrect use of the anatomical term platysma. The proper reference here would be to the pectoralis muscle. In the same record, the first sentence of the first paragraph under the subheading "Hospital Course" reads as follows: "The patient was brought to the OR and under general anesthesia after giving Keflex one gram; was explored and it was found that the implant had ruptured over to the zygoma midline, appearing as if hemorrhage had occurred." That is an incorrect use of the term zygoma (T. 278-279).

188. A reasonably prudent plastic surgeon would have used the term "xiphoid" in order to communicate accurately the nature of the procedure (T. 279).

189. In another copy of Patient B's February 26th discharge summary, there appear some corrections and the initials "JH"; yet Respondent never corrected any of the incorrect references to the zygoma (Ex. 8B, p. 20; T. 279).

190. In his operative report for February 25, 1997, Respondent notes the preoperative diagnosis as "Sudden swelling of breasts over lower zygoma; rule out hemorrhage." That is another incorrect use of the term zygoma (Ex. 8A, p. 11; T. 279-280).

191. A reasonably prudent plastic surgeon would have used the term xyphoid in order to communicate accurately the nature of the problem (T. 280).

192. The noted postoperative diagnosis is "Herniation of the breast implant medially producing swelling over zygoma." That is another incorrect use of the term zygoma (Ex. 8A, p. 11; T. 280).

193. A reasonably prudent plastic surgeon would have used the term xyphoid in order to communicate the diagnosis accurately (T. 280).

194. The first three lines under the subheading "Procedure" read "Some bleed remaining, some hematoma present. Good hemostasis was obtained; 2-O Vicryl suture used to approximate fascia over the zygoma." That is another incorrect use of the term zygoma (T. 280-281).

195. A reasonably prudent plastic surgeon would have used the term xyphoid in order to communicate accurately the nature of the procedure (T. 281).

196. Although Respondent eventually corrected two of these three notes some six weeks after they were first transcribed, the preoperative diagnosis still referred to zygoma (Ex. 8B, p. 2; T. 281).

197. The note under "Present Illness" was handwritten, not transcribed. That entry reads "Sudden swelling over"--and then the word zygoma is crossed out and the word sternum is written over it with the notation 4/10/97 and initials. The note also states "Rule out bleeding" with an R slash zero. The use of the word zygoma, which was later corrected on 4/10/97, was incorrect (Ex. 8B, p. 18; T. 281-282).

198. A reasonably prudent plastic surgeon would have used the term "sternum" in order to communicate accurately the site of the swelling (T 282).

199. It is important to use correct anatomical terms in medical records in order to enable the treating physician or other physicians to interpret appropriately what treatment was rendered to the patient at a time remote from the treatment, in the case of the treating physician, and both at the time of treatment and at a remote time in the case of other treating physicians. The use of inaccurate terminology results in the needless risk of confusion about exactly what type of surgery or treatment was performed (T. 282-283).

200. Respondent's incorrect use of the terms zygoma, platysma, and alveolar with respect to the breast surgery that he performed on Patient B in February 1997 deviated from minimally acceptable standards of recordkeeping (T. 283-284).

**CHARGE B.2.b.: FAILING TO ENTER OPERATIVE REPORTS IN PATIENT MEDICAL RECORDS FOR SURGERY PERFORMED ON PATIENT A IN OR ABOUT JANUARY 1996, PATIENT C IN OR ABOUT FEBRUARY 1997, AND PATIENT D IN OR ABOUT JULY 1996, AND/OR ENTERING INADEQUATE OPERATIVE RECORDS FOR SURGERY PERFORMED ON PATIENT A IN OR ABOUT JANUARY 1997 AND PATIENT B ON OR ABOUT FEBRUARY 25, 1997, AND/OR ENTERING OPERATIVE REPORTS INCLUDING BLANK SPACES FOR SURGERY PERFORMED ON PATIENT A IN OR ABOUT JUNE 1996, PATIENT E IN OR ABOUT APRIL 1997, AND/OR PATIENT G IN OR ABOUT JULY 1992**

**B.2.b.: Patient A - January 1996**
**Failure to enter an operative note**

201. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he failed to enter an operative report for surgery performed on Patient A in or about January 1996 (see findings of fact regarding charge B.1.f. - Patient A, at p. 17 above).

**B.2.b.: Patient A - June 1996**
**The operative report for liposuction on June 12, 1996 includes blank spaces**

202. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because for his surgery on Patient A in or about June 1996, he entered operative reports containing blank spaces (Ex. 7, p. 5).

203. Information is missing from Respondent's operative report of the liposuction that he performed on Patient A on June 12, 1996. There are three blanks in that record. The context of the report does not suggest what information is missing where the second and third blanks appear (T. 510-511).

204. A reasonably prudent plastic surgeon would not leave blank spaces in an operative report (T. 511).

205. An incomplete operative note may be missing important information about the care rendered (T. 511).

206. It is a deviation from minimally acceptable standards of recordkeeping to fail to fill in blank spaces left in a operative report in a patient's chart (T. 511-512).

207. It is important to enter complete operative reports in patients' charts in order to document the care rendered for both the physician's subsequent treatment and for other treating physicians (T. 511-512, and see FOF 118 at page 16 above).

208. The needless risk to a patient if an incomplete operative report is entered in his chart is that information critical to his care may not be available in the event that he needs subsequent treatment (T. 512, and see FOF 119 at page 17 above).

209. Respondent's entry, for the surgery that he performed on Patient A on June 12, 1996, of a report containing blank spaces deviated from minimally acceptable standards of recordkeeping (T. 512-513).

**B.2.b.: Patient A**
**Inadequate enries in the operative record for surgery in January 1997**

210. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he entered inadequate operative records for surgery performed on Patient A in or about January 1997 (Ex. 7, p. 6; T. 513-516).

211. In January 1997, Respondent next operated on Patient A and performed another liposuction. The operative report indicates that Patient A was coming in for further touch-ups on liposuction, but the note on the actual January 27th procedure is minimal. The report shows only that fifteen minutes were waited and that using a crease and a liposuction cannula, liposuction was performed to get the desired result. The report fails to state which area of the body was treated (Ex. 7, p. 6; T. 513-514).

212. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed operative note after performing plastic surgery, set forth in FOFs 117-119 at pages 16-17 above, apply in the circumstances of this surgery (T. 514-516).

213. Respondent failed to enter an adequate record for this particular surgery by failing to include information that a reasonably prudent plastic surgeon would have included.

Respondent failed to record any information as to the size of the cannula, how much fat was removed, the nature of the incision, and whether he performed liposuction using a machine or syringe (T. 514-515).

214. Respondent's inadequate entry of an operative report or lack of operative report for the surgery that he performed in January 1997 deviated from minimally acceptable standards of recordkeeping (T. 516).

**B.2.b.: Patient B**
**Inadequate entries in the operative record for surgery on February 25, 1997**

215. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he entered inadequate operative records for surgery that he performed on Patient B in or about February 1997 (Ex. 8A, p. 11; T. 284-287).

216. A reasonably prudent plastic surgeon would have entered an operative note in Patient B's chart for the surgery that he performed on or about February 25, 1997 (T. 284).

217. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed operative note after performing plastic surgery, set forth in FOFs 117-119 at pages 16-17 above, apply in the circumstances of this surgery (Ex. 8A, p. 11; T. 284-285).

218. Respondent's use of the term "zygoma" in Patient B's record was inaccurate (T. 285).

219. In addition, Respondent's preoperative diagnosis was rule out hemorrhage or hematoma, but that was not accurate: his narrative indicates that the pocket was made larger, to accommodate the insertion of larger breast implants. That does not correspond to the diagnosis of hematoma (T. 286-287).

**B.2.b.: Patient C**
**Failure to enter an operative note**

220. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he failed to enter an operative note for surgery that he performed on Patient C in or about February 1997 (see findings of fact regarding charge B(1)(f) at page 17 above).

221. Patient C's operative record does not indicate whether the patient had ptosis of the brow or ptosis of the eyelid. These are different conditions, both anatomically and as to insurance reimbursement. In order to be reimbursable, ptosis of the brow and/or eyelid would have to cause a visual field deficit, and that could have contributions from both the eyelid and the brow (T. 354-355).

**B.2.b.: Patient D - July 1996**
**Failure to enter an operative note**

222. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he entered operative reports containing blank spaces for surgery

that he performed on Patient D in or about July 1996 (see findings of fact regarding charge B(1)(f) - Patient D at page 18 above).

**B.2.b.: Patient E**
**Blanks in operative report of April 1997**

223. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because for the surgery that he performed on Patient E on or about April 10, 1987, he entered operative notes that contained blank spaces (Ex. 11A, pp. 5-6; Ex. 11B. pp. 5-6; T. 379-382).

224. In Respondent's operative note for the liposuction that he performed on Patient E on April 10, 1997, there are several blanks in the operative narrative. In the first paragraph, two blanks appear as to the medications given before starting surgery. One more blank appears in the first paragraph on the second page of the note. It is not apparent from the context what word or phrase is missing (T. 379-380).

225. Even Respondent could not fill in a blank in his own record (T. 1155-1156).

226. A reasonably prudent plastic surgeon would have included complete information as to the medications and dosages administered and would not leave blanks in an operative note, because such a record is incomplete and does not accurately describe the entire procedure (T. 380-381).

227. Respondent's entry, for the surgery that he performed on Patient E on April 10, 1997, of a report containing blank spaces deviated from minimally acceptable standards of recordkeeping. An incomplete record may fail to communicate pertinent information needed to document the care or to evaluate a patient if subsequent treatment by the same physician or by others is required (T. 381-382).

**B.2.b: Patient G**
**Operative report for surgery performed in or about July 1992 included blank spaces**

228. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because for surgery that he performed on Patient G in or about July 1992 he entered operative reports containing blank spaces (Ex. 13, pp. 72-73; T. 585-590).

229. Respondent's operative report for the bilateral reduction mammoplasty V-type that he performed on Patient G on or about July 22, 1992 contains many blank spaces and is missing information (Ex. 13, p. 72-73; T. 585-586).

230. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed operative note after performing plastic surgery, set forth in FOFs 117-119 on pages 16-17 above, apply in the circumstances of this surgery (T. 586-587).

231. By leaving blank spaces in his operative report for the surgery that he performed on Patient G on July 22, 1992, Respondent deviated from minimally acceptable standards of recordkeeping (Ex. 13, pp. 72-73; T. 587).

232. The first blank appears in the preoperative diagnosis, recorded as a "*--blank--* hypertrophy of the breasts bilateral symptomatic." It is uncertain from the context of the report what word or information is missing (Ex. 13, pp. 72-73; T. 587-588).

233. The next blank appears in the first paragraph in the following sentence: "The nipples were outlined and methylene blue at five millimeters circumferentially around the nipple and--*blank*--marks were made." It is uncertain from the context of the report what word or information is missing (Ex. 13, pp. 72-73; T. 588).

234. The next blank appears in the third paragraph on the second page of the operative record, which reads, "At this point after the stripping was done, the flap was raised with the inferior line just one centimeter below the nipple and the new infra-mammary line--*blank*--from the median removed by leaving a small amount of tissue over the fat of the chest wall was removed." Again, it is uncertain from the context of the report what word or information is missing (Ex. 13, pp. 72-73; T. 588-589).

235. Another blank appears three paragraphs down. There is the notation "After this was completed through a separate stab wound, a ten millimeter Jackson Pratt drain was inserted into place. The wound was final closed with continuous 4-O Vicryl, using a purse-string method around the nipple to overcome the--*blank*--between the diameter of the nipple." In this case, by rearranging some of the words, one may discern that the reference is to the discrepancy between the areola and the surrounding skin, but one could not be certain (Ex. 13, pp. 72-73; T. 589-590).

236. Respondent's having left these blanks was a deviation from acceptable medical standards of recordkeeping (Ex. 13, pp. 72-73; T. 590).

**CHARGE B.2.c.: RESPONDENT FAILED TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE CARE AND TREATMENT OF THE PATIENT. RESPONDENT'S RECORDKEEPING WAS INADEQUATE AND DISORGANIZED IN THAT HE FAILED TO ENTER ANESTHESIA RECORDS AND/OR ENTERED INADEQUATE ANESTHESIA RECORDS LACKING DOCUMENTATION OF TIME OF ADMINISTRATION OF SEDATIVES AND HYPNOTICS, AND/OR PATIENT VITAL SIGNS DURING PROCEDURES, IN THE MEDICAL RECORDS OF PATIENT B IN OR ABOUT JUNE 1996, PATIENT D IN OR ABOUT MARCH 1995, AND/OR PATIENT E IN OR ABOUT APRIL 1997**

**STANDARDS OF PRACTICE WITH RESPECT TO CREATING AND MAINTAINING AN ANESTHESIA RECORD**

237. STANDARD OF CARE AS TO ANESTHESIA RECORDS AND VITAL SIGNS A reasonably prudent plastic surgeon would have entered an anesthesia record for each surgery in the chart, including such information as vital signs before, during, and after surgery, including the pulse and blood pressure, pulse oximetry, and oxygen saturation recordings. The record should include allergies to medications, medications that the patient was taking, and any given before surgery, with the dosage and time of administration. At intervals timed by noting them on the anesthesia record, the medication and its time, dosage, and route of administration should be recorded when it is given. A reasonably prudent plastic surgeon documents the patient's vital signs before, during, and after surgery at fifteen-minute intervals. It is also important to note vital signs after any intramuscular medicine takes effect and before surgery, to be sure that the patient is in satisfactory condition so that surgery can proceed (T. 258-260, 357-359, 383-384).

238. IMPORTANCE OF AN ANESTHESIA RECORD INCLUDING VITAL SIGNS It is important that an appropriate anesthesia record be entered in the patient's chart. Such a record serves to document the vital signs before medication is administered, so that there is a baseline for monitoring the patient during surgery. The baseline is important because medication often has a profound effect upon blood pressure, pulse, and oxygen saturation. An anesthesia record enables a physician to recognize a trend or change in the vital signs related to the administration of medication, which them permits him to

adjust the dosage to avoid or manage complications or problems that may arise during surgery (T. 262, 359-360).

239. RISKS OF FAILURE TO COMPLY WITH REQUIREMENTS TO MAINTAIN AN ANESTHESIA RECORD INCLUDING VITAL SIGNS The needless risk to which a patient is exposed if a physician fails to comply with the standard of care as to the creation and maintenance of an adequate anesthesia record is that without a record of blood pressure, pulse, and oxygen saturation just before surgery, it is very difficult to assess any changes related to the anesthetics administered and to know whether the patient's vital signs were within normal limits. Even death could ensue if the physician were without information adequate to treat the patient effectively (T. 261-263).

**B.2.c.: Patient B**

240. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because in or about June 1996, as to Patient B, he failed to enter anesthesia records and/or entered anesthesia records lacking documentation of time of administration of sedatives and hypnotics, and/or patient vital signs during surgery (Ex. 8A, p. 3; T. 257-263).

241. In or about June 1996, Respondent performed liposuction on Patient B's right and left hips and the back side of the hips. In connection with that surgery, Respondent administered a local anesthetic, sedation, and several medications, midazolam (spelled Medazolan in the chart) and morphine sulfate (Ex. 8A, p. 3; T. 258).

242. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed anesthesia record after performing plastic surgery, set forth in FOFs 237-239 at page 30 above, apply in the circumstances of this surgery (T. 258-261, 263).

243. Respondent failed to create and maintain an anesthesia record for this surgery. He noted only the time that he administered Versed and morphine, and the dosage of the medication that he administered during surgery. Other required information is missing (T. 260).

244. A reasonably prudent plastic surgeon would have documented the time that Versed (midazolam) and morphine were administered to Patient B (T. 260).

245. Respondent's failure to enter an anesthesia record deviated from minimally acceptable standards of medical practice and recordkeeping (T. 263).

**B.2.c.: Patient D**

246. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because in or about March 1995, as to his surgery on Patient D, he entered anesthesia records lacking documentation of the time of administration of sedatives and hypnotics and/or patient vital signs (Exs. 10A, 10B, pp. 11-12; T. 355-361).

247. In March 1995, Respondent performed liposuction on both of Patient D's trochanteric areas (the bulges on the outside of the hips) (Ex. 10B, pp. 11-12; T. 356).

248. In connection with that surgery, Respondent administered a local anesthesia using one percent Xylocaine without epinephrine but with bicarbonate, 8.6 milligrams of Metaxalone, a muscle relaxant, and sedation (Ex. 10B, pp. 11-12; T. 356-357).

249. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed anesthesia record after performing plastic surgery, set forth in FOFs 237-239 at page 30 above, apply in the circumstances of this surgery (T. 357-360).

250. Respondent's note as to the anesthesia that he adminstered to Patient D during surgery lists the medications, shows the dilution of the local anesthetic and saline, and mentions the administration of the Metaxalone. Respondent failed, however, to document the time that anesthesia was administered and what Patient D's vital signs were at any time during its administration (T. 358-359).

251. Respondent failed to enter an anesthesia record that met minimally acceptable standards of recordkeeping. There is no anesthesia record in Patient D's chart or any information indicating that vital signs were taken or documented. Respondent's recordkeeping as to the anesthesia that he administered to Patient D deviated from minimally acceptable standards of practice (T. 360-361).

**B.2.c.: Patient E**

252. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because in or about April 1997, as to his surgery on Patient E, he entered anesthesia records lacking documentation of the time of administration of sedatives and hypnotics, and/or patient vital signs during surgery (Exs. 11A, 11B, pp. 5-6; T. 382-385).

253. The general minimally acceptable standard of care and findings of fact as to the recording of an adequately detailed anesthesia record after performing plastic surgery, set forth in FOFs 237-239 at page 30 above, apply in the circumstances of this surgery (T. 356-360).

254. Respondent failed to enter an anesthesia record for this surgery (T. 382).

255. The note that Respondent entered in Patient E's chart as to the anesthesia that he admininstered during surgery consisted of one paragraph about preanesthesia and another about anesthesia and the tumescent solution given (T. 383).

256. Respondent failed to document the time that he administered anesthesia to Patient E (T. 383).

257. Respondent failed to document what Patient E's vital signs were at any time relating to the administration of anesthesia (T. 383)

258. The standard or accepted interval at which vital signs should be documented in cases like that of Patient E is every fifteen minutes during surgery (T. 383-384).

259. Respondent's anesthesia records for the liposuction that he performed on Patient E in April 1997 deviated from minimally acceptable standards (T. 383-385).

**CHARGE B.2.d.: FAILING TO ENTER AN APPROPRIATE DISCHARGE SUMMARY FOR PATIENT B IN OR ABOUT FEBRUARY 1997**

260. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because in or about February 1997, he failed to enter an appropriate discharge summary for Patient B (Ex. 8A, p. 10; Ex. 8B, p. 20; T. 287-290, 315-318, 332-333).

261. As to the surgery that he performed on Patient B in February 1997, Respondent failed to include any information in his discharge summary about which breast was involved or the amount of blood or hemorrhage (T. 287-288, 315-318).

262. A reasonably prudent plastic surgeon would have included the missing information in his discharge summary (T. 288).

263. Respondent incorrectly used the anatomical term "zygomatic area" in his discharge summary (T. 288).

264. Respondent's discharge diagnosis was "dislocation of breast implant medially with hematoma formation." Respondent misdiagnosed hematoma formation (T. 288-289).

265. Respondent later modified the discharge summary. The phrase "with hematoma formation" was crossed out and Respondent's initials placed next to the change (Ex. 8B, p. 20).

266. The difference between the original discharge summary and the amended one suggests that Respondent at first dictated the diagnosis of hematoma in one of Patient B's breasts but later decided that there was no hematoma (Ex. 8B, p. 20; T. 332-333).

267. Respondent's discharge diagnosis is inconsistent with the narrative that follows it (T. 289).

268. A reasonably prudent plastic surgeon would not have noted hematoma formation in Patient B's discharge summary (T. 289).

269. Respondent's entry of this discharge summary for Patient B's hospitalization of February 25-26, 1997 deviated from minimally acceptable standards of recordkeeping. There are several alterations of the summary and the discharge diagnosis is inconsistent with the clinical picture of the patient's condition and the treatment rendered (T. 289-290).

**CHARGE B.2.e.: FAILING TO DOCUMENT THE REASON A PLANNED RHINOPLASTY WAS NOT PERFORMED AFTER CONSENT WAS OBTAINED FROM PATIENT G FOR A "BILATERAL REDUCTION MAMMOPLASTY AND NASOPLASTY" (sic) IN OR ABOUT JULY 1992**

270. Respondent failed to maintain a record for each patient that accurately reflects the care and treatment of the patient. Respondent's recordkeeping was inadequate and disorganized because he failed to document the reason that a planned rhinoplasty was not performed after he had obtained consent from Patient G for a "bilateral reduction mammoplasty and nasoplasty" (sic) in or about July 1992 (Ex. 13, pp. 53-56, 66, 72; T. 590-595).

271. In Patient G's chart, Respondent recorded a history and a physical examination and noted, under the summary and recommendation, the impression of bilateral breast

enlargement and ptosis, producing symptoms and deformity of nose. Respondent noted, "I recommend bilateral breast reduction and mammopexy" and "deformity of nose. Recommend implantation of cartilage from behind left ear" (Ex. 13, pp. 53-56; T. 591-592).

272. Mammopexy, or a breast lift, is included in the procedure known as reduction mammoplasty (T. 592).

273. The history and physical examination that Respondent noted in July 1992 are much more detailed than those appearing in other, more recent patients' files. Patient G's record contains a great deal of historical information that is organized and complete, and the physical examination also progresses through the various parts of the body documenting both positive and negative findings (Ex. 13, pp. 53-56; T. 593).

274. Respondent's operative report on the surgery that he performed on Patient G contains blank spaces and describes only the breast surgery; it makes no reference to nasal surgery (Ex. 13, p. 72; T. 593).

275. Respondent failed to document anywhere in his record why he did not perform the nasoplasty listed on the consent form that Patient G signed (Ex. 13, pp. 66, 72; T. 593-594).

276. A reasonably prudent plastic surgeon would document why he did not perform the nasoplasty listed in the consent. Since consent for it was obtained, the surgical plan included two procedures, and there should be some record of why one was not done (T. 594).

277. Respondent's failure to document in or about July 1992 the reason that he did not perform the nasoplasty listed in Patient G's signed consent deviated from minimally acceptable standards of recordkeeping (T. 594-595).

## OBSERVATIONS AND IMPRESSIONS OF RESPONDENT'S BEHAVIOR DURING THE HEARING

Because it is difficult if not impossible to discern it by reading the transcript of this proceeding, the Committee wishes to set forth some of its observations of Respondent's conduct during the hearing.

1. Respondent spoke out, often loudly, and made inappropriate physical gestures in reaction to questions or remarks not directed to him; he also made angry gestures in response to the testimony of various witnesses. On the first day of the hearing, for example, he erupted during the testimony of the Department's first expert witness and had to be admonished by the Administrative Officer and calmed down by his attorney (T. 200).

At other times, Respondent was so subdued, and apparently sedated, that his answers upon examination could hardly be heard (T. 960, 976, 999, 1007, 1453, 1459, 1461, 1467). On those occasions, as well, in reaction to questions or remarks, Respondent would sometimes roll his eyes up so that only the whites were visible.

2. During his own testimony, whether being examined by his own attorney or the prosecuting attorney, Respondent stated that he has an excellent memory (T. 1588), yet he had great difficulty in remembering questions and answering them directly and succinctly (e.g., T. 1963, 1284-1285). He often rambled and had to be reminded by the Administrative Officer to make his answers responsive to the questions that he was asked (T. 938, 983, 1017, 1020, 1059, 1062-1063, 1071, 1099-1100, 1341, 1421, 1428-1429).

When exhibits were placed before him, including his own patient records, Respondent was often unable to read from them, either aloud or to himself, so that their contents had to be read to him before he could respond to questions about them (T. 993-994, 1030-1031, 1203-1204, 1207-1208, 1220-1224, 1248-1249). When asked to look at a designated page of a particular exhibit, Respondent shuffled the exhibits before him and often had to be helped by his attorney to find the right page (T. 999, 1072-1073). Moreover, he seemed to be unaware of what was in his own records.

In addition, on some occasions, Respondent was loud, angry, and inappropriately condescending in his answers (T. 1053-1054, 1091-1092, 1137-1140, 1224, 1229-1230), and his attorney had to address him in a harsh and scolding manner in order to check his inappropriate behavior.

3. Although Respondent, through his attorney, introduced patient records that he had certified were complete and accurate copies of his office records, it became evident during the hearing that those records were not complete. That omission eventually was substantially remedied by Respondent's introduction, through his attorney, of additional records, but only after the prosecution had presented most of its direct case (T. 1261-1267).

When questioned about errors and omissions relating to his records, such as missing photographs that Respondent testified to having taken of his patients, inclusion of incorrect anatomical terms in operative notes, and entry of notes containing blank spaces where words or phrases were evidently missing, Respondent repeatedly blamed them on the inefficiency of his secretary (T. 973, 1107, 1153-1154, 1164-1165, 1256-1257, 1333).

4. Some of Respondent's responses seemed incredible. In one instance in particular, he stated that in February 1997, when he was about to perform surgery in his office, he had an anesthesiologist or a nurse anesthetist on staff "all the time" and then immediately contradicted himself and admitted that he had neither (T. 1108-1110).

5. A general theme of Respondent's testimony was the assertion that he has attention deficit disorder and that because he has that disability he should not be held to the same standards as physicians who are not disabled; he also asserted that he should be given special assistance by the State so that he could meet the community standard for recordkeeping and patient care (e.g., T. 1089-1092).

## CONCLUSIONS

As to the facts, the Hearing Committee concludes as follows:

1. Respondent has a psychiatric condition that impairs his ability to practice.

2. Respondent practiced the profession of medicine while impaired by mental disability.

3. Respondent practiced the profession of medicine with negligence on more than one occasion.

4. Respondent failed to maintain a record for each patient that accurately reflects his care and treatment of the patient.

## VOTE OF THE HEARING COMMITTEE

In view of the foregoing, the Hearing Committee concludes as to the specifications and votes unanimously as follows:

**FIRST SPECIFICATION:**
Having a psychiatric condition which impairs the ability to practice

**SUSTAINED**

**SECOND SPECIFICATION:**
Practicing while impaired

**SUSTAINED**

**THIRD SPECIFICATION:**
Negligence on more than one occasion

**SUSTAINED**

**FOURTH SPECIFICATION:**
Failure to maintain records

**SUSTAINED**

## DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee finds that Respondent's incomplete, often incomprehensible records, together with his inability to diagnose accurately and create an appropriate treatment plan, resulted in repeated, inadequate, and inappropriate operations that were technically poorly executed.

The Committee also finds that Respondent has a psychiatric disorder that is either not adequately treated or controlled or not adequately in remission, and it therefore materially and adversely affects his ability to practice medicine.

After seriously considering all possible penalties in this matter, the Committee concludes that either finding requires that Respondent's license be REVOKED.

This penalty represents the Determination of the Hearing Committee, as does its unanimous vote on the charges and specifications.

## ORDER

Based upon the foregoing, **it is hereby ordered that:**

Respondent's license to practice medicine in New York State is hereby **REVOKED.**

Dated: Rockville Centre, New York
March 26, 1999

Patrick F. Carone M.D.
PATRICK F. CARONE. M.D.
Chairperson

RUTH HOROWITZ, PH.D.
ARTHUR J. WISE, M.D.

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

**IN THE MATTER**

**OF**

**JAMES THOMAS HORNE, M.D.**

AMENDED
STATEMENT
OF
CHARGES

JAMES THOMAS HORNE, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 22, 1962, by the issuance of license number 089644 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Respondent has a psychiatric condition which impairs his ability to practice medicine. This condition has been diagnosed as cerebral dysfunction characterized primarily in the judgment areas of the frontal lobes.

B. Respondent practiced the profession while impaired by mental and/or physical disability during the period from in or before 1996 to date. During this period, Respondent's impairment was evidenced by conduct including but not limited to the following:

1. Formulating an inappropriate plan of treatment and/or rendering inappropriate care and treatment to patients, as follows:

   a. Failing to monitor Patient E appropriately before and during surgery in or about April 1997, and failing to take or record vital signs.

b. Failing to take Patient A's vital signs prior to the administration of sedatives and hypnotics and/or delaying unreasonably in proceeding with surgery after the administration of anesthesia in or about April 1997.

c. Formulating an inappropriate plan in or about February 1997 to perform liposuction on Patient A on multiple sites with local anesthesia alone, and/or administering sedation without proper monitoring.

d. Misdiagnosing a hematoma, which was his noted indication for re-operation on Patient B's breast in February 1997, and/or rendering inappropriate treatment for a hematoma.

e. Failing to take or note adequate medical histories and/or to perform or note adequate physical examinations of Patients A in or about June 1996, Patient B in or about June 1996 and February 1997, Patient C in or about October 1996 and/or Patient E in or about January 1997.

f. Failing to enter an operative report in the records of Patient A in or about January 1996, Patient C in or about February 1997, and Patient D in or about July 1996, for surgery performed.

g. Prepping the operative field after rather than before administering local anesthesia in connection with liposuction performed on Patient A in or about June 1996; i.e. out of appropriate chronological order.

h. Failing to monitor Patient F appropriately after the administration of sedation and during an operative procedure in or about January 1994 with the patient in a prone position, and/or giving antibiotics after, not before, surgery, i.e. out of appropriate chronological order, and/or failing to evaluate and treat Patient F appropriately for chronic pain after the surgery, including inappropriately prescribing narcotics, including Percocet, until in or about October 1995.

i. Inappropriately electing to do a secondary closure of a debrided necrotic wound in Patient G's breast in or about August 24, 1992.

j. failing to monitor Patient B appropriately during surgery in or about June 1996.

2. Inadequate and disorganized recordkeeping, including:

   a. Using wrong anatomical terms; e.g. "zygoma"and "platysma" with respect to Patient B's breast augmentation surgery in or about February 1997.

   b. Failing to enter operative reports in patient medical records for surgery performed on Patient A in or about January 1996, Patient C in or about February 1997, and Patient D in or about July 1996, and/or entering inadequate operative records for surgery performed on Patient A in or about January 1997 and Patient B on or about February 25, 1997, and/or entering operative reports including blank spaces for surgery performed on Patient A in or about June 1996, Patient E in or about April 1997, and/or Patient G in or about July 1992.

   c. Failing to enter anesthesia records and/or entering inadequate anesthesia records lacking documentation of time of administration of sedatives and hypnotics, and/or patient vital signs during procedures, in the medical records of Patient B in or about June 1996, Patient D in or about March 1995 and/or Patient E in or about April 1997.

   d. Failing to enter an appropriate discharge summary for Patient B in or about February 1997.

e. Failing to document the reason a planned rhinoplasty was not performed after consent was obtained from Patient G for a "bilateral reduction mamoplasty and nasoplasty" (sic) in or about July 1992.

f. Failing to maintain an appropriate narcotics log documenting drugs dispensed as against drugs purchased during 1996-1997.

3. Writing prescriptions inappropriately for psychotropic and addictive drugs in his own name, for his wife and for Patient F during the period 1994-1996.

4. Presenting at hospital and other pharmacies and exhibiting rage and/or other inappropriate behavior in demanding medications for his office use or for his wife in or before 1997.

## SPECIFICATION OF CHARGES

### FIRST SPECIFICATION

### HAVING A PSYCHIATRIC CONDITION WHICH IMPAIRS THE ABILITY TO PRACTICE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(8)(McKinney Supp. 1998) by having a psychiatric condition which impairs the licensee's ability to practice as alleged in the facts of the following:

1. Paragraph A.

### SECOND SPECIFICATION

### PRACTICING WHILE IMPAIRED

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(7)(McKinney Supp. 1998) by practicing the profession while impaired by alcohol, drugs, physical disability, or mental disability as alleged in the facts of the following:

2. Paragraphs A and B, B.1, B.1(a)-(i), B.2, B.2(a)-(f), B.3 and/or B.4.

### THIRD SPECIFICATION

### NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) 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:

3. Paragraph B.1 and B.1(a)-(j).

## FOURTH SPECIFICATION

## FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined ir N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) 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:

4. Paragraph B.2 and 2(a)-(e).

DATED: August , 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct