STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

September 27, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Stanley Tyson West, M.D.
1015 Madison Avenue, Suite 302
New York, New York 10021

Robert S. Deutsch, Esq.
Aaronson Rappaport Feinstein
& Deutsch, LLP
757 Third Avenue
New York, New York 10017

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Stanley Tyson West, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-304) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

STANLEY TYSON WEST, M.D.

DETERMINATION

AND

ORDER

BPMC #02-304

COPY

JOHN W. CHOATE, M.D., Chairperson, **A. MAJID ESHGHI, M.D.**, and **MS. CARMELA TORRELLI**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by practicing the profession of medicine with gross negligence on a particular occasion (six specifications) and with negligence on more than one occasion (one specification), by practicing the profession of medicine with gross incompetence (one specification) and with incompetence on more than one occasion (one specification), by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient (five

specifications), by practicing the profession of medicine fraudulently (one specification), and by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department (one specification).

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

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	October 9, 2001[1]
Date of Service of Notice of Hearing and Statement of Charges:	October 9, 2001
Answer to Amended Statement of Charges Dated:	October 26, 2001
Prehearing Conference Date:	October 23, 2001
Hearing Dates:	October 30, 2001 November 28, 2001 December 6, 2001 December 7, 2001 December 11, 2001 January 18, 2002 January 23, 2002 February 8, 2002 February 26, 2002 April 12, 2002
Deliberation Dates:	June 7, 2002 June 28, 2002 July 12, 2002

[1] On October 23, 2001 the original Statement of Charges dated October 9, 2001 (Ex. 1A) was replaced by an amended Statement of Charges dated October 23, 2001 (Ex. 1B) upon the request of the Petitioner and without objection from the Respondent.

Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	Diane Abeloff, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Aaronson Rappaport Feinstein & Deutsch, LLP 757 Third Avenue New York, N.Y. 10017 By: Robert S. Deutsch, Esq.

WITNESSES

For the Petitioner:	Stanley Birnbaum, M.D. Patient A Paul Scher, OPMC Investigator Patient E Patient D
For the Respondent:	Stanley Tyson West, M.D. John Koulos, M.D. Hilda Hutcherson, M.D. Marc K. Wallack, M.D. Sandra Wilson, R.N. Francis L. Hutchins, Jr., M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations 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 cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Stanley Tyson West, M.D. ["the Respondent"] was authorized to practice medicine in New York State on December 24, 1963 by the issuance of license number 091650 by the New York State Education Department (Ex. 2).
2. The Respondent graduated from Hahnemann Medical College in Philadelphia, Pennsylvania in 1959 and then completed a one-year rotating internship at Cooper Hospital in Camden, New Jersey (Tr. 796-799; Ex. B).
3. From 1960 through 1962 the Respondent served as a Captain in the United States Air Force. During this period the Respondent spent over a year in Vietnam where he worked as a trauma surgeon in a MASH unit. The Respondent was awarded a Bronze Star and received an Honorable Discharge. (Tr. 800-801; Ex. B).
4. In 1963 the Respondent started a three-year residency in Obstetrics and Gynecology at Albert Einstein College of Medicine-Montefiore Hospital in Bronx, New York, which he completed in 1966 (Tr. 801-802; Ex. B).

5. Following the completion of his residency the Respondent did a two-year fellowship in reproductive endocrinology and infertility at the Moses Research Institute at Montefiore Hospital. After the fellowship ended the Respondent worked full-time at Montefiore Hospital. (Tr. 802-804).

6. Around 1968 the Respondent started a part-time private practice specializing in gynecology, reproductive endocrinology and infertility. By 1970 the Respondent stopped working at Montefiore Hospital and he opened a full-time private office in Manhattan. Since the opening of this office the Respondent has and continues to specialize in endocrinology and infertility. (Tr. 804).

7. Some time after the Respondent completed his formal medical education he developed an interest in myomectomies. The Respondent learned to perform myomectomies by reading about them and by scrubbing in with a physician from New York Medical College who performed myomectomies on occasion. The Respondent started performing myomectomies himself and over time, with growing experience and improved techniques, he became proficient in performing myomectomies. To date the Respondent has performed a few thousand myomectomies. (Tr. 805-811, 822-825 and 831-832).

8. Over the course of his career the Respondent has been affiliated with various medical institutions in the New York City metropolitan area; he has taught students and residents from several New York City area medical institutions; and, he has had several articles published in peer journals and written a book called "The Hysterectomy Hoax". (Tr. 814-815, 819-822 and 827-828; Ex. B).

9. Finally, the Respondent is Board Certified in Obstetrics and Gynecology and he is Board Eligible in Reproductive Endocrinology (Tr. 811-812).

GENERAL FINDINGS AS TO MEDICAL ISSUES

10. Myomectomy is the removal of a leiomyoma which is also known as a myoma or fibroid. Leiomyomas, myomas or fibroids are tumors arising in the muscle wall of the uterus. (Tr. 33-34).

11. The main indications for performing a myomectomy are abnormally heavy bleeding, pain, and the pressure phenomenon – that the tumor gets so large that it compresses neighboring organs. Occasionally infertility can be an indication for removal, as well as rapid growth. (Tr. 34).

12. If myomectomy is performed to try to alleviate a fertility problem, an evaluation of other causes of infertility, such as closed tubes, hormonal imbalance, and infertile partner, should be considered (Tr. 36, 1205-1206, 1518-1520 and 1539; Exs. 3A, 4A, 5A and 6A).

13. Hormonal conditions, malignancies, or polyps that might cause abnormal bleeding are generally excluded by the surgeon before performing a myomectomy (Tr. 36-37).

14. The surgeon is ultimately responsible for deciding whether to perform an operation. When the surgeon determines that an operation is not appropriate for a patient, the surgeon should first try to convince the patient that the operation is not good for the patient. If the surgeon is unsuccessful and the patient still wants the operation, the surgeon should refuse to perform the surgery. All relevant conversations should be documented in the record. (Tr. 47, 365-366 and 399).

15. Since the uterus remains after a myomectomy, the surgeon needs to ensure that the lining of the uterus, the endometrium, is not malignant. Uterine cancer typically affects women in their 40's and up, but can occur in any age group. Abnormal bleeding is a common sign of uterine cancer which often leads to the decision to perform an endometrial biopsy. (Tr. 295, 316-317, 341-342, 355 and 425).

16. A Pap Smear is a screening tool to assist in the diagnosis of gynecologic malignancies, primarily of the uterine cervix. Confirmation of a gynecologic malignancy requires a histologic (tissue) diagnosis. Generally, women should have a Pap Smear on an annual basis, including those undergoing gynecological surgery. (Tr. 39, 426 and 508).

SPECIFIC FINDINGS AS TO EACH PATIENT

Patient A

17. On August 24, 1998 Patient A, a 42 year old female with a fibroid, after having consulted with two other gynecologists, sought the opinion of the Respondent regarding the elective removal of the fibroid. She complained that the fibroid made her stomach slightly larger than normal. She stated that she had no other complaints, the fibroid did not cause any pain, she was not bleeding heavily, and the fibroid did not interfere with her life. (Tr. 546-548; Ex. 3A, p. 2).

18. Patient A lived with her boyfriend. The Respondent noted in the patient's medical record that she "abstains" from sexual activity. He also noted that she "wants pregnancy", but it is unclear as to the time. (Tr. 900; Ex. 3A, p. 2).

19. The Respondent did not perform a fertility workup (Tr. 67-68 and 72; Ex. 3A).

20. On October 23, 1998 the Respondent performed a myomectomy and reconstruction of the uterus on Patient A at St. Vincent's Hospital and Medical Center ["St. Vincent's"] in Manhattan, New York (Ex. 3B, pp. 3 and 30-31).

21. Although Patient A testified that she had problems urinating in the hospital, *i.e.* voiding frequently in small amounts, there is no mention in either the physician or nursing notes postoperatively of any urinary complaints by the patient (Tr. 133, 138-139 and 553-556; Ex. 3B, pp. 39-41).

22. On October 25, 1998 Patient A was discharged from St. Vincent's (Ex. 3B, pp. 3 and 77).

23. According to Patient A's testimony she could neither sleep nor urinate following her discharge from the hospital. She stated that as the week progressed her stomach and legs became more and more distended. She claims to have informed the Respondent of these problems on October 26th, October 29th and October 30th, 1998. According to her testimony the Respondent never asked any questions about the lack of urination, the distension or the difficulty with sleeping. (Tr. 558-573 and 653).

24. Since inability or difficulty in urinating is a recognized postoperative complication of pelvic surgery, the Respondent should have told Patient A to come to his office when she spoke to him on October 26, 1998 (Tr. 79).

25. On November 2, 1998 Patient A went to the Respondent's office for her regularly scheduled postoperative appointment. The Respondent noted in the patient's medical record "* large hematoma extending down legs, uterus seems to have bled (firm mass to umbilicus)". The Respondent ordered CBB, PT and PTT. (Ex. 3A, p. 2).

26. The Respondent failed to determine the cause of the firm mass up to the umbilicus. The Respondent's care deviated from acceptable medical standards in that he should have performed further evaluation, including, but not limited to, bladder function. (Tr. 80-81, 94, 170, 180 and 1556; Ex. 3A).

27. Patient A's symptoms continued and her general condition worsened. On Friday, November 6, 1998, Patient A returned to the Respondent's office and the Respondent noted in the patient's medical record "Appears to have urinary distention (has not urinated for some time ? hours). Does not look well, HGB ↓ - Readmit". (Tr. 578-585; Ex. 3A, p. 3).

28. Patient A was readmitted to St. Vincent's for urinary retention on November 6, 1998 (Tr. 671; Ex. 3B, pp. 81-83 and 86-89).

29. After Patient A was readmitted to St. Vincent's, a CT Scan was performed which identified a bladder perforation (Ex. 3B, pp. 81-83 and 174-178).

Patient B

30. Patient B, a 36 year old female with a history of a prior myomectomy, cone biopsy, hypertension, heavy bleeding and unprotected sex, was initially seen by the Respondent at his office on November 3, 1994 (Ex. 4A).

31. On March 31, 1995 a hysterosalpingogram ["HSG"] ordered by the Respondent was performed on Patient B in an outpatient facility. The primary purpose of an HSG is for an evaluation of fertility. The HSG performed on Patient B showed that neither tube was patent. (Tr. 207-211; Ex. 4A).

32. The Respondent's medical record for Patient B is silent as to whether the patient's "heavy" menses interfered with her daily activities or was painful. The medical record does not contain any evidence of an evaluation for possible anemia. (Ex. 4A).

33. The Respondent recommended a myomectomy. The reasons for the performance of this surgery are heavy bleeding (as noted in the record) and infertility (since the record contains an HSG). (Tr. 971 and 977; Ex. 4A).

34. The Respondent performed the myomectomy on Patient B due to heavy bleeding and pain (Tr. 977, 997 and 1033-1034; Ex. 4A).

35. In some instances a gynecologist treating a patient for heavy bleeding may try to medically control the bleeding prior to resorting to surgery. In this instance the Respondent chose not to. The use of replacement iron therapy and/or agents such as Lupron, is a matter of clinical judgment. Furthermore, in the case of Lupron it is necessary to weigh the benefits against the risks in subsequent surgery. (Tr. 258-261, 989-991 and 1531-1534; Ex. 4A).

36. Patient B did not appear to be severely anemic. Although her hematocrit and hemoglobin levels were lower than normal, they apparently met the hospital criteria for induction of anesthesia. (Tr. 58-59 and 257-258; Ex. 4A and Ex. 4B, p. 8).

37. On June 15, 1995 the Respondent admitted Patient B to St. Vincent's for surgical management of menorrhagia secondary to a fibroid uterus (Ex. 4B, pp. 2-5 and 66-67).

38. On June 15, 1995 the Respondent performed lysis of adhesions and excised adenomyosis from multiple sites. Since adenomyosis is known to cause heavy bleeding (menorrhagia), the surgery was indicated. (Tr. 248-252 and 307).

39. The Operative Report dated June 15, 1995 does not indicate that any apparent problems were encountered in the lysis of adhesions or does it mention any potential compromise of blood supply to the intestine. Absent these findings there is no indication for an intraoperative surgical consultation or that the Respondent's exploration of the abdomen was inadequate. (Tr. 1013-1014; Ex. 4B, pp. 14-16).

40. On June 17, 1995 Patient B was discharged from St. Vincent's (Ex. 4B, pp. 2 and 74).

41. On or about June 20, 1995 Patient B noticed a brownish fluid discharge from her incision. She was readmitted to St. Vincent's on June 26, 1995. On June 27, 1995 she was taken to the operating room for an exploratory laparotomy. (Ex. 4B, pp. 75-76, 78-80 and 165-168).

42. During the exploratory laparotomy the surgeon, Dr. Marc K. Wallack, found that there was evidence of an injury to the sigmoid colon. However, after hearing the testimony of the witnesses for both parties, the etiology of the injury is unclear. (Tr. 236, 238, 242-244, 300-302, 304, 1025 and 1441-1443; Ex. 4B, pp. 165-168).

Patient C

43. Patient C, a 52 year old female, was initially seen by the Respondent at his office on May 11, 1994. She had a history of a heavy menses with clots and she complained of fatigue. In addition, the Respondent performed a physical examination and found that she had an enlarged uterus, approximately 8 to 9 months size. The Respondent recommended a supra cervical hysterectomy. (Tr. 311-312; Ex. 5A, p. 1).

44. On July 15, 1994 the Respondent admitted Patient C to St. Luke's Roosevelt Hospital Center ["St. Luke's"] in Manhattan, New York, for surgical management of menorrhagia secondary to a fibroid uterus and ovarian cyst (Ex. 5B, pp. 1-4 and 152-153). Later that day the Respondent performed a total abdominal hysterectomy and bilateral salpingo-oopherectomy on Patient C (Tr. 321-322; Ex. 5A, pp. 2-3 and Ex. 5B, pp. 241-242).

45. During the operation Patient C sustained increased blood loss and had to be given 4 units of blood. In addition, she received 2 units of blood after the surgery. (Tr. 314; Ex. 5B).

46. Patient C was anemic prior to surgery and her anemia was not treated preoperatively. Furthermore, the Respondent has no record of any attempt to determine the patient's hematologic status, *i.e.* anemia, in his office record for the patient. (Ex. 5A). Finally, the hysterectomy, although indicated, was not an emergency.

47. Consequently, the Respondent's failure to treat Patient C's anemia preoperatively deviated from acceptable medical standards (T. 313-315).

48. The Respondent also failed to perform preoperative endometrial sampling (Tr. 316; Ex. 5A).

49. Preoperative endometrial sampling would either rule-in or rule-out the possibility of endometrial carcinoma and would therefore affect the nature and extent of the surgery to be performed (Tr. 212-214 and 316-317). Additionally, the incidence of endometrial cancer increases with age (Tr. 342).

50. The Respondent's failure to perform preoperative endometrial sampling constituted a deviation from acceptable medical standards.

51. During the surgery the Respondent requested an intraoperative consultation with a general surgeon. Dr. Arnold Belgraier, a general surgeon, then responded to the operating room and assisted the Respondent in the dissection and lysis of extensive pelvic adhesions. As part of the dissection the left ureter was traced. According to the operative report of July 15, 1994, the right ureter was identified to the bifurcation of the internal and external iliac arteries, but it was not traced distally. (Tr. 322-323; Ex. 5A, pp. 2-3 and Ex. 5B, pp. 241-242 and 251).

52. On July 26, 2002 Patient C underwent additional surgery performed by Dr. David Kaufman to correct an injury to the right ureter. An obstruction of the right ureter was discovered and repaired. (Tr. 334-335; Ex. 5B, pp. 244-246).

53. Although the injury to the patient's right ureter occurred during the prior surgery, it has not been established how this injury occurred. Failure to trace the entire length of the ureter in the absence of any suspicion of damage or compromise is not a deviation from acceptable gynecological surgical standards.

Patient D

54. Patient D, a 38 year old female with a history of three prior myomectomies, was initially seen by the Respondent at his office on June 13, 1994. She went to see the Respondent to find out if he could help her get pregnant. (Tr. 359-360, 1180-1181 and 1665; Ex. 6A, p. 1).

55. On October 9, 1996 the Respondent admitted Patient D to St. Vincent's for surgical management of pelvic adhesions, fibroid tumors, and closed fallopian tubes (Tr. 360-361; Ex. 6B, pp. 1-3 and 15).

56. On October 10, 1996 the Respondent performed an abdominal myomectomy, debulking of adenomyosis, and lysis of adhesions (Tr. 360-361; Ex. 6B, pp. 23-25).

57. On October 12, 1996 Patient D was discharged from St. Vincent's (Ex. 6B, pp. 1-3).

58. On or about October 25, 1996 Patient D noticed food contents seeping from her surgical wound. She was readmitted to St. Vincent's on October 31, 1996 for what was ultimately diagnosed as an enterocutaneous fistula (Tr. 372-373; Ex. 6B, pp. 65 and 68-72).

59. The Respondent failed to perform preoperative endometrial sampling (Tr. 361; Ex. 6A).

60. The Respondent's failure to perform preoperative endometrial sampling was below acceptable medical standards for the following reasons:

a. The patient's initial visit on June 13, 1994 did not include any evaluation of ovulatory status. The fact that the patient previously had two miscarriages does not necessarily support the conclusion that the patient was currently ovulating.

b. Substantial time had elapsed between the patient's initial office visit and the subsequent surgery. This passage of time would increase the necessity for updating the patient's ovulatory status.

c. Endometrial sampling is one of several recognized indicators of ovulatory status.

61. Although in retrospect the operations performed by the Respondent did not substantially improve the patient's fertility, it has not been established to the satisfaction of the Hearing Committee that the Respondent lacked adequate medical indication to perform these operations (Tr. 361-362).

62. When the Respondent performed the myomectomy and lysis of adhesions on Patient D, he used a Pfannenstiel incision. Due to the three prior myomectomies, Patient D had a frozen pelvis. (362-363; Ex. 6B, pp. 23-25).

63. The choice of incision in most surgical procedures is a matter of judgment based upon the surgeon's training and experience. The use of a vertical incision in this patient would not enhance the Respondent's ability to deal with a frozen pelvis. Pfannenstiel incisions are commonly used by gynecologic oncologists in the performance of radical pelvic surgery (Tr. 366-367 and 1193).

64. At the time of the surgery performed on October 10, 1996 a Foley catheter was inserted into the patient's uterine cavity and a second was inserted into her urinary bladder (Ex. 6B, p. 23). These Foley catheters were removed at 12:00 noon on October 11, 1996 (Ex. 6B, p. 11).

65. Since an intraoperative dye test performed on the patient did not reveal any leakage, the removal of the Foley catheters on the first postoperative day does not constitute a deviation from acceptable medical standards (Tr. 392-394; Ex. 6B, pp. 23-25).

66. The Operative Report dated October 10, 1996 does not indicate that any apparent problems were encountered in the lysis of adhesions or does it mention any potential compromise of blood supply to the intestine. Absent these findings there is no indication for an intraoperative surgical consultation or that the Respondent's exploration of the abdomen was inadequate. (Tr. 274-275 and 375-376; Ex. 6B, pp. 23-25).

Patient E

67. Patient E, a 46 year old female, with a history of hypothyroidism, a prior laparoscopy, uterine fibroids, and irregular periods with endometrial hyperplasia, was initially seen by the Respondent at his office on September 30, 1992 (Tr. 1224; Ex. 7A, p. 2).

68. The Respondent performed a physical examination on Patient E and told her that her uterus was retroverted and fixed and that she had fibroids (Tr. 728-729; Ex. 7A, p. 2).

69. A Pap Smear was reported as having been performed two months prior to the patient's initial visit (Ex. 7A, p. 2).

70. There is an indication in the patient's medical record of a previous laparoscopy and of hyperplasia (Ex. 7A, p. 2). The patient testified that she provided the Respondent with a copy of the endocrine workup which was performed during the summer of 1992 (Tr. 725-726).

71. On December 1, 1992 the Respondent admitted Patient E to St. Vincent's for surgical correction of a fibroid uterus and repair of fallopian tubes (Ex. 7B, pp. 1-3 and 6). Later that day the Respondent performed lysis of adhesions, fulguration of endometriosis, multiple myomectomy, and left salpingectomy (Ex. 7B, pp. 13-15).

72. Although in retrospect the operations performed by the Respondent did not substantially improve the patient's fertility, it has not been established to the satisfaction of the Hearing Committee that the Respondent lacked adequate medical indication to perform these operations.

73. On December 3, 1992 Patient E was discharged from St. Vincent's (Ex. 7B, pp. 1-3).

74. During the early morning hours of December 4, 1992 Patient E, complaining of abdominal pain, returned to St. Vincent's where she was seen in the Emergency Room. She was readmitted to St.. Vincent's, observed for a day, and then discharged on December 5, 1992. (Tr. 443-444; Ex. 7B, pp. 52-55 and 83).

75. On December 9, 1992 Patient E, complaining of continued abdominal pain with increased abdominal distention, nausea and vomiting, along with fever and chills, was readmitted to St. Vincent's with a diagnosis of peritonitis (Ex. 7D, pp. 85-91).

76. On December 10, 1992 Dr. Vincent Scarpinato performed an exploratory laparotomy on Patient E. The preoperative diagnosis was perforated viscus. The actual findings of Dr. Scarpinato were consistent with perforated sigmoid colon. (Ex. 7D, pp. 208-210).

77. The Respondent's Operative Report dated December 1, 1992 does not indicate that any apparent problems were encountered in the lysis of adhesions or does it mention any potential compromise of blood supply to the intestine. Absent these findings there is no indication for an intraoperative surgical consultation or that the Respondent's exploration of the abdomen was inadequate. (Ex. 7B, pp. 13-15).

Patient F

78. Patient F, a 48 year old female with an ovarian cyst and fibroids, was initially seen by the Respondent at his office on February 7, 1994 (Tr. 503-505; Ex. 8A, p. 2).

79. The Respondent's medical record for Patient F does not contain any menstrual history other than that her cycles are every 32 days, lasts for 5days, and are accompanied by mild cramps. Additionally, the patient's history as recorded is inadequate for a patient who is subsequently scheduled for major gynecological surgery. The patient's medical record also lacks any description of symptomology or pelvic findings that would provide an adequate indication for such major gynecological surgery. Furthermore, the Respondent listed fibroids and ovarian cyst as the patient's chief complaint. These are physical findings, not complaints. (Tr. 503-506; Ex. 8A, p. 2).

80. There is no indication in the patient's medical record of a Pap Smear result within one year of the surgery or the performance of an endometrial biopsy. At age 48 the patient was at a slight, but increased risk of endometrial carcinoma. (Tr. 507-508; Ex. 8A).

81. On July 26, 1994 the Respondent performed a multiple myomectomy and right oopherectomy on Patient F at St. Luke's (Ex. 8B, pp. 41-42).

82. The performance of a right oopherectomy in a 48 year old female patient who is at risk of ovarian cancer, is clearly indicated (Tr. 521-522 and 527-528). However, the performance of a myomectomy and uterine reconstruction in such a patient is not generally accepted as a procedure of choice. Most gynecologists given this situation would perform a total abdominal hysterectomy. (Tr. 509-510 and 523).

APPLICATION FOR REAPPOINTMENT TO

ST. VINCENT'S HOSPITAL AND MEDICAL CENTER

83. On October 25, 1999 the Respondent was interviewed by Paul Scher, a Supervising Medical Conduct Investigator with the Office of Professional Medical Conduct ["OPMC"], and Dr. Tepedino, an OPMC Medical Coordinator. During this interview the Respondent was asked questions about his educational background, his professional background, and his care and treatment of seven patients. At the end of the interview the Respondent was told that he would be informed in writing when the investigation was closed or he would hear from the legal branch of the OPMC if there were to be a hearing. (Tr. 707, 711-712 and 1402).

84. Subsequent to the October 25, 1999 interview the Respondent received a letter requesting several more of his medical records and the Respondent provided those records in December 1999 (Tr. 1412; Exs. 3A and 6A).

85. The Respondent was never informed that the investigation was closed (Tr. 712 and 1421).

86. On or about January 7, 2000 the Respondent completed an application form for reappointment to St. Vincent's entitled "Request for Reappointment to Saint Vincents Hospital & Medical Center". The Respondent incorrectly answered "No" to the following question which appears in the reappointment application: "To the best of your knowledge, are you now or have you ever been the subject of a professional conduct inquiry, investigation or proceeding in this state or any other state?" (Tr. 1405; Ex. 9).

87. The Respondent's application for reappointment was approved on January 18, 2000 by Dr. John Koulos, the acting director of the Department of Obstetrics and Gynecology at St. Vincent's (Tr. 1345-1346, 1358 and 1367; Ex. 9). The Respondent had informed Dr. Koulos that he was going to be questioned by the state (Tr. 1362-1364 and 1374-1375).

88. Although the Petitioner proved that the Respondent's answer constituted a willful misrepresentation as to whether he is now or ever has been the subject of a professional conduct inquiry, investigation or proceeding, the Petitioner failed to prove that the Respondent made this misrepresentation with an intent to deceive.

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C, D, E and/or F, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, C, D and F, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with gross incompetence. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E and/or F.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E and/or F.

The Respondent did not order excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent lacked adequate medical indication to perform any of the gynecologic surgical procedures performed on Patients A, B, D, E and F, except the myomectomy performed on Patient F[2].

The Respondent did not practice medicine fraudulently or beyond its authorized scope. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent knowingly misrepresented or concealed a known fact in connection with his application for reappointment to St. Vincent's with intent to deceive.

The Respondent did willfully make or file a false report, or failed to file a report required by law or by the department of health or the education department. The Petitioner has proved by a preponderance of the evidence that the Respondent willfully misrepresented or concealed a known fact in connection with his application for reappointment to St. Vincent's.

[2] Although the Respondent was negligent for performing a myomectomy on Patient F without adequate medical indication, the Hearing Committee was not convinced that this lack of adequate medical indication to perform this particular procedure constituted "Unwarranted Tests/Treatment" as defined by § 6530(35) of the Education Law.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of Stanley Birnbaum, M.D., and the factual testimony of Patient A, Patient E, Patient D and OPMC Investigator Paul Scher, in its efforts to establish its case against the Respondent. Dr. Birnbaum is Board Certified in Obstetrics and Gynecology (Tr. 25; Ex. 10).

The Respondent's case relies primarily upon the medical testimony of Francis L. Hutchins, Jr., M.D., and Hilda Hutcherson, M.D., the factual testimony of John Koulos, M.D., and Sandra Wilson, R.N., and the medical and factual testimony of the Respondent and Marc K. Wallack, M.D.. The Respondent, Dr. Hutchins and Dr. Hutcherson are Board Certified in Obstetrics and Gynecology and Dr. Wallack is Board Certified in Surgery (Tr. 1385, 1436 and 1500; Ex. F; See finding 9, *supra*).

The Hearing Committee found that all medical witnesses who testified at this hearing were qualified and gave credible testimony. Furthermore, the Hearing Committee also found that all factual witnesses who testified were credible, except Patient D. Patient D did not maintain a consistent level of believability throughout her testimony. In addition, she did not appear to be either objective or unbiased. Consequently, the Hearing Committee had various concerns about the reliability of her testimony.

The most important witness to testify in support of the Respondent's case, was the Respondent himself. The Hearing Committee found the Respondent to be a skilled and experienced medical practitioner who was knowledgeable about the particular area of medicine in which he specialized. Additionally, he appeared sincere and honest and he directly addressed the questions that he was asked by the members of the Hearing Committee. Although he firmly believes that his treatment of each of the particular patients was proper, he recognized that his recordkeeping was lacking. However, he was reluctant to admit that his preoperative workup and postoperative care were, at times, inadequate.

General Discussion

The Hearing Committee noted that most, if not all, of the particular patients who were the subject of this hearing were referred to the Respondent from other gynecologists and/or sought out the Respondent themselves.

With respect to those patients who were referred to the Respondent from other gynecologists, many of the referring gynecologists, in the Hearing Committee's opinion, had performed basic laboratory evaluations, including, but not limited to, Pap Smears and endocrine workups. Therefore, the duplication of such tests by the Respondent would be unwarranted and costly.

With respect to those patients who sought out the Respondent themselves, the Hearing Committee found that these patients had a recognized gynecological pathology and a strong desire for preservation of the uterus.

In addition, there appears to be a clear pattern of the Respondent's deficiency relating to recordkeeping and office documentation. A review of the patient records maintained by the Respondent reveal that there is inadequate information describing patient symptoms and physical findings.

The Hearing Committee believes that the Respondent's surgical skills were consistent with those of most gynecologic surgeons. However, the Respondent's preoperative evaluations were, at times, inadequate and incomplete. Furthermore, although the Respondent is technically competent at what he does, his selection of patients for myomectomy was sometimes questionable.

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, as well as the unwarranted tests/treatment issues, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients as well as the pertinent factual testimony.

The resolution of the fraudulent practice and false report issues required an examination of the St. Vincent's application for reappointment (Ex. 9) and the evaluation of the factual testimony of Investigator Scher, Dr. Koulos and the Respondent.

The Hearing Committee found that the Respondent's postoperative care of Patient A and his preoperative workup of Patients C, D and F were inadequate and constituted a deviation from acceptable medical standards and that the Respondent lacked adequate medical

indication to perform a myomectomy on Patient F. Although the Hearing Committee sustained the negligence charges relating to each of these patients, the Hearing Committee also found that the Respondent's skill and factual knowledge of obstetrics and gynecology was adequate and it therefore concluded that he was not incompetent. In addition, the Hearing Committee does not believe that any of the proven allegations of negligence was egregious or conspicuously bad as to rise to the level of gross negligence. Furthermore, the Hearing Committee was not convinced that the Respondent's lack of adequate medical indication to perform the myomectomy on Patient F constituted "Unwarranted Tests/Treatment" as defined by § 6530(35) of the Education Law in view of the fact that surgical intervention was clearly indicated (See finding 82, *supra*).

Finally, with respect to the fraudulent practice and false report charges, the Hearing Committee found that the St. Vincent's application for reappointment filed by the Respondent clearly contained a false statement that was willfully made by the Respondent. However, the Hearing Committee was not convinced that the Respondent made this statement with intent to deceive.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

Sustained: A and A3

Not Sustained: A1 and A2

Factual Allegations relating to the treatment of Patient B

Sustained: B[3]

Not Sustained: B1a, B1b, B2 and B3

Factual Allegations relating to the treatment of Patient C

Sustained: C[4], C1a and C1b

Not Sustained: C2

Factual Allegations relating to the treatment of Patient D

Sustained: D[5] and D1a

Not Sustained: D2, D3, D4 and D5

Factual Allegations relating to the treatment of Patient E

Sustained: E[6]

Not Sustained: E1a, E1b, E2 and E3

Factual Allegations relating to the treatment of Patient F

Sustained: F, F1a, F1b and F2[7]

Application for Reappointment to St. Vincent's Hospital and Medical Center

Sustained: G[8]

[3] Factual allegation B is sustained, except that Patient B was admitted to St. Vincent's on June 15, 1995 and the Respondent did not deviate from medically accepted standards.
[4] Factual allegation C is sustained, except that Patient C was admitted to St. Luke's on July 15, 1994.
[5] Factual allegation D is sustained, except that Patient D was 38 years old on October 9, 1996.
[6] Factual allegation E is sustained, except that the Respondent did not deviate from medically accepted standards.
[7] Factual allegation F2 is sustained only to the extent that the Respondent lacked adequate indication to perform a myomectomy. Although the myomectomy was not indicated, the right oopherectomy was.

Specifications

Gross Negligence

1st Specification	(Treatment of Patient A)	Not Sustained
2nd Specification	(Treatment of Patient B)	Not Sustained
3rd Specification	(Treatment of Patient C)	Not Sustained
4th Specification	(Treatment of Patient D)	Not Sustained
5th Specification	(Treatment of Patient E)	Not Sustained
6th Specification	(Treatment of Patient F)	Not Sustained

Negligence on More than One Occasion

7th Specification — Sustained

Sustained Factual Allegations in Support of the 7th Specification:

Treatment of Patient A:	A and A3
Treatment of Patient C:	C, C1a and C1b
Treatment of Patient D:	D and D1a
Treatment of Patient F:	F, F1a, F1b and F2

Gross Incompetence

8th Specification	(Treatment of Patients A, B, C, D, E and F)	Not Sustained

Incompetence on More than One Occasion

9th Specification	(Treatment of Patients A, B, C, D, E and F)	Not Sustained

Unwarranted Tests/Treatment

10th Specification	(Treatment of Patient A)	Not Sustained
11th Specification	(Treatment of Patient B)	Not Sustained
12th Specification	(Treatment of Patient D)	Not Sustained

[8] Factual allegation G is sustained, except that the Respondent did not intend to deceive.

13th Specification (Treatment of Patient E) Not Sustained

14th Specification (Treatment of Patient F) Not Sustained

Fraudulent Practice

15th Specification Not Sustained

(Application for Reappointment to St. Vincent's Hospital and Medical Center)

False Report

16th Specification Sustained

(Application for Reappointment to St. Vincent's Hospital and Medical Center)

Sustained Factual Allegation in Support of the 16th Specification: G

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be suspended for a period of one year ["the suspension], that the suspension is to be stayed, and that the Respondent is to be placed on probation for the one-year period of the suspension. In addition, the terms of probation shall include a requirement for a Practice Monitor. The complete terms of probation are attached to this Determination and Order as Appendix II.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the

underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee believes that in view of all the circumstances, a one-year stayed suspension, connected to probation, is an appropriate penalty. Furthermore, the Hearing Committee recognizes that its primary responsibility is to protect the public and it firmly believes that it is fulfilling this responsibility by imposing probation with provision for a Practice Monitor.

The Hearing Committee found the Respondent to be a technically competent surgeon. In addition, the Hearing Committee detected a common pattern among many of the particular patients who were the subject of this hearing. First, the patients sought out the Respondent and specifically requested the procedures that the Respondent ultimately performed. Second, before the initial visit with the Respondent the patients had previously undergone multiple gynecological surgeries. Third, many of the complications that developed were recognized complications, *i.e.* uteral damage and bowel injuries. Fourth, the etiology of the surgical complications still remains unclear to the Hearing Committee.

Nevertheless, the Hearing Committee was troubled by the Respondent's preoperative workups and selection of patients for major gynecological surgery. In addition, the Hearing Committee noted that many of the sustained misconduct charges emanated from or were aggravated by inadequate recordkeeping.

The Hearing Committee believes that the most effective way to address its concerns is to require some oversight of the Respondent's gynecological practice. While probation provides continuing supervision over a period of time, straight probation, although

useful, is not enough. It needs to be supplemented by a specialized form of oversight. A Practice Monitor would provide the necessary specialized oversight, thereby insuring the safety of the public. Furthermore, a Practice Monitor would have the responsibility to review the Respondent's patient records on an ongoing basis. Therefore, a Practice Monitor would serve as a safeguard in assuring the quality of the patient records maintained by the Respondent.

Given the totality of the circumstances regarding this matter and the fact that the gross negligence and the ordinary and gross incompetence charges were not proven, the Hearing Committee believes that the revocation of the Respondent's medical license is not warranted.

The Hearing Committee does not wish to be misunderstood as to in any way condoning the Respondent's conduct. The penalty imposed herein is designed to affirm the Hearing Committee's disapproval of the Respondent's conduct while imposing a fair punishment and offering sufficient protection to the public.

The Hearing Committee believes that by allowing the Respondent to practice medicine under the strict conditions it is imposing, the public is sufficiently protected and the Respondent can continue to provide an important service to the community.

ORDER

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

1. The 7th and 16th Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The 1st, 2nd, 3rd, 4th, 5th, 6th, 8th, 9th, 10th, 11th, 12th, 13th, 14th and 15th Specifications of professional misconduct contained within the Amended Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED** for a period of one year ["the suspension"], the suspension is to be **STAYED** and the Respondent is to be placed on **PROBATION** for the one-year period of the suspension; and

4. The **TERMS OF PROBATION** shall include a requirement for a **PRACTICE MONITOR**; and

5. The Respondent shall comply with all **TERMS OF PROBATION** as set forth in Appendix II, which is attached hereto and made part of this Order; and

6. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York
September 25 , 2002

JOHN W. CHOATE, M.D.
Chairperson

A. MAJID ESHGHI, M.D.
CARMELA TORRELLI

TO: STANLEY TYSON WEST, M.D.
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APPENDIX I

APPENDIX I

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

IN THE MATTER

OF

STANLEY TYSON WEST, M.D.

AMENDED STATEMENT OF CHARGES

STANLEY TYSON WEST, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 24, 1963, by the issuance of license number 091650 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about October 23, 1998, Respondent performed a myomectomy and reconstruction of the uterus on Patient A, a 42 year old, para 0, at Saint Vincent's Hospital and Medical Center, New York, New York. ("St. Vincent's") On or about November 6, 1998, Patient A was readmitted for urinary retention, which condition was ultimately diagnosed as caused by a perforated bladder. (Patient A and the other patients in the Statement of Charges are identified in the annexed appendix.)

Respondent deviated from medically accepted standards in that he:

1. Failed to perform an appropriate pre-operative work-up, including but not limited to an adequate endocrine and infertility work-up.

2. Performed a myomectomy and reconstruction of the uterus

without adequate indication.

3. Failed to timely recognize and appropriately respond to a post-operative complication suggested by Patient A's urinary complaints and by a large subcutaneous hematoma extending up to the umbilicus.

B. On or about June 14, 1995, Respondent admitted Patient B to Saint Vincent's Hospital, New York, New York for surgical management of menorrhagia secondary to a fibroid uterus. Patient B was 36 years old, gravida 1, para 0, and had a history of a previous myomectomy and coninazation of the uterus. Respondent deviated from medically accepted standards in that he:

1. Failed to perform an adequate pre-operative work-up, including but not limited to:
   a. Failing to take a pap smear and perform endometrial sampling.
   b. Failing to take steps to correct pre-operative anemia.

2. Lacked adequate indication to perform an excision of adenomyosis.

3. Failed to adequately explore the abdomen and/or obtain an

intra-operative surgical consultation. A post-operative exploratory laparotomy performed on June 27, 1995 revealed that the sigmoid colon had been almost totally transected.

C. On or about July 14, 1994, the Respondent admitted Patient C to St Luke's Roosevelt Hospital, New York, New York ("St. Luke's") for surgical management of menorrhagia secondary to a fibroid uterus and ovarian cyst. Respondent performed a total abdominal hysterectomy and bilateral salpingo-oopherectomy. Postoperatively the patient required further surgical intervention for an obstruction of the right ureter. Respondent deviated from medically accepted standards in that he:

1. Failed to perform an adequate pre-operative work-up, including but not limited to:
   a. Failing to take appropriate steps to correct pre-operative anemia.
   b. Failing to perform an endometrial sampling.

2. Failed to trace the right ureter.

D. On or about October 9, 1996 the Respondent admitted Patient D to Saint Vincent's for surgical management of pelvic adhesions, fibroid tumors and closed fallopian tubes. Patient D was 40 years old, para 0, and had a history of 3 previous myomectomies. On or about October 10, 1996 Respondent performed an abdominal myomectomy, debulking of adenomyosis, and lysis of adhesions. On or about October 31, 1996, Respondent readmitted Patient

D for what was ultimately diagnosed as an enterocutaneous fistula. Respondent deviated from medically accepted standards in that he:

1. Failed to perform an adequate pre-operative work-up, including but not limited to:

   a. Failing to perform an endometrial sampling.

2. Lacked adequate medical indication to perform either a myomectomy and/or debulking of adenomyosis.

3. Inappropriately persisted in entering the abdomen through an incision which presented many technical difficulties, including lack of adequate visualization.

4. Prematurely removed a Foley catheter from Patient D's bladder. The Foley catheter was removed on October 12, 1996.

5. Failed to adequately explore the abdomen and/or obtain an intra-operative surgical consult.

E. On or about December 4, 1992 the Respondent admitted Patient E to Saint Vincent's Hospital for surgical correction of a fibroid uterus and repair of fallopian tubes. Patient E was 46 years old, gravida II, para 0. Respondent deviated from medically accepted standards in that he:

1. Failed to perform an adequate pre-operative work-up, including

but not limited to:

a. Failing to take a pap smear and perform endometrial sampling.

b. Failing to perform an endocrine and infertility work-up.

2. Lacked adequate indication to perform a myomectomy and debulking of adenomyosis.

3. Failed to adequately explore the abdomen and/or obtain a surgical consult. A post-operative exploratory laparotomy performed on or about December 10, 1992 revealed a perforation of the sigmoid colon.

F. On or about July 26, 1994 the Respondent admitted Patient F to Saint Luke's for a multiple myomectomy, right oopherectomy and excision of endometrioma. Patient F was 48 years old, Gravida II and Para II. Respondent deviated from medically accepted standards in that he :

1. Failed to perform an adequate pre-operative work-up, including but not limited to:

a. Failing to take and/or note an adequate history.

b. Failing to take a pap smear and perform endometrial sampling.

2. Lacked adequate indication to perform a myomectomy, right oopherectomy and excision of endometrioma.

G. On an application for reappointment to St. Vincent's dated January 2, 2000, the Respondent knowingly and falsely represented that he had never "been the subject of a professional conduct inquiry, investigation or proceeding in this state or any other state", when, in fact, he knew that he was the subject of a New York State Department of Health, Office of Professional Medical Conduct investigation. The Respondent intended to deceive.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

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

1. Paragraphs A, A1, A2, and/or A3.
2. Paragraphs B, B1, B1(a), B1(b), B2 and/or B3.
3. Paragraphs C, C1, C1(a), C1(b), and/or C2.
4. Paragraphs D, D1(a), D2, D3, D4, and/or D5.
5. Paragraphs E, E1, E1(a), E1(b), E2, and/or E3.
6. Paragraphs F, F1, F1 (a), F1(b), and/or F2.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

7. Paragraphs A, A1, A2, A3 B, B1, B1(a), B1(b), B2, B3, C, C1, C1(a), C1(b), C2, D, D1(a), D2, D3, D4, D5, E, E1, E1(a), E1(b), E2, E3, F, F1, F1(a), F1(b) and/or F2.

EIGHTH SPECIFICATION

GROSS INCOMPETENCE

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

8. Paragraphs A, A1, A2, A3 B, B1, B1(a), B1(b), B2, B3, C, C1, C1(a), C1(b), C2, D, D1(a), D2, D3, D4, D5, E, E1, E1(a), E1(b), E2, E3, F, F1, F1(a), F1(b) and/or F2.

NINTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

9. Paragraphs A, A1, A2, A3 B, B1, B1(a), B1(b), B2, B3, C, C1, C1(a), C1(b), C2, D, D1(a), D2, D3, D4, D5, E, E1, E1(a), E1(b), E2, E3, F, F1, F1(a), F1(b), and/or F2.

TENTH THROUGH FOURTEENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

10. Paragraphs A and A2.
11. Paragraphs B and B2.
12. Paragraphs D and D2.
13. Paragraphs E and E2.
14. Paragraphs F and F2.

FIFTEENTH SPECIFICA

FRAUDULENT P E

Respondent is charged with com ofessional misconduct as defined by N.Y. Educ. Law §6530(2) by pr e profession of medicine fraudulently as alleged in the facts of the fol

15. Paragraph C

SIXTEENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined

in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

16. Paragraph G.

DATED: October 23, 2001
New York, New York

Roy Nemerson

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. The Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession. The Respondent acknowledges that if he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against the Respondent's license pursuant to New York State Public Health Law §230(19).

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

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

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

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

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

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

8. The Respondent shall practice medicine only when monitored by a licensed physician, Board Certified in Obstetrics and Gynecology ("the Practice Monitor"), proposed by the Respondent and subject to the written approval of the Director of OPMC.

   a. The Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the Practice Monitor, including on-site observation. The Practice Monitor shall visit the Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by the Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the Practice Monitor shall be reported within 24 hours to OPMC.

   b. The Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. The Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

   d. The Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to the Respondent's practice after the effective date of this Order.

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