STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

January 4, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich Gayle, Esq.
NYS Dept. of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Lee S. Goldsmith, Esq.
Goldsmith & Richman, P.C.
747 Third Avenue
New York, New York 10017

David Korman, M.D.
206 Albemarle Road
Brooklyn, New York 11218

RE: In the Matter of David Korman, M.D.
Effective Date 01/11/96

Dear Ms. Gayle, Mr. Goldsmith and Dr. Korman :

Enclosed please find the Determination and Order (No. 95-239) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. The Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

DAVID KORMAN, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 95-239

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board")[1], consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on December 20, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) October 13, 1995 Determination finding Dr. David Korman (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Department of Health received on November 1, 1995. James F. Horan served as Administrative Officer to the Review Board. Lee S. Goldsmith, Esq. filed a brief for the Respondent, which the Review Board received on December 8, 1995. Anne Hroncich Gayle, Esq. filed a reply brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on December 14, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

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[1]Dr. Winston Price did not participate in the deliberations in this case.

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with negligence on more than one occasion, gross negligence, incompetence on more than one occasion, moral unfitness, willfully harassing, abusing or intimidating patients and fraud. The Petitioner began this proceeding by an Order from the Commissioner of Health summarily suspending the Respondent's license to practice medicine upon a finding that the Respondent's continued practice constituted an imminent danger to the public health. By an Interim Determination on July 27, 1995, the Hearing Committee recommended that the Commissioner vacate the Interim Order.

The Hearing Committee's October 13, 1995 Determination sustained only the charges of negligence on more than one occasion and incompetence on more than one occasion. The Committee sustained those charges relating to care in oncology which the Respondent provided to two patients, whom the record refers to as Patients A and E. The Committee found that the Respondent failed to follow up abnormalities in laboratory data obtained for Patient A. The Committee found that the Patient's level of CEA, a tumor antigen on a cancer cell, was elevated considerably beyond normal limits by March, 1992, but that the Respondent failed to conduct an aggressive evaluation of the Patient's clinical status, such as a sonogram, until January, 1993. The Committee found that a delay of three months following an elevated CEA level from October, 1992 to a sonogram in January, 1993 was inappropriate.

The Committee found further that the Respondent treated Patient E with chemotherapy for a period of five years. The Committee found that such treatment for such a long period of time was not within the acceptable standard of care and that, based upon the stage of Patient E's breast cancer, such therapy would have been acceptable for a two year period. The Committee concluded that the Patient received excessively prolonged chemotherapy as the result of the Respondent's incorrect evaluation of the staging of the Patient's cancer. The Committee concluded that is was necessary for an oncologist to accurately establish the stage of a cancer tumor and that the failure to do so, thereby resulting in an inappropriate period of treatment, constituted negligence and incompetence in the practice of medicine.

In discussing the evidence, the Hearing Committee noted that they found the Respondent's expert witness Dr. Kaplan to be persuasive and that they gave little weight to the testimony by the Petitioner's expert Dr. Fialk.

The Committee voted to suspend the Respondent's license for two years, stayed the suspension and placed the Respondent on two years probation. The Committee ordered that during the probation's first year, that the Respondent must practice in a supervised setting and that during the probation's second year, the Respondent must practice with a monitor. The terms of probation require that the Respondent's supervisor during the first year must be Board Certified in oncology and that during the second year the Respondent's monitor must be Board Certified in oncology.

REQUESTS FOR REVIEW

The Respondent asks that the Review Board clarify the Hearing Committee's penalty or remand to the Hearing Committee for clarification, as to whether the Respondent has to undergo a period of probation, if the Respondent chooses not to continue practicing oncology. The Respondent contends that all the sustained charges relate to oncology rather than internal medicine. The Respondent states that he wishes to continue practicing internal medicine, but has no intention of practicing oncology if he must satisfy the Committee's probation terms. The Respondent requests that the Review Board limit the Committee's penalty to the practice of oncology and permit the

Respondent to practice internal medicine, without further limitations and restrictions, other than what one would agree would be principles of good medical practice. The Respondent contends that the Hearing Committee sustained only two of nineteen charges against the Respondent, that both sustained charges involved oncology and that the Respondent has agreed to limit his practice to internal medicine. The Respondent argues that it would be patently unfair to place restrictions on his practice of internal medicine, when there were no sustained charges involving internal medicine.

The Petitioner contends that the Hearing Committee's Order clearly applies to the Respondent's whole medical practice and is not limited to oncology practice only. The Petitioner notes that the Respondent testified that ninety-seven to ninety-eight per cent of his practice for twenty-five years had been in oncology. The Petitioner contends that based on that testimony and other evidence before the Committee, it was appropriate to require a supervisor and then a practice monitor be certified in oncology. The Petitioner contends that a Board Certified Oncologist would also be Certified in internal medicine. The Petitioner notes that the Hearing Committee expressed concern about the Respondent's practices in general and about the manner by which the Respondent administered chemotherapy to patients, which the Committee found to be potentially harmful and found to have become outmoded. The Petitioner questions how the public can be protected if the Respondent is allowed to embark on the broader specialty of internal medicine. The Petitioner argues that if the Committee had intended to limit the Respondent's probation to only oncology, that the penalty would be inappropriate.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of negligence on more than one occasion and incompetence on more than one occasion in the treatment of Patients A and E. The Committee's Determination is consistent with their findings, that the Respondent failed to follow up abnormal laboratory results in treating Patient A and

incorrectly evaluated the staging of Patient E's cancer, resulting in excessively prolonged chemotherapy for Patient E.

The Review Board interprets the Hearing Committee's penalty, requiring probation first in a supervised setting and then with a monitor, to apply to the Respondent's entire practice and not merely to the Respondent's oncology practice. Based upon this interpretation, the Review Board sustains the Hearing Committee's penalty. The Review Board does not believe that a penalty limiting supervision to oncology would be appropriate in this case and we would have overturned such a penalty and applied probation to the Respondent's entire license, if we had interpreted the Committee's intent to be to limit their penalty to oncology.

The Review Board concludes that the Respondent's negligence and incompetence in treating Patients A and E reflect his general competence to practice medicine. In treating Patient A, the Respondent failed to follow up abnormal test results. In treating Patient E, the Respondent failed to diagnose the proper stage of the Patient's disease. Diagnosis is basic to all branches of medicine and the Respondent would be called upon to analyze test results and diagnose conditions as an internist, even without continuing to practice oncology. Further, the Respondent testified that his practice for twenty-five years has involved ninety-seven to ninety-eight per cent oncology. The Respondent committed acts of negligence and incompetence in the specialty in which he has practiced almost exclusively for twenty-five years. These acts of misconduct lead the Board to find that we can not protect the public by merely accepting the Respondent's non-binding assurance that he will abandon practicing oncology and practice in the broader specialty of internal medicine. The Board has no guarantee that the Respondent would not display the same deficiencies in general internal medicine that he has displayed in oncology.

The Committee's penalty offers a reasonable supervised program that will allow the Respondent to correct his deficiencies and return to an unlimited practice at the end of the probation term. As the Petitioner points out, a supervisor or monitor who is Board certified in oncology, would be Board certified in internal medicine. If the Respondent still plans to abandon oncology for internal

medicine the Respondent can, subject to the Office of Professional Medical Conduct's approval, choose an oncologist supervisor or monitor with a large percentage of practice in internal medicine, who could guide the Respondent in the transition to general internal medicine, from the more narrow specialty in which the Respondent has concentrated his practice almost exclusively for twenty-five years.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **SUSTAINS** the Hearing Committee's October 13, 1995 Determination finding the Respondent David Korman guilty of professional misconduct.

2. The Review Board **SUSTAINS** the Hearing Committee's Penalty.

ROBERT M. BRIBER

SUMNER SHAPIRO

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF DAVID KORMAN, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Korman.

DATED: Delmar, New York

Dec. 29, **1995**

SUMNER SHAPIRO

IN THE MATTER OF DAVID KORMAN, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Korman.

DATED: Schenectady, New York

June 4, 1995

ROBERT M. BRIBER

IN THE MATTER OF DAVID KORMAN, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Korman.

DATED: Roslyn, New York
Dec 29, 1995

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF DAVID KORMAN, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Korman.

DATED: Syracuse, New York
29 Dec , 1995

William A Stewart

WILLIAM A. STEWART, M.D.