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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

December 7, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2509
Empire State Plaza
Albany, NY 12237

Gregory Stamm, Esq.
Stamm, Reynolds & Stamm
5555 Main Street
Williamsville, NY 14222

Paul Steckmeyer, M.D.
17 Long Avenue
Hamburg, NY 14075

RE: In the Matter of Paul J. Steckmeyer, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 99-301) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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: mla

Enclosure

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

COPY

IN THE MATTER

OF

PAUL J. STECKMEYER, M.D.

DETERMINATION

AND

ORDER

ORDER #99-301

A Notice of Hearing and Statement of Charges, both dated October 22, 1998, were served upon the Respondent, **Paul J. Steckmeyer, M.D.** **Donald Cherr, M.D. (Chair),** **George C. Simmons, Ed.D.,**[1] and **Charles J. Vacanti, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **Susan F. Weber, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Department of Health appeared by Kevin C. Roe, Esq., Associate Counsel. The Respondent appeared by Francis J. Offermann, Jr. Esq.,of counsel, Offermann, Cassano, Greco & Slisz, LLP until January, 1999, when Stamm, Reynolds & Stamm, Gregory Stamm, Esq., of counsel, was substituted and appeared as Respondent's representative.

Evidence was received, witnesses were sworn or affirmed and were heard, and transcripts of these proceedings were made. After consideration of the entire record the Hearing Committee issues this Determination and Order.

---

[1] George C. Simmons replaced Nancy J. Macintyre, R.N., Ph.D, after the first day of hearings.

PROCEDURAL HISTORY

Date of service of Notice of Hearing and Statement of Charges:	November 20, 1998
Answer to Statement of Charges	December 1, 1998
Pre-Hearing Conference:	December 30, 1998
Dates of Hearings:	
Troy, NY	January 14, 1999
Buffalo, NY	February 23, 1999
East Elmhurst, NY	March 8, 1999
East Elmhurst, NY	April 16, 1999
Buffalo, NY	April 22 and 23, 1999
Buffalo, NY	May 7, 1999
Buffalo, NY	May 12, 13 and 14, 1999
Buffalo, NY	June 17 and 18, 1999
Buffalo, NY	July 8, 1999
Buffalo, NY	August 6, 1999
Received Respondent's Proposed Findings of Fact and Summary of Proceedings:	September 24, 1999
Received Petitioner's Proposed Findings of Fact, conclusions and Final Argument:	September 28, 1999
Witnesses for the Department of Health:	Edward Stroh, M.D. G. Stewart Ray, M.D.
Witnesses for the Respondent:	Paul J. Steckmeyer, M.D. Dilip Patel, M.D. Peter W. Forgach, M.D. James V. Aquavella, M.D.
Deliberations Held:	
October 1, 1999	Rochester, NY
November 6, 1999	Albany, NY
November 17, 1999	Rochester, NY

STATEMENT OF CASE

The Department of Health (hereinafter "the Department" or "Petitioner") has charged Paul Steckmeyer, M.D. (hereinafter "the Respondent") with sixty specifications of professional misconduct. The allegations concern Respondent's medical care and treatment of eight patients[2]. More specifically, the Respondent is charged with eight specifications of gross negligence, eight specifications of gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, eight specifications of excessive treatment, fifteen specifications of fraud, and fifteen specifications of moral unfitness.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order as Appendix 1.

FINDINGS OF FACT

The following findings were made after a review of the entire record. Numbers in parentheses refer to transcript pages or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if ar was considered and rejected in favor of the evidence cited. All Hearing Committee determinations were unanimous unless otherwise stated.

---

[2] During the Hearing, Petitioner dropped all charges related to the ninth patient, Patient F. purposes of this Determination and Order, there will be no further references to the dropped charge specifications related to them.

1. Respondent was authorized to practice medicine in New York State on May 1, 1974, by the issuance of license number 119916. (Exhs. 1, A)

2. Diabetic retinopathy is the leading cause of new cases of legal blindness among working-age Americans. Most patients with diabetes mellitus ultimately develop characteristic abnormalities of the retinal blood vessels. Diabetic retinopathy in its earliest stages is characterize by increased retinal vascular permeability, which can lead to fluid accumulation in the retina. Late vascular closure causes retinal ischemia. In the most advanced stages, new vessel proliferation (neovascularization) of the optic disc (NVD) and neovascularization elsewhere on the retina (NVE), vitreous hemorrhage, retinal detachment, and neovascular glaucoma may develop. (Exh. D T. 9-12).

3. There are two types of diabetic retinopathy: nonproliferative and proliferative. Nonproliferative diabetic retinopathy is characterized by leakage of the retinal blood vessels causir the retina to become edematous, that is, swollen or thickened. Proliferative diabetic retinopathy is caused by closure of the retinal blood vessels which fosters the growth of abnormal new blood vessels, called neovascularization. (Exh. D; T. 9-12)

4. The natural history of nonproliferative and proliferative diabetic retinopathy, as well as the indications for and the value of surgery, have been examined in two major clinical trials: the diabetic retinopathy study (1976) and the early treatment diabetic retinopathy study (1985). (Exh. D)

5. Two different of methods of laser surgery are used to treat diabetic retinopathy depending on the pathology being treated. Panretinal photocoagulation is applied throughout most

of the fundus to inhibit growth and facilitate regression of new vessels (neovascularization or neo) on the retinal surface and the anterior chamber angle. Focal photocoagulation of leaking microaneurysms, and/or grid photocoagulation in areas of edema apparently arising from diffused capillary leakage, are used in the posterior pole to reduce or eliminate macular edema. . (Exh. D; T. 9-12)

6. As there is a potential for side effects and complications from laser photocoagulation surgery, it should be performed only for appropriate indications. (Exh. D)

7. Focal (or grid) laser surgery is indicated for the treatment of nonproliferative diabetic retinopathy with clinically significant macular edema. Clinically significant macular edema is defi as:

> Thickening of the retina at or within 500 microns of the center of the macula (fovea); or
> Hard exudates at or within 500 microns of the center of the macula, if associated with thickening of the adjacent retina--not residual hard exudate remaining after the disappearance of retinal thickening; or
> A zone or zones of retinal thickening one disc area or larger, any part of which is within one disc diameter of the center of the macula. (Exh. D; T. 12-16, 590-591, 660, 1623-1624, 2134)

8. Focal laser surgery is typically accomplished using 50 to 200 micron size laser shots to the macular area, either directly applied to the leaking aneurysms, if they can be identified, or in a grid pattern. Treatment may require five to six hundred focal laser shots if the posterior pole were edematous. It would be most unusual to for a patient to require as many as eight focal laser treatments, but this may be necessary in a patient being followed for a number of years with central

retinal vein occlusion or branch retinal vein occlusion, or if the edema keeps on increasing. (T. 1497, 1498, 1804 - 1806)

9. Panretinal laser surgery is indicated for the treatment of high risk proliferative diabetic retinopathy. High risk proliferative diabetic retinopathy is defined as:

> Neovascularization of the disc greater than one-quarter to one-third disc area; or
> Vitreous or preretinal hemorrhage associated with less extensive neovascularizatic of the disc; or
> Neovascularization elsewhere one-half disc area or more in size. (Exh. D; T. 15-17, 661, 1569-1574, 1914, 2119).

10. Typically, full panretinal treatment is accomplished by applying 3500 laser shots of 150 to 500 microns in size in one, two or three sessions over a four to five week period of time to the mid and far periphery. (Exh. 4; T. 30, 58-60, 134, 846-849, 932, 1486, 1591, 2083-2084)

11. Full panretinal treatment may also be accomplished by applying 3500 to 4500 shots o 200 to 500 microns or greater in three to four sessions, rarely up to seven sessions, three to four weeks apart. (T.1497, 1624, 1801)

12. In the macular area, focal treatment usually involves use of fewer applications of up tc 200 micron size spots at lower power. Outside the macula, in panretinal photocoagulation, the clinician applies many (700 or more) larger micron-size spots at higher power to effectuate treatment. There is less sensitivity to pain outside the macula, and larger size spots cover the large treatment area more quickly. A darkly pigmented patient may receive a therapeutic laser spot at 9 to 100 milliwatts, while a lightly pigmented patient will require more laser energy -- 200 milliwatt for example -- to get the same therapeutic effect. If there is blood within the vitreous cavity, or

cataract, then higher power is required to effect a therapeutic laser treatment. (T.132 - 134).

13. Panretinal laser surgery may be indicated for severe nonproliferative retinopathy (preproliferative) if access to health care is difficult or follow-up cannot be assured. (Exh. D)

14. Fundus photos and fluorescein angiography provide significant additional information the ophthalmologist evaluating diabetic retinopathy. They are used as a guide for treating clinical significant macular edema, as a means of evaluating the cause of unexplained decreased visual acuity, and can identify macular capillary nonprofusion or macular edema as possible explanations for visual loss, and as an aid in identifying subtle areas of neovascularization or capillary dropout when abundant preproliferative signs are present. When considering laser treatment, they can show exactly where treatment is needed and where it is not needed. These studies also serve to document the indications for surgery for the clinician and others reviewing the treatment provided. (Exhs. B, D; T. 22-23, 45-46, 1476-1477, 1633, 2167-2168)

15. After focal laser surgery, patients are asked to return in three to four months unless they have severe nonproliferative or proliferative retinopathy, which necessitates closer follow-up, or unless the clinician has been unable to complete the focal treatment for some reason. At the follow-up visit, the macula is examined carefully to detect any residual macular edema. The edema is assessed particularly for its presence or absence in the center of the fovea. If the fovea is flat and dry, no additional laser treatment is required and the patient should return in another three to four months. If the fovea is still edematous, additional treatment is usually given. A second fluorescein angiogram is usually not required because the problem areas are obvious. In the areas of swelling, the clinician re-treats open microaneurysms and diffuse areas of edema in a grid pattern. Treatment

is usually applied up to 300 microns from the fovea unless the source of edema appears to be farther away. If the clinician is unsure whether the edema has resolved or unsure of the source of the leakage, stereoscopic color photograph and another fluorescein angiogram should be ordered. Sometimes in borderline cases of edema, the angiogram influences the decision to re-treat based on the amount of leakage. After the second focal laser session, patients are asked to return in three to four months. If the fovea is still edematous, another fluorescein angiogram is usually ordered. The angiogram demonstrates the source of the leakage, the state of the capillaries around the fovea, and the extent and confluence of laser scars in the previous treatment. If leakage appears to be coming from untreated areas of retina or areas that have received only one grid treatment, these areas should be treated. If leakage appears to be coming from areas that have already been treated twice with a grid pattern and the laser scars look fairly confluent, additional treatment to those areas probably should not be given. The additional treatment is often not effective at reducing edema and a third grid treatment may severely reduce vision from that area of the retina. After a second session of focal laser surgery, patients are again asked to return in three to four months. If the fovea is flat, the patient should be seen again in four months. If the macula is still edematous, the clinician should try to determine if the edema is coming from untreated areas of the retina or areas that have not received confluent treatment. Another fluorescein angiogram may be helpful. If additional treatment is given, patients usually develop significant atrophy of the retinal pigment epithelium (RPE) in the fovea and deterioration of paracentral and even central visual function. The prognosis is poor with or without further treatment. Edema does not resolve in some patients

despite multiple treatments. The clinician may be doing more harm than good in these patients by re-treating confluently large areas of the parafoveal retina. (Exh. D; T. 1935-1944)

FINDINGS AS TO PATIENT A

16. Patient A was a 64 year old male with adult onset diabetes first seen by Respondent on January 12, 1990. Respondent's indirect examination of the retina was documented as: no hemorrhages, abnormal vessels or abnormalities of the macula in either eye with soft exudation nasal to the disc in the right eye and soft exudation temporal to the fovea in the left eye. Direct examination of the right eye was documented as: disc negative, peripapillary-few hemorrhages, hard exudate and microaneurysm near fovea, fovea-negative. Direct ophthalmic examination of the left eye was documented as: disc - negative, fovea - negative, peripapillary - hard exudate around fovea, one microaneurysm. Respondent diagnosed cataract in both eyes and background diabetic retinopathy in both eyes, and scheduled intravenous fluorescein angiogram (IVFA) and fundus photos for the following day. (Exh. 2, pp. 2-3)

17. On January 13, 1990, Respondent performed a contact lens examination with a biomicroscope, inappropriately documented as "gonio", on Patient A. Results were documented as: right eye - no neo seen, mild background diabetic retinopathy throughout posterior pole and around fovea; left eye - neo coming off disc superiorly and background diabetic retinopathy throughout posterior pole. (Exh. 2, p. 4)

18. Fundus photos and IV fluorescein angiogram were done on January 13, 1990. Respondent's documented interpretation of these studies was:

> Fundus photos-both eyes-background diabetic retinopathy; IVFA capillary drop out areas, considerable leakage superiotemporal arcade left eye, background diabetic retinopathy both eyes. (Exh. 2, p. 50)

19. The January 13, 1990 photographic studies were interpreted by G. Stewart Ray, M.D., at the request of the Department of Health. The fundus photo of the right eye showed fine exudates in the superior temporal posterior pole; small hemorrhages scattered through the photograph. Fundus photos of the left eye showed yellow spots in the superior posterior pole suggesting exudates near the macula and remotely in the upper temporal posterior along the arcad with mild to moderate retinal hemorrhages. Fluorescein angiography of the right eye showed a moderate number of aneurysms with late leakage of a moderate amount into the inferior posterior pole inside the arcade and moderately extensive late leakage in the peripheral posterior pole inferiorly with a mild amount around the fovea. Angiography of the left eye showed capillary loss the arterial venous phase with increasing leakage over the superior one-third of the posterior pole with a mild amount surrounding the fovea. According to Dr. Ray, these studies do not show the presence of hard exudates within 500 microns of the fovea and demonstrate the absence of neovascularization. The presence of macular edema could not be determined because stereopsis had not been achieved. Overall, these studies show moderate background diabetic retinopathy, left eye greater than right eye. (Exh. 30; T. 2231a-2236a)

20. On January 13, 1990, Respondent scheduled Patient A for focal laser surgery of the right eye and panretinal laser surgery of the left eye. (Exh. 2, p. 50)

21. Focal laser surgery may have been indicated in the left eye. Focal laser surgery was not indicated for the right eye. Panretinal laser surgery was not indicated for either eye. (Exhs. B, D; T. 26-29, 37, 223-225, 263, 1564-1569)

22. On January 27, 1990, Respondent performed laser surgery on Patient A's left eye. Respondent documented panretinal photocoagulation of the left eye with 1,002 laser shots of 50 and 300 microns in size at 50 to 260 milliwatts to the posterior pole and peripheral areas. Respondent's treatment plan included "focal" surgery of the right eye on February 10, 1990, and panretinal surgery of the left eye on March 17, 1990. (Exh. 2, p. 55)

23. On February 10, 1990, Respondent performed laser surgery on Patient A's right eye. Respondent documented panretinal photocoagulation of the right eye with 1,021 shots of 50, 100 and 150 micron sizes at 50 to 220 milliwatts, to the macula and perimacula areas. On this date, Respondent scheduled Patient A for panretinal laser surgery of the left eye on March 17, 1990, and panretinal laser surgery of the right eye on March 31, 1990. (Exh. 2, p. 56)

24. On February 16, 1990, Patient A was seen by Respondent with an unknown, undocumented history and undocumented complaint. It is unknown whether this visit occurred at either of Respondent's offices or while Respondent was at the hospital performing surgery. Respondent diagnosed vitreous hemorrhage of the right eye. (Exh. 2, pp. 6-7)

25. On February 21, 1990, Patient A was seen by Respondent at his office for a five day return visit regarding the previously diagnosed vitreous hemorrhage. There is no documentation o an examination of the retina. (Exh. 2, pp. 8-9)

26. On March 7, 1990, Patient A was seen by Respondent at his office for a two week return visit regarding the previously diagnosed vitreous hemorrhage. It was noted that the hemorrhage was clearing. An examination of the retina was not documented. (Exh. 2, pp. 2-11)

27. On March 17, 1990, Respondent performed laser surgery on Patient A's left eye. Respondent documented panretinal photocoagulation of the left eye using 1,106 shots of 50, 200 and 300 microns to the posterior pole, mid and far periphery at 50 to 120 milliwatts. On this date, Respondent scheduled panretinal laser surgery of the right eye on March 31, 1990, with a note to check for neo, and panretinal laser surgery of the left eye on March 26, 1990. (Exh. 2, p. 57)

28. On March 28, 1990, Patient A returned for a three week re-check regarding the vitreous hemorrhage of the right eye. Respondent's documentation of this exam does not include examination of the retina. (Exh. 2, pp. 12-13)

29. On March 31, 1990, Respondent performed laser surgery on Patient A. Respondent documented panretinal photocoagulation of the right eye with 401 shots of 300 microns to the periphery, at 200 to 340 milliwatts. Respondent noted that the number of shots was limited by the vitreous hemorrhage. There is no documentation of an examination of the right eye to check for neovascularization, as set forth in Respondent's treatment plan (Exh.2, p. 57). On this date, Respondent's treatment plan includes panretinal surgery of the left eye on May 19, 1990, and panretinal laser surgery of right eye on May 26, 1990, noting that the right eye should be checked for neovascularization. (Exh. 2, p. 58)

30. On May 19, 1990, Respondent performed laser surgery on Patient A .Respondent documented panretinal photocoagulation of the posterior pole and mid periphery of the left eye

using 1,064 shots, 50 and 300 micron sizes, at 50 to 250 milliwatts. No examination of the left eye for neovascularization, is documented. Nevertheless, on this date Respondent planned further panretinal laser surgery of the left eye. (Exh. 2, p. 59)

31. On May 26, 1990, Respondent performed laser surgery on Patient A's right eye. Respondent documented panretinal photocoagulation to the right eye, with 1102 shots of 300 microns at 280 to 360 milliwatts. Location of this treatment is not documented. On this date, Respondent planned further panretinal laser surgery of the left eye on July 7, 1990, and of the right eye on July 21, 1990. (Exh. 2, p. 60)

32. On July 7, 1990, Respondent documented performing panretinal laser surgery on the mid periphery of Patient A's left eye at Lakeshore Hospital, using 963 shots of 300 microns at 340 to 420 milliwatts. Respondent noted that the planned panretinal laser surgery of the right eye on July 21, 1990 should be kept, and that further panretinal laser surgery of the left eye should be scheduled. (Exh. 2, p. 61)

33. On July 21, 1990, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye with 1,102 shots of 300 microns at 300 to 500 milliwatts, to the posterior pole and periphery. On this date, Respondent planned additional panretinal laser surgery on the left eye for August 25, 1990, and panretinal laser surgery of the right eye on September 15, 1990. (Exh. 2, p. 62)

34. On August 8, 1990, Patient A was seen at Respondent's office for a six month complete eye examination, and was complaining of very blurry vision in both eyes. Indirect opthalmic examination of the retina documents: normal vessels and macula in both eyes, few

hemorrhages in the right eye, occasional hemorrhages in the left eye, occasional exudation in the right eye and hard exudation around fovea in the left eye. Direct opthalmic examination of the re documents: few microaneurysms with some neovascularization going up superiotemporal arcade the right eye, and few fine exudates around fovea in the left eye. Respondent added a note that there was apparent neovascularization off the disc superiotemporally. (Exh. 2, pp. 14-15; T. 926-927)

35. On August 8, 1990, medical justification for panretinal laser surgery had not been documented for either eye. (Exhs. B, D; T. 26-29, 37, 223-225, 263, 1564-1569)

36. On August 25, 1990, Respondent again performed laser surgery on Patient A's left eye at Lakeshore Hospital. Respondent documented panretinal photocoagulation using 1,102 shot of 50 and 200 microns at 50 to 440 milliwatts to the posterior pole and periphery of the left eye. On this date, Respondent planned panretinal laser surgery of the right eye on September 22, 1990, and panretinal laser surgery of the left eye on October 13, 1990. (Exh. 2, p. 63)

37. On September 22, 1990, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the periphery of the right eye using 1,317 shots of 300 microns at 140 to 230 milliwatts. On this date, Respondent planned further panretinal laser surgery on the left eye for October 20, 1990, and for the right eye on November 10, 1990. (Exh. 2, p. 65)

38. No documentation is contained in Respondent's office record regarding the October 20th appointment for panretinal laser surgery of the left eye. (Exh. 2)

39. On November 10, 1990, Respondent documented that he performed panretinal photocoagulation laser surgery on Patient A's left eye using 437 shots of 50 microns at 250 to 650 milliwatts to the posterior pole. On this date, Respondent planned additional laser surgery to the posterior pole of the left eye on December 29, 1990, and panretinal laser surgery of the right eye ("check for neo - may turn into focal") on November 17, 1990. (Exh. 2, p. 64)

40. On November 14, 1990, Patient A was seen at Respondent's office for a three month return visit and fundus check. Indirect examination of the retina was documented as: right eye fovea-negative, rare blot hemorrhage; left eye exudate-fovea rare blot hemorrhage. Direct examination of the retina was documented as: right eye - disc negative, fovea one blot hemorrhage in a few around; left eye fovea - hard exudate and one blot hemorrhage, no neo, disc negative. (Exh. 2, p. 16)

41. On November 14, 1990, no medical justification was documented for either panretinal or focal laser surgery. (Exh. D, pp. 28-29; T. 26-29, 37, 223-225, 263, 1564-1569)

42. On November 17, 1990, Respondent performed laser surgery on Patient A at Lakeshore Hospital, and documented panretinal photocoagulation to the right eye with 1,206 shots of 50 and 300 microns at 50 to 700 milliwatts to the posterior pole and periphery. Respondent documented treatment to one area of considerable "viny neo" inferiotemporal to fovea. On this date, Respondent scheduled panretinal laser surgery of the left eye on December 29, 1990, and another panretinal laser surgery of the right eye on January 5, 1991. (Exh. 2, p. 66)

43. On December 29, 1990, Respondent documented performing panretinal photocoagulation of Patient A's left eye using 1,247 shots of 50 and 300 microns at 50 to 250

milliwatts to the parafoveal temporal macular area and far periphery. Respondent noted that this area is fully treated now. Nevertheless, on this date Respondent scheduled another office appointment in two and one-half weeks and another panretinal laser surgery of the left eye, for February 14, 1991. (Exh. 2, p. 67)

44. On January 5, 1991, Respondent performed another panretinal photocoagulation on Patient A, documenting 1391 laser shots of 50 microns at 50 to 150 milliwatts to the posterior pole Respondent documented that considerable "viny" neovascularization was treated directly, as were many microaneurysms. The eye on which the surgery was performed on this date was not documented. Other documentation in the medical record indicates that the right eye was treated on this date. On this date also, Respondent scheduled panretinal laser surgery of the left eye on February 14, 1991, and panretinal laser surgery of the right eye on March 18, 1991. (Exh. 2, p. 68)

45. Patient A was seen in Respondent's office on January 16, 1991 for a two month return visit. No examination of the retina was documented. (Exh. 2, pp. 18-19)

46. Patient A was seen in Respondent's office on February 13, 1991 for a complete eye examination. Indirect examination of the retina was documented as: normal vessels and macula in both eyes, hemorrhages above the fovea and scattered blot hemorrhages with few scattered exudation in the right eye; and occasional blot hemorrhages and hard exudate away from the fovea in the left eye. Direct examination of the retina was documented as: right eye one blot hemorrhage temporal edge of fovea, couple of blot hemorrhages near fovea, no neo seen; left eye - hard

exudate side of fovea, microaneurysm below fovea, no neo seen. Respondent planned to perform further laser surgery. (Exh. 2, pp. 20-21)

47. On May 29, 1991, Patient A was seen at Respondent's office for a three week fundus check. Direct examination documents: right eye - rare blot hemorrhage and microaneurysm, fove - rare blot hemorrhage and microaneurysm around-one blot hemorrhage in it; left eye - disc negative, peripapillary no neo, fovea negative, rare blot hemorrhage and microaneurysm and hard exudate well temporal to fovea. (Exh. 2, pp. 22-23)

48. On August 21, 1991, Patient A was seen at Respondent's office for a three month complete eye examination with complaints of decreased vision and night vision since his stroke. Indirect examination of the retina documents: no hemorrhages, no exudation, normal vessels, and normal macula. Rare blot hemorrhages were noted in the right eye and a few blot hemorrhages were noted in left eye. Direct examination of the retina documents: right eye - blot hemorrhage, one blot hemorrhage nasal to fovea and superiotemporal with microaneurysm, no neovascularization; left eye - no neovascularization, rare blot hemorrhage. At this office visit, Respondent planned another focal laser surgery of the right eye. (Exh. 2, pp. 24-25)

49. Findings for the February, May and August visits in 1991 do not contain appropriate medical justification or indications for focal or panretinal laser surgery. When Respondent was asked why he scheduled focal laser surgery for the right eye at this time, he could not identify a reason. (Exhs. B, D; T. 28-29, 953, 1614-1625)

50. On September 21, 1991, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documents Argon laser for microvascular abnormalities (focal

laser surgery) of the right eye, with 897 shots of 50 microns at 50 to 390 milliwatts to the posterior pole. Respondent noted that several areas of "viny neo" were seen. On this date, Respondent scheduled panretinal laser surgery of the right eye on November 9, 1991. (Exh. 2, p. 69)

51. On November 9, 1991, Respondent performed laser surgery at Lakeshore Hospital on Patient A's right eye. Respondent documents panretinal photocoagulation of the right eye using 1,246 shots at 300 microns and 200 to 340 milliwatts to the far periphery. Respondent noted that the far periphery "is almost done." Respondent scheduled another panretinal laser surgery of the right eye for December 28, 1991. His note of this plan was changed to add the word "grid." (Exh. 2, p. 70)

52. On November 27, 1991, Patient A was seen at Respondent's office for a three month revisit and fundus check. Indirect examination documents: right eye - occasional blot hemorrhage temporal to the fovea and rare elsewhere, exudation above fovea and around fibrosis, fovea macula negative; left eye - few blot hemorrhages, exudation normal, fibrosis temporal fovea, macula negative. Direct examination documents: right eye - disc negative, peripapillary negative, fovea shows edema above and below with occasional blot hemorrhages around, no neo seen, fovea a little distorted, not flat; left eye - disc and peripapillary negative, fovea-retinal pigment epithelium depigmentation (RPE), possible edema, no neo seen, hemorrhages out in periphery. (Exh. 2, pp. 26-27)

53. On November 27, 1991, laser surgery was not indicated to either eye. (Exh. B, Exh. D; T. 26-29, 37, 223-225, 263, 1564-1569)

54. On December 28, 1991, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documented focal grid Argon laser for diabetic retinopathy to th right eye with 726 shots of 50 microns at 50 to 270 milliwatts to the parafovea and beyond slightl (Exh. 2, p. 71)

55. On February 25, 1992, Patient A was seen at Respondent's office for a three month complete eye examination. Respondent documented indirect examination as: right eye - rare blot hemorrhages, exudation negative, vessels normal, macula normal; left eye - few blot hemorrhages, exudation negative, vessels normal, macula normal. Direct examination was documented as: right eye - disc negative, no neo seen, peripapillary - negative, rare blot hemorrhages, fovea - two to three microaneurysms nasal and in, one temporal edge all lasered; left eye - disc negative, peripapillary - several blot hemorrhages, no neo seen, fovea negative. (Exh. 2, pp. 26-19)

56. On May 27, 1992, Patient A was seen at Respondent's office for a three month follow-up and fundus check. Respondent documented indirect examination as: right eye - rare blot hemorrhage, exudation negative, vessels normal, macula normal; left eye - rare blot hemorrhage, exudation negative, vessels normal, macula normal. Direct examination was documented as: right eye - disc negative, peripapillary - rare blot hemorrhage, no neo seen, fovea - possible edema, couple of blot hemorrhages above fovea and inferiotemporal with microaneurysms; left eye - disc negative, peripapillary - rare blot hemorrhage, no neo seen, fovea negative. Respondent scheduled focal laser surgery of the right eye and planned a complete eye examination with "gonio" of the left eye for neovascularization. (Exh. 2, pp, 30-31)

57. On May 27, 1992, laser surgery was not indicated to either eye. (Exh. B, Exh. D; T. 26-29, 37, 223-225, 263, 1564-1569)

58. On June 13, 1992, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documents focal laser for microvascular anomalies and panretinal photocoagulation of the left eye, using 1,626 shots of 50 and 300 microns at 50 to 750 milliwatts. He noted treatment of some "focal neo." Respondent also noted that the patient needed full panretinal photocoagulation of the left eye. On this date, Respondent planned panretinal laser surgery of the right eye on August 6, 1992. (Exh.2, p. 72)

59. On August 6, 1992, Respondent performed laser surgery on Patient A's right eye at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the right eye using 1,121 shots of 200 micron size at 50 to 550 milliwatts, treating the mid periphery. On this date, Respondent planned additional panretinal laser surgery of the right eye for September 25, 1992. (Exh. 2, p. 73)

60. Patient A was seen at Respondent's office on September 21, 1992, for a four month complete eye examination and a "gonio" examination of the left eye for neovascularization. Neithe a gonioscopic nor a contact lens examination is documented in Respondent's record for this office visit. Indirect examination is documented as: right eye - hemorrhages negative, exudation negative vessels normal, macula - fovea a little atrophic; left eye - hemorrhages negative, exudation negative vessels normal, macula normal. Direct examination was documented as: right eye - disc negative, peripapillary - negative, no neovascularization, some blot hemorrhages temporal and above fovea

and elsewhere; left eye - no neovascularization, disc negative, fovea - blot hemorrhage at top, som RPE depigmentation in fovea, peripapillary negative. (Exh. 2, pp. 32-33)

61. On September 21, 1992, neither focal nor panretinal laser surgery was indicated for either eye. (Exhs. B, D; T. 26-29, 37, 223-225, 263, 1564-1569, 1623-1624)

62. On October 9, 1992, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documented panretinal photocoagulation to the right eye using 1,001 shots of 50, 100, and 200 micron sizes, at 400 to 1000 milliwatts, to the mid periphery and far periphery with some "focal neo" treated. On this date, Respondent planned another panretinal laser surgery of the right eye on December 4, 1992. (Exh. 2, p. 74)

63. On December 4, 1992, Respondent performed panretinal photocoagulation laser surgery on Patient A's right eye at Lakeshore Hospital. Respondent documented using 1,222 shots of 50 and 300 microns at 50 to 250 milliwatts to the entire far periphery and parafovea. Respondent noted the far periphery was complete for 360 degrees. On this date, Respondent scheduled yet another panretinal laser surgery of the right eye on January 22, 1993. (Exh. 2, p. 75)

64. On December 23, 1992, Patient A was seen at Respondent's office for a three month fundus check. Indirect examination was documented entirely negative, except the macula of the right eye showed retinitis pigment scattered/possible laser marks. Direct examination was documented as: right eye - disc negative, peripapillary - laser marks, no exudates, no neovascularization, fovea - blot hemorrhage superiotemporal to fovea edema or epithelial retinal new, blot hemorrhage temporal; right eye - disc negative, peripapillary no hemorrhages or exudates, no neovascularization, fovea - one blot hemorrhage at top RPE depigmentation, flat.

Contact lens examination with biomicroscope, inappropriately labeled "gonio" by Respondent, of the left eye was documented as: some edema noted, whirl pattern of the internal limiting membra possibly thickened. Respondent planned panretinal laser surgery of the right eye and an IV fluorescein angiogram and fundus photos on January 9, 1993. (Exh. 2, pp. 34-35)

65. On January 9, 1993, fundus photos and IV fluorescein angiogram were done, apparently at Lakeshore Hospital. Respondent documented his interpretation of these studies as: fundus photo, both eyes-background diabetic retinopathy; IV fluorescein angiogram no areas of neovascularization noted in either eye, has focal edema in both eyes right eye more than left eye. On this date, Respondent planned focal laser surgery of the left eye for neovascularization detected from "gonio." (Exh. 2, p. 57)

66. On the same date as the photographic studies described above, Patient A was seen at Respondent's office. A contact lens examination with a biomicroscope (approximately two weeks after the last such examination and inappropriately labeled "gonio" by Respondent) was documented as: right eye - disc negative, fovea - epithelial membrane, slight to moderate edema over fovea, no exudates anywhere, no IRMA noted, occasional blot hemorrhages especially over fovea, no neovascularization anywhere; left eye - fovea - tiny RPE depigmentation at edge with couple of blot hemorrhages, internal limiting membrane appears thickened, scattered rare blot hemorrhages, disc negative, blot hemorrhages superionasal edge of fovea, no IRMA noted. To this report, Respondent added in his own handwriting: couple of tiny spots of neovascularization along the superior vein (superiotemporal vein), superior vein neo two areas, three to four disc diameters out. At this office visit, Respondent scheduled focal laser surgery for neovascularization of the left

eye and directed that the January 22, 1993 laser appointment be kept but changed from the right eye to the left eye . (Exh. 2, pp. 36-37)

67. The January 9, 1993 photographic studies were interpreted by G. Stewart Ray, M.D. as follows:

> Fundus photo OD - moderately extensive atrophy along the superior arcade with few white spots inferiorly, some small hemorrhages and some peripheral pigmentation
>
> Fundus photo OS - hyper pigmentation in the peripheral posterior pole.
>
> Fluorescein angiogram OD - many areas of hyper fluorescence in the posterior pole up to the macula. These correspond roughly to the pale spots seen on the color photograph. Capillary loss is suspected in the macula; late leakage is diffuse and profound involving all but the very center of the fovea.
>
> Fluorescein angiogram OS - hyper fluorescence adjacent to the disc at one to two o'clock persists and markedly increases; a suggestion of capillary loss is seen in the central posterior pole.

Fluorescein angiography of the left eye did not show hard exudate within 500 microns of the center of the fovea, neovascularization or macular edema, although stereopsis was obtained. Dr. Ray's overall impression was moderately severe preproliferative diabetic retinopathy, post laser treatment both eyes. (Exh. 30; T. 2237a-2242)

68. On January 9, 1993, laser surgery was not indicated for either eye. (Exhs. B, D, 30; T. 26-29, 37, 223-225, 263, 1564-1569)

69. On January 22, 1993, Respondent performed laser surgery on Patient A at Lakeshore Hospital. Respondent documented Argon laser for microvascular abnormalities of the left eye (focal laser surgery) using 364 shots of 50 microns to the parafovea, upper fovea and areas of IRMA up above the disc. (Exh. 2, p. 76)

70. While not needed to diagnose clinically significant macular edema or proliferative diabetic retinopathy, fluorescein angiography can provide significant additional information to the ophthalmologist evaluating diabetic retinopathy. It can identify macular capillary nonprofusion or macular edema as possible explanations for visual loss, and can aid in identifying subtle areas of neovascularization or capillary dropout when abundant preproliferative signs are present. These tests can show exactly where treatment is needed and where it is not needed. Fundus photography and fluorescein angiography also serve to document the disease status and indications for surgery, or lack thereof. (Exh. B, Exh. D; T. 22-23, 45-46, 1476-1478, 1633, 2167-2168)

71. Patient A underwent 22 laser procedures: 14 to the right eye and 8 to the left eye. One photographic study was done prior to the initiation of treatment and one photographic study immediately prior to the last laser treatment. Further photographic studies could have aided in the evaluation and treatment of Patient A and would have provided documentation of the indications, o lack of indications, for laser surgery. However, the clinician may be able, through the contact lens examination at the time of laser surgery, to establish to his or her satisfaction the appropriate sites for laser treatment without additional photographic studies. (Exhs. B, D; T. 22-23, 46, 963, 970 - 974,1476-1477, 1633, 2167-2168)

72. Typically, full panretinal photocoagulation is accomplished by applying a total of 3500 spots of 500 microns in size in three to four sessions, with three to four weeks between each session. The purpose of panretinal laser surgery is to attempt to prevent worsening of diabetic retinopathy and therefore to preserve vision. It is appropriate to accomplish the treatment as soon

as it is reasonably and safely possible, leaving time between treatments for the effect of the treatment to manifest itself. (Exhs. D; T. 661, 1486, 1591, 1914, 2119, 1555-1557)

73. Of the 14 laser procedures to the right eye, 12 were characterized by Respondent as panretinal photocoagulation and two were characterized as focal grid laser surgery. Of the eight procedures to the left eye, six were characterized by Respondent as panretinal photocoagulation and two as focal laser surgery. Respondent limited the size of the shots used for panretinal laser surgery to 300 microns, thus necessitating approximately six times more sessions than would be needed if the standard 500 micron size shot was used in the periphery. Respondent unnecessarily subjected Patient A to an excessive and inappropriate number of laser treatments. (Exhs. B, D; T. 15-17, 38-43, 661, 590-591, 2119, 1914)

PATIENT B

74. Patient B, a 58 year old male, was first seen at Respondent's office on February 20, 1990, for a complete eye examination, complaining that for the past month he has noticed decreased visual acuity in the left eye. After examination, Respondent diagnosed cataract in both eyes, left greater than right. Respondent scheduled Patient B for cataract surgery with intraocular lens replacement of the left eye. (Exh. 4, pp. 1-2)

75. On March 6, 1990, Patient B was seen at Respondent's office for pre-cataract surgery testing. (Exh. 4, pp. 5-6)

76. On March 23, 1990, Respondent performed cataract surgery with intraocular lens replacement of the left eye. Follow-up visits at Respondent's office occurred on March 24, March

28, April 11, April 25, May 16 and May 23, 1990. Routine office visits occurred on August 29 and October 24, 1990, and March 13, 1991. (Exh. 4, pp. 6-23)

77. On September 10, 1991, Patient B was seen at Respondent's office complaining of very blurry vision of the left eye, having felt a "popping" in the left eye about one month previous and experiencing floaters for the past week and a half. Indirect examination of the left eye was documented as: central retinal vein occlusion (CRVO), markedly constricted arterioles, and dilate veins. Direct examination of the left eye was documented as: CRVO, massively dilated veins, many hemorrhages, foveal edema in macula and around fovea. (Exh. 4, pp. 24-25)

78. One week later, on September 18, 1991, Patient B was seen at Respondent's office for a return visit, still complaining of floaters and blurry vision. Direct examination of the left eye was documented as: definite hemorrhages in the posterior pole with foveal edema. (Exh. 4, p. 26)

79. Patient B was again seen at Respondent's office on October 2, 1991, for a two week return visit, reporting that his left eye was about the same. Direct examination of the left eye was documented as: macular edema and hemorrhages throughout the posterior pole. Fundus photographs and IVFA were scheduled at Lakeshore Hospital for November. (Exh. 4, pp. 28-29)

80. On October 9, 1991, Patient B was again seen at Respondent's office for a one week return visit. Indirect examination of the left eye was documented as: myriad hemorrhages with macular edema. (Exh. 4, p. 30-31)

81. On October 30, 1991, Patient B was seen at Respondent's office for a three week return visit, complaining of blurred vision in the left eye. No examination of the retina was documented. (Exh. 4, p. 32-33)

82. On November 9, 1991, fundus photos and IVFA were performed on Patient B. Respondent's documented interpretation of these studies was:

> Fundus photo OS massive hemorrhaging, CRVO.
> Fundus photo OD-within normal limits.
> IVFA OD-within normal limits.
> IVFA OS-massive hemorrhages.

Respondent's original plan was to observe Patient B. This plan was crossed out in his records, and panretinal laser surgery of the left eye was planned for December 14, 1991. (Exh. 4, p. 76)

83. Patient B was also seen in Respondent's office on the date of the photographic studies. A contact lens examination of the left eye with biomicroscopic, inappropriately labeled "gonio" by Respondent, was documented as: disc with swollen vessels, marked (illegible), foveal edema unde a fold (tent), no neo seen, massive hemorrhage throughout posterior pole, no rubeosis seen. (Exh. 4, p. 34)

84. Patient B was seen at Respondent's office on December 19, 1991, for a one month return visit with complaints of blurred visual acuity in the left eye - no changes. Indirect examinati of the left eye was documented as: lots of hemorrhages around the foveal area. Respondent's plan was to have Patient B keep his Saturday laser appointment. (Exh. 4, pp. 36-37)

85. Central retinal vein occlusion (CRVO) occurs when the central vein through which blood flows out of the eye becomes blocked, causing a backup of blood, engorgement of the veins and capillaries, and hemorrhage. CRVO has two varieties: ischemic and nonischemic. With nonischemic CRVO, blood backs up into the eye but there is not a disruption of the capillaries and thus not a large area without blood flow. It is characterized by macular edema. Nonischemic

CRVO is treated with observation. Ischemic CRVO is characterized by neovascularization of the retina, neovascularization of the iris, or neovascular glaucoma. Ischemic CRVO is treated with a full course of panretinal photocoagulation. (T. 50-53, 57, 62-63, 362)

86. Respondent's records for Patient B do not document signs of ischemic CRVO. Panretinal laser surgery was not indicated. (Exh. 4; T., 62-63)

87. The November 9, 1991 photographic studies were interpreted by G. Stewart Ray, M.D. His findings were:

> Fundus photo OD[3] - detail is moderately obscured by the quality of the photography temporally; one white spot below the disc temporally suggests a cotton-wool spot but cannot be confirmed.
>
> Fundus photo OS - profuse hemorrhaging and blurring of the disc margins are present with increased vascularity on the disc and obscuration of the fovea by intra retinal hemorrhage.
>
> IVFA OS hemorrhage obscures much of the details; the disc becomes moderately hyperfluorescent, the vein are distended, there is moderate leakage of the superior posterior pole vessels and there is extensive edematous elevation of the central macula.

Dr. Ray's overall impression was central retinal vein occlusion of the left eye; normal fluorescein angiogram of the right eye. (Exh. 30)

88. On December 14, 1991, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,007 shots of 300 micron size at 180 to 240 milliwatts to the mid periphery. On this date, Respondent scheduled panretinal laser surgery of the left eye for February 8, 1992.(Exh. 4, p. 77)

---

[3] In the interests of brevity, the following ophthalmic terms will sometimes be employed in text: OD means right eye; OS means left eye; OU means both eyes.

89. On February 8, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,002 shots of 300 micron size at 180 to 360 milliwatts, treating the periphery and mid periphery. On this date, Respondent scheduled further panretinal laser surgery of the left eye for March 28, 1992 and an office exam for February 12, 1992. (Exh. 4, p. 78)

90. On February 12, 1992, Patient B was seen at Respondent's office for a five week return visit, complaining of blurred vision in the left eye. No retinal examination of the left eye was documented. (Exh. 4, pp. 40-41)

91. On March 18, 1992, Patient B was seen at Respondent's office for a complete eye examination. Indirect examination was documented as: right eye - normal; left eye - diffuse hemorrhages, severe edema, massive exudation, vessels normal, macula - edema. Direct examination was documented as: right eye - normal; left eye - same as indirect examination, especially temporally hemorrhages and exudates. (Exh. 4, pp. 42-43)

92. On March 28, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,003 shots of 300 microns at 190 to 440 milliwatts to the mid and far periphery. On this date, Respondent scheduled Patient B for another panretinal laser surgery to the left eye on May 16, 1992. (Exh. 4, p. 79)

93. On May 16, 1992, Respondent performed the scheduled panretinal photocoagulation on Patient B's left eye. Respondent documented panretinal photocoagulation of the mid and far

periphery using 560 shots of 300 microns at 280 ti 600 milliwatts. On this date, Respondent scheduled Patient B for panretinal laser surgery to the left eye for July 10, 1992. (Exh. 4, p. 80)

94. On July 18, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,167 shots of 150 microns at 270 to 1,000 milliwatts to the parafovea in a grid fashion, and to the mid periphery. On this date, Respondent scheduled Patient B for panretinal laser surgery on September 11, 1992. (Exh. 4, p. 81)

95. On September 11, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,003 shots of 200 microns at 250 to 450 milliwatts to the far periphery. On this date, Respondent scheduled Patient B for panretinal laser surgery of the left on October 30, 1992. (Exh. 4, p. 82)

96. On October 5, 1992, Patient B was seen at Respondent's office for a complete eye examination. Indirect examination was documented as: right eye - normal; left eye - scattered blood hemorrhages, fibrosis frond off disc, exudation normal, vessels normal, macula -hemorrhage near fovea. Direct examination was documented as: right eye - normal; left eye - considerable fibrosis extends mostly superio, considerable sheathing of vessels, (illegible) nasal to fovea, temporal to. (Exh. 4, pp. 46-47)

97. On October 30, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,002 shots of 200 and 300 microns at 130 to 200 milliwatts to the mid periphery, which he noted was essentially

fully treated. On this date, Respondent scheduled Patient B for panretinal surgery of the left eye or December 18, 1992. (Exh. 4, p. 83)

98. On December 18, 1992, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,200 shots of 300 microns at 160 to 280 watts shots to the far periphery, which he notes is fully treated. On this date, Respondent scheduled Patient B for panretinal laser surgery of the left eye on February 5, 1993. (Exh. 4, p. 84)

99. On January 11, 1993, Patient B was seen at Respondent's office for a three month return visit to check the anterior segment and intraocular pressure. No examination of the retina was documented. Respondent's plan of treatment included panretinal laser surgery of the left eye on February 5, 1993. (Exh. 4, pp. 47-48)

100. On March 5, 1993, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 981 shots at 300 microns and 50 to 250 milliwatts, again to the mid and far periphery. On this date, Respondent scheduled Patient B for further panretinal laser surgery of the left eye on May 7, 1993. (Exh. 4, p. 85)

101. On April 26, 1993, Patient B was seen at Respondent's office for a complete eye examination. Indirect examination was documented as: right eye - normal; left eye - no hemorrhages, no exudation, vessels normal, macula - RPE depigmentation around foveal area. Direct examination was documented as: right eye - normal; left eye - disc and peripapillary-fibrosis

stalk off disc superiotemporal in arcade, fibrosis, H + H (illegible), fovea - sheathed vessels in peripapillary area. (Exh. 4, pp. 50-51)

102. On May 7, 1993, Respondent performed laser surgery on Patient B at Lakeshore Hospital. Respondent documented panretinal photocoagulation to the left eye using 876 shots of 150 and 300 microns at 100 to 180 milliwatts to the mid periphery and posterior pole. He noted that panretinal photocoagulation of the left eye was now complete. (Exh. 4, p. 86)

103. Respondent performed ten panretinal laser sessions on Patient B's left eye over a period of eighteen months. Each of the surgeries was scheduled outside the 45 day global treatment period for reimbursement purposes. Typically, full panretinal treatment is accomplished by applying a total of approximately 3,500 to 4,500 shots of between 200 to 500 microns in size, using smaller size shots closer in and larger size shots in the periphery, in sessions at two to four week intervals. Respondent inappropriately subjected Patient B to an excessive number of panretinal laser surgeries, scheduled at greater than four week intervals. (Exh. 4; T. 38, 846-849, 932, 1486, 1591, 1801-1804, 2083-2084)

104. One photographic study was obtained prior to the initiation of treatment. Further studies would have added little to the treatment in this case, but would have documented the lack of medical justification for the surgical treatment given to Patient B. (Exh. B, Exh. D; T. 22-23, 45-46, 1476-1478, 1631-1633, 2167-2168)

PATIENT C

105. Patient C was a 53 year old diabetic female with endophthalmitis, first seen by Respondent during the first week of October 1991, at Buffalo General Hospital. Respondent

referred Patient C to James C. Aquavella, M.D. who admitted her to Strong Memorial Hospital in Rochester, New York. Patient C was discharged from Strong Memorial Hospital on October 15, 1991 with prescriptions for Timoptic, Gentamicin and Bacitracin. (Exh. C, Exh. 6, p. 8)

106. Patient C's right eye was essentially blind, without hope of rehabilitation. Under these circumstances, reduction of intraocular pressure would not be a concern. Rather, long-term patient discomfort and disfigurement are the outcomes to be avoided. (T. p. 1654 - 1657)

107. Patient C was seen at Respondent's office on October 16, 1991 for follow-up and an intraocular pressure check on the right eye. No comfort problems were documented. Vision in the right eye was no light perception. Intraocular pressures were not documented. Respondent diagnosed glaucoma secondary to endophthalmitis in the right eye. Treatment with Timoptic, Gentamicin and Bacitracin were continued, and the patient was scheduled to return in one week. (Exh. 6, pp. 8-9)

108. On October 23, 1991, Patient C was seen at Respondent's office for her scheduled return visit. Comfort problems were documented generally as: last night patient had awful pain in the right eye. Duration, nature and a more specific description of intensity of the pain were not recorded. Intraocular pressure in the right eye was 50. Respondent diagnosed blind right eye, endophthalmitis right eye, and secondary glaucoma right eye. Respondent continued the previous medications and started Atropine, Diamox, Pred Forte. No pain medication was prescribed. Respondent scheduled Patient C for surgery on October 25, 1991. (Exh. 6, pp. 10-10a)

109. On October 25, 1991, Respondent performed ultrasound cyclodialysis on Patient C at Lakeshore Hospital. Respondent documented that this procedure was "performed to reduce

intraocular pressure." Patient C's presurgical intraocular pressure was documented as 33. Cyclodialysis is the destruction of the ciliary body by use of ultrasound. The ciliary body supplies the eye with fluid and is responsible for intraocular pressure. (Exh. 6, p. 73, Exh. 7; T.67-78)

110. Patient C was seen at Respondent's office following surgery on October 25, 1991. Intraocular pressure was recorded as 36. (Exh. 6, pp. 11-12)

111. At the time of treatment, use of ultrasound to perform cyclodialysis was a relatively simple device to help control patient discomfort by reducing interocular pressure while at the same time leaving open future treatment options. (T.1661- 1663)

112. Dr. Aquavella testified that the cyclodialysis procedure is minimally invasive and was clearly medically indicated, despite the fact that the eye was blind. Enucleation of the eye would have been the only surgical alternative. (T.1700-1703)

113. Patient C was seen at Respondent's office on October 30, 1991, November 6, 1991, November 13, 1991, November 27, 1991, December 11, 1991, December 18, 1991, January 8, 1992, January 27, 1992, January 29, 1992, January 31, 1992, February 12, 1992, and February 19, 1992, for follow-up. Retinal examinations were not recorded, except for the office visit of December 18, 1991. On that date, indirect examination of the retina was documented as: left eye-occasional blot hemorrhage, rare hard exudate, occasional soft exudate, vessels normal, macula normal. Direct examination was documented as: left eye-small blot hemorrhage at the temporal edge of the fovea with no laser at this time, disc negative, peripapillary area-few blot hemorrhages, no neo, occasional hard exudate, microaneurysms. (Exh. 6, pp. 13-36)

114. On April 1, 1992, Patient C was seen at Respondent's office for a one and half month return visit and fundus check of the left eye. Respondent documented direct examination of the retina as: left eye-rare blot hemorrhages, hard exudate temporal to fovea, vessels normal, macula normal. Direct examination was documented as: rare blot hemorrhages, no neo, hard exudate well nasal to fovea, with hard exudate close by, scattered hard exudate, hard exudate above fovea and around. On this date, Respondent scheduled Patient C for photographic studies for April 4, 1992, and for focal laser surgery to the left eye with retrobulbar anesthesia on April 11. 1992. (Exh. 6, pp. 37-38)

115. On April 4, 1992, photographic studies were obtained. Respondent's documented interpretation of these studies was:

Fundus photo OS - background diabetic retinopathy
IVFA OS - some capillary dropout, no definite neovascularization, very slight to slight macular edema mostly parafoveal.
Respondent's plan as documented on the report of photographic study was focal laser OS, including two tiny tufts of neovascularization. (Exh. 6, p. 74)

116. On April 4, 1992, after the photographic studies, Respondent examined Patient C at his office. Contact lens examination with a biomicroscope, inappropriately labeled "gonio" by Respondent, was documented as: left eye-disc negative, fovea without edema but has hard exudate at its edge, tiny tuft of neo inferionasal about as far as she can go, scattered hemorrhages, hard exudate mostly above and temporal to fovea, no neo elsewhere, mid periphery small blot hemorrhage. Respondent scheduled Patient C for focal laser surgery "with focal neo" using retrobulbar anesthesia April 25, 1992. (Exh. 6, pp. 39-40)

117. G. Stewart Ray, M.D., interpreted the April 4, 1992, photographic studies as follows:

Fundus photos OS - yellow spots suggestive of exudates are in the temporal macula adjacent to the fovea and outwardly for one disc diameter. Cotton wool spots are strongly suggested outside the arcade and there is a superior temporal medium sizedhemorrhage blot and flame;

IVFA OS - a few pinpoint fluorescent spots are seen in the central posterior pole; capillary loss is noted in the inferior posterior pole outside of the arcade; late leakage is present from 12:00 to 10:00 and spares the central fovea. Capillary loss is also seen in the nasal mid periphery.

Dr. Ray's overall impression was mild to moderate background diabetic retinopathy OS. The hard exudate noted was not within 500 microns of the center of the fovea, no neovascularization was identified, stereopsis was obtained and no edema was present. (Exh. 30; T.2269-2270)

118. Dr. Ray testified that the hard exudates evident in the April 4, 1992 photos are close to the fovea, and that he was not able to determine from the photos whether the hard exudates were associated with macular edema. (T.2269 A)

119. On April 25, 1992, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye under retrobulbar anesthesia, using 211 shots of 50 microns to one area of possible neovascularization inferionasally. (Exh. 6, p. 75)

120. Patient C was next seen at Respondent's office on July 8, 1992, for follow-up and a complete eye examination. Indirect examination of the left eye was documented as: rare blot hemorrhage, hard exudate temporal superio to fovea, vessels normal, macula normal. Direct examination of the left eye was documented as: disc negative, no neo, peripapillary-several blot

hemorrhages, few hard exudates, fovea-hard exudates superiotemporal to "neo" treated, blot hemorrhages, microaneurysms. No edema was noted. (Exh. 6, pp. 41-42)

121. On October 20, 1992, Patient C was seen at Respondent's office for a three month fundus check of the left eye. Indirect examination was documented as: blot hemorrhages above and temporal to fovea, hard exudate below, exudation- negative, vessels normal, macula normal. Direct examination of the left eye was documented as: disc negative, peripapillary-occasional hard exudate, occasional blot hemorrhage, fovea-negative except blot hemorrhage temporal edge many hard (presumed to be exudate) superiotemporal to fovea, no neovascularization noted. Macular edema was not noted. On this date, Respondent scheduled Patient C for focal laser surgery of the left eye. (Exh. 6, pp. 43-44)

122. Documentation provided by Respondent does not establish clear indication for focal laser surgery. Clinically significant macular edema was not noted, and although the presence of hard exudate was noted, the distance of the hard exudate from the center of the fovea was not set forth. (Exh. B, Exh. D; T. 12-15, 78-85, 660, 2134, 1623-1624)

123. On January 8, 1993, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) to the left eye using 571 shots of 50 microns at 50 to 420 milliwatts to the macular area. He noted that no neovascularization was seen in the macular area. (Exh. 6, p. 76)

124. Patient C was seen in Respondent's office on January 19, 1993, for a six month complete eye examination. Indirect examination of the left eye was documented as: OD (sic) hemorrhages unable, hard exudates top of fovea and over and around disc, vessels unable, macula

unable; OS hemorrhages negative, exudation negative, vessels negative, macula negative. Direct examination of the left eye was documented as: disc and peripapillary-rare blot hemorrhages, several hard exudates, no neovascularization, fine drusen (illegible) around it, flat, hard exudates temporal edge and (illegible), clump of hard exudate above fovea. No macular edema was noted, no microaneurysms were noted. On this date, treatment to the left eye was apparently planned or scheduled. (Exh. 6, pp. 45-46)

125. On April 20, 1993, Patient C was seen at Respondent's office for a three month fundus check. Indirect examination of the left eye was documented as: hard exudates below disc. Direct examination of the left eye was documented as: fovea - slight RPE hypopigmentation in it, blot hemorrhage (illegible) hard exudates superiotemporal to fovea, disc negative, peripapillary few hard exudates around, no neo, blot hemorrhages, microaneurysms in region of hard exudates. Respondent scheduled Patient C for focal laser surgery of the left eye. (Exh. 6, pp. 47-48)

126. On April 20, 1993, focal laser surgery was not indicated. (Exh. B, Exh. D; T. 12-15, 78-85, 660, 2134, 1623-1624)

127. On April 30, 1993, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 783, 50 micron size shots of 50 to 360 milliwatts to the posterior pole. He documented that some neovascularization was treated focally. On this date, Respondent scheduled Patient C for focal laser surgery of the left eye on June 25, 1993. (Exh. 6, p. 77)

128. On June 25, 1993, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery)

of the left eye using 514, 50 and 100 micron size shots of 50 to 190 milliwatts to the posterior pole and the entire mid periphery. He noted that some neovascularization was treated focally. (Exh. 6, p. 78)

129. Patient C was next seen in Respondent's office on May 12, 1994, for a complete eye examination after having cardiac bypass surgery in November, 1993. Indirect examination of the left eye was documented as: peripapillary and disc - rare hard exudate, rare blot hemorrhage, fovea negative. Direct examination of the left eye was documented as: peripapillary and disc-negative/rare hard exudate (illegible) blot hemorrhage/no neo, several scattered blot hemorrhages and exudates, fovea-partial thickness foveal hole nasal, hard exudate and blot hemorrhages superionasal to fovea or flower petal edema (cystoid). On this date, Respondent scheduled Patient C for photographic studies on May 14, 1994. (Exh. 6, pp. 49-50)

130. On May 12, 1994, photographic studies of Patient C's left eye were obtained. Respondent's documented interpretation was:

> Fundus photo - background diabetic retinopathy
> IVFA - slight to moderate foveal edema, several areas of considerable leakage as with neo, considerable dropout, several areas seen, needs laser OS (illegible) to grid (illegible) may need focal "neo versus PRP." (Exh. 6, p. 79)

131. On May 27, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 403 shots of 50 and 100 microns at 50 to 170 milliwatts to scattered areas of neovascularization and microaneurysms. On this date, Respondent scheduled Patient C for focal laser surgery and focal "neo" of the left eye on June 10, 1994. (Exh. 6, p. 80)

132. On June 10, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) and neovascularization of the left eye using 403 shots of 50 and 200 microns at 50 to 200 milliwatts to the entire posterior pole and part of the mid periphery. Respondent documented that no definite neovascularization was seen, nor was IRMA seen. On this date, Respondent scheduled Patient C for further laser surgery of the left eye for June 17, 1994. (Exh. 6, p. 81)

133. On June 17, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 424 shots of 50 microns at 50 to 220 milliwatts to the entire posterior pole. Respondent noted a need to treat the mid periphery and far periphery. On this date, Respondent scheduled Patient C for additional focal laser surgery on July 15, 1994. (Exh. 6, p. 82)

134. On July 15, 1994, Patient C's scheduled focal laser surgery was rescheduled for July 22, 1994, due to laser failure. (Exh. 6, p. 83)

135. On July 22, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 509 shots of 50 microns at 50 to 450 milliwatts to the macula (illegible) and posterior pole. Respondent noted 'some IRMA-neo focally near ST arcade." On this date, Respondent scheduled Patient C for focal laser surgery on August 26, 1994. (Exh. 6, p. 84)

136. On August 24, 1994, Patient C was seen at Respondent's office complaining of photophobia of the left eye. Indirect examination of the left eye was documented as: hard exudate well above fovea. Direct examination of the left eye was documented as: few hard exudates, rare

blot hemorrhage, partial thickness foveal hole, RPE depigmentation in and around fovea, neovascularization starting nasal mid periphery, fibrosis nasal to disc 3 to 4 disc diameters out, retinal hemorrhage. On this date, Respondent scheduled Patient C for focal laser surgery and "focal neo" of the left eye on August 26, 1994. (Exh. 6, pp. 55-56)

137. On August 26, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) and "focal neovascularization" of the left eye using 580 shots of 50 and 200 microns at 200 to 390 milliwatts to the entire mid periphery. Respondent noted a need for more treatment to the posterior pole and far periphery. On this date, Respondent scheduled Patient C for focal laser surgery and "focal neo" of the left eye on October 25, 1994. (Exh. 6, p. 85)

138. On December 1, 1994, Patient C was seen at Respondent's office for a three month complete eye examination. It was noted that three weeks previously, the patient had started dialysis once a month. Indirect examination of the eye was documented as: few blot hemorrhages, scattered rare hard exudate, fovea normal. Direct examination of the left eye was documented as: negative, rare hard exudate/no neo/slight neo along (4 disc diameter out) inferiotemporal arcade 3 disc diameter; fovea - RPE depigmentation in and around it, blot hemorrhages at temporal edge, flat. Respondent's plan was to have Patient C keep her previously scheduled laser appointment for the following day. (Exh. 6, pp. 57-58)

139. On December 2, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) and neovascularization of the retina (panretinal laser surgery) to the left eye using 60

shots of 50 and 300 microns and 50 to 270 milliwatts to the entire posterior pole and some far periphery, and some "neo" treated directly. On this date, Respondent scheduled Patient C for additional laser surgery on December 9, 1994. (Exh. 6, p. 87)

140. On December 9, 1994, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) and panretinal photocoagulation of the left eye using 902 shots of 300 microns at 150 to 200 milliwatts to the far periphery. On this date, Respondent scheduled Patient C for panretinal laser surgery of the left eye on December 23, 1994. (Exh. 6, p. 86)

141. On January 13, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital, documenting panretinal photocoagulation of the left eye using 702 shots of 200 microns and 140 to 200 milliwatts to the far periphery. Respondent documented "no neo or IRMA seen." On this date, Respondent scheduled Patient C for another panretinal laser surgery on January 20, 1995. (Exh. 6, p. 88)

142. The purpose of panretinal laser surgery is to cause regression of neovascularization in an attempt to prevent further complications. The treatment goal is an absence of neovascularization. Once Patient C's neovascularization, previously documented as slight, had regressed, further panretinal laser surgery was not indicated. (Exhs. B, D; T., pp. 78-85, 661, 1570-1574, 2119, 2189)

143. On January 20, 1995, Respondent again performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 700

shots of 200 microns at 140 to 230 milliwatts of power to the far periphery. Respondent documented "no neo seen, no IRMA seen." (Exh. 6, p. 89)

144. On February 10, 1995, Respondent performed further panretinal photocoagulation surgery to Patient C's left eye at Lakeshore Hospital, documenting use of 501 shots of 150 and 200 microns at 120 to 230 milliwatts to the far periphery. Respondent documented "no neo or IRMA seen." On this date, Respondent again scheduled Patient C for panretinal laser surgery of the left eye on March 4, 1995. (Exh 6, p. 90)

145. On June 15, 1995, Patient C was seen at Respondent's office for a six month complete eye examination. Chief complaint was noted as "patient doesn't want anymore lasers-can see again now." Indirect examination was documented as: preretinal hemorrhages around disc, blot hemorrhages near fovea. Direct examination of the left eye was documented as: neovascularization 2 disc diameter out the superiotemporal arcade, hemorrhages on disc, few and fine neo on disc, rare hard exudates, neo one to 5 disc diameter nasal to disc at 9:00; fovea-few blot hemorrhages in and around it flat, hard exudates inferiotemporal edge (couple). On this date, Respondent scheduled Patient C for laser surgery. (Exh. 6, p, 60).

146. On July 15, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital, documenting panretinal photocoagulation of the left eye using 801 shots of 50, 100, 200 and 300 microns and from 50 to 340 milliwatts of power to the parafovea, posterior pole and periphery. Respondent documented that some "neo" was treated directly nasal to the disc. On this date, Respondent scheduled Patient C for additional panretinal laser surgery on July 28, 1995. (Exh. 6, p. 91)

147. On September 21, 1995, Patient C was seen at Respondent's office for a three month fundus check. Direct examination of the left eye was documented as several blot hemorrhages (illegible) no exudate, no neo seen; fovea negative. Direct examination of the left eye was documented as: disc negative peripapillary scattered blot hemorrhages, preretinal hemorrhages, rare hard exudate; fovea flat RPE depigmentation in and around, blot hemorrhage temporal edge no exudate. Contact lens examination of the left eye was documented as: fovea-RPE depigmentation in flat fovea no exudate noted, blot hemorrhage edge of and beyond fovea; disc-neo noted on disc about one half central, neo just below superiotemporal arcade 3 disc diameter out, several preretinal hemorrhages, rare hard exudate, little neo inferionasal arcade 2 to 3 disc diameter out just above inferionasal arcade 3 disc diameter out, neo one half disc diameter nasal to disc 9:00, possible neo spots about 2 disc diameter superiotemporal arcade area. On this date, Respondent scheduled Patient C for panretinal laser surgery and "focal neo" of the left eye on September 29, 1995. (Exh.6, p. 61-2)

148. On September 29, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented panretinal photocoagulation and Argon for "neovascularization of retina OS" using 1,002 shots of 50, 100, 150 and 300 microns with a power range of 150 to 250 milliwatts. Respondent documented that neovascularization was treated directly in the posterior pole. On this date, Respondent scheduled Patient C for further panretinal laser surgery and "focal neo" on October 6, 1995. (Exh. 6, p. 92)

149. On October 13, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented panretinal photocoagulation and "Argon for

neovascularization of retina OS" using 1,100 shots of 50 and 300 microns in an 80 to 260 milliwatt power range to the parafovea and mid periphery. On this date, Respondent scheduled Patient C for another panretinal laser surgery on October 20, 1995. (Exh. 6, p. 93)

150. On October 27, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital, documenting panretinal laser photocoagulation of the left eye using 658 shots of 50 and 300 microns at 50 to 250 milliwatts of power to the parafovea and mid periphery. On this date, Respondent scheduled Patient C for further panretinal laser surgery of the left eye the next day, October 28, 1995. (Exh. 6, p. 94)

151. On October 28, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 902 shots of 300 microns in the 182 to 320 milliwatt power range to the mid and far periphery. On this date, Respondent scheduled Patient C for panretinal laser surgery on November 18, 1995. (Exh.6, p. 95)

152. On November 18, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital, documenting panretinal photocoagulation of the left eye using 504 shots of 300 microns at 170 to 270 milliwatts to the mid periphery. On this date, Respondent scheduled Patient C for another panretinal laser surgery to the left eye on November 25, 1995. (Exh. 6, p. 96)

153. On November 25, 1995, Respondent performed laser surgery on Patient C at Lakeshore Hospital. Respondent documented panretinal photocoagulation of the left eye using 1,247 shots of 200 microns at 200 to 460 milliwatts to the posterior pole. He noted that some

"neo" was treated directly. On this date, Respondent scheduled Patient C for another panretinal laser surgery of the left eye the following day, on November 26, 1995. (Exh. 6, p. 97)

154. On November 26, 1995, Respondent performed laser surgery on Patient C's left eye at Lakeshore Hospital, documenting panretinal photocoagulation of the left eye using 2,461 shots a 50, 200 and 300 microns in size and 170 to 550 milliwatts of power to the posterior pole and periphery. Respondent noted that some "neo" in the posterior pole was treated directly. On this date, Respondent scheduled Patient C for another laser surgery to the left eye on December 9, 1995. (Exh. 6, p. 98)

155. On November 28, 1995, Patient C was seen at Respondent's office complaining of pain after the laser treatment and that her vision never went back to way it was. Direct and indirect examination of the left eye was documented as: fovea - RPE depigmentation in and around flat, blot hemorrhages at temporal edge, no exudate. No further examination or treatment was documented. (Exh. 6, pp. 63-64)

156. On December 9, 1995, Respondent again performed pan retinal photocoagulation laser surgery on Patient C's left eye at Lakeshore Hospital. Respondent documented using 1,123 shots of 50 and 300 microns at 50 to 270 milliwatts to the posterior pole and far periphery. Respondent noted that the entire left eye had been treated, that panretinal photocoagulation was completed, and that no neovascularization or IRMA was seen. (Exh. 6, p. 99)

157. On December 21, 1995, Patient C was seen at Respondent's office for a six month complete eye examination, complaining that her vision was still blurry in the left eye but no worse. Indirect examination of the left eye was documented as: rare blot hemorrhages, fovea negative.

Direct examination of the left eye was documented as: peripapillary and disc negative, few scattered blot hemorrhages, no neo; fovea blot hemorrhage at temporal edge, drusen in fovea few, no ES flat. (Exh. 6, pp. 65-66)

158. On March 25, 1996, Patient C was seen at Respondent's office for a fundus check. Contact lens examination was documented as: couple of hard exudates nasal to fovea, several blot hemorrhages around fovea, no definite edema, (illegible) drusen and RPE depigmentation in and around. Indirect examination of the left eye was documented as: peripapillary and disc negative fovea few blot hemorrhages temporal. Direct examination of the left eye was documented as: disc negative, few scattered blot hemorrhages; peripapillary-rare hard exudate, no neo few hard exudate around it; fovea blot hemorrhages around it, RPE depigmentation in and around exudate nasal to fovea. Photographic studies were ordered. (Exh. 6, pp. 67-68)

159. Photographic studies were obtained on May 22, 1996. G. Stewart Ray, M.D. interpreted these studies as:

> Fundus photos OS whitish spots suggest either cotton-wool spots with infarct, photographic aberration or RPE atrophy. The detail does not lend itself to accurate interpretation.
>
> IVFA OS numerous small, indeed, tiny, marks are in the peripheral posterior pole suggesting previous laser marks. Capillary loss appears to be present in the central macula and there is a hypofluorescent line along the inferior posterior pole suggesting a thin line of preretinal hemorrhage. Late leakage surrounds the inferior macula and to a lesser extent temporal and superior. Late leakage is also seen around the inferior arcade and upper temporal.

Overall impression was proliferative diabetic retinopathy of the left eye with small vitreous hemorrhage and extensive but very small panretinal laser marks. (Exh. 30)

160. Respondent performed 23 separate laser surgeries on Patient C's left eye. Eight procedures documented by Respondent as "focal" were conducted between April 4, 1992 and July 22, 1994. Fifteen procedures documented by Respondent as "panretinal" were conducted between August 26, 1994 and December 9, 1995. In many instances, Respondent retreated Patient C within six to ten days of the previous treatment, too soon to determine whether the previous treatment had been effective and therefore risking over treatment. By employing 50 to 200 micron size shots at 200 or less milliwatts of power, Respondent delivered many non-therapeutic shots. In this manner, Respondent inappropriately and unnecessarily extended the number of sessions and therefore delayed completion of full treatment. Respondent performed an excessive number of laser surgeries. (Exhs. B, D; T. 39-43, 84-85, 1486-1493, 1496, 1500, 1555-1557, 1591, 2119, 2167-2176)

161. During the course of the 23 separate laser procedures, Respondent performed only two photographic studies. A final study was performed in May, 1996. Additional studies could have documented the indications for surgery, if any, and assisted in the evaluation and treatment of Patient C. (Exhs. B, D; T. 22-23, 46, 88-89, 1476-1477, 1633, 1782)

PATIENT D

162. Patient D, a 61 year old male with a history of diabetes mellitus, was first seen in Respondent's office on May 19, 1991. Respondent documented indirect examination as: right eye scattered hemorrhages/veins constricted, exudation negative vessels negative macula macular edema; left eye scattered blot hemorrhages, occasional soft exudation vessels normal macula normal. Direct examination was documented as: right eye - fovea - edema with hemorrhage

temporal and inferior (illegible) occasional soft hemorrhage, peripapillary-scattered blot hemorrhage, disc good; left eye fovea - few blot hemorrhages in and around rare exudates, peripapillary-negative. Respondent scheduled photographic studies for May 11, 1991. (Exh. 8, pp. 1-2)

163. On May 11, 1991, photographic studies were obtained. Respondent's documented interpretation of these studies was:

> Fundus photo OD-macular edema and background diabetic retinopathy.
> Fundus photo OS-background diabetic retinopathy
> IVFA OD macular (foveal) edema, moderate degree
> IVFA-OS mild foveal, mostly parafoveal edema.

Respondent planned laser treatment of both eyes. (Exh. 8, p. 60)

164. Dr. G. Stewart Ray, M.D. interpreted these studies as:

> Fundus photo OD a moderate number of blot hemorrhages are present with a probable small exudate in the inferior posterior pole between the macula and arcade.
> Fundus OS-a moderate number of blot and dot hemorrhages are seen with white spots suggesting cotton-wool spots or artifacts
> IVFA OD there appears to be 2 cilioretinal arteries; significant capillary loss throughout the posterior pole with extensive aneurysms.
> IVFA OS probable increase in the CFZ with leaking surrounding the fovea; mild late leakage into the temporal aspect of the macula adjacent to the fovea.

Dr. Ray's overall impression was background diabetic retinopathy with moderately severe capillary loss and late leakage bilaterally. Hard exudate was not present within 500 microns of the center of the fovea of either eye. The presence or absence of macular edema could not be determined from this photographic study. (Exh. 30; T., 2284-2290)

165. On May 11, 1991, the day of the photographic studies, Patient D was also seen at Respondent's office. A contact lens examination with biomicroscope, inappropriately labelled "gonio," was documented as: OD - massive foveal edema with some cystic component, scattered hemorrhages, some exudate away from fovea, no neo seen, disc negative, around the periphery some fine hemorrhages only; OS - moderate foveal edema, disc OK, soft exudate, scattered blot hemorrhages, mid periphery negative. Respondent scheduled Patient D for laser surgery for both eyes. (Exh. 8, pp. 3-4)

166. Based upon Respondent's office records and the photographic studies, there was adequate medical justification indication for focal laser surgery of the right eye. Focal surgery of th left eye was not indicated. (Exhs. B, D; T.92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

167. On June 1, 1991, Respondent performed laser surgery on Patient D at Lakeshore Hospital. Respondent documented Argon laser surgery for macular edema and diabetic retinopathy of the right eye using 463 shots of 50 microns at 100 to 480 milliwatts in modified grid form to the parafoveal and outer macular areas. Respondent's plan was to have Patient D keep his June 12, 1991 laser appointment for the left eye. (Exh. 8, p. 63)

168. On June 8, 1991, Respondent performed laser surgery on Patient D's left eye at Lakeshore Hospital. He documented Argon laser surgery for macular edema and diabetic retinopathy of the left eye using 492 shots of 50 microns at 70 to 350 milliwatts to the parafovea. On this date, Respondent scheduled Patient D for focal surgery of the left eye on July 27, 1991. (Exh. 8, p. 64)

169. On July 27, 1991, Respondent performed laser surgery on Patient D's left eye at Lakeshore Hospital, documenting "Argon laser surgery for microvascular anomalies" of the left eye using 432 shots of 50 microns at 90 to 260 milliwatts to the posterior pole. (Exh. 8, p. 65)

170. On August 7, 1991, Patient D was seen at Respondent's office for a three month return visit and fundus check. Respondent documented indirect examination as: right eye scattered blot hemorrhages, exudation negative, vessels normal, macula possible foveal edema; left eye scattered blot hemorrhages, exudation negative, vessels normal, macula laser scars temporal fovea (cataracted). Direct was documented as: OD-fovea-as indirect; OS unable. Patient D was diagnosed with cataract in both eyes and scheduled for precataract testing and cataract surgery . with intraocular lens implant in both eyes. (Exh. 8, pp. 5-6)

171. Cataract surgery was performed on August 15, 1991. Follow-up visits occurred on August 20, September 11, September 25, and October 23, 1991. Respondent performed cataract surgery on the right eye on October 24, 1991. Patient D was seen for follow-up visits on October 25, and November 19, 1991. No examination of the retina was documented. (Exh. 8, pp. 7-22)

172. Patient D was seen in Respondent's office on December 10, 1991 for a three week return visit, complaining of black spots in the right eye. Indirect examination of the right eye was documented as: hemorrhages-negative. Direct examination of the right eye was documented as: one microaneurysm near fovea, RPE hypo and hyper pigmentation in foveal area with few microaneurysms in the area. (Exh. 8, pp. 23-24)

173. On April 28, 1992, Patient D was seen in Respondent's office. Indirect examination of the retina documented: OD- several blot hemorrhages, exudation negative, vessels negative,

macula - - RPE depigmentation in fovea; OS - hemorrhages temporal edge of fovea scattered elsewhere, exudation - negative, vessels - normal, macula - normal. Direct examination documented: OD - disc and peripapillary-scattered blot hemorrhages, fovea-RPE hypo and hyper (pigmentation), no neovascularization, no edema (the word "fovea" was inserted between the words "no" and "edema"), hard exudate around it and blot hemorrhages temporal and above it; OS - disc - negative, peripapillary few blot hemorrhages, no neo, fovea - negative, blot hemorrhages temporal, hard exudate inferionasal, no foveal edema. On this date, Respondent scheduled Patient D for focal laser surgery of both eyes. (Exh. 8, pp. 25-26)

174. On April 28, 1992, focal laser surgery was not indicated for either eye. Respondent's records fail to document adequate medical justification for focal laser surgery. (Exhs. B, D; T. 92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

175. On May 23, 1992, Respondent performed laser surgery on Patient D at Lakeshore Hospital, documenting Argon laser for microvascular anomalies (focal laser surgery) of the right eye using 736 shots of 50 microns at 50 to 700 milliwatts to the parafovea. (Exh. 8, p, 66)

176. On May 26, 1992, Patient D was seen in Respondent's office. No examination of the retina was documented. (Exh. 8, pp. 27-28)

177. On June 16, 1992, Patient D was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - scattered blot hemorrhages, hard exudation above fovea, vessels normal, macula RPE in and around fovea; left eye - scattered blot hemorrhages, exudation negative, vessels normal, macula RPE hyper and hypo pigmentation around it. Direct examination of the retina was documented as: disc and peripapillary - laser marks around fovea,

fovea - hard exudate superiotemporal edge fovea, soft exudate below disc, RPE depigmentation in fovea; left eye disc and peripapillary - normal, several blot hemorrhages, fovea hard exudates temporally, blot hemorrhages inferiotemporal and temporal to it no (illegible), soft exudate (illegible). On this date, Respondent planned to continue Argon grid surgery and scheduled Patient D for Yag laser surgery of the right eye on June 20, 1992. (Exh. 8, pp. 29-30)

178. On June 20, 1992, Respondent performed Yag surgery on Patient D at Lakeshore Hospital. (Exh. 8, p. 67)

179. Patient D was seen in Respondent's office on July 7, 1992. No examination of the retina was documented. (Exh. 8, p. 33)

180. On July 28, 1992, Patient D was seen in Respondent's office for a three week return visit and complete eye examination. Indirect examination of the retina was documented as: right eye - scattered blot hemorrhages, exudation negative, vessels normal, macula RPE depigmentation in and around fovea; left eye - scattered blot hemorrhages, exudation negative, vessels normal, macula-RPE depigmentation in and around fovea. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - scattered blot hemorrhages, fovea - RPE depigmentation, hard exudate above fovea, little neo stalk nasal disc 1.5 disc diameters out, soft exudate; left eye - disc negative, peripapillary few blot hemorrhages, hard exudate temporal to disc, no neo seen, fovea RPE depigmentation, hard exudates inferionasal. On this date, Respondent scheduled Patient D for focal "neo and IRMA" of the right eye on August 8, 1992, and focal "IRMA" of the left eye on July 31, 1992. (Exh. 8, pp. 35-35a)

181. On July 28, 1992, focal laser surgery was not indicated for either eye. (Exhs. B, D; T. 92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

182. On July 31, 1992, Respondent performed laser surgery on Patient D at Lakeshore Hospital, again documenting Argon laser for microvascular anomalies. Focal laser surgery of the parafovea and rest of macula of the left eye was documented, using 895 shots of 50 microns at 50 to 200 milliwatts. On this date, Respondent scheduled Patient D for further focal laser surgery of the left eye on September 16, 1992, and instructed Patient D to keep his previous appointment for laser surgery of the right eye on August 28, 1992. (Exh. 8, p. 68)

183. On September 29, 1992, Patient D was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - scattered blot hemorrhages, exudation negative, vessels normal, macula - RPE depigmentation in and around fovea; left eye scattered blot hemorrhages, exudation negative, vessels normal, macula - RPE depigmentation in and around fovea. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - scattered blot hemorrhages, no neovascularization, fovea hard exudate at top and below, RPE depigmentation in it; left eye - disc negative, no neovascularization, peripapillary -scattered blot hemorrhages, fovea - RPE depigmentation in and around it, blot hemorrhages below, hard exudate above it. On this date, Respondent again scheduled Patient D for focal laser surgery of both eyes. (Exh. 8, pp. 36-37)

184. On September 29, 1992, focal laser surgery was not indicated for either eye .(Exhs. B, D; T. 92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

185. On November 27, 1992, Respondent performed laser surgery on Patient D at Lakeshore Hospital, documenting: Argon laser for microvascular anomalies (focal laser surgery) of the right eye using 783 shots of 50 microns at 50 to 110 milliwatts to the temporal half of the posterior pole. Respondent's plan was to have Patient D keep his previous appointment for laser surgery of the left eye. (Exh. 8, p. 69)

186. On December 9, 1992, Respondent performed laser surgery on Patient D at Lakeshore Hospital, and documented Argon laser for microvascular anomalies. Focal laser surgery of the macular area of the left eye was documented using 587 shots of 50 microns at 50 to 200 milliwatts. Respondent scheduled Patient D to be seen in the office the next day regarding a chalazion. (Exh. 8, p. 70)

187. On December 10, 1992, Patient D was seen at Respondent's office for surgical removal of a chalazion from the left lower lid. (Exh. 8, pp. 38-39)

188. On December 17, 1992, Patient D had a follow-up examination in Respondent's office. No examination of the retina was documented. (Exh. 8, pp. 40-41)

189. On February 9, 1993, Patient D was seen in Respondent's office for a complete eye examination. Indirect examination of the retina was documented as: right eye - scattered blot hemorrhages, rare hard exudate, vessels normal, macula - RPE hypo and hyper pigmentation in and around flat fovea; left eye - scattered blot hemorrhages, exudation negative, vessels normal, macula RPE hypo and hyper pigmentation in and around flat fovea. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - scattered blot hemorrhages, hard exudate well superionasal to fovea with microaneurysm near and scattered, no neovascularization, rare soft

exudate, fovea - RPE hypo and hyper pigmentation in and around flat, no hemorrhage or exudate; left eye - disc negative, peripapillary - scattered blot hemorrhages, no neovascularization, fovea - blot hemorrhage just temporal to fovea, hard exudates temporal with microaneurysms in area, RPE hypo and hyper pigmentation in and around flat fovea. At this office visit, Respondent scheduled Patient D for laser surgery of both eyes. (Exh. 8, pp. 42-43)

190. On February 9, 1993, focal laser surgery was not indicated for either eye. Respondent documents the absence of appropriate indications for focal laser surgery. (Exhs. B, D; T. 92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

191. On March 3, 1993, Respondent again performed laser surgery on Patient D's left eye at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies OS (focal laser surgery) using 487 shots of 50 microns at 50 to 180 milliwatts to the entire posterior pole. Respondent also documented treatment of "some IRMA". On this date, Respondent planned to have Patient D keep the March 5, 1993 appointment for focal laser surgery of the right eye. (Exh. 8, p. 71)

192. On March 5, 1993, Respondent performed laser surgery on Patient D's right eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) using 538 shots of 50 microns at 50 to 230 milliwatts to the posterior pole, temporal side. On this date, Respondent scheduled Patient D for further focal laser surgery of right eye on May 7, 1993. (Exh. 8, p. 72)

193. On May 7, 1993, Respondent performed laser surgery on Patient D at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser

surgery) of the right eye using 651 shots of 50 microns at 50 to 320 milliwatts to the macular area, and to the inferiotemporal and superiotemporal quadrants of the posterior pole. Respondent documented that no neovascularization was seen and that Patient D "needs more laser in superiotemporal, superionasal, inferionasal. On this date, Respondent scheduled Patient D for further focal laser surgery to the right eye, for July 2, 1993. (Exh. 8, p. 73)

194. Patient D was seen in Respondent's office on May 18, 1993, for a three month fundus check. Indirect examination of the retina was documented as: right eye - rare blot hemorrhage, exudation negative, vessels normal, macula RPE - depigmentation in and around flat fovea; left eye - hemorrhages negative, exudation negative, vessels negative, macula RPE depigmentation in and around flat fovea. Direct examination of the retina was documented as: right eye - disc negative, no neovascularization, peripapillary negative except few blot hemorrhages and soft exudate and hard exudate, fovea RPE hypo and hyper pigmentation in and around flat fovea, no hemorrhages or exudate; left eye disc and peripapillary - negative except for few blot hemorrhages, no neovascularization, fovea-RPE hypo and hyper pigmentation in and around flat fovea, no hemorrhages or exudate. On this date, Respondent planned to have Patient D keep his July 2, 1993 appointment for focal surgery of the right eye. (Exh. 8, pp. 44-45)

195. On May 18, 1993, focal surgery was not indicated for the left eye. Respondent's office records document the absence of appropriate indications. (Exhs. B, D; T. 92, 660, 1623-1624, 2134, 2158-2165, 2172-2176)

196. On July 2, 1993, Respondent performed laser surgery on Patient D at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser

surgery) of the right eye using 436 shots of 50 microns at 50 to 460 milliwatts to the entire posterior pole and some of the mid periphery. Respondent documented that no neovascularization was seen but some IRMA was treated, and that Patient D need the mid periphery finished. On this date, Respondent scheduled Patient D for further focal laser surgery of the right eye on August 20, 1993. (Exh. 8, p. 74)

197. On August 20, 1993, Respondent performed laser surgery on Patient D at Lakeshore Hospital. Respondent again documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 468 shots of 50 microns at 100 to 350 milliwatts, to the entire posterior pole. Respondent documented that no neovascularization or IRMA was seen. (Exh. 8, p.75)

198. Respondent performed thirteen separate focal laser procedures on Patient D, eight to the right eye and five to the left eye, over a period of approximately 28 months. Fundus photos and IVFA studies were obtained prior to the first surgery and not thereafter. Further photographic studies should have been obtained to document indications for surgery, if such indications were present, and to assist in the evaluation of treatment of Patient D. (Exh. D; T.22-23, 46, 93-94, 1476-1477, 1633, 1782, 2165-2167, 2170)

199. Respondent's claimed methodology for conducting focal laser surgery means that approximately only one in five laser shots results a therapeutic spot being delivered to the eye (T.p. 700-714). Respondent's laser delivered only 70% of the power setting. (T.p704).Use of 50 micron size spots, the minimum size, together with low power, results in delivery of many non-therapeutic shots. (T. p.589) Many of the procedures were conducted without intervening office

visits to determine the results of previous surgery. The ten focal laser procedures performed on Patient D were excessive, inappropriate and unnecessary. (Exhs. B, D; T. 94-95, 1486, 1493, 1496-1497, 1556-1557, 1591, 1623-1624, 2158-2165, 2172-2176)

PATIENT E

200. Patient E was a 62 year old female with a history of diabetes melitis and high blood pressure when first seen by Respondent on June 23, 1992. At the first office visit, Respondent scheduled Patient E for photographic studies. (Exh. 10, pp. 2-3)

201. On July 30, 1992, Patient E was seen at Respondent's office and visual field testing was conducted. No retinal examination was documented. (Exh. 10, pp. 4-5)

202. On July 11, 1992, photographic studies of Patient E were conducted. Respondent's documented interpretation was:

> Fundus photo-OD-background diabetic retinopathy.
> Fundus photo-OS-background diabetic retinopathy.
> IVFA OD-background diabetic retinopathy. LIS macular edema.
> IVFA OS macular edema and neovascularization over macula.
> (Illegible) (Exh. 10, p. 52)

203. G. Stewart Ray, M.D. interpreted the July 11, 1992 photographic studies as follows:

> Fundus photo OD - a few small hemorrhages are seen; the arterioles appeared narrowed and irregular. The media is moderately hazy or the photograph is out of focus.
> Fundus photo OS - sightly hazy photograph with abnormal architecture suggesting macular edema and few microaneurysms and hemorrhages.
> IVFA OD - the central macula appears to be intact with a few aneurysms noted. Late leakage develops and surrounds the fovea in an irregular pattern.
> IVFA OS - profound capillary loss is seen in the temporal periphery of

the posterior pole including the macula. Fuzzy fluorescein appears fairly early and suggests NVE (neovascularization elsewhere along the inferior arcade but this cannot be confirmed. Late leakage is into at least a portion of the fovea.

Dr. Ray's overall impression was severe preproliferative or early proliferative diabetic retinopathy OS with extensive capillary loss; mild or moderate background diabetic retinopathy of the right eye. (Exh. 30; T. 2297-2301)

204. On July 11, 1992, the same day as the photographic studies, Patient E was seen at Respondent's office. The contact lens examination with biomicroscope, inappropriately labeled "gonio" by Respondent, was documented as: right eye - disc sharp, pink, negative, fovea -negative except two small drusen, is flat, hemorrhage and two microaneurysms near hemorrhage, occasional blot hemorrhage in posterior pole, no neo seen, mid periphery perfect; left eye-fovea RPE depigmentation in it, one clump of neo noted just below fovea with fibrosis going up, preretinal membrane all the way across fovea (fibrose) blot hemorrhages and neovascularization around preretinal membrane over fovea. Respondent referred Patient E to Steve Charles, M.D. for removal of the preretinal membrane of the left eye. (Exh. 10. pp. 6-8)

205. On July 20, 1992, Patient E was seen by Steve Charles, M.D. at the Center for Retina and Vitreous Surgery in Memphis, Tennessee. After a full evaluation of Patient E, including photographic studies and a detailed report, which documenting the presence of "significant macula edema OS, " Dr. Charles performed focal laser surgery of the left eye using 49, 100 micron size shots. (Exh. A.a)

206. On July 28, 1992, Patient E was seen at Respondent's office. Direct examination of the left eye was documented as: fovea-scarred-partial thickness foveal hole-some hemorrhages at bottom, some laser marks. (Exh. 10, pp. 8-9)

207. Patient E was seen at Respondent's office on August 4, 1992 and August 18, 1992, for evaluation and treatment of glaucoma. No examination of the retina was documented on these occasions. (Exh. 10, pp. 10-13)

208. On September 29, 1992, Patient E was seen at Respondent's office for a return visit and fundus check. Indirect examination of the retina was documented as: right eye-hemorrhages negative, exudation negative, vessels normal, macula-RPE depigmentation; left eye-rare blot hemorrhages, exudation negative, vessels negative, macula-RPE depigmentation in fovea. Direct examination of the retina was documented as: right eye-disc negative, peripapillary-few blot hemorrhages, no neo, fovea one microaneurysm nasal edge, blot hemorrhages temporal; left eye - disc negative, peripapillary-few blot hemorrhages, soft exudate inferior to disc, neo well temporal to fovea. On this date, Respondent scheduled Patient E for focal laser surgery and "focal neo" of the left eye. Respondent also scheduled Argon laser trabeculoplasty of the left eye. (Exh. 10, pp. 14-15)

209. On October 23, 1992, Respondent performed Argon laser trabeculoplasty to Patient E's left eye at Lakeshore Hospital. (Exh. 10, p. 60)

210. On October 27, 1992, Patient E was seen at Respondent's office in follow-up to the October 23 procedure. No examination of the retina was documented. Respondent's plan reiterated the scheduling of Patient E for laser surgery. (Exh. 10, pp. 16-17)

211. On September 29, 1992, focal laser surgery was not indicated for either eye. After Respondent's initial evaluation and photographic studies, focal laser surgery of the left eye was performed by Dr. Charles. Respondent's September 29, 1992, direct examination of the retina documents the absence of appropriate indications in both eyes. (Exhs. B, D; T. 12-15, 38-43, 44-45, 115-117, 660, 1623-1624, 2119, 2134)

212. On December 9, 1992, Respondent performed laser surgery at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 1389, 50 and 100 micron size shots, mostly 50 micron size, to the parafovea. Respondent noted that some "focal neo" was treated. On this date, Respondent scheduled Patient E for focal laser and possible grid surgery to the left eye for April 16, 1993. (Exh. 10, p. 61)

213. On December 23, 1992, Patient E was seen at Respondent's office. Respondent documented indirect examination of the retina as: right eye - scattered blot hemorrhages, exudation negative, vessels negative, macula negative; left eye - no hemorrhages noted, exudation negative, vessels normal, macula-RPE changes in it. Respondent documented direct examination of the retina as: right eye - disc negative, peripapillary-few blot hemorrhages, neo noted nasal to disc 2 disc diameter s over, soft exudate and neo growing, fovea-negative except scattered microaneurysm and blot hemorrhages away from IRMA temporal to fovea. IRMA two disc diameter above disc, IRMA inferiotemporal to disc about two disc diameter, IRMA three disc diameter below disc; left eye - peripapillary-few blot hemorrhages small and scattered, one tiny blot hemorrhage on top of flat, RPE depigmentation, microaneurysm, one hard exudate temporal edge, IRMA v. "neo" (illegible) below fovea, hard exudate well temporal with microaneurysms. On this

date, Respondent scheduled Patient E for laser surgery to both eyes, left eye first, right eye second. (Exh. 10, pp. 18-19)

214. On December 23, 1992, laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 38-43, 44-45, 115-117, 660, 1623-1624, 2119, 2134)

215. On December 30, 1992, Respondent performed laser surgery on Patient E at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 630, 50 and 150 micron size shots at 120 to 390 milliwatts to the posterior pole. Respondent documented treatment to "focal neo, IRMA," and microaneurysms. Respondent documented his plan to have Patient E keep her appointment for laser surgery of the left eye. (Exh. 10, p. 62)

216. On April 16, 1993, Respondent performed laser surgery on Patient E at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 493, 50 micron size shots at 50 to 310 milliwatts to the entire posterior pole. Respondent documented treatment to very slight IRMA and that no neovascularization was seen. (Exh. 10, p. 64)

217. On April 20, 1993, July 27, 1993, and September 15, 1993, Patient E was seen for follow-up at Respondent's office. Laser surgeries were not scheduled at these visits. (Exh. 10, pp. 20-29)

218. On May 4, 1995, Patient E was seen at Respondent's office. Direct and indirect examinations of the retina were documented. The contact lens examination with biomicroscope of the right eye was documented as: considerable foveal edema with few blot hemorrhages in it, some

cystoid edema of fovea, macular detachment with macular fluid, five hard exudates above fovea. disc negative, foveal-scattered blot hemorrhages, mid periphery rare blot hemorrhages, no neo seen. Contact lens examination of the left eye was documented as: subretinal fluid and hard exudate inferiotemporal to fovea, foveal cyst nasal edge, several blot hemorrhages in and around fovea, well temporal to fovea area of fibrosis associated with them, several preretinal hemorrhages especially inferior, mid periphery- considerable subretinal (infiltrate?). Respondent scheduled photographic studies. (Exh. 10, pp. 30-31)

219. On May 25, 1995, photographic studies were obtained. Respondent's documented interpretation was:

> Fundus photo OD - RPE depigmentation in and around, background diabetic retinopathy.
> Fundus photo OS - considerable background diabetic retinopathy.
> IVFA OD - minimal macular edema, background diabetic retinopathy.
> IVFA OS - minimal macular edema, background diabetic retinopathy, preretinal hemorrhages OS. (Exh. 10, p. 56)

220. G. Stewart Ray, M.D. interpreted the May 25, 1995 photographic studies as follows:

> Fundus photo OD - A few white spots are seen outside the arcade with atrophy of the RPE; a modest number of small dot hemorrhages are scattered in all four quadrants of the posterior pole, and other white spots might represent cotton-wool spots.
> Fundus photo OS - laser treatment is suggested by the atrophy of very small marks with exudates and edema encroaching upon fixation from below and slightly more remote temporally.
> IVFA OD - filling appears to be significantly delayed into more than one minute. The detail is not visible. OD eventually shows late hyperfluorescence in the posterior pole without directly involving the fovea.
> IVFA OS - In the A/V, there is hyperfluorescence in the local blots associated with the white defects in color. Preretinal hyperfluorescence suggests lower nasal

vitreous hemorrhage.

The photograph studies of the right eye do not demonstrate macular edema and there is no suggestion in the photographs that macular edema is present. Dr. Ray's overall interpretation was severe preproliferative diabetic retinopathy of the left eye with vitreous hemorrhage, and moderate diabetic retinopathy of the right eye. (Exh. 30; T. 2300-2304)

221. On May 25, 1995, Patient E was seen at Respondent's office. A contact lens examination with biomicroscope of the retina was documented as: right eye - appears fovea flat, some microaneurysm and blot hemorrhages scattered around fovea, disc negative, no neovascularization seen, rare areas of blot hemorrhage mid periphery; left eye - disc negative, some foveal edema, moderate, area of fibrosis in fovea, scattered blot hemorrhages around it, area of neovascularization temporal to fovea, scattered drusen well superiotemporal to fovea, some fibrosis below fovea, preretinal hemorrhage inferior, scattered blot hemorrhages. On this date, Respondent scheduled Patient E for laser surgery of both eyes. His plan was to scheduled focal laser surgery of the right eye first, and schedule focal "neo," and possible panretinal laser surgery of the left eye thereafter. (Exh. 10, pp. 32-33)

222. In May 1995, laser surgery was not indicated for the right eye. Adequate indications are not documented in Respondent's records, nor the photographic studies. The left eye was the more severely effected, and laser surgery was probably indicated for the left eye. (Exhs. B, D; T. 12-15, 38-43, 44-45, 115-117, 660, 1623-1624, 2119, 2134)

223. On June 10, 1995, Respondent performed laser surgery on Patient E's right eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the right eye using 501 shots of 50 microns at 50 to 470 milliwatts to the parafovea.

On this date, Respondent scheduled additional focal laser surgery to the right eye for June 24, 1995. (Exh. 10, p. 65)

224. On June 24, 1995, Respondent performed and documented laser surgery on Patient E's right eye at Lakeshore Hospital, using 764 shots of 50 microns at 50 to 1000 milliwatts to the entire posterior pole. Respondent documented that no neovascularization was seen and that some IRMA was treated directly. On this date, Respondent planned laser surgery ("focal neo" and possibly panretinal) to the left eye for July 1, 1995. (Exh. 10, p. 66)

225. On July 1, 1995, Respondent performed laser surgery on Patient E's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascularization of the retina to the left eye using 687 shots of 50 microns at a power range of 50 to 650 milliwatts to the parafovea and macula. Respondent documented that no neovascularization or IRMA was seen. (Exh. 10, p. 67)

PATIENT G

226. Patient G was a 65 year old female with a history of diabetes mellitus when first seen at Respondent's office on February 22, 1989. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation negative, vessels normal, macula normal; left eye - hemorrhages negative, exudation in fovea, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - few hard exudate, few microaneurysms nasal to fovea; left eye - one medium and one fine drusen, microaneurysms and find hemorrhages below fovea, disc negative. Respondent scheduled Patient G for photographic studies at Lakeshore Hospital for March 1989. (Exh. 14, pp. 1-2)

227. On March 11, 1989, photographic studies were obtained, presumably at Lakeshore Hospital. Respondent's documented interpretation of the studies was:

> Fundus photos - OU background diabetic retinopathy.
> IVFA OU - background diabetic retinopathy both eyes, with some macular edema parafoveally left eye.

Respondent's documented plan was to perform modified grid laser surgery of both eyes (Exh. 14, p. 83)

228. An undated office record, apparently corresponding to the March 11, 1989 photographic studies, does not contain a report of contact lens examination with biomicroscope, but contains the words "skip, no neo" and Respondent's plan to schedule laser for both eyes, right eye first, left eye second." (Exh. 14, p. 89)

229. G. Stewart Ray, M.D. interpreted the March 11, 1989 photographic studies as follows:

> Fundus photo OD - a few tiny hemorrhages are suggested as is an exudate above and temporal to the fovea.
> Fundus OS - a few flame hemorrhages and a threatening exudate nasal to the fovea.
> IVFA OD - a few irregular aneurysms are present with very slight late leakage superior and inferior sparring the fovea.
> IVFA OS - a few more aneurysms are seen than in the fellow eye and there is late leakage lower nasal to the fovea.

The hard exudate identified in the right eye was not within 500 microns of the center of the fovea and was not threatening vision. Macular edema was not present in the right eye. Macular edema was probably present in the left eye. Dr. Ray's overall interpretation of these studies was mild background diabetic retinopathy, no neovascularization evident in either eye and with possible clinically significant macular edema in the left eye. (Exh. 30; T. 2312-2316)

230. In March 1989, focal laser surgery was probably indicated for the left eye. Focal laser surgery was not indicated for the right eye. (Exhs. B, D, 30; T.. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

231. On March 25, 1989, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 54 shots of 100 microns at 50 milliwatts to an undocumented area of the macula. (Exh. 14, p. 90)

232. On April 1, 1989, Respondent performed laser surgery on Patient G's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) using 46 shots of 50 microns at 90 to 140 milliwatts to an undocumented area of the retina (Exh. 14, p. 91)

233. On May 31, 1989, Patient G was seen at Respondent's office for a three month complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages - none seen, exudation - above fovea, vessels normal, macula - exudation; left eye - hemorrhages one blot, exudation - near fovea, vessels normal, macula - exudation. No direct or contact lens examination of the retina was documented. At this office visit, Respondent scheduled Patient G for laser surgery of both eyes, right eye first, left eye second. (Exh. 14, pp. 3-4)

234. On May 31, 1989, laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

235. On June 24, 1989, Respondent performed and documented Argon laser (focal) surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented using 93 shots of

50 microns in the 70 to 130 milliwatt range of power, to an unspecified area of the retina. (Exh. 14, p. 92)

236. On July 1, 1989, Respondent again performed laser surgery on Patient G at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 122 shots of 50 microns at 70 to 120 milliwatts to an unspecified area of the retina. (Exh. 14, p. 93)

237. On October 11, 1989, Patient G was seen at Respondent's office two months late for a three month return visit for complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation negative, vessels normal, macula normal; left eye - one blot hemorrhage, exudation-some circinate nasal to, vessels normal, macula normal. Direct examination was documented as: disc OK both eyes, fovea both eyes with some hard exudate at its edge. Respondent's plan included "no laser." (Exh. 14, pp. 5-6)

238. On February 21, 1990, Patient G was seen at Respondent's office for a four month follow-up visit and complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation negative, vessels normal, macula normal; left eye - hemorrhages negative, exudation - couple of spots near fovea, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - rare hemorrhage little exudate at top of fovea; left eye one microaneurysm in fovea, area of hard exudate near fovea. No laser surgery was scheduled. (Exh. 14, pp. 7-8)

239. On March 14, 1990, Patient G was seen at Respondent's for a two week return visit. No examination of the retina is documented. (Exh. 14, pp. 9-10)

240. On May 30, 1990, Patient G was seen at Respondent's office. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation negative, vessels normal, macula normal; left eye - one hemorrhage, three hard exudate dots around macula, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - fovea and disc negative, peripapillary - one microaneurysm nasal to fovea; left eye - negative except few blot hemorrhages and few hard exudates, one microaneurysm inferionasal edge, hard exudate. At this office visit, Respondent scheduled Patient G for laser surgery of the left eye. (Exh. 14, pp. 11-12)

241. On May 30, 1990, focal laser surgery was not indicated for the left eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933, 1935-1944)

242. On June 9, 1990, Respondent performed laser surgery on Patient G's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the left eye using 167 shots of 50 microns at 50 to 150 milliwatts to the posterior pole. (Exh. 14, p. 94)

243. On October 10, 1990, Patient G was seen at Respondent's office for a complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation negative, vessels normal, macula - RPE depigmentation; left eye - hemorrhages negative, exudation - above fovea and elsewhere, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - depigmentation from laser, disc negative, occasional hemorrhage; left eye - small blot hemorrhage below fovea, hard exudate, exudate vertical line above fovea, few microaneurysms, few hemorrhages and hard exudates, no neo. On

this date, Respondent scheduled Patient G for laser surgery of the left eye with attention to the supertemporal arcade above fovea. (Exh. 14, pp. 13-14)

244. On October 20, 1990, focal laser surgery was not indicated for the left eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933, 1935-1944)

245. On October 26, 1990, Respondent again performed laser surgery on Patient G's left eye at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 440 shots of 50 microns at 90 to 270 milliwatts to the parafoveal area. Respondent documented one slight area of bleeding as the only problem. (Exh. 14, p.95)

246. On January 16, 1991, Patient G was seen in Respondent's office for a three month fundus check. No indirect examination was recorded. Direct examination of the retina was documented as: right eye - disc negative, couple of fine hemorrhages nasal to fovea and one microaneurysm, rare microaneurysm; left eye - disc negative rare blot hemorrhage, fovea-one tiny blot hemorrhage at bottom. (Exh. 14, pp. 14-16)

247. On April 17, 1991, Patient G was seen in Respondent's office for a three month complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages - hard exudate adjacent, exudation - one soft exudate below disc, vessels normal, macula normal; left eye blot hemorrhage, vessels normal, macula normal. Direct examination of retina was documented as: right eye - fovea and peripapillary - few blot hemorrhages, microaneurysm and hard exudate, scattered hemorrhages, no neovascularization, disc OK; left eye

- fovea - blot hemorrhage below fovea, peripapillary - occasional blot hemorrhage. At this office visit, Respondent scheduled Patient G for laser surgery of the right eye. (Exh. 14, pp. 17-18)

248. On April 17, 1991, focal laser surgery of the right eye was not indicated. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

249. On May 16, 1991, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 291 shots of 50 microns and 50 to 350 milliwatts of power to the posterior pole, "mostly parafoveal." (Exh. 14, p. 96)

250. On October 23, 1991, Patient G was seen in Respondent's office for a six month complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation - little bottom of fovea, vessels normal, macula normal; left eye - hemorrhages negative, exudation - little dot below fovea, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, hard exudate below and nasal, few microaneurysms around fovea, few blot hemorrhages above it; left eye - disc negative, blot hemorrhage below fovea, hard exudate and microaneurysm. At this office visit, Respondent scheduled Patient G for focal laser surgery of both eyes, right eye first and left eye one week later. (Exh. 14, pp. 19-20)

251. On October 23, 1991, focal laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

252. On October 26, 1991, Respondent performed laser surgery on Patient G at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser

surgery) of the right eye using 319 shots of 50 microns at 50 to 320 milliwatts to the posterior pole. Respondent documented his plan for Patient G to keep her appointment for "IRMA OS" in one week. (Exh. 14, p. 97)

253. On November 2, 1991, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 468 shots of 50 microns at 50 to 350 milliwatts to the posterior pole, mostly parafoveally. Respondent documented no problems except a tiny spot of bleeding. (Exh. 14, p. 98)

254. On March 4, 1992, Patient G was seen in Respondent's office for a complete eye examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation - hard around fovea, vessels normal, macula normal; left eye - hemorrhages negative, exudation negative, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - rare blot hemorrhage, exudate goes up to fovea nasal, couple of microaneurysms around it, no neo seen, fovea negative other than blot hemorrhages and microaneurysm; left eye - disc and peripapillary negative, rare blot hemorrhage, fovea - rare blot hemorrhage and hard exudate nasal, no neo seen. At this office visit, Respondent scheduled Patient G for "focal IRMA" of both eyes. (Exh. 14, pp. 21-22)

255. On March 4, 1992, focal laser surgery was not indicated to either eye. (Exhs. B, D; T.. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

256. On March 7, 1992, Respondent performed laser surgery on Patient G at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser

surgery) of the right eye using 791 shots of undocumented size using 50 to 200 milliwatts of power to the posterior pole, especially parafovea. (Exh. 14, p. 99)

257. On March 21, 1992, Respondent performed laser surgery on Patient G at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the left eye using 156 shots of 50 microns between 50 and 310 milliwatts of power to the parafovea and posterior pole. (Exh. 14, p. 100)

258. On June 10, 1992, Patient G was seen in Respondent's for a three month fundus check. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation-fovea hard exudate, areas of hard exudate four disc diameter above disc inferiotemporal and superiotemporal to fovea, vessels normal, macula normal; left eye - hemorrhages negative, exudation - hard exudate above fovea and at its top, some superionasal to disc, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, rare blot hemorrhage, fovea - negative except hard exudate nasal edge, one microaneurysm well nasal to nasal hard exudate, blot hemorrhage middle of exudate superionasal to fovea, no neo, couple of blot hemorrhages well above disc; left eye - disc negative, rare blot hemorrhage, fovea - couple of blot hemorrhages on it, hard exudate above, blot hemorrhage or microaneurysm top of fovea, possible neovascularization in superiotemporal arcade above fovea. At this office visit, Respondent scheduled focal laser surgery of both eyes. (Exh. 14, pp. 23-24)

259. On June 10, 1992, focal laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1948)

260. On June 13, 1992, Respondent performed and documented Argon laser surgery (focal laser surgery) on Patient G's right eye at Lakeshore Hospital. Using 949 shots of 50 micron at 50 to 250 milliwatts to the macular area, mostly parafoveally. (Exh. 14, p. 101)

261. On July 8, 1992, Patient G was seen in Respondent's office complaining of tearing and discharge in the left eye. Respondent diagnosed conjunctivitis of the left eye. He instructed Patient G to keep her previously scheduled laser surgery appointment. (Exh. 14, pp. 25-26)

262. On July 9, 1992, Respondent performed laser surgery on Patient G at the Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 845 shots of 50 microns at 50 to 500 milliwatts to the macular area. (Exh. 14, p. 102)

263. On September 28, 1992, Patient G was seen in Respondent's office; indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation - hard exudate at edge and near fovea, vessels normal, macula normal; left eye - hemorrhages negative, exudation - hard exudate foveal edge and below fovea, hard exudate below disc, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - few blot hemorrhages, no neovascularization, fovea negative except hard exudate nasal edge and well temporal; left eye - disc negative, peripapillary few blot hemorrhages, no neovascularization, fovea - blot hemorrhage inferionasal to fovea, hard exudate above fovea and superior edge. (Exh. 14, pp. 27-28)

264. On November 4, 1992, Patient G was seen in Respondent's office complaining of redness and tears in both eyes. Conjunctivitis was diagnosed and medications prescribed. (Exh. 14, pp. 29-30)

265. On November 25, 1992, December 7, 1992, December 16, 1992, December 21, 1992, January 4, 1993, and January 11, 1993, Patient G was seen in Respondent's office for follow-up of conjunctivitis. No examinations of the retina were documented. (Exh. 14, pp. 29-42)

266. On February 1, 1993, Patient G was seen in Respondent's office for a refraction and a fundus examination. Indirect examination of the retina was documented as: right eye - hemorrhages negative, exudation - hard exudate macular area, one superiotemporal to fovea, vessels normal, macula normal; left eye - rare blot hemorrhage, exudation - hard exudate macular area, couple below fovea, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - hard exudate macular area, no neo seen, fovea - hard exudate nasal edge; left eye - disc negative, peripapillary - few blot hemorrhages and microaneurysm, few hard exudates, no neo seen, fovea - blot hemorrhage and hard exudate bottom of it. At this office visit, Respondent scheduled Patient G for focal laser surgery of both eyes. (Exh 14, pp. 45-46)

267. On February 1, 1993, laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1948)

268. On February 26, 1993, Patient G was seen in Respondent's office for a return visit prior to laser surgery. (Exh. 14, pp. 43-44)

269. On February 26, 1993, Respondent performed laser surgery on Patient G's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the left eye using 300 shots of 50 microns at 50 to 120 milliwatts of power to the entire posterior pole. (Exh. 14, p. 103)

270. On March 5, 1993, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 400 shots of 50 microns at 50 to 150 milliwatts to the macula. Respondent noted that Patient G "needs further treatment." Respondent scheduled focal laser surgery to the right eye for June 11, 1993. (Exh. 14, p. 104)

271. On June 2, 1993, Patient G was seen in Respondent's for a complete eye examination. Indirect examination of the retina was documented as: right eye - scattered blot hemorrhages, scattered hard exudates, vessels normal, macula normal; left eye - hemorrhages negative, hard exudate temporal to disc, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary negative, fovea-negative, blot hemorrhages above it, hard exudate in and along fovea, microaneurysms superionasal, no neo, hard exudate well temporal with blot hemorrhage next to it; left eye - disc negative, peripapillary-few blot hemorrhages, fovea RPE depigmentation in and around flat fovea, blot hemorrhages above it, no neo seen, soft exudate nasal to disc with some blot hemorrhages. Respondent planned to have Patient G keep her previously arranged June 11, 1993 appointment for laser surgery. (Exh. 14, pp. 47-48)

272. On June 2, 1993, laser surgery was not indicated to the right eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1948)

273. On June 11, 1993, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the right eye using 476 shots of 50 microns and a power range of 50 to 210 milliwatts to the entire posterior pole. Respondent noted that no neovascularization or IRMA was seen. (Exh. p. 105)

274. On June 28, 1993, Patient G was seen in Respondent's office. No retinal examination was documented. (Exh. 14, pp. 49-50)

275. On September 8, 1993, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - few blot hemorrhages scattered, disc negative, hard exudate above fovea and temporal; left eye - disc negative, hard exudate between disc and fovea, scattered blot hemorrhage. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - few blot hemorrhages and hard exudate, no neo, fovea - blot hemorrhage fine in it, hard exudate temporal to it, no neo; left eye - disc negative, peripapillary - considerable hard exudate between disc and fovea, fovea - RPE depigmentation with blot hemorrhages in and above it, no neo seen, hard exudate one disc diameter temporal to (illegible). At this office visit, Respondent scheduled Patient G for further focal laser surgery of both eyes, right eye first, then left eye. (Exh. 14, pp. 51-52)

276. On September 8, 1993, focal laser surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1948)

277. On September 24, 1993, Respondent performed laser surgery on Patient G at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 466 shots of 50 microns at 50 to 170 milliwatts to the macular area. Respondent's plan was to have Patient G keep her October 8, 1993 appointment for focal laser surgery of the left eye. (Exh. 14, p. 106)

278. On October 8, 1993, Respondent performed laser surgery on Patient G's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery)using 894 shots of 50 microns to the posterior pole, with a power range of 50 to 230 milliwatts. Respondent documented "no neo or IRMA seen." (Exh. 14, p. 107)

279. On December 13, 1993, Patient G was seen in Respondent's office for a complete eye examination. Indirect examination of the retina was documented as: right eye - peripapillary - scattered blot hemorrhages, scattered hard exudate, fovea - negative, RPE depigmentation nasal edge; left eye - peripapillary - scattered blot hemorrhages, scattered hard exudates, fovea-negative. Direct examination of the retina was documented as: right eye - peripapillary-few hard exudates scattered, few blot hemorrhages, no neovascularization; fovea -RPE depigmentation nasal edge fovea, blot hemorrhage top of fovea and few hard exudates superiotemporal to fovea; left eye peripapillary - scattered hard exudate and blot hemorrhages, no neovascularization, fovea-RPE depigmentation in and around it, flat, no hemorrhage or exudate, blot hemorrhage above fovea. At this office visit, Respondent scheduled focal surgery to the right eye. (Exh. 14, pp. 53-54)

280. On December 13, 1993, focal surgery was not indicated for either eye. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1933)

281. On January 21, 1994, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital, and documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 444 shots of 50 microns and 50 to 150 milliwatts of power to the macular area. Respondent documented "no IRMA or neo seen." (Exh. 14, p. 108)

282. On April 4, 1994, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - peripapillary - few hard exudates, fovea - negative (illegible); left eye - peripapillary - few hard exudates, fovea - negative (illegible). Direct examination of the retina was documented as: right eye - peripapillary-scattered hard exudate few blot hemorrhages, fovea-negative some drusen below, flat, hemorrhage and exudates well above, no neovascularization, no neovascularization, flat blot hemorrhage top and around RPE in and around, RPE in and around fovea. (Exh. 14, pp. 55-56)

283. On July 13, 1994, Patient G was seen in Respondent's office; indirect examination of the retina was documented as: right eye - peripapillary-few scattered blot hemorrhages, fovea-RPE depigmentation nasal edge, hard exudate above fovea; left eye - peripapillary - hard exudate 1.5 disc diameter nasal to disc, fovea - hard exudate temporal to fovea. Direct examination of the retina was documented as: right eye - peripapillary - several scattered blot hemorrhages, no neo seen, areas of hard exudate, fovea - RPE depigmentation in and around it, flat, some hemorrhage around it, few hard exudate scattered; left eye - peripapillary - few scattered hard exudates and blot hemorrhages, no neovascularization, area of hard exudates nasal to disc, fovea - RPE depigmentation in it, flat, few blot hemorrhages at top, no exudates. (Exh. 14, pp. 57-58)

284. On August 31, 1994, September 19, 1994, and September 26, 1994, Patient G was seen in Respondent's office for conjunctivitis. No examination of the retina was documented at these visits. (Exh. 14, pp. 59-64)

285. On October 19, 1994, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - peripapillary - rare blot hemorrhage, fovea - RPE depigmentation in flat fovea; left eye - peripapillary - few blot hemorrhages, circinate pattern, exudate two disc diameter nasal to disc, fovea normal. Direct examination of the retina was documented as: right eye - peripapillary - few scattered blot hemorrhages, no neovascularization seen, fovea - RPE depigmentation in flat fovea, blot hemorrhages and rare hard exudate around it; left eye - peripapillary - negative, few scattered blot hemorrhages, no neovascularization seen, circinate pattern nasal to disc, rare exudate seen, fovea - few blot hemorrhages in and around flat, one hard exudate temporal to fovea. (Exh. 14, pp. 65-66)

286. On January 16, 1995, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - peripapillary-hard exudate and scattered rare blot hemorrhage, fovea-RPE depigmentation; left eye - peripapillary - few scattered hemorrhages, fovea - RPE changes in, circinate nasal. Direct examination of the retina was documented as: right eye - peripapillary-few scattered blot hemorrhages, no neo seen, few scattered hard exudates, fovea - RPE depigmentation in and around, flat, blot hemorrhages in it, no neovascularization seen; left eye - peripapillary - few scattered blot hemorrhages, no neovascularization seen, circinate pattern nasal to disc and soft exudate, fovea-RPE depigmentation in and around, blot hemorrhages nasal edge. (Exh. 14, pp., 67-68)

287. On April 24, 1995, Patient G was seen in Respondent's office. No examination of the retina was documented. (Exh. 14, pp. 69-70)

288. On May 1, 1995, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - peripapillary-hard exudate superiotemporal to disc, few blot hemorrhages (illegible), fovea - RPE depigmentation in and around it; left eye - peripapillary-ring of hard exudate nasal to disc, scattered blot hemorrhages, fovea- negative. Direct examination of the retina was documented as: right eye - peripapillary - negative except few scattered blot hemorrhages, no neovascularization seen, scattered hard exudates, fovea - few blot hemorrhages at top and around intra retinal, RPE depigmentation in and around flat fovea; left eye - peripapillary - few scattered blot hemorrhages, no neovascularization, circinate ring nasal to disc, rare soft exudate, fovea - few blot hemorrhages around it, hard exudate temporal edge, RPE depigmentation in and around it, hemorrhages around it and in it. At this office visit, Respondent scheduled focal laser surgery of both eyes. Photographic studies were ordered. (Exh. 14, pp. 71-72)

289. On May 13, 1995, photographic studies were obtained. Respondent's documented interpretation was:

> Fundus photo right eye - appears to be drusen in and around fovea and background diabetic retinopathy; left eye appears to be drusen in and around fovea and background diabetic retinopathy.
> IVFA OD - many (illegible) in and around fovea, no foveal edema, no SRNV (sub retinal neovascularization) seen
> IVFA OS - same as OD.

Respondent's documented plan was to observe Patient G at yearly intervals. (Exh. 14, p. 84)

290. G. Stewart Ray, M.D. interpreted the May 13, 1995 photographic studies on Patient G as follows:

Fundus photo OS - it is dark and lacks sufficient contrast to accurately interpret.
Fundus photo OD - there appears to be atrophy of the RPE in the posterior pole and macula suggesting possible previous laser; there is venous beading in both arcades.
IVFA OS - there is a fairly large area of hypofluorescence in the macula suggesting capillary loss; this remains dark. Staining is present without apparent significant la leakage.
IVFA OD - staining without significant late leakage.

Clinically significant macular edema was not present. Dr. Ray's overall impression was backgroun diabetic retinopathy in both eyes, post laser. (Exh. 30; T. 2316-2319)

291. On May 13, 1995 laser surgery was not indicated for either of Patient G's eyes. (Exhs. B, D; T. 12-15, 21-34, 129-130, 590-591, 660, 1623-1624, 1915-1948)

292. On May 20, 1995, Respondent performed laser surgery on Patient G's left eye at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 799 shots of 50 microns in size and 50 to 460 milliwatts of power to the parafovea, outer macula and an area of circinate nasal to the fovea. Respondent documented "no neovascularization or IRMA seen." On this date, Respondent scheduled Patient G for further focal laser surgery to the left eye for August 19, 1995, and planned to have Patient G keep her June 3, 1995 appointment for focal laser surgery of the right eye. (Exh. 14, p. 110)

293. On June 3, 1995, Respondent performed laser surgery on Patient G's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the right eye using 561 shots of 50 microns and 50 to 350 milliwatts to the entire posterior pole and mid periphery. Respondent documented that some circinate rings were treated and that no neovascularization or IRMA was seen. On this date, Respondent planned to

have Patient G keep her previously scheduled appointment for focal laser surgery on August 19. 1995. (Exh. 14, p. 111)

294. On June 19, 1995, Patient G was seen in Respondent's office. Contact lens examination with biomicroscope of the right eye was documented as: RPE hyper and hypo pigmentation in and around flat fovea, blot hemorrhages intra retinal and fovea, no exudate present, appears flat, hard exudate inferotemporal to fovea in ring shape, hard exudate and blot hemorrhages scattered, some circinate rings, no neovascularization seen, disc negative, mid periphery-rare blot hemorrhage, few hard exudates scattered. Contact lens examination of the left eye was documented as: hard exudate into fovea temporal, blot hemorrhage rare, hard exudates nasal, fovea - RPE depigmentation in and around it, disc negative, scattered hard exudate and blot hemorrhages, circinate ring nasal to disc, rare soft exudate, mid periphery -scattered blot hemorrhages, no neovascularization seen, scattered hard exudate. (Exh. 14, pp. 73-74)

295. On October 18, 1995, Patient G was seen in Respondent's office. No examination of the retina was documented. (Exh. 14, pp.75-76)

296. On October 27, 1995, Respondent performed and documented Argon laser surgery on Patient G's left eye at Lakeshore Hospital, using 728 shots of 50 microns and 50 to 390 milliwatts to the entire posterior pole and mid periphery, mostly in paramacula areas. Respondent documented that "no neovascularization or IRMA was seen." (Exh. 14, p. 112)

297. Respondent performed 22 focal laser procedures on Patient G, 11 to each eye. . The number of focal laser procedures performed on Patient G was excessive. (Exhs. B, D; T. 39-34, 130, 590-591, 1493-1496, 1556-1557, 1623-1624, 1849-1851, 1919, 1935-1943, 2119)

298. During the course of 22 focal laser procedures, Respondent obtained two photographic studies. Fundus photographs and IVFA were obtained prior to initiation of the course of treatment and immediately before the last charged surgery. Further photographic studies should have been obtained to assist in the evaluation and treatment of Patient G and document the indications, if any, for surgery. (Exh. B, Exh. D; T. 22-23, 46, 131, 1476-1477, 1633, 2167-2168)

PATIENT H

299. When seen by Respondent on October 3, 1988, Patient H was a 62 year old male with a history of diabetes mellitus. On that date, indirect examination of the retina was documented as: negative for all categories in both eyes. Direct examination of the retina was documented as: right eye - disc, peripapillary, and fovea negative; left eye - hard exudate near disc, fovea and disc negative. Respondent diagnosed early background diabetic retinopathy of the left eye. (Exh. 18, pp. 4-5)

300. On April 16, 1990, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - hemorrhages negative, hard exudation above fovea, vessels normal, macula normal; left eye - rare blot hemorrhage, exudation negative, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc and peripapillary negative, fovea - hard exudate above fovea and nasal to it, one microaneurysm; left eye - fovea - negative, rare blot hemorrhage. Respondent diagnosed background diabetic retinopathy of both eyes and scheduled photographic studies for April 21, 1990. (Exh. 18, pp. 6-7)

301. Photographic studies were obtained on April 21, 1990. Respondent's documented interpretation of these studies was:

> Fundus photos - both eyes : background diabetic retinopathy
> IVFA : no neovascularization, disc OK, background diabetic retinopathy both eyes.

Respondent documented his plan to perform focal laser surgery on both eyes which had already been scheduled. (Exh. 18, p. 48)

302. G. Stewart Ray, M.D. interpreted the April 21, 1990 photographic studies as follows:

> Fundus photo OD - a circinate exudate is non threatening in the upper temporal quadrant and lower nasal.
> Fundus photo OS - appears normal.
> IVFA OD - four or five tiny aneurysms are present in the central macula with definite but minimal late leakage.
> IVFA OS - only a suspicion of tiny abnormalities is present.

Dr. Ray's overall impression was retinopathy probably diabetic, mild, with no evidence of clinicall significant macular edema. (Exh. 30[4]; T. 2325-2327)

303. On April 21, 1990, the same day as the photographic studies were performed, Patient H was seen in Respondent's office. A contact lens examination, inappropriately labeled "gonio" by Respondent, was documented as: right eye - fovea negative, disc negative, some areas of soft exudate and microaneurysm, hemorrhages, mid periphery negative, no neovascularization; left eye - fovea negative, scattered hemorrhages and exudates, disc OK. Respondent scheduled focal laser surgery for both eyes, right eye first. (Exh. 18, pp. 8-9)

---

[4] Dr. Ray's report incorrectly dates the April 21, 1990 studies as September 21, 1990.

304. On April 21, 1990, laser surgery was not indicated for either eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660, 1623-1624, 2134)

305. On May 26, 1990, Respondent documented performing Argon laser surgery for microvascular abnormalities (focal laser surgery) of the right eye on Patient H at Lakeshore Hospital, using 206 shots of 50 microns at 50 to 650 milliwatts to an undocumented area of the retina. (Exh. 18, p. 52)

306. On June 9, 1990, Respondent performed laser surgery on Patient H at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye using 103 shots of 50 microns at between 50 and 150 milliwatts of power to an undocumented area of the retina. (Exh. 18, p. 53)

307. On July 23, 1990, Patient G H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare fine blot hemorrhage, exudation negative, vessels normal, macula normal; left eye - occasional blot hemorrhage to below disc, exudation negative, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - negative, little hard exudate inferotemporal to disc, fovea - negative with hard exudate temporal to fovea; left eye - disc negative, peripapillary negative, hard exudate above fovea, fovea and parafovea negative. (Exh. 18, pp. 10-11)

308. On March 11, 1991, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as normal in both eye for all categories. Direct examination of the retina was documented as: right eye - fovea negative, disc negative,

peripapillary - rare blot hemorrhage; left eye - fovea, peripapillary, and disc negative. (Exh. 18, pp. 12-13)

309. On September 16, 1991, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: rare blot hemorrhages in both eyes, exudation, vessels, and macula normal in both eyes. Direct examination of the retina was documented as: right eye - fovea and disc-couple of blot hemorrhages inferior portion, no neovascularization, peripapillary-rare blot hemorrhage, hard exudate and microaneurysm superiotemporal; left eye - fovea and disc - negative, hard exudate well temporal with microaneurysm, peripapillary - rare blot hemorrhage, no neovascularization. At this visit, Respondent scheduled focal laser surgery of both eyes. (Exh. 18, pp. 14-15)

310. On September 16, 1991, laser surgery was not indicated for either eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660, 1623-1624, 2134)

311. On September 28, 1991, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) of Patient H's left eye at Lakeshore Hospital, using 222 shots of 50 microns at 50 to 370 milliwatts of power to the posterior pole. Respondent documented his plan to have Patient H keep his previously scheduled October 12, 1991 appointment for focal laser surgery of the right eye. (Exh. 18, p. 54)

312. On October 7, 1991, Patient H was seen in Respondent's office. No examination of the retina was documented. (Exh. 18, pp. 16-17)

313. On October 11, 1991, Respondent again performed laser surgery on Patient H at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser

surgery) of the right eye using 184 shots of 50 microns at 50 to 300 milliwatts to the posterior pole and the parafovea. (Exh. 18, p. 55)

314. On March 23, 1992, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: one blot hemorrhage below disc of the right eye, all other categories negative or normal for both eyes. Direct examination of the retina was documented as: right eye - rare blot hemorrhage, no neovascularization, fovea - blot hemorrhage temporal edge with previous treatment, microaneurysm superiotemporal, hard exudate; left eye - hard exudate just temporal to disc, no associated microaneurysms, few blot hemorrhages, few hemorrhage and exudate, hard exudate well above fovea-superiotemporal arcade with associated microaneurysm. Respondent scheduled focal laser surgery of the left eye with primary attention to "area of hard E just below superiotemporal arcade." (Exh. 18, pp. 18-19)

315. On March 23, 1992, laser surgery was not indicated for Patient H's left eye. (Exh. B, Exh. D; T.. 12-15, 144-145, 590-591, 601-611,660-661, 1623-1624, 2134)

316. On April 6, 1992, Patient H was seen in Respondent's office complaining that he could not see with his new glasses. No examination of the retina was documented. (Exh. 18, pp. 20-21)

317. On April 18, 1992, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) on Patient H's left eye at Lakeshore Hospital. He documented using 166 shots of 50 microns at a power range of 50 to 430 milliwatts to the posterior pole. (Exh. 18, p. 56)

318. On April 20, 1992, Patient H was seen in Respondent's office. No examination of the retina was documented. (Exh. 18, pp. 22-23)

319. On July 15, 1993, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare blot hemorrhages, exudation negative, vessels normal, macula negative; left eye - blot hemorrhage, hard exudate above and around fovea, vessels normal, macula negative. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - rare blot hemorrhage, rare microaneurysm, no neovascularization, hard exudate well below fovea treated, blot hemorrhage at bottom, fovea - RPE depigmentation, flat, no exudate, scattered blot hemorrhage in "p.p."; left eye - disc negative, no neovascularization, peripapillary - several blot hemorrhages, hard exudate, fovea - blot hemorrhage nasal edge with hard exudate above it, couple of microaneurysms, RPE depigmentation, flat, no "E" (edema). At this office visit, Respondent scheduled focal laser surgery of the left eye. (Exh. 18, pp. 24-25)

320. On July 15, 1993, focal laser surgery was not indicated for the left eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660-661, 1623-1624, 2134).

321. On July 23, 1993, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye on Patient H at Lakeshore Hospital, using 447 shots of 50 microns and 50 to 410 milliwatts of power to the entire posterior pole, especially over the foveal area. Respondent documented the absence of neovascularization and IRMA. (Exh. 18, p. 58)

322. On October 21, 1993, Patient G was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare blot hemorrhage, exudation negative,

vessels normal, macula normal; left eye - few blot hemorrhages, hard exudate above and below fovea, vessels normal, macula normal. Direct examination of the retina was documented as: right eye - disc negative, peripapillary - negative, no neovascularization, fovea -many hard exudate nasal to fovea, blot hemorrhage bottom fovea; left eye - disc negative, no neovascularization, peripapillary - scattered hard exudates, fovea-negative, blot hemorrhage nasal edge, lasered hard exudates, nasal and superior to that, hard exudate below fovea, (illegible) anomalies which are treated. At this office visit, Respondent scheduled Patient H for further focal laser surgery of both eyes. (Exh. 18, pp. 26-27)

323. On October 21, 1993, focal laser surgery was not indicated for either eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660, 1623-1624, 2134)

324. On November 27, 1993, Respondent performed laser surgery on Patient H at Lakeshore Hospital, documenting Argon laser for microvascular anomalies (focal laser surgery) of the right eye using 579 shots of 50 microns at 50 to 250 milliwatts to the posterior pole. Respondent documented the absence of neovascularization and IRMA. Respondent scheduled Patient H for further focal laser surgery of the right eye on March 4, 1994. (Exh. 18, p. 61)

325. On December 11, 1993, Respondent performed laser surgery on Patient H's left eye at Lakeshore Hospital. Respondent documented Argon laser for microvascular anomalies (focal laser surgery) of the left eye using 502 shots of 50 microns at 50 to 180 milliwatts of power to the posterior pole. Respondent documented that no neovascularization or IRMA was seen. On this date, Respondent scheduled Patient H for further focal laser surgery of the left eye in March 1994. (Exh. 18, p. 64)

326. On February 10, 1994, Patient H was seen in Respondent's office. Examination of the retina (indirect and direct) was documented as: right eye - peripapillary and disc - negative except few blot hemorrhages, rare hard exudate, no neovascularization, fovea - RPE changes or blot hemorrhages, direct - RPE hypo and hyper depigmentation in and around, hard exudate inferionasal and inferiotemporal; left eye - peripapillary - exudates scattered around perimeter of macula, scattered blot hemorrhage, disc negative, several hard exudate and blot hemorrhage, fovea - direct - RPE depigmentation in and around, flat, exudate in periphery in macula, hard exudate nasal to fovea, no neovascularization, flat. Respondent planned to have Patient H keep his March 1994 appointment for laser surgery, left or right eye unspecified. (Exh. 18, pp. 28-29)

327. On February 10, 1994, focal laser surgery was not indicated to either eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660-661, 1623-1624, 2134)

328. On April 15, 1994, Respondent performed laser surgery on Patient H's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) to the right eye using 620 shots 50 microns at 50 to 380 milliwatts to the entire posterior pole and "360" of the mid periphery. On this date, Respondent documented his plan to have Patient H keep an April 22, 1994 appointment for focal laser surgery of the left eye and a May 17, 1994 appointment for a fundus check. (Exh. 18, p. 68)

329. On April 22, 1994, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) on Patient H's left eye at Lakeshore Hospital, using 547 shots of 50 microns in the 100 to 550 milliwatt range to the macular area. Respondent

documented that no neovascularization or IRMA was seen. On this date, Respondent scheduled Patient H for further focal laser surgery to the left eye on July 23, 1994. (Exh. 18, p. 70)

330. On May 17, 1994, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - peripapillary and disc - disc negative, rare blot hemorrhage, fovea - blot hemorrhage in it; left eye - peripapillary and disc - few scattered blot hemorrhages, fovea - hard exudate above it. Direct examination of the retina was documented as: right eye - peripapillary and disc - few hard exudates, few blot hemorrhages, no neovascularization, fovea - slight RPE depigmentation in it, flat, no hemorrhage or exudate; left eye - peripapillary and disc - several areas of hard exudate, no neovascularization, fovea normal. At this office visit, Respondent planned to have Patient H keep his July 1994 appointment for focal laser surgery of the left eye. (Exh. 18, pp. 30-31)

331. On July 23, 1994, Respondent performed laser surgery on Patient H at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the left eye using 532 shots of 50 microns in the 50 to 360 milliwatt power range to the macula and paramacular areas. Respondent documented that no neovascularization or IRMA was seen. On this date, Respondent scheduled Patient H for another focal laser surgery to the left eye on October 22, 1994. (Exh. 18, p. 74)

332. On August 23, 1994, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare blot hemorrhages, fovea negative; left eye - peripapillary-scattered exudate superiotemporal to fovea, scattered blot hemorrhages, fovea negative. Direct examination of the retina was documented as: right eye - peripapillary-negative

except rare blot hemorrhages, no neovascularization seen, hard exudate well below fovea, fovea - RPE hypo and hyper depigmentation in and around flat, no "E" (edema), one tiny blot hemorrhage bottom of fovea; left eye - peripapillary-negative except few hard exudate and blot hemorrhages, no neo seen, patch of hard exudate superiotemporal to fovea, fovea - little RPE depigmentation in flat, no hemorrhage or exudate. At this office visit, Respondent planned to have Patient H keep his October 1994 appointment for laser surgery of the left eye. (Exh. 18, pp. 32-33)

333. On October 22, 1994, Respondent performed laser surgery on Patient H at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) and neovascularization (panretinal) of the retina of the left eye using 501 shots of 50 microns at 90 to 1000 milliwatts, to the macula and paramacular areas. Respondent documented that some "viny" neovascularization was treated focally in the inferiotemporal posterior pole. On this date, Respondent scheduled Patient H for focal laser surgery of the left eye on November 5, 1994. (Exh. 18, p. 77)

334. On November 5, 1994, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) and neovascularization (panretinal) of Patient H's left eye at Lakeshore Hospital, using 313 shots of 50 microns at 100 to 350 milliwatts to the entire posterior pole and entire mid periphery. Respondent documented that no IRMA or neovascularization was seen. (Exh. 18, p. 79)

335. On December 1, 1994, Patient H was seen in Respondent's office; indirect examination of the retina was documented as: right eye - peripapillary and disc-rare blot hemorrhage, fovea normal; left eye - peripapillary and disc-few scattered blot hemorrhages, fovea

normal. Direct examination of the retina was documented as: right eye - peripapillary and disc - negative, rare blot hemorrhages, few hard exudates, area of circinate two disc diameters nasal to disc, 3:30 meridian, fovea-few treated microaneurysms around it, RPE depigmentation in and around it flat; left eye - peripapillary and disc-rare blot hemorrhage, few hard exudate, no neovascularization, fovea - RPE depigmentation in it, flat, no hemorrhage or exudate. At this office visit, Respondent scheduled Patient H for focal laser surgery of the right eye. (Exh. 18, pp. 34-35)

336. On December 1, 1994, laser surgery to Patient H's right eye was not indicated. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660-661, 1623-1624, 2134)

337. On December 3, 1994, Respondent performed laser surgery on Patient H's right eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) to the right eye using 498 shots of 50, 100, 150, 200 and 300 microns and from 50 to 1000 milliwatts to two areas of circinate, one nasal and one inferiotemporal. Respondent documented that no neovascularization was seen. (Exh. 18, p. 83)

338. On March 9, 1995, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare blot hemorrhage, fovea - RPE depigmentation in and around it, flat; left eye - rare blot hemorrhage, fovea normal. Direct examination of the retina was documented as: right eye - peripapillary and disc - scattered blot hemorrhages, no neovascularization, rare hard exudate, fovea - slight RPE depigmentation in and around it, flat, no hemorrhage or exudate; left eye - disc and peripapillary - blot hemorrhage and hard exudates around, hard exudates inferiotemporal to fovea, fovea - few scattered blot hemorrhages, hard exudates well above fovea, slight RPE depigmentation in and around fovea, flat, no hemorrhage or

exudate, no neovascularization. A further notation states: left eye - hard exudate superiotemporal and hard exudate elsewhere. But for continuing vitamins, the treatment plan is illegible. (Exh. 18, pp. 36-37)

339. On June 13, 1995, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - rare blot hemorrhage, fovea essentially negative; left eye - rare blot hemorrhage, fovea negative. Direct examination of the retina was documented as: right eye - peripapillary and disc - rare blot hemorrhage, few hard exudates, no neovascularization, circinate ring well above disc, fovea - treated blot hemorrhages around it, slight RPE depigmentation in and around it, flat, no "E" (edema"), circinate ring inferiotemporal to fovea one disc diameter away; left eye - peripapillary and disc - negative no neovascularization, no neovascularization, fovea - few blot hemorrhages, few hard exudates, slight RPE depigmentation in and around it, flat, no hemorrhage or exudate. At this office visit, Respondent scheduled Patient H for focal laser surgery of the right eye "to reduce exudative process and stabilize vision." (Exh. 18, pp. 38-39)

340. On June 13, 1995, laser surgery was not indicated as an appropriate treatment for Patient H's right eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660-661, 1623-1624, 2134).

341. On June 24, 1995, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) to Patient H's right eye at Lakeshore Hospital, using 501 shots of 50 microns in the 50 to 500 milliwatt power range to the posterior pole and mid

periphery. Respondent documented that no neovascularization or IRMA was seen. (Exh. 18, p. 85)

342. On September 21, 1995, Patient H was seen in Respondent's office. Indirect examination of the retina was documented as: right eye - disc negative, no neovascularization, rar blot hemorrhage, fovea negative; left eye - rare blot hemorrhage, fovea negative. Direct examination of the retina was documented as: right eye - disc negative, no neovascularization, peripapillary - few scattered blot hemorrhages, fovea - RPE depigmentation in and around, blot hemorrhage temporal to it, flat, blot hemorrhage well superiotemporal; left eye - disc negative, neovascularization 5:30 meridian three disc diameter below disc, peripapillary - few blot hemorrhages, fovea very slight RPE depigmentation in and around, flat, no hemorrhage, hard exudate above fovea. At this office visit, Respondent scheduled laser surgery for both eyes. (Exh. 18, pp. 40-41)

343. On September 21, 1995, laser surgery was not indicated for either eye. (Exh. B, Exh. D; T. 141-144, 12-15, 129-130, 590-591, 660-661, 1623-1624, 2134)

344. On September 29, 1995, Respondent performed laser surgery on Patient H at Lakeshore Hospital, documenting Argon laser for microvascular anomalies (focal laser surgery) to the right eye using 425 shots of 50 microns at 100 to 410 milliwatts to the macular area with some shots elsewhere in the posterior and mid periphery for 360 degrees. (Exh. 18, p. 88)

345. On November 12, 1995, Respondent performed laser surgery on Patient H's left eye at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) and neovascularization (panretinal) of the retina of the left eye using 338 shots

of 50, 100, and 300 microns in the 50 to 290 milliwatt range to the entire posterior pole and mid periphery. Respondent documented that "neo" was treated directly. (Exh. 18, p. 92)

346. Respondent performed 17 separate laser surgeries on Patient H, seven procedures to the right eye and ten procedures to the left eye. Subsequent surgeries to a particular eye were scheduled without an intervening office examination. The number of focal laser procedures performed on Patient H was excessive. (Exhs. B, D; T. 39-34, 145, 590-591, 1493-1496, 1556-1557, 1623-1624, 1849-1851, 1919, 1935-1943, 2119)

347. Respondent performed photographic studies prior to initiating the course of treatment and not thereafter. (Exh. B, Exh. D; T. 22-23, 46, 131, 1476-1477, 1633, 2167-2168)

PATIENT I

348. Patient I was a 50 year male with a history of diabetes mellitus when first seen by Respondent on August 3, 1994, after having been struck in the right eye with a small particle while working. A corneal abrasion was diagnosed and Patient I was asked to return in one week. (Exh. 16, pp. 1-2)

349. On August 9, 1994, Patient I was seen in Respondent's office for follow-up. Indirect examination of the right eye only was documented as: peripapillary - rare blot hemorrhage, fovea negative, posterior pole and periphery is negative for 360 degrees without lesions or foreign bodies. (Exh. 16, pp. 3-4)

350. On August 23, 1994, Patient I was seen in Respondent's office for a two week follow- up and complete eye examination. Indirect examination of the retina was documented as: right eye - peripapillary - rare blot hemorrhage, fovea negative; left eye - peripapillary - hard

exudate superiotemporal to fovea, few blot hemorrhages, fovea negative. Direct examination of the retina was documented as: right eye - peripapillary - few scattered blot hemorrhages, no neovascularization seen, rare soft exudate, fovea - negative, few blot hemorrhages around fovea; left eye - peripapillary few blot hemorrhages, no neovascularization seen, fovea negative, few blot hemorrhages around fovea, rare (crossed out) hard exudate scattered, some superiotemporal to fovea. At this office visit, Respondent scheduled Patient I for focal laser surgery to the left eye with primary attention superiotemporal to the fovea. Photographic studies were neither requested nor obtained. (Exh. 16, pp. 5-6)

351. Focal laser surgery to the left eye was not indicated. The rare or scattered hard exudate, some superiotemporal to fovea, were not vision threatening and were not associated with clinically significant macular edema. No photographic studies were obtained. (Exh. 16; T. 153-155, 613-617)

352. On September 2, 1994, Respondent performed laser surgery on Patient I at Lakeshore Hospital. Respondent documented Argon laser surgery for microvascular anomalies (focal laser surgery) of the left eye, using 514 shots of 50 and 100 microns at 50 to 450 milliwatts to the macula. Respondent documented treatment of one neovascular frond superiotemporal to the fovea directly. On this date, Respondent scheduled Patient I for further focal laser surgery of the left eye on December 2, 1994, for possible "focal neo" of the left eye. (Exh. 16, p. 15)

353. On September 5, 1995, Patient I was seen in Respondent's office for an emergency visit, complaining that he woke up with intermittent double vision and a slight headache. Indirect examination of the retina was documented as: right eye - few scattered blot hemorrhages, fovea

negative; left eye - peripapillary and disc - rare blot hemorrhages mostly temporal to fovea, fovea - RPE changes. Direct examination of the retina was documented as: right eye - peripapillary and disc - scattered blot hemorrhages, no neovascularization, fovea -hard exudate above fovea, circinate ring, few blot hemorrhages around it; left eye - peripapillary and disc - no neovascularization, scattered blot hemorrhages; fovea - hard exudate above fovea, slight RPE depigmentation around fovea, few blot hemorrhages around frond of neovascularization superiotemporal to fovea. Respondent diagnosed proliferative diabetic retinopathy of the left eye and scheduled laser surgery for both eyes. Respondent noted that surgery of the right eye was "to control macula exudation especially above fovea" and that surgery of the left eye was for "focal neo" superiotemporal to the fovea to control neo and macular exudation. (Exh. 16, pp. 7-8)

354. On September 5, 1995, focal surgery may have been indicated to treat the circinate ring in Patient I's right eye, if the circinate ring was within 500 microns of the fovea and associated with clinically significant macular edema. Laser surgery to the left eye was not indicated. (T. 153-155, 613-617)

355. On September 15, 1995, Respondent documented performing Argon laser surgery for microvascular anomalies (focal laser surgery) and neovascularization of the retina (panretinal laser surgery) to Patient I's left eye at Lakeshore Hospital, using 947 shots of 50 microns at 50 to 390 milliwatts power to the entire posterior pole and mid periphery. Respondent noted that some neovascularization was treated in the superiotemporal arcade area four disc diameters out. Respondent documented that no neovascularization or IRMA was seen elsewhere. (Exh. 16, p. 18)

356. On September 22, 1995, Respondent performed laser surgery on Patient I at Lakeshore Hospital, documenting Argon laser surgery for microvascular anomalies (focal laser surgery) to the right eye using 1,136 shots of 50 microns to the entire posterior pole and mid periphery for 360 degrees, using 50 to 260 milliwatts power. Respondent documented that no neovascularization or IRMA was seen. (Exh. 16, p. 21)

357. Photographic studies should have been obtained prior to the initiation of treatment to aid in the evaluation and treatment of Patient I and to document the indications, if any, for surgery. (T. 155-157)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact set forth above. All conclusions were reached by unanimous vote of the Hearing Committee unless otherwise noted.

The Hearing Committee voted as set forth below. Citations in parenthesis refer to the Findings of Fact which support each factual allegation.

Paragraph A:	SUSTAINED
Paragraph A.1:	NOT SUSTAINED (by a vote of 2 to 1)
Paragraph A.2:	SUSTAINED
Paragraph A.3:	SUSTAINED
Paragraph A.4:	SUSTAINED
Paragraph B:	SUSTAINED
Paragraph B.1:	NOT SUSTAINED (2 to 1 vote)
Paragraph B.2:	SUSTAINED
Paragraph B.3:	SUSTAINED
Paragraph C:	SUSTAINED
Paragraph C.1:	NOT SUSTAINED (2 to 1 vote)
Paragraph C.2:	NOT SUSTAINED (2 to 1 vote)

Paragraph C.3:	SUSTAINED (2 to 1 vote)
Paragraph C.4:	SUSTAINED
Paragraph D:	SUSTAINED (2 to 1 vote)
Paragraph D.1:	SUSTAINED
Paragraph D.2:	SUSTAINED
Paragraph D.3:	SUSTAINED
Paragraph E:	SUSTAINED
Paragraph E.1:	Not requested
Paragraph E.2:	Not requested
Paragraph E.3:	NOT SUSTAINED
Paragraph E.4:	SUSTAINED
Paragraph E.5:	SUSTAINED
Paragraph G:	SUSTAINED
Paragraph G.1:	SUSTAINED
Paragraph G.2:	SUSTAINED
Paragraph G.3:	SUSTAINED
Paragraph H:	SUSTAINED
Paragraph H.1:	SUSTAINED
Paragraph H.2:	SUSTAINED
Paragraph H.3:	SUSTAINED
Paragraph I:	SUSTAINED
Paragraph I.1:	SUSTAINED
Paragraph I.2:	SUSTAINED
Paragraph I.3:	DROPPED

SPECIFICATIONS

FIRST THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

The Hearing Committee concluded that the following Specifications should be sustained. The paragraph references are the Factual Allegations which support each Specification.

First Specification:	The facts in Paragraphs A, A.2, A.3, A.4
Second Specification:	The facts in Paragraphs B, B.2, B.3,
Third Specification:	The facts in Paragraphs C, C.3, C.4
Fourth Specification:	The facts in Paragraphs D, D.1, D.2, D.3,
Fifth Specification:	The facts in Paragraphs E, E.4, E.5
Seventh Specification:	The facts in Paragraphs G, G.1, G.2, G.3,
Eighth Specification:	The facts in Paragraphs H, H.1, H.2, H.3,

(Specification #6 was withdrawn by the petitioner.)

TENTH THROUGH EIGHTEENTH SPECIFICATION
GROSS INCOMPETENCE

The Hearing Committee, by a unanimous vote, did not sustain the Tenth through Eighteenth speicifications.

NINETEENTH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

The Hearing Committee sustained the Nineteenth Specification based on the facts in Paragraphs A, A.2, A.3, A.4, B, B.2, B.3, C, C.3, C.4, D, D.1, D.2, D.3, E, E.4, E.5, G, G.1, G.2, G.3, H, H.I, H.2, H.3, I, I.1, and I.2.

TWENTIETH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

The Hearing Committee voted unanimously not to sustain the Twentieth Specification.

TWENTY-FIRST THROUGH TWENTY-EIGHTH SPECIFICATIONS
EXCESSIVE TREATMENT

Twenty-first Specification:	The facts in Paragraphs A, A.4
Twenty-second Specification:	The facts in Paragraphs B, B.3,
Twenty-third Specification:	The facts in Paragraphs C, C.4
Twenty-fourth Specification:	The facts in Paragraphs D, D.3,

Twenty-fifth Specification: The facts in Paragraphs E, E.5
Twenty-sixth Specification: The facts in Paragraphs G, G.3,
Twenth-seventh Specification: The facts in Paragraphs H, H.3,
The Hearing Committee did not sustain the Twenty-eighth Specification.

TWENTY-NINTH THROUGH FORTY-FIFTH SPECIFICATIONS
FRAUD

Twenty-ninth Specification: The facts in Paragraph A and A.3
Thirtieth Specification: The facts in Paragraph A and A.4
Thirty-first specification: The facts in Paragraph B and B.2
Thirty-second Specification: The facts in Paragraph B and B.3
Thirty-third Specification: The facts in Paragraph C and C.3
Thirty-fourth Specification: The facts in Paragraph C and C.4
Thirty-fifth Specification: The facts in Paragraph D and D.2
Thirty-sixty Specification: The facts in Paragraph D and D.3
Thirty-seventh Specification: The facts in Paragraph E and E.4
Thirty-eighth Specification: The facts in Paragraph E and E.5
Thirty-ninth Specification: The facts in Paragraph G and G.2
Fortieth Specification: The facts in Paragraph G and G.3
Forty-first Specification: The facts in Paragraph H and H.2
Forty-second Specification: The facts in Paragraph H and H.3
Forty-third Specification: The facts in Paragraph I and I.2
The Hearing Committee did not sustain the Forty-fourth Specification.

FORTY-FIFTH THROUGH SIXTIETH SPECIFICATIONS
MORAL UNFITNESS

Forty-fifth Specification: The facts in Paragraph A and A.3
Forty-sixth Speicification: The facts in Paragraph A and A.4
Forty-seventh Specification: The facts in Paragraph B and B.2
Forty-eighth Specifiction: The facts in Paragraph B and B.3
Forty-nonth Specification: The facts in Paragraph C and C.3
Fiftieth Specification: The Facts in Paragraph C and C.4

Fifty-first Specification:	The facts in Paragraph D and D.2
Fifty-second Specification:	The facts in Paragraph D and D.3
Fifty-third Specification:	The facts in Paragraph E and E.4
Fifty-fourth Specification:	The facts in Paragraph E and E.5
Fifty-fifth Specification:	The facts in Paragraph G and G.2
Fifty-sixth Specification:	The facts in Paragraph G and G.3
Fifty-seventh Specification:	The facts in Paragraph H and H.2
Fifty-eighth Specification:	The facts in Paragraph H and H.3
Fifty-ninth Specification:	The facts in Paragraph I and I.2

The Hearing Committee did not sustain the Sixtieth Specification.

DISCUSSION

Respondent was charged with 60 specifications alleging professional medical misconduct under Education Law Section 6530 in the care and treatment of nine patients. During the course of these proceedings, the allegations and specifications regarding Patient F were dropped, as were allegations E. 1 and 2 and I. 3. Education Law Section 6530 sets forth numerous forms of conduct which constitute professional misconduct but does not provide definitions. During its deliberations, the Hearing Committee employed the suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine set forth in the memorandum of NYS Department of Health General Counsel Henry M. Greenberg entitled "Definitions of Professional Misconduct Under the New York Education Law". They are:

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, which failure is manifested by conduct that is egregious or conspicuously bad.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of the profession.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that s/he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Respondent was also charged with eight specifications of providing excessive treatment and 16 specifications of moral unfitness. The Hearing Committee determined that **excessive treatment** is treating a patient after the patient required no further treatment, whose pathology was under control, or unnecessarily prolonging or extending treatment without medical justification. **Moral unfitness** is inferred from the totality of the circumstances of Respondent's care of the named patients.

Using these definitions as a framework, the Hearing Committee unanimously concluded that the Petitioner sustained its burden of proof regarding the majority of the charges brought against Respondent, by a preponderance of the evidence. The rationale for the Committee's determination that Respondent's treatment of each of the patients presented during the hearing failed to meet acceptable standards of medical care follows. Because the record establishes a common pattern in the Respondent's treatment of these patients, this discussion will address the factors common to

these patients which the Hearing Committee found especially persuasive and relied upon in making its determination.

The Hearing Committee first determined the credibility of the parties' witnesses. Petitioner presented Edward Stroh, MD, a board certified ophthalmologist specializing in retinal disease, whose practice is limited to vitreoretinal diseases. (Exh.20) Dr. Stroh had reviewed portions of Respondent's patients' records out of order and somewhat piecemeal from Petitioner, and had provided three written reports on these patients to Petitioner as the various pieces of patient records were given to him for review. Nevertheless, Dr. Stroh's testimony covered each patient's entire record. The Committee did not rely upon Dr. Stroh's written reports, but rather upon his testimony. The Hearing Committee found Dr. Stroh's testimony credible and thorough, although he was unusually and unnecessarily obstructive under cross-examination. This unfortunately prolonged and needlessly complicated the hearing of this case.

For reasons which the Hearing Committee need not determine, neither the original nor copies of color photographic studies or fluorescein angiogram studies performed on the patients in this case were provided to the Petitioner or made available until presentation of Respondent's case. Consequently, although he had reviewed the reports of these studies contained in patient records, Dr. Stroh was unable to testify from the studies themselves. The Hearing Committee felt the studies would be helpful in reaching a determination, and so they were admitted into evidence as part of Respondent's case. They were made available to Petitioner for its review.

Petitioner presented G. Stewart Ray, MD, a board certified ophthalmologist and Professor of Ophthalmology at Albany Medical College (Exh. 29), who had reviewed and commented in

writing (Exh. 30) upon the original color photographic studies and fluorescein angiogram studies Respondent had made available during the hearing. Dr. Ray's report and testimony were limited to interpreting the photographic studies. The Hearing Committee found Dr. Ray highly qualified ar his testimony highly credible and thorough in every respect.

Respondent presented three expert witnesses, all of whom the Hearing Committee found extremely well-qualified and uniformly helpful. Dilip Patel, M.D. is a board certified ophthalmologist with specialized training in retina and vitreous diseases. He is Associate Clinical Professor of Ophthalmology at the State University of New York at Buffalo, and has known Respondent both as a resident in ophthalmology at Veterans Hospital in Buffalo and later as a practicing ophthalmologist. Peter W. Forgach, MD., is a board certified ophthalmologist subspecializing in the treatment of retinal disease who practices in the Buffalo area, where he is associated with the Daughters of Charity, Sister's Hospital and the Millard Fillmore Hospital. James V. Aquavella, M.D., is a Clinical Professor of Ophthalmology at the University of Rochester who practices ophthalmology specializing in corneal and anterior segment diseases in the Rochester area. All three experts have known Respondent professionally. Dr. Patel and Dr. Forgach testified that they had reviewed and discussed the patient records with Respondent personally prior to testifying. Dr. Aquavella also gave testimony about his own treatment of Patient C in this case.

Respondent testified extensively about his care and treatment of these eight patients. He explained his somewhat personal laser treatment methodology in detail. Respondent said he would commence each focal treatment near the fovea with 50 micron-size shots at 50 or 100 milliwatts of power, in order to avoid causing patients pain or unnecessary treatment. Similarly in panretinal

photocoagulation, Respondent's operative records show that in doing pan retinal photocoagulation he would typically use no larger than 300 micron size shots in the mid and far periphery, rather than the 400, 500, or 600 micron sizes Dr. Patel and Dr. Stroh testified using. In order to perform a full panretinal photocoagulation treatment, then, Respondent would need more shots than the usual number a clinician would typically require; use of so many shots would require many more treatment sessions for Respondent's patients, and consequently extend the course of treatment over time. Respondent testified that, although his methodology resulted in many more laser "shots" than traditional treatment, perhaps only one shot in five resulted in a therapeutic burn to the patient. Therefore, he argued, the numbers of shots recorded for treatment of each patient could not be relied upon as a measure of whether treatment given was excessive. (T.701-711) In explaining why patients whom he had treated with hundreds of laser shots showed, upon fluorescein angiographic study, few if any laser burns or hard exudation left behind by treated microaneurysms Respondent testified that his Meditec dye laser machine had a special ability to erase microaneurysms leaving no trace of a laser burn. (T.686-7) At power less than 200 milliwatts, Respondent testified, the Meditec dye laser he used until 1996 delivered only about 30% of the power displayed. Further reduction in power delivered resulted from aging of the laser machine's dye. (T.701- 711)

Dr. Stroh testified that use of a 50 micron spot size at 50 milliwatts of power would not result in a laser spot to the retina. Sometimes a laser spot can result at 90 or 100 milliwatts, he said. (T. 589, 132-133) Extrapolating from Respondent's tesimony that his Meditec laser delivered only 30% of the power displayed, 50 microns at less than 300 milliwatts of power would not effect a

burn and therefore would be sub-therapeutic (300 milliwatts x 30%= 90 milliwatts delivered). Numerous treatments Respondent gave these patients were documented in their records at settings which would be entirely or partially non-therapeutic

With regard to the charges that, in treating Patients A, B, C, D, E, H, and I, Respondent should have obtained more frequent fundus photographic studies and fluorescein angiography, which would have documented medical justification, or lack thereof, for laser surgery, as well as provided the clinician with more detail, in some instances, of the location of disease processes, Respondent testified that using the contact lens during treatment provided him with as much or better information than such studies. However, both Respondent's and Petitioner's experts testified as to the benefits of these studies in cases as apparently intractable as those under consideration in this case. In addition, Respondent testified that many patients would not tolerate the studies, although there was no evidence of patient non-compliance in Respondent's records of these patients' care.

With the exceptions noted in specific findings of fact for particular patients set forth above, the Hearing Committee found that, generally, the photographic studies which were performed did not establish medical justification for the laser treatments which followed. Further, if these patients were suffering from intractable disease processes such as to require the extensive and extended laser treatments Respondent gave, the patients could have benefitted from angiography. All the expert witnesses testified that, in addition to documenting a patient's condition for the record, photographic and angiographic studies can aid the clinician in determining the source of recurring macular edema, hemorrhages or neovascularization. Absent patient refusal, a prudent physician

would employ every tool available in pursuit of a successful treatment. As a result, the Committee reached the conclusion that Respondent did not obtain or perform further such studies because they would only have served to document the lack of medical justification for treatment. With regard to Patients A, B, C, and E the Committee determined that the studies Respondent obtained were sufficient, given the lack of other indications for laser treatment. In other words, Respondent need not have put the patients through further studies to confirm that there was not sufficient medical justification to treat them. However, with regard to Patients D, G, H and I, the Committee determined that additional studies might have served to justify surgeries performed (D), or would certainly have aided Respondent in his treatment of the patient (G and H), or that, in the case of Patient I, the failure to obtain a fluorescein angiographic study prior to commencing a course of laser treatment was substandard .(T.151-157)

The Hearing Committee recognized that it is possible that medical justification for surgical intervention may be present but just not recorded by the clinician from time to time. Further, the Hearing Committee recognized that occasionally the clinician may use her or his judgment that a patient, although not displaying the classic indications for a particular treatment, may in fact benefit from such treatment because of circumstances unique to that patient and known to the clinician. However, the repeated failure to record such justification, either upon office examination or in operative notes throughout the course of Respondent's treatment of these eight patients requires the conclusion that the medical justification was indeed lacking. Except as specifically set forth in the findings above regarding particular laser surgeries, the only evidence in the record upon which to find medical justification is the Respondent's own testimony. Occasionally, Respondent's

testimony was supported by his expert witness' general statements that the clinician is the best judge of whether treatment is needed. Respondent's experts were hard pressed to find justification in the patients' medical records for the extensive treatment given, but did corroborate Respondent's testimony upon occasion. On balance, the Hearing Committee did not find such testimony entirely credible.

With regard to the First through Fifth and Seventh through Ninth specifications of Gross Negligence, in weighing the evidence presented regarding the Respondent's treatment of each of the eight individual patients, the Hearing Committee judged that Respondent failed to meet acceptable standards of medical care, and was therefore negligent in each patient's case. The Hearing Committee also considered the specification of gross negligence with regard to each individual patient. Because of the many instances where Respondent rendered non-therapeutic treatments, or performed treatments which were not medically indicated, or performed excessive numbers of treatments, the Hearing Committee sustained the charge of gross negligence with regard to each individual patient. The Hearing Committee was convinced by the sheer weight of the instances of negligence that the charge of gross negligence must be sustained.

With regard to the Twenty-first through Twenty-seventh Specifications of excessive treatment, based on the preponderance of credible evidence in the record the Hearing Committee concluded that Respondent treated each of these patients when the medical justification for such treatment was lacking, sometimes after the patient required no further treatment because his or her pathology was under control, or unnecessarily prolonged or extended treatment without

documenting any medical justification. Respondent's argument that his treatments were not excessive because his patients' vision was not harmed does not hold weight here, since the reason he did not harm their vision is that in many instances his treatments were completely non-therapeutic. In any event, causing physical harm is not an element of the charges in this case.

The Twenty-ninth through the Forty-third Specifications charge fraud. Fraud is an intentional misrepresentation or concealment of a known fact. Intent can be inferred from the facts in evidence. The credible evidence in this case clearly establishes that Respondent induced these eight patients to submit to laser surgeries which were not medically indicated. He scheduled and then performed invasive and potentially harmful procedures upon the eyes of his trusting patients, for the most part elderly individuals whose general health was often precarious. The Hearing Committee found that some of the laser surgeries Respondent performed on these patients were indeed medically indicated. Respondent probably did arrest the disease processes in these patients. However, those patients who did, in fact, have conditions requiring laser treatment were subjected to more surgeries than should have been needed because Respondent delivered so many sub-therapeutic doses. Many procedures were performed without any documented medical justification. Timely photographic testing and documentation of patients' disease processes were not done in most cases, the Committee found, in order to leave no record of the lack of medical justification for subsequent treatment. The Hearing Committee concluded that Respondent intended to mislead his patients as to the need for laser treatment, the number of necessary treatments, as well as the frequency and efficacy of the treatments, and thus his treatment of these patients was fradulent.

With regard to the Forty-fifth through Fifty-ninth Specifications of Moral Unfitness. The Hearing Committee determined that Respondent's repeated pattern of gross negligence and fraudulent practice, during the approximately six years involved in this case, were evidence of moral unfitness to practice medicine in the State of New York. The Committee found no evidence that Respondent had insight into his behavior, inescapable under the weight of the evidence amassed against him. Rather he tried to evade the import of such evidence and place the responsibility elsewhere. For example, regularly scheduling successive surgeries six weeks or more apart, improperly recording "gonio" when a less expensive exam had in fact been performed, and failing to record clinically significant findings for laser surgery were blamed repeatedly upon circumstances outside the Respondent's control. In sum, Respondent's failure to accept responsibility for any of his actions, in addition to the volume of egregiously negligent treatment of his vulnerable patients, led the Committee to conclude that Respondent is morally unfit to practice medicine.

DETERMINATION AS TO PENALTY

Pursuant to the Findings of Fact and Conclusions of Law set forth above, the Hearing Committee unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked and a monetary penalty imposed. This determination was reached upon due consideration of the penalties available pursuant to statute, including revocation, suspension and/or probation for a period of time, censure and reprimand, and/or the imposition of a monetary penalty.

The credible evidence in the record establishes a clear and consistent pattern of conduct by Respondent in the care and treatment of every named patient in this case. Inflicting repeated laser treatments without medical justification, extending a course of treatment through the use of sub-therapeutic laser doses -- even if no "harm" resulted to his patients' vision --, requiring patients to undergo unnecessary treatments for conditions they in many instances did not have, evidences a cruel destain for the medical and psychological welfare of these patients.

The Committee did not find the Respondent incompetent; the Committee found that he in fact knew what he was doing. He carefully undertreated so as to avoid damaging patients' eyes while performing unnecessary laser treatments. This is gross negligence in the treatment of the named patients and fraud upon them, such as to evidence moral unfitness to practice medicine in th State of New York. The Committee determined that neither a period of retraining nor restricted practice, with or without monitoring or probation, would be likely to correct this behavior and adequately assure that the public's trust is protected. While a period of suspension would remove the risk to the public temporarily, it would not provide a long-term solution to the problems posed by this Respondent's behavior in the practice of medicine. Therefore, the Committee determined that Respondent's license to practice should be revoked and a monetary penalty of $3000 per proven specification should be imposed.

ORDER

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

1. The First through Fourteenth, Nineteenth, Twenty-first through Twenty-seventh, Twenty-ninth through Forty-third, and Forty-fifth through Fifty-ninth Specifications of professional misconduct as set forth in the Statement of Charges (Exh.1) are **SUSTAINED;**

2. The Fifteenth, Twentieth, Twenty-eighth, Forty-fourth, and Sixtieth Specifications of professional misconduct are **DISMISSED;**

3. Respondent's license to practice medicine as a physician in the State of New York be and hereby is **REVOKED,** commencing on the effective date of this Determination and Order; and

4. Respondent is hereby ordered to pay a monetary penalty of $3,000 per Specification Sustained, totaling One Hundred Fifty-Six Thousand Dollars ($156,000.00).

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

DATED: Rochester, New York
December 5, 1999

DONALD CHERR, M.D. (CHAIR)

GEORGE C. SIMMONS, Ed.D.
CHARLES J. VACANTI, M.D.

TO:

Kevin C. Roe, Esq.
Associate Counsel
New York State Department of Health
Corning Tower Building - Room 2509
Empire State Plaza
Albany, NY 12237

Paul Steckmeyer, M.D.
17 Long Avenue
Hamburg, NY 14075

Gregory Stamm, Esq.
Stamm, Reynolds & Stamm
Attorneys for the Respondent
5555 Main Street
Williamsville, NY 14222

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
PAUL J. STECKMEYER, M.D.	:	CHARGES

----------X

PAUL J. STECKMEYER, M.D., the Respondent, was authorized to practice medicine in New York State on May 1, 1974, by the issuance of license number 119916 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached appendix) from on or about January 1990 to on or about November 1995 at his office, 17 Long Avenue, Hamburg, New York, and/or Lake Shore Hospital, Inc., 845 Routes 5 and 20, Irving, New York, for ophthalmic complaints. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.
2. Respondent performed focal laser photocoagulation (FLP) procedures without adequate medical justification.
3. Respondent performed panretinal photocoagulation (PRP) procedures without adequate medical justification.

4. Respondent performed an excessive number of PRP procedures on Patient A.

B. Respondent treated Patient B from on or about February 1990 to on or about January 1995 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

2. Respondent performed PRP procedures without adequate medical justification.

3. Respondent performed an excessive number of PRP procedures on Patient B.

C. Respondent treated Patient C from on or about October 1991 to on or about March 1996 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

2. Respondent performed cyclodiathermy and/or cyclodialysis on October 25, 1991, without adequate medical justification.

3. Respondent performed PRP procedures without adequate medical justification.

4. Respondent performed an excessive number of PRP procedures on Patient C.

D. Respondent treated Patient D from on or about April 1991 to on or about June 1994 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

2. Respondent performed FLP procedures without adequate medical justification.

3. Respondent performed an excessive number of FLP procedures on Patient D.

E. Respondent treated Patient E from on or about June 1992 to on or about May 1996 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to undertake an adequate trial of oral and/or topical medications prior to Argon laser trabeculoplasty.

2. Respondent performed Argon laser trabeculoplasty on October 23, 1992, without adequate medical justification.

3. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

4. Respondent performed FLP procedures without adequate medical justification.

5. Respondent performed an excessive number of FLP procedures on Patient E.

F. Respondent treated Patient F from on or about September 1992 to on or about May 1996 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care, in that:

1. Respondent performed Argon laser trabeculoplasty on January 8, 1993, without adequate medical justification.

G. Respondent treated Patient G from on or about February 1989 to on or about June 1996 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.
2. Respondent performed FLP procedures without adequate medical justification.
3. Respondent performed an excessive number of FLP procedures on Patient G.

H. Respondent treated Patient H from on or about July 1988 to on or about August 1996 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient H failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

2. Respondent performed laser photocoagulation procedures without adequate medical justification.

3. Respondent performed an excessive number of laser photocoagulation procedures on Patient J.

I. Respondent treated Patient I from on or about August 1994 to on or about September 1995 at his office and/or Lake Shore Hospital, Inc., for ophthalmic complaints. Respondent's care and treatment of Patient I failed to meet acceptable standards of medical care, in that:

1. Respondent failed to order, perform, and/or obtain fundus photographs and/or fluorescein angiography in a timely manner.

2. Respondent performed PRP procedures without adequate medical justification.

3. Respondent performed an excessive number of PRP procedures on Patient I.

SPECIFICATIONS

FIRST THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4)(McKinney Supp. 1998) in that, Petitioner charges:

1. The facts in Paragraphs A and A.1, A.2, A.3, and/or A.4.

2. The facts in Paragraphs B and B.1, B.2, and/or B.3.

3. The facts in Paragraphs C and C.1, C.2, C.3, and/or C.4.

4. The facts in Paragraphs D and D.1, D.2, and/or D.3.

5. The facts in Paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.

6. The facts in Paragraphs F and F.1.

7. The facts in Paragraphs G and G.1, G.2, and/or G.3.

8. The facts in Paragraphs H and H.1, H.2, and/or H.3.

9. The facts in Paragraphs I and I.1, I.2, and/or I.3.

TENTH THROUGH EIGHTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6)(McKinney Supp. 1998) in that, Petitioner charges:

10. The facts in Paragraphs A and A.1, A.2, A.3, and/or A.4.

11. The facts in Paragraphs B and B.1, B.2, and/or B.3.

12. The facts in Paragraphs C and C.1, C.2, C.3, and/or C.4.

13. The facts in Paragraphs D and D.1, D.2, and/or D.3.

14. The facts in Paragraphs E and E.1, E.2, E.3, E.4, and/or E.5.

15. The facts in Paragraphs F and F.1.

16. The facts in Paragraphs G and G.1, G.2, and/or G.3.

17. The facts in Paragraphs H and H.1, H.2, and/or H.3.

18. The facts in Paragraphs I and I.1, I.2, and/or I.3.

NINETEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of New York Education Law §6530(3)(McKinney Supp. 1998) in that, Petitioner charges two or more of the following:

19. The facts in Paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2, B.3; C and C.1, C.2, C.3, C.4; D and D.1, D.2, D.3; E and E.1, E.2, E.3, E.4, E.5; F and F.1; G and G.1, G.2, G.3; H and H.1, H.2, H.3; I and I.1, I.2, I.3.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5)(McKinney Supp. 1998) in that, Petitioner charges two or more of the following:

20. The facts in Paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2, B.3; C and C.1, C.2, C.3, C.4; D and D.1, D.2, D.3; E and E.1, E.2, E.3, E.4, E.5; F and F.1; G

and G.1, G.2, G.3; H and H.1, H.2, H.3; I and I.1, I.2, I.3.

TWENTY-FIRST THROUGH TWENTY-EIGHTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with ordering excessive treatment not warranted by the condition of the patient in violation of N.Y. Education Law §6530(35)(McKinney Supp. 1998) in that, Petitioner charges:

21. The facts in Paragraphs A and A.4.
22. The facts in Paragraphs B and B.3.
23. The facts in Paragraphs C and C.4.
24. The facts in Paragraphs D and D.3.
25. The facts in Paragraphs E and E.5.
26. The facts in Paragraphs G and G.3.
27. The facts in Paragraphs H and H.3.
28. The facts in Paragraphs I and I.3.

TWENTY-NINTH THROUGH FORTY-FOURTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently in violation of New York Education Law §6530(2)(McKinney Supp. 1998) in that, Petitioner charges:

29. The facts in Paragraphs A and A.3.

30. The facts in Paragraphs A and A.4.

31. The facts in Paragraphs B and B.2.

32. The facts in Paragraphs B and B.3.

33. The facts in Paragraphs C and C.3.

34. The facts in Paragraphs C and C.4.

35. The facts in Paragraphs D and D.2.

36. The facts in Paragraphs D and D.3.

37. The facts in Paragraphs E and E.4.

38. The facts in Paragraphs E and E.5.

39. The facts in Paragraphs G and G.2.

40. The facts in Paragraphs G and G.3.

41. The facts in Paragraphs H and H.2.

42. The facts in Paragraphs H and H.3.

43. The facts in Paragraphs I and I.2.

44. The facts in Paragraphs I and I.3.

FORTY-FIFTH THROUGH SIXTIETH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine in violation of New York Education Law §6530(20)(McKinney Supp. 1998) in that, Petitioner charges:

45. The facts in Paragraphs A and A.3.

46. The facts in Paragraphs A and A.4.

47. The facts in Paragraphs B and B.2.

48. The facts in Paragraphs B and B.3.

49. The facts in Paragraphs C and C.3.

50. The facts in Paragraphs C and C.4.

51. The facts in Paragraphs D and D.2.

52. The facts in Paragraphs D and D.3.

53. The facts in Paragraphs E and E.4.

54. The facts in Paragraphs E and E.5.

55. The facts in Paragraphs G and G.2.

56. The facts in Paragraphs G and G.3.

57. The facts in Paragraphs H and H.2.

58. The facts in Paragraphs H and H.3.

59. The facts in Paragraphs I and I.2.

60. The facts in Paragraphs I and I.3.

DATED: October 22, 1998
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct