STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

February 10, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

PUBLIC

E. Marta Sachey, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2503
Albany, New York 12237

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

V. Georges Hufnagel, M.D.
433 South Beverly Drive
Beverly Hills, California 90212

Robert H. Harris, Esq.
Schneider, Harris & Harris
1015 Broadway
Woodmere, New York 11598

RE: In the Matter of V. Georges Hufnagel, M.D.

Dear Ms. Sachey, Mr. Scher, Dr. Hufnagel and Mr. Harris:

Enclosed please find the Determination and Order (No. 98-33) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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/sc

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

-OF-

V. GEORGES HUFNAGEL, M.D.

Respondent

DETERMINATION

AND

ORDER

BPMC-98-33

A Notice of Referral Proceeding and Statement of Charges, both dated May 8, 1997, were served upon the Respondent, V. Georges Hufnagel, M.D. **BENJAMIN WAINFELD, M.D. (Chair), ANTHONY CLEMENDOR, M.D. and DANIEL W. MORRISSEY, O.P.** , duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter "the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ESQ., ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Henry M. Greenberg, General Counsel, E. Marta Sachey, Esq., Associate Counsel of counsel. The Respondent appeared by Wood & Scher, Anthony Z. Scher, Esq. of counsel and Schneider, Harris & Harris, Robert H. Harris, Esq., of counsel. Evidence was received, statements were heard and transcripts of these proceedings were made.

After consideration of the entire record, the Committee issues this Determination and Order.

STATEMENT OF CASE

This case was brought pursuant to Public Health Law Section 230(10)(p). This statute provides for an expedited proceeding where a licensee is charged solely with a violation of Education Law Section 6530(9). In such cases, a licensee is charged with misconduct based upon prior professional disciplinary action or criminal conviction. The scope of this expedited proceeding is limited to a determination of the nature and severity of the penalty to be imposed upon the licensee.

In the instant case, Respondent is charged with professional misconduct pursuant to Education Law § 6530(9)(b) (having been found guilty of professional misconduct by a duly authorized professional disciplinary agency of another state). The charges herein arise from Respondent having been found guilty of professional misconduct by the Division of Medical Quality, Board of Medical Quality Assurance, Dept. of Consumer Affairs, State of California (hereinafter the California Board) whereupon her license to practice medicine in California was revoked. The Respondent's misconduct included gross negligence, incompetence, falsification of documents related to the practice of medicine, creating false medical records with fraudulent intent, committing acts of dishonesty or corruption and excessive use of diagnostic procedures, The allegations in this proceeding are set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix One.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to exhibits. These citations represent

evidence found persuasive by the Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. V. Georges Hufnagel, M.D. (hereinafter, "Respondent"), was licensed to practice medicine in New York State on August 24, 1979, by the issuance of license number 139500 by the New York State Education Department. (Ex. 1)

2. On or about August 14, 1989, the California Board issued a Decision revoking Respondent's California Physician's and Surgeons Certificate. The revocation took effect in September of 1996. (Exs. 5 and 6)

3. The California Board found that the Respondent had committed acts which constituted unprofessional conduct. (Ex. 5)

4. The actions which were found by the California Board to constitute unprofessional conduct included submitting false insurance reports and/or claims for reimbursement; performing second surgical procedures on patients too soon after the initial surgery; failing to clearly inform a patient of all surgical options; failing to perform a hysterectomy when it was indicated; performing unnecessary surgery; recommending unnecessary surgeries; unnecessary hospitalization of patients; creating false medical records; negligent and incompetent performance of surgery; and excessive use of diagnostic procedures. (Ex. 5)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Committee unless noted

otherwise.

The Committee concluded that the Department has sustained its burden of proof in this matter. The preponderance of the evidence demonstrates that Respondent was found guilty of professional misconduct by a duly authorized professional disciplinary agency. The underlying conduct which resulted in the Respondent's revocation of her license to practice medicine would, if committed in New York, constitute professional misconduct under New York law. Specifically, the Committee found the Respondent's actions would fall within the definitions of misconduct set forth at N.Y. Education Law §6530(2) (Practicing the profession fraudulently), N.Y. Education Law §6530(4) (Gross negligence), N.Y. Education Law §6530(5) (Incompetence on more than one occasion), N.Y. Education Law §6530(21) (Willfully making or filing a false report) and N.Y. Education Law §6530(35) (Ordering of excessive tests or treatment).

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be **revoked.** This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee consideration of what penalty to impose started with the acceptance of the California decision and the underlying findings of fact. The Committee

found the fraudulent acts committed in California to be of a very serious nature and a serious breach of acceptable professional conduct. The Committee views such conduct as evidence of a lack of moral fitness for the practice of medicine. The Committee also found the Respondent's acts of misconduct relating to her medical treatment of patients to represent a threat to the medical consumer in this state. It is the Committee's duty to protect the consumers of medical services of this state. The practice of medicine is a privilege to be bestowed on those who warrant it. The Respondent has showed that she does not possess the necessary good moral character to be allowed to exercise this privilege. The Committee unanimously determined that a person capable of such conduct should not be afforded the privilege of practicing medicine in New York and that revocation is the only appropriate sanction under the circumstances.

The Committee found some of the Respondent's responses to their questions either evasive or not credible. Specifically those questions relating to her medical education residency, current office operation, the number of times she was married and her past mistreatment and its relevance to this proceedings. The Committee did not find any new evidence with respect to the prior fraudulent behavior which would lead them to conclude there was no possibility of it happening again. The Respondent never assumed responsibility for her own actions. Although the Respondent acknowledged her psychological impairment she has not taken any action to obtain treatment. When an illness has an impact on a physician's ability to practice it is the Committee's duty to take steps to protect the public.

ORDER

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

1. The single Specification of professional misconduct, as set forth in the Statement of Charges (Appendix I) is **SUSTAINED**;

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

DATED: New York, New York
2/5 **, 1998**

BENJAMIN WAINFELD, M.D. (CHAIR)
Anthony Clemendor, M.D.
Daniel W. Morrissey, O.P.

TO: **E. Marta Sachey, Esq.**
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
Corning Tower Building - Rm. 2503
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Anthony Z. Scher, Esq.
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The Harwood Building
Scarsdale, New York 10583

Robert H. Harris, Esq.
Schneider, Harris & Harris
1015 Broadway
Woodmere, New York 11598

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
V. GEORGES HUFNAGEL, M.D.	:	CHARGES

----------X

V. GEORGES HUFNAGEL, M.D., the Respondent, was authorized to practice medicine in New York State on August 24, 1979 by the issuance of license number 139500 by the New York State Education Department. Respondent currently is registered with the New York State Education Department to practice medicine for the period March 1, 1997 through February, 1999 with a registration address of 433 South Beverly Drive, Beverly Hills, California 90212.

FACTUAL ALLEGATIONS

1. The State of California Board of Medical Quality Assurance, by Order dated August 14, 1989, inter alia, found Respondent guilty of gross negligence in violation of California Business and Professions Code §2234(b) with regard to two patients, of incompetence in violation of California Business and Professions Code §2234(d) with regard to six patients, in violation of California Business and Professions Code §2234(e) which provides that unprofessional conduct includes "[t]he commission of any act involving dishonesty or corruption which is substantially related to

the qualifications, functions, or duties of a physician and surgeon" with regard to nine patients, in violation of California Business and Professions Code §2261 which provides that unprofessional conduct includes "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine ...which falsely represents the existence or nonexistence of a state of facts ..." with regard to six patients, and in violation of California Business and Professions Code §725 which provides that unprofessional conduct includes "...[r]epeated acts of clearly excessive use of diagnostic procedures ..." with regard to one patient.

2. More specifically, the California Board's determination that Respondent committed acts constituting unprofessional conduct, inter alia, included the following:

- Respondent, with regard to Patient Marsha C., attempted to suture a uterine laceration and perforation on the asymptomatic patient seven days after the patient underwent a suction curettage for an incomplete abortion, performed a uterine suspension despite uterine inflammation and potential infection, recorded in the operative report that fetal tissue was present in the abdomen when it was not, and billed for procedures and treatments not performed including enterotomy/large bowel, suture of intestine, biopsy of ovary and trachelorrhaphy.

- Respondent, with regard to Patient Jolina A., performed two non-emergency surgeries on two consecutive days, on the first a laparoscopy and liver biopsy and on the second a hysteroscopy, dilation of the cervix, currettage of the uterus, cervical laser and urethral dilation, and billed twice for the dilation and currettage, billed twice for a comprehensive history when one was only done and that by another physician, billed for a bowel

exploration which was not performed and billed for a liver biopsy that was done by another.

- Respondent, with regard to Patient Rama H., failed to perform a hysterectomy despite post surgical findings of a large leiomyomata uteri, adenomyosis and endometriosis and the patient's persistent menometrorrhagia following Respondent's performance of an exploratory laparotomy and other procedures, failed to provide the patient a clear option regarding treatment choices, and billed for an enterotomy and endometrial biopsy which were not performed.

- Respondent, with regard to Patient Jan L., sent the patient a letter discussing the patient's "fibroid tumors" and recommending "direct evaluation" to "avoid a hysterectomy" after the patient had secured a second opinion and after a second ultrasound which conflicted with a prior one regarding a possible fibroid tumor and after the patient cancelled her pre-operative appointment with Respondent because of the conflicting information. The California Board characterized Respondent's letter as "an instrument of terror contemplated by [R]espondent to coerce the patient into returning for several procedures which [R]espondent had every reason to believe were unnecessary."

- Respondent, with regard to Patient Christine S., wedged out further uterine tissue despite the diagnosis of adenomyosis during a February 1986 operation, excised fatty adhesions from the posterior fundus for cosmetic reasons which would further increase the risk of more adhesions during a June 1986 operation, and ordered excessive laboratory tests during the patient's February 1986 hospital admission.

- Respondent, with regard to Patient Marsha W., billed for procedures not performed, such as ventral hernia repair and laparoscopy, charged twice for a bilateral salpingoplasty when only one was done and listed on the insurance billing diagnoses of endometriosis and adenomyosis when Respondent knew or had reason to know the diagnoses were untrue.

- Respondent, with regard to Patient Karen G., over-reacted to the patient's bradycardia and performed a laparotomy and continued with multiple surgical procedures despite the presumptive diagnosis of bradycardia.

- Respondent, with regard to Patient Deborah S., billed for procedures which were not performed, such as hymenectomy, plastic revision of the hymen and plastic repair of the introitus and billed for an anal spincteroplasty and hemorrhoidectomy which were procedures performed by another physician.

- Respondent, with regard to Patient Alicia G., billed for services Respondent did not perform, such as complex initial consultation, extended hospital visit and comprehensive consultation, admitted the patient to the hospital although there were no documented symptoms which required hospitalization and created a physician's note and, four months after the hospitalization, a "progress" note, attempting to fraudulently justify what Respondent then must have realized to have been an unjustified hospitalization.

- Respondent, with regard to Patient Florence C., billed for plastic repair of the labia which was not done.

- Respondent, with regard to Patient Isabell M., recorded in the operation record that she had performed an appendectomy when she had not, billed more than once for the same procedures, specifically three extended visits when only one was done and a pelvic reconstruction as well as abdominal reconstruction, and billed for an appendectomy which was performed by another physician.

- Respondent, with regard to Patient Debra SA., had the patient sign a surgical consent form which included tuboplasty and lysis of adhesions although the patient did not require these procedures and would not reasonably require them in the near future and which consent form falsely represented the existence of a state of facts on Respondent's part as it presupposed that Respondent found a need for such surgery.

3. The California Board, inter alia, revoked Respondent's physicians and surgeons certificate based separately on each of six patient cases. The revocation took effect in approximately September 1996 following various judicial appeals and stays in the Matter of Vicki Georges Hufnagel v.

Medical Board of California, including Judgment Denying Petition for Writ of Mandate, filed 9/3/96 (Superior Court County of Los Angeles), Statement of Decision on Remand from Court of Appeals Second Appellate District, filed 7/23/96 (Superior Court County of Los Angeles) and Appeal from Judgement of Superior Court of Los Angeles, filed 6/23/94 (California Court of Appeals Second Appellate District).

4. The conduct underlying the California Board's finding of unprofessional conduct would, if committed in New York State, constitute professional misconduct under N.Y. Educ. Law §6530(4) [gross negligence on a particular occasion] and/or §6530(5) [incompetence on more than occasion] and/or §6530(2) [fraudulent practice] and/or §6530(21) [willfully making or filing a false report] and/or §6530(35) [ordering of excessive tests] (Mckinney Supp. 1997).

SPECIFICATION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(9)(b)(Mckinney Supp. 1997) by reason of her having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York State, constitute professional misconduct under the laws of New York State in that, Petitioner charges the facts in Paragraphs 1 through 4.

DATED: May 8, 1997
Albany, New York

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