ST TE OF NEW Y(RK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

February 12, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Nisaruddin Khan, M.D.
1504 West State Street
Olean, New York 14760

Douglas M. Nadjari, Esq.
420 Lakeville Road
Lake Success, New York 11042

Joseph H. Cahill, Esq.
NYS Department of Health
Bureau of Professional
Medical Conduct
Corning Tower, Room 2509
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Nisaruddin Khan, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-040) 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 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.

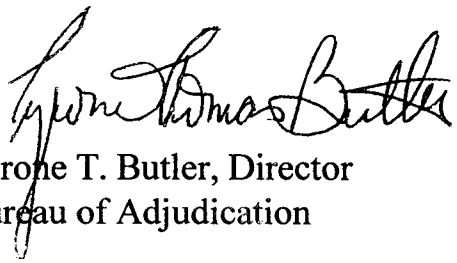
The notice of review served on the Administrative Review Board should be forwarded to:

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:djh

Enclosure

STATE OF NY : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER
OF

Nisaruddin Khan, M.D.

DETERMINATION
AND
ORDER
BPMC #03-40

Kendrick A. Sears, M.D., CHAIRPERSON, Datta Wagle, M.D. and **Ms. Jean Krym**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **Timothy J. Trost, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After Consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	May 14, 2002
Pre-Hearing Conference:	June 7, 2002

Hearing Date:		
	June 7, 2002	Steven Park, M.D. PAT. C, p 87-192 PAT. B, p 192-238
	July 22, 2002	Steven Park, M.D. PAT. D, p 245-429 PAT. A, p 430-456
	July 23, 2002	Stevens Botens p 473-528 [redacted] p 529-549
	August 19, 2001	Steven Park, M.D. PAT. A, p 589-680 PAT. F, WITHDRAWN PAT. H, p 705-756
	August 20, 2002	Steven Park, M.D. PAT. I, p 773-825 PAT. G, p 830-962 PAT. E, p 965-1001
	September 30, 2002	Nisaruddin Khan, M.D. PAT. B, p 1063-1247
	October 4, 2002	Carl Gerace p 1251-1315 Nisaruddin Khan, M.D. PAT. C, p 1317-1495
	October 28, 2002	Nisaruddin Khan, M.D. PAT. C, p 1500-1560 PAT. D, p 1561-1675 PAT. I, p 1676-1726 PAT. E, p 1727-1764
	November 15, 2002	Nisaruddin Khan, M.D. PAT. A, p 1769-1987
	November 25, 2002	Nisaruddin Khan, M.D. PAT. A, p 1993-2067 PAT. G, p 2064-2068 PAT. H, p. 2069-2223

Place of Hearing:	Brighton Ctyd. Marriott Corporate Woods Brighton, NY Four Points Sheraton Walden Avenue Cheektowaga, NY

Date of Deliberations: December 28, 2002

Petitioner appeared by:
Joseph H. Cahill,
Associate Counsel
Bureau of Professional
Medical Conduct
Corning Tower
Empire State Plaza
Albany, NY 12237
(518) 486-6862

Respondent appeared by:
Douglas M. Nadjari, ESQ.
420 Lakeville Road
Lake Success, NY 11042
(516)326-1880

On June 7 only
Jeffrey A. Lazroe, ESQ.
118 West Mohawk
Buffalo, NY 14_____

WITNESSES

For the Petitioner:
Steven Park, M.D.
Steven Botens
[redacted]

For the Respondent:
Nisaruddin Khan, Respondent
Carl Gerace

STATEMENT OF CHARGES

There are 17 specifications involving 9 patients. The case regarding Patient F was withdrawn by the Petitioner. Specifications include negligence on more than one

occasion, incompetence on more than one occasion, gross negligence, gross incompetence and failure to keep adequate medical records.

DEFINITIONS OF MISCONDUCT

NEGLIGENCE

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct. 195 A.D.2d 86.88.606 N.Y.S.2d 381 (3d Dept. 1993). Injury damages and proximate cause are not essential elements in a medical disciplinary proceeding. (I.d.)

The statutory definition of "negligence for professional misconduct purposes requires proof of negligence "on more than one occasion" N.Y. Educ. Law § 6530(3). The Court of Appeals has interpreted "occasion" to mean an event of some duration, occurring at a particular time and place and not simply "...a discrete act of negligence which can occur in an instant." Rho v. Amback ("Rho"). 74 N.Y.2d 315.322.546 N.Y.S.2d 1005 (1989). While several acts of negligence occurring during a single autopsy do not constitute professional misconduct

(Rho), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct. Orosco v. Sobol 162 A.D.2d 834.557 N.Y.S.2d 738 (3d Dept. 1990).

GROSS NEGLIGENCE

"Gross negligence" in the specific context of a professional misconduct proceeding, may consist of "a single act of negligence of egregious proportion of multiple acts of negligence that cumulatively amount to egregious conduct..." (Rho, supra at 322). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho, supra at 322.

No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if its established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient. Post v. State of New York

Department of Health, 245 A.D.2d 985.986.667 N.Y.S.2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct. See Miniell v. Commissioner of Health, 222 A.D.2d 750.751-752, 634 N.Y.S.2d 856 (3d Dept. 1995).

INCOMPETENCE

Incompetence is a lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 609, 651 N.Y.S.2d 249 (3d Dept. 1996). The statutory definition requires proof of practicing with incompetence "on more than one occasion." N.Y. Educ. Law § 6530(5). "On more than one occasion" in relation to incompetence would presumably carry the same meaning as it does in relation to negligence on more than one occasion, discussed above.

GROSS INCOMPETENCE

Gross incompetence is incompetence that can be characterized as significant or serious and that has potentially grave consequences. Post, supra at 986.

EXPERT TESTIMONY AND WITNESS CREDIBILITY

Dr. Steve Park

Dr. Park testified on behalf of the Department of Health on all patient cases. He is a Board Certified Ophthalmologist with an active practice in Rochester, New York. He performs cataract surgery and corneal transplants as well as practicing general ophthalmology. He graduated with honors from Northwestern University and graduated from the University of Illinois Medical School. He completed a three year residency program in ophthalmology at the University of Cleveland.

As part of his training, he assisted 200 cataract surgeries before performing them by himself. He then performed over 100 cataract surgeries under supervision. Dr. Park won awards in residency training from the Ohio Ophthalmological Society. He subsequently did a one year fellowship related to corneal transplants in Rochester, New York. Dr. Park has been an Assistant Professor of Clinical Medicine at the University of Rochester since 1991.

Dr. Park has taught residents the proper methods of cataract surgery. He is affiliated with Strong Memorial Hospital, Parkridge Hospital and Rochester General Hospital. He is licensed to practice medicine in New York. Dr. Park has conducted research in cataract surgery and

intraocular transplantations. He has published more than 10 papers and about 20 abstracts. Most of the papers and abstracts were related to issues concerning cataract surgery and/or intraocular lens transplants. Since 1991, Dr. Park's primary focus of practice has been cataract surgery and clinic consultations. He has performed more than 7000 cataract surgeries since that time. He serves on the Quality Assurance committee at West Falls Surgery Center.

Dr. Park is exceptionally qualified as an expert in the area of ophthalmological surgery, particularly cataract surgery. He testified concerning all patient cases. He testified honestly and impartially. He demonstrated a complete command of the relevant issues, factual as well as medical. His testimony was grounded in sound medical principles and practice. He gave reasons for his opinions that were both persuasive and rational. He showed absolutely no bias of any kind toward the Respondent. When questioned about the alleged bias based upon an event 10 years before, he demonstrated that his testimony was objective, impartial and reliable. Attacks by Respondent's counsel on Dr. Park's were groundless and meritless. The Committee gave his testimony very great weight in evaluating the Department's case.

Dr. Nisaruddin Khan

Dr. Khan testified in his own behalf on all patient cases both as fact witness and as expert witness. Because he is the Respondent and his license is the subject of this hearing, he is most definitely an interested party. He has strong financial, personal and professional interests at stake. His testimony was, at various times, evasive, inconsistent, non-responsive to questions, biased in his own favor, illogical, contrary to documentary evidence and defensive. Serious reservations concerning Respondent's credibility flow from his testimony. Respondent frequently gave contradictory answers to questions within a brief span of time. Respondent testified he was board certified "today" (T.1096), (September 30, 2002) when, in fact, he had not completed the process at the time and was subject to review of his surgery by members of the American Association of Physician Specialists, a non-ABMS organization. Respondent demonstrated a poor grasp of basic medical concepts and terminology related to cancer, antibiotics, biopsies, anesthesia and more. Respondent seemed to tailor his answers to fit the need of the moment. He rarely admitted errors, even when prompted to do so by his counsel. He demonstrated limited insight into serious surgical problems.

The testimony of STEVEN BOTENS and CARL GERACE was considered not probative. The testimony of [redacted] (PAT I) was most compelling and clearly established factual allegations. I1 and I2

PRELIMINARY DISCUSSION

Both Dr. Khan and Dr. Park relied extensively on the poster size exhibits showing the anatomy of the eye and they frequently drew their own illustrations on a chalkboard. For the benefit of those reading this document without access to that evidence or the transcript, a layman's description of some of the anatomical features of the eye will be attempted here.

The eye is a large sphere, not quite perfectly round, of which approximately 90% to 95% is hollow and filled with a sticky gelatinous substance called vitreous. Near the front of the eye, from the point of view of a cross section (looking at a person's profile), there is a 360° vertical membrane-like structure made up of strands or ligaments within a membrane which are called zonules. These strands stretch inward and attach in the center to a structure called the lens capsule and which ligaments hold and support this capsule in place. This entire structure is impervious and serves to hold in the vitreous. This

capsule is filled with a clear soft substance which is called the crystalline lens of the eye. This capsule, with the lens removed, is frequently referred to as "the bag" into which the artificial lens that is part of the cataract procedure may be inserted.

Directly in front of the suspended capsule is the iris which is visible when looking at a person from the front. This is the body which expands and contracts in response to brightness of light and which contains pigment making up one's eye color. The iris is a 360° flat membrane-like body with an open center, which open space is called the pupil. Directly behind the pupil lies the lens structure which is very close to but not ordinarily touching the iris and which lens structure is visible through the open center space surrounded by the iris. The part of the eye posterior to the iris, including the lens structure, the vitreous, and retina is called the posterior chamber. The part that is of most concern to this proceeding is the lens capsule and its supporting structures along with those structures posterior to the iris and anterior to the actual lens capsule. The outer limits of this round area are defined by a tissue structure called the ciliary body to which body is connected the outer boundary of the iris and to which is also connected the zonules and the membrane

which holds and supports the lens capsule. The zonular structure is in tension and creates a pulling force where it is attached to the ciliary body which serves to form a small shelf immediately forward of the zonules. This area is called the ciliary sulcus.

Moving again forward to finish the description of the anatomy, there is a dome-like structure covering, but not touching, the iris called the cornea. The space within this dome from the inner surface of the cornea back to the forward surface of the iris is called the ANTERIOR CHAMBER (forward of the iris).

The expert's discussion of this material is contained in the transcript beginning at page 27 through page 84. The term "posterior chamber implant," used hundreds of times in this hearing record, refers to placing the lens implant within that limited area either within the lens capsule (bag) or into the shelf-like structure called the ciliary sulcus around the edge of the eye and forward of the capsule support structure. This area is the extreme forward portion of the posterior chamber. A posterior chamber implant is never done beyond or behind this bag structure within the vitreous cavity. Thus, when referring to a posterior chamber implant, one must always mean that

the implant is forward of the zonulary support and bag structure.

A more accurate description of this anatomical feature is found at T.186, 187 wherein it is noted that if the capsule bag would not hold the intraocular lens haptics, they would slide along the surface of the zonular membrane and lodge in the ciliary sulcus automatically. (The intraocular lens is a round synthetic structure with two S-shaped arms stretching outward from each side called haptics. These structures support the lens and hold it in place.)

When the zonular/capsular structure breaks at any point or is perforated, vitreous comes through to the forward position of the eye. If the break is large enough, the lens implant can fall through the structure into the vitreous cavity.

One instance of confusing terminology in the record is the use of the term "anterior CAPSULE" and "posterior CAPSULE." A more accurate description is that there is but ONE lens capsule. The front part of the capsule membrane is the anterior PORTION of the capsule. This is the part which is cut open and partially removed in order to remove the cataract and insert the lens implant. The back surface of the capsule is not the posterior capsule but the

posterior PORTION of the lens capsule. This is the part that is subject to breakage which would cause the lens to de-center or fall away into the vitreous cavity.

GENERAL FINDINGS OF FACT AS TO RESPONDENT

1. NISARUDDIN KHAN, M.D., Respondent, was authorized to practice medicine in New York State on October 30, 1981, by the issuance of license number 148273 by the New York State Education Department, with a registration address of 1504 W. State Street, Olean, New York 14760.

2. Dr. Khan received his medical degree from SCB Medical College in Cuttack in 1967. He did one year of primary health care. From 1969 to 1971, he worked as an Assistant Surgeon in neurosurgery at the SCB Hospital. He passed the ECFMG exam in 1974. Between 1975 and 1976, he did a one year residency in psychiatry in Iowa State Hospital. Respondent passed the Flex exam in 1977.

   From 1976 to 1979, Respondent worked as a PCP for geriatric patients at a psychiatric facility. From 1979 to 1980, Respondent did the second year of a residency in a general surgery in Cleveland, Ohio.

From 1980 to 1981, Respondent worked at ECMC in Buffalo as a resident in the Department of Medicine. Between 1981 and 1985, Respondent completed a residency in St. Louis City Hospital in ophthalmology. From 1985 to 1987, Respondent worked in solo practice in Illinois. Since 1987, Respondent has worked at Olean General Hospital and had provisional privileges at Brooks Memorial Hospital.

PATIENT A FINDINGS OF FACT

3. Patient A was a 19-year-old male scheduled for a YAG laser membranectomy on January 29, 1997. The stated reason for the procedure was the removal of a membrane covering the crystalline lens on the front of the anterior capsule (Ex. 4G at 5).

4. Dr. Khan's History of Present Illness for Patient A appears to be in error. The History states "the patient developed gradual dimination of vision in both eyes, more so in the right eye, to a point where she (sic) had problems reading small print and saw glare. Thus, she (sic) was visually disabled for which cataract extraction with intraocular lens implant has been recommended" (Ex. 4G at 5). However, this patient was a male and only 19 years old. He was involved in a trauma related to a motor vehicle accident on December 14, 1996. He was hit in the right eye with shattered glass (Ex. 4B at 6, Ex. 4C at 6). He subsequently suffered from endophthalmitis and corneal laceration of the right eye (Ex. 4C at 6). He did not have an IOL lens implant on January 29, 1997 (Ex. 4G 1-9).

5. The term "crystalline lens" refers to a natural lens (T.432). A membrane refers to a film of cellular

debris (T.433). A membrane can impair the patient's visual axis (T.434). The membrane is described by Respondent as covering the crystalline lens on the front of the anterior capsule (Ex. 4G at 5). The membrane is believed to be secondary to endophthalmitis. Endophthalmitis is a bacterial infection of the eye (T.434).

6. On January 27, 1997, Patient A's visual acuity was 20/80 in the right eye. The patient had a normal intraocular pressure of 14. Patient A had a traumatic cataract and pupillary membrane of the right eye (Ex. 4A at 51). A pupillary membrane is a membrane on the anterior capsule of the lens (T.443). Dr. Khan recommended a YAG membranectomy of this date (Ex. 4A at 51).

7. A YAG laser creates microexplosions. The explosions can destroy the membrane or cause a tear in the membrane (T.435).

8. Dr. Khan describes the procedure as a YAG laser membranectomy and notes "Membrane in on pupil-OD" (sic) (Ex. 4G at 2).

9. The Laser Procedure Report in the hospital record signed by Dr. Khan reported a YAG laser membranectomy

of the right eye with "Excellent" results (Ex. 4G at 7).

10. The patient was scheduled to have cataract extraction with IOL implant on March 12, 1997. It was inappropriate to perform the YAG procedure on January 29, 1997 (T.439-440). The membrane could have been removed as part of the planned cataract surgery for March 1997 (T.440).

11. Patient A had inflammation and endophthalmitis. There were red blood cells and infiltrated debris, as well as vitreous inside the eye. When this debris cleared, it left a thin membrane on the pupillary aperture (T.440). The patient had visual acuity of 20/80 in the affected eye at this time. This was neither very good vision nor very poor vision. The patient was scheduled to have cataract surgery within a reasonable time. There was, therefore, no reason to do another procedure to remove a membrane when a month later the surgeon planned to take out the cataract since he could remove the membrane at that time. (T.440-441).

12. Furthermore, there are significant risks associated with a YAG membranectomy. The YAG can increase inflammation. The YAG laser creates microexplosions.

The surgeon is trying to tear the membrane off of the anterior capsule of the lens. If there is a small error of focus, wrong aim or similar small mistakes, the surgeon can rupture the anterior capsule of the lens which would cause the cataract to mature more rapidly (T.441).

13. It was below the standard of care to schedule this YAG procedure on January 29, 1997 because the cataract surgery was scheduled for March 1997 (T.441). There was no indication for this treatment at all (T.442).

14. On January 30, 1997, one day after the YAG procedure, the patient's visual acuity in the right eye had dropped to "hand motion." Visual acuity is judged by the smallest letter the patient can see. The minus sign refers to the number of missed letters. The top line on a standard eye chart is 20/400, usually it is a big "E". If a patient cannot see the 20/400 line, the next measurement is to "count fingers". The patient is shown fingers and asked to count them. Counting fingers can be done at distances, from one foot, to ten feet or so. If a patient is unable to see the fingers in front of his eyes, the next test is using hand motion. The surgeon waves a hand in

front of the patient's face and asks if he can see the hand and in which direction it is being waved (T.444-445). If a patient cannot see hand motion, the next test is light perception (LP). A bright light is shined into the patient's eye (T.445) and he is asked if he can see it.

15. It would not be a normal result of a YAG membranectomy for a patient's visual acuity to decline from 20/80 to hand motion. Further, the purpose of the YAG procedure was to improve Patient A's visual acuity, according to Dr. Khan's notes (T.446).

16. On February 13, 1997, the patient's visual acuity in the right eye was still only hand motion. Dr. Khan's plan was for a phacoemulsification with posterior lens implant of the right eye (Ex.4A at 7).

17. There was not adequate documentation in Dr. Khan's office notes concerning the reason(s) or etiology for the decline in the patient's visual acuity (T.448). There should have been a note:

    1. Concerning the degree of inflammation within the eye.

2. Whether there was a puncture of the anterior capsule due to the YAG laser that may have caused the cataract to mature more quickly.

18. There should also have been a dilated fundus exam to make sure there were not retinal detachments or sudden hemorrhage. The surgeon must seek the reason why the patient's vision has decreased so much (T.448). Such an evaluation was not noted in Dr. Khan's office records for these dates (T.449).

19. It was below the standard of care to fail to investigate, evaluate and document the reason for the dramatic decline in visual acuity under these circumstances (T.449).

20. Dr. Khan's examination on January 30, 1997 also failed to address inflammation, retinal detachment or other complications. This was also below the standard of care (T.450).

21. Retinal detachment needed to be investigated as a possibility in this patient. Patient A was at a high risk of multiple complications, having already gone through traumatic injury, inflammation following the injury and also endophthalmitis. The patient was 19 years old, he had a long life ahead of him and he needed to be aggressively treated and followed. If

there was a retinal detachment or posterior segment complication, the window of opportunity for treatment is narrower. Retinal detachment needed to be treated within a couple of weeks, not a couple of months (T.451).

22. The inflammation also needed to be addressed. Inflammation causes its own set of complications such as cystoid macula edema, ptysis, which refers to the eye becoming so inflamed it can actually shrivel up, and the onset of glaucoma. Rapid cataract progression may also occur (T.452).

23. If there was a posterior segment complication, it needed attention. Retinal detachment surgery or vitreous surgery may have to be performed. Inflammation causing a sudden decrease in vision should be treated very aggressively with steroid eye drops (T.453).

24. Performing a YAG laser procedure on this patient, under these circumstances, for this reason, is an extremely unusual procedure. It is never done because of the possibility of rupturing the anterior capsule, especially when the membrane will be removed in cataract surgery anyway. Most patients are treated with very aggressive steroids, eventually the

membrane thins out over time and the vision is not significantly compromised (T.454).

25. On March 11, 1997, the patient's visual acuity was only light perception, which is even worse than hand motion (T.456).

26. Respondent performed a repeat iridectomy on Patient A on June 6, 1997. On June 25, 1997, Dr. Khan removed the anterior chamber intraocular lens implant, performed an anterior vitrectomy, membranectomy and removal of purported epithelial down growth (Ex. 4I and Ex. 4J at 14).

27. Dr. Khan's History and Physical notes for Patient A dictated on June 24, 1997 indicated that the best corrected visual acuity in the patient's right eye was hand motion. A slit lamp examination revealed a membrane covering the entire pupil in the right eye and elevated intraocular pressure of 30 in the same eye. In addition, there was 2+ anterior chamber cells and flare in the right eye. Respondent stated that the Patient A had developed postoperative secondary glaucoma and recurrent uveitis in the right eye. The planned procedure for June 25, 1997 was removal of the intraocular lens, anterior vitrectomy and removal of pupillary membrane (Ex. 4J at 6-7).

28. Uveitis is a generic term for any inflammation inside the eye. It could have been related to the original accident, subsequent surgical trauma or the type of implant. In this case, Dr. Khan's notes indicate that he thought that the anterior chamber implant, in proximity to the iris tissue, was contributing to the inflammation, uveitis and glaucoma (T.562-563).

29. Postoperative secondary glaucoma means that the glaucoma is probably related to the surgery. Glaucoma is increased intraocular pressure inside the eye which is too high for the health of the optic nerve (T.563-564). In postoperative secondary glaucoma, there is an inflammation inside the eye. The cells fill up around the eye and are believed to clog up the drains inside the eye. There also may be inflammation along the trabecular meshwork itself (trabeculitis). This meshwork gets inflamed and the filters do not function properly so that there is excessive fluid build-up (T.565-566).

30. The foot plates of the anterior chamber implant (called haptics in posterior implants) can irritate the trabecular meshwork or irritate the iris so there is more inflammation and more cells released. This

can cause an increase in intraocular pressure (T.567).

31. Patient A's intraocular pressure of 30 was above normal, 21 is a common reference point for the upper limit of normal pressure (T.568).

32. 2+ anterior chamber cells refers to cells in the eye and flare refers to a measure of inflammation inside the eye. 2+ is mild to moderate inflammation inside the eye (T.568).

33. There are 2 different microscopes used by ophthalmologists, one is a slit lamp which is very high powered and shines a beam through the eye from side to side to delineate structures. An intraoperative microscope uses a broad beam and cannot delineate fine details inside the eye (T.568-569).

34. Dr. Khan's handwritten operative note concerning the June 25, 1997 operation on Patient A stated that he was "cutting the epithelial downgrowth and membrane around the pupil" (Ex. 4J at 17).

35. Dr. Khan's dictated operative note for the same procedures stated "some epithelial downgrowth were (sic) cleaned with Vannas scissors and the pupillary membrane was cleaned" (Ex. 4J at 14).

36. Epithelial growth occurs when, due to a previous surgery or traumas, an opening into the eye is created. The cells from the outside layer of the eye on the conjunctiva or the cornea migrate and the proliferate. When a person has a corneal scratch, epithelial cells migrate to cover the scratch, then grow very rapidly. These cells have very high mitotic activity, they proliferate very rapidly. They grow in sheets to cover up the defects. However, these cells are supposed to be on the outside of the cornea but if the cells gain an entrance through an opening into the eye, the cells can then grow along the inside of the eye. The significance of this abnormal growth is that the cells may grow and cover up the trabecular meshwork, they may also grow along the iris and deform it. Most significantly, epithelial downgrowth can cause glaucoma by clogging up the trabecular meshwork. This is a very difficult condition to treat and it is a virtual death sentence for the eye (T.571-573, emphasis added).

37. The standard of care for a surgeon who suspects epithelial downgrowth is to obtain a biopsy or to send the membrane to a pathology laboratory to make

certain of the diagnosis. It is not possible to distinguish epithelial downgrowth from other acellular membranes without microscopic verification (T.573-574).

38. Respondent did not send the suspected epithelial downgrowth to a lab for a pathology examination and report. (T.574, Ex. 4J).

39. The standard of care for follow-up on a patient with epithelial down growth requires the removal of the affected area. In this case, the entire affected area of the iris would have to be removed. Cryo-freezing is also done in an attempt to ensure that every last cell has been destroyed. A single cell or clump of cells, if left behind, could proliferate again. Postoperatively, the surgeon has to follow the patient very closely and apply laser treatments in the area where he thinks there may be cell proliferation (T.574-575).

40. It was below the standard of care to attempt to remove epithelial downgrowth using Vannas scissors. The cells are growing on the surface of the iris. They cannot be teased out. They cannot be seen. The entire iris would have to be removed. The operative note for this procedure did not indicate that Dr.

Khan removed the superanterior segment of the iris with scissors, another possibility. Such a surgery would be very extensive and was not done by Dr. Kahn (T.575-576).

41. Dr. Khan's office notes for Patient A do not indicate any follow-up on the diagnosis of epithelial downgrowth (T.576).

42. On December 11, 1997, Dr. Khan's office notes indicated corneal scars on the right eye of Patient A. [The original trauma to the eye occurred due to shattered windshield glass in December of 1996] (Ex. 4B and 4C, Ex. 4A at 15). In addition, Dr. Khan drew a picture of the cornea of the right eye showing (presumably) the location of the scars (Ex. 4A at 15). This was the first time corneal scars were mentioned in Dr. Khan's office notes. Possible etiologies for corneal scars include trauma from the accident or from the various surgeries performed by Dr. Khan on Patient A (T.578).

43. If accident trauma caused the injury to the cornea, the trauma would be on the external aspect of the cornea. A slit lamp examination would reveal whether the scar was on the external aspect.

44. If the corneal scarring was from surgical trauma, the scarring would be on the inside of the eye. It would be on the endothelial surface of the cornea and could also be seen through a slit lamp examination.

45. On February 10, 1998, Dr. Khan's office notes indicated "extensive corneal scars" on both the left and the right eye of Patient A (Ex. 4A at 14). The patient's visual acuity in the right eye was listed as "CF", count fingers. Corneal scarring presented certain risks to the patient. The patient's vision may be poor from the corneal scar alone. In addition, corneal scars make subsequent surgical manipulation more difficult to perform because the surgeon has more difficulty looking through the cornea (T.579-580). Finally, if there was corneal scarring on the internal aspect of the endothelium, it meant that the cornea had been injured from the previous surgeries, in addition to the original trauma, so that the cornea has become much more compromised (T.580).

46. The standard of care with regard to the treatment of corneal scarring is dependent upon an accurate assessment of the etiology of the scar. If the scar is on the external aspect of the cornea due to the

accident, then a procedure using a contact lens or refraction would be performed. In this procedure, a contact lens is fitted on top of the cornea which masks any irregularity in the surface of the cornea. Thus, if a patient has very poor vision with corneal scarring and the contact lens over the cornea dramatically improves the patient's vision, the surgeon knows that the pathology was in the cornea, not in the retina or the optic nerve of the eye (T.581). On the other hand, if the contact lens does not improve the patient's vision, the surgeon knows that the patient's visual problems are not restricted to the cornea but that there are other problems such as nerve or retina damage (T.581).

47. The ability to distinguish whether corneal scarring is external or internal would be part of the training of an ophthalmologist resident in his second year of training (T.581).

48. The failure to distinguish the source of corneal scarring poses certain risks to patients. If the corneal scarring was from the previous surgeries, then further surgery might make the cornea worse. If the scarring was from the original trauma, then the

need for corneal transplant must be evaluated (T.582).

49. Dr. Khan's notes are unclear as to the cause of corneal scarring. Usually, when there is surgical trauma to the eye, the term corneal edema, corneal swelling or microcystic edema would be used. When a surgeon notes corneal scar, that term normally is used for external scars such as motor vehicle accidents (T.583).

50. On March 1, 1998, Dr. Khan attempted to "suture in" a posterior chamber intraocular lens implant. When that attempt failed, Respondent inserted another anterior chamber intraocular lens implant (Ex. 4L at 16).

51. The purpose of the March 11, 1998 surgery was to insert another implant into Patient A's right eye, in the posterior chamber away from the iris. Presumably, the idea behind this surgery was that the existing anterior chamber lens implant was contributing to inflammation inside the eye. Dr. Khan unsuccessfully attempted to put in a sulcus posterior lens. Dr. Khan then placed another implant into the anterior chamber (T.584).

52. An implant could not properly be placed into the posterior chamber of the eye without an anchor or additional support. There was not enough support to put the implant into the posterior chamber in the first place, that is why Dr. Khan had already inserted a lens into the anterior chamber. The chance of then putting another implant into the posterior chamber was almost zero (T.584-585). If a surgeon desired to put an implant into the posterior chamber under these circumstances, he would have to have provided an anchor or support for the implant. To provide adequate support, the surgeon must put a suture on to the implant and these sutures would then have to be passed through the sclera to be anchored in position (T.586). Dr. Khan's operative note stated that he attempted to put the implant in the ciliary sulcus without any mention of sutures being ready. Also, the site must be prepared. The surgeon has to make a flap. The eye must be prepared for the "sewing in" of a posterior chamber lens. There was no evidence of that (T.586).

53. This patient was a 19-year-old male who had a perfectly good left eye. He was basically blind in the other eye. To perform multiple surgeries on the

right eye, the surgeon has to have a good reason. The surgery has to be worth the risk, it must be likely to help the injured eye or increase depth perception (T.588). The right eye had gone through multiple traumas and surgeries by this time. It now had a corneal scar. If the patient had retinal detachment or cystoid macula edema or optic nerve injury, the surgeries are for nothing and may cause additional trauma (T.588).

54. Dr. Khan's office records did not document an evaluation of the patient's retina or optic nerve prior to the operation on March 11, 1998 (T.589). The standard of care required the surgeon to make such an evaluation. In a 19-year-old patient, the least invasive procedure would have been to provide a contact lens if such lens provided sufficient improvement in peripheral vision and depth of focus (T.589). There are aphakic contact lenses that have been successfully used for many years (T.589).

55. It was also below the standard of care to insert another anterior chamber lens when the first anterior lens could not be tolerated. This is why the first lens had been removed (T.590).

DISCUSSION: PATIENT A

There are striking aspects of this patient's care that must be highlighted. First, a YAG membranectomy is a procedure that is primarily intended for use to destroy opacities in the posterior capsule of pseudophakic patients. The YAG is not intended for use on patients who retain their natural lens. Dr. Park had never heard of a YAG laser being used to perform a membranectomy on a patient such as Patient A, who retained his natural lenses. The YAG certainly could destroy the membrane, however, the danger of this usage is that in the process, the surgeon runs a significant risk of also damaging the anterior capsule. Performing the YAG procedure about six weeks before a planned cataract surgery exposes the patient to risk unnecessarily. During the cataract surgery, the membrane could be removed as part of the implant process. Surgical removal of the membrane has a lower risk of injury to the anterior capsule than use of the microexplosions created by the YAG laser. Respondent's YAG procedure was not simply unconventional, it risked the patient's anterior capsule unnecessarily.

The precipitous decline in the patient's vision had to be evaluated on January 30, 1997. The decline was from 20/80 to hand motion in a three-day period and one day after

surgery. Respondent had a duty to investigate the reason for this catastrophic change. A necessary part of such evaluation would include an examination of the fundus, the retina and the posterior pole in general. This was not done and no satisfactory answer was provided for the omission.

The procedure performed on June 25, 1997 was notable for the diagnosis and excision by scissors of "epithelial downgrowth" by Respondent. Dr. Park described this growth as a virtual death sentence for the eye, requiring radical excision, cryosurgery and a poor ultimate prognosis. The diagnosis of epithelial downgrowth requires assistance from a pathologist. A specimen would have to be removed and evaluated to confirm the diagnosis. Respondent testified adamantly that he diagnosed the growth clinically and was positive in his diagnosis but he does not explain the absence of radical excision, cryosurgery and treatment for this most serious condition. He cannot explain the lack of any reference to this growth after June 25, 1997. Respondent's testimony on this issue is difficult to accept. If he really believed the patient had epithelial downgrowth, one would expect extensive references to this problem throughout the medical records following June 25, 1997. If Respondent made an error of diagnosis, one would

expect him to admit the error to the hearing panel. Yet neither alternative has occurred. The implications of such a diagnosis were enormous for Patient A. His entire course of treatment would be affected by such a diagnosis. This is not a "record keeping" issue. It goes to the heart of medical practice.

The March 11, 1998 procedure posed its own set of problems. Respondent attempted to put a posterior chamber implant into an eye that could not possibly support it. This eye had been traumatized by accident, surgeries including YAG procedures, iridectomy, vitrectomy and previous implants. There was absolutely no possibility of success. Respondent had already put an anterior chamber implant into the eye because of lack of support for a posterior implant. Respondent was then forced to insert another anterior implant. The entire sequence seems to lack clarity in surgical decision-making. In addition, Respondent failed to evaluate the condition of the retina or the optic nerve preoperatively. Respondent did not prescribe non-surgical, and therefore less traumatic conservative devices such as aphakic lens, prior to March 11, 1998. If Patient A's retina or macula was significantly compromised, Respondent's surgical decision

making would be altered. A posterior pole evaluation was therefore essential prior to March 11, 1998.

The overall care of this patient was below the minimum standards of care in diagnosis, evaluation, surgical performance and follow-up care. The errors were both conceptual and practical. Respondent's testimony was not reassuring relative to his skill and exercise of judgment.

CONCLUSIONS AS TO PATIENT A

A1. **Respondent inappropriately performed a YAG membranectomy on Patient A's right crystalline lens on or about January 29, 1997.**

Respondent should not have performed a YAG membranectomy on Patient A on January 29, 1997 under the circumstances. Factual allegation #A1 is the first of several instances throughout the charges of weak surgical judgment in this instance based on lack of knowledge. It was not so much a careless decision but one sounding in incompetence. Respondent should have known better. Contrary to Respondent's written summation, Dr. Park took grave issue with the procedure based both on the technical difficulty and the risk (T.441) and also the appropriateness of undertaking an obviously unnecessary procedure at this time.

A2. **Respondent failed to timely document the reason that Patient A's visual acuity had declined from 20/80 to "hand motion" in a three-day period.**

Respondent as much as admitted that his charting procedure was sparse. The decline in visual acuity in the patient was almost catastrophic. There should have been an evaluation and documentation to establish the "reason". This is failure to exercise ordinary care, thus negligence, and failure to maintain an adequate medical record. This allegation does not involve incompetence. Clearly, Respondent does know how to document and understands the necessity of doing so.

A3. **Respondent failed to adequately evaluate Patient A's right eye on January 30, 1997 with regard to inflammation, possible retinal detachment and/or other complications.**

Dr. Park explained quite clearly the standard of care (T.451) regarding the need to evaluate the eye for complications. Simply ascribing the condition to trauma is not an evaluation of the condition of the eye but rather a statement of the primary presenting cause. This is the failure to use ordinary care; it is not an issue involving knowledge or skill. It constitutes negligence.

A4 and A5. **Withdrawn.**

A6. **Respondent performed a repeat iridectomy on June 6, 1997. On June 25, 1997, he then removed the anterior chamber intraocular lens implant, performed an anterior vitrectomy, membranectomy and removal of epithelial downgrowth in the anterior chamber. Respondent failed to adequately diagnose and/or document the diagnosis related to the epithelial downgrowth.**

The Respondent, at first unequivocally, diagnosed epithelial downgrowth (T.1829 and 1834). He then failed to observe a basic standard practice (T.573) that all such growths must be confirmed by pathology because of the serious consequences which accompany the diagnosis and because it is difficult to be certain by virtue of the nature of the tissue itself. The Respondent said he was certain of his diagnosis, he was not merely suspicious (T.1936). Respondent's diagnosis was inadequate because he did not understand its significance. Although he did mention his finding and the procedure for treating it in the operative report, there was no continuing observation and evaluation of this grave condition to be found in the chart.

The Respondent noted using a scissors to remove the downgrowth while admitting (T.1933) that it was impossible to remove all the cells because they are microscopic. Yet

to leave any cell behind would likely cause a recurrence. The Respondent's lack of skill and knowledge are now magnified because he did not use the correct procedure for removing the epithelial downgrowth (T.574-576). This is incompetence and failure to maintain adequate medical records.

A7. **Respondent failed to document the etiology of corneal scars listed in his office record on December 11, 1997.**

Based on Findings of Fact #40-47, this constitutes a failure to maintain adequate medical records. It is noted that the cross-examination of the Respondent on this issue showed him to be most evasive and (deliberately?) obtuse (T.1941-1947).

A8. **Respondent attempted to suture in a posterior chamber intraocular lens implant on March 11, 1998. When that attempt failed, Respondent inserted another anterior chamber intraocular lens.**

A8(a). **Respondent failed to document the condition of the retina or the optic nerve.**

Finding #54 supports specification #10. Although there is a record of a funduscopic exam in the hospital chart, there is no such entry in the office notes which is the location where the exam took place.

A8(b). **Respondent failed to prescribe appropriate non-surgical alternatives to Patient A, such as aphakic lens, prior to March 11, 1998 surgery.**

Finding #54 supports a specification of negligence on these facts. Although the Respondent testified that the patient refused contact lenses (T.1844), there is no such documentation in the office note (T.678) which is the location where the alleged conversation took place. Therefore, there was no conversation.

A8(c). **Respondent inappropriately inserted a second anterior chamber intraocular lens.**

The entire surgery of March 11, 1998 was "heroic" in nature and undertaken because the patient was without a lens (since June of 1997). The Respondent removed the first anterior lens implant on June 25, 1997 because it was causing the complications which commonly occur with an anterior placement. The March 11, 1998 surgery posed all the risks of invasive surgery as well as all the complications therefrom to a patient for whom a contact lens might have been sufficient. This constitutes negligence.

Dr. Park did testify that the surgery which the Respondent "...planned on..." (T.653) is appropriate, meaning the attempt to sew in a posterior IOL. However, this

statement, elicited on cross-examination through a leading question, is construed to mean (through the context of the line of questioning) that the planned surgery was appropriate in light of the fact that the patient made an alleged informed consent. This statement is not construed as a contradiction or recantation of all of Dr. Park's prior testimony. Dr. Park was not critical of the "plan" (T.584). Furthermore, there is no allegation that the plan was inappropriate although there is some evidence that it was ill-advised.

A9. **Respondent, on March 9, 1998, noted the patient's visual acuity as 20/200 with "extensive corneal scar."**

A9(a). **Respondent inappropriately recommended a corneal transplant without adequate assessment that the corneal scars caused the decreased vision.**

A9(b). **Respondent failed to adequately evaluate the patient's posterior pole, and/or nerve and/or the patient's visual prognosis prior to recommending this additional surgery.**

These factual allegations were not adequately established to serve as a basis for a finding of misconduct.

PATIENT B - FINDINGS OF FACT

56. Patient B was a 70-year-old male who was scheduled for a cataract extraction and intraocular lens implant of the left eye at Brooks Memorial Hospital on May 14, 2001 (Ex. 5C at 3-4).

57. Patient B's past medical history included insulin-dependent diabetes for 25 years, hypertension, colon cancer, right leg amputation due to diabetes and heart surgery five years earlier (Ex. 5C at 4).

58. Patient B's eye examination on May 10, 2001 revealed a 3+ posterior subcapsular cataract in the left eye. A funduscopic examination indicated senile macular degeneration in both eyes, as well as diabetic retinopathy in both eyes (Ex. 5C at 6).

59. The patient's visual acuity was 20/60 in the left eye (Ex. 5A at 12). In addition, the patient had peripheral marginal degeneration in the central cornea of the right eye (Ex. 5A at 13).

60. Senile macular degeneration, which is now usually called macular degeneration, refers to the accumulation of waste products called drusen. The drusen accumulates in the back surface of the retina, reducing visual acuity. Sometimes, the drusen can lead to bleeding underneath the retinal surface,

referred to as subretinal neovascularization. Such bleeding can cause a marked decrease in visual acuity (T.199).

61. According to Dr. Khan's operative note, the May 14, 2001 procedure was a routine cataract surgery without complications (T.200, Ex. 5C at 7 and 20).

62. However, by May 21, 2001, the patient's visual acuity in the left eye had decreased to 20/400, the intraocular lens had shifted nasally, that is, it had dislocated (T.201, Ex. 5A at 8-9). In addition, the patient had keratitis (Ex. 5A at 9).

63. By June 25, 2001, the patient was suffering from pseudophakic bullous keratopathy in the left eye. This condition, known as PBK, refers to blisters in the cornea. These blisters are caused by a fluid imbalance related to swelling of the epithelium of the cornea. Such blisters on the cornea can cause a compromise in visual acuity and foreign body sensations in the eye (T.203-204).

64. In addition, Dr. Khan's notes on June 25, 2001 indicated that the patient had cystoid macula edema in his left eye (Ex. 5A at 5).

65. Dr. Kahn's notes reflect routine postoperative care complicated by corneal and retinal pathology (T.206).

66. Dr. Khan's notes for the last visit, July 9, 2001 made no mention of cystoid edema or corneal swelling in the patient's left eye (T.206, Ex. 5A at 2-3).

67. Patient B was seen by Dr. Lahood on July 13, 2002 and also on subsequent dates (Ex. 5B).

68. When Dr. Lahood saw Patient B on July 13, 2001, he found the patient's visual acuity to be 20/400+. The patient's cornea showed folds and edema. Folding refers to significant corneal swelling. Further, the pupillary margin was stretched and thinned temporarily and was adherent to the incision at the 2 to 3 o'clock position (Ex. 5B at 7, T.209).

69. In addition, the left eye, on which surgery was performed, had an iris which was now adherent to the area where the incision was made during Dr. Khan's surgery (T.209).

70. The cause of the pupillary margin being stretched and thinned and adherent to the incision was mechanical trauma from Dr. Kahn's surgery (T.209).

71. "Thinning" referred to the iris being quite thin, and one was able to see blood vessels at the one o'clock position (T.210). There was sufficient mechanical trauma to shake pigments away from the iris (T.210).

72. Furthermore, Dr. Lahood also noted that the posterior capsule was markedly disrupted, the lens haptic was past the break point of the capsule (T.211, Ex. 5b at 6).

73. Dr. Lahood also noted that the left eye had vitreous herniation, which vitreous was incarcerated into the anterior chamber and was extending to the wound (T.211-213, Ex. 5b at 6-7).

74. The surgery performed by Dr. Khan on May 14, 2001 caused a break in the posterior capsule, vitreous came forward and became incarcerated to the wound and the implant dislocated. These are all major complications of cataract surgery and such complications should be reflected in the operative note for the procedure (T.213-214).

75. The standard of care for ophthalmological surgery requires that any complications be noted in the operative report. Respondent failed to note such complications and violated the standard of care thereby (T.214-215).

76. Following the May 14, 2001 surgery, Patient B developed cystoid macula edema and corneal swelling. These are not uncommon short-term sequelae of cataract surgery (T.216). However, in the setting of

a patient with posterior capsule rupture and vitreous incarceration, the chance of corneal decompensation was much greater and complications from cystoid macular edema would be increased (T.216).

77. Accordingly, corneal and cystoid macular edema requires more aggressive topical drug treatment than was prescribed by the Respondent (T.216).

78. Dr. Khan failed to perform a timely evaluation of vitreous herniation and posterior capsule disruption (T.216).

79. It is below the standard of care for an ophthalmologist to fail to evaluate or document his evaluation of vitreous herniation and posterior capsular disruption (T.217).

80. A surgeon should document these conditions and treat them (T.217).

81. Dr. Kahn's notes for May 21, 2001 failed to document any complicating factors that would have increased the likelihood of cystoid macula edema and pseudophakic post keratopathy (T.217).

82. It is the surgeon's responsibility to note any postoperative complication from surgery and to perform an eye exam to determine if such

complications occurred. Dr. Khan failed to document a retinal examination of this patient (T.217-218).

83. In a diabetic patient such as Patient B, a surgeon needs to be very aggressive with the medical treatment, following the patient very closely (T.218).

84. Concerning vitreous herniation, it is the surgeon's responsibility to perform a vitrectomy as completely as possible (T.219).

85. Likewise, it is the surgeon's responsibility to make sure he's found a stable position in which to place the intraocular lens implant (T.219).

86. The medication used by Dr. Khan after Patient B's surgery were not steroid drops and were not nearly as strong as steroid drops (T.221-222).

87. Surgical trauma was the cause of vitreous herniation in this patient. For the vitreous to come to a wound postoperatively meant that there had to have been a leak in the eye (T.224-225). A vitreous herniation would cause the IOL to dislocate. The IOL will not dislocate on its own and suck the vitreous out (T.226).

88. In Patient B, not only did the lens decenter but the patient also suffered corneal decompensation, which is a very serious complication (T.226-227).

89. The complications in this surgery would have been obvious and should have been detected the first day following surgery. These were not subtle findings. These complications were obvious findings and most surgeons would note them on the first post-op day (T.231-232).

DISCUSSION: PATIENT B

This 70-year-old man who had a history of severe diabetes with amputation, diabetic retinopathy, macular degeneration and hypertension. Respondent performed cataract surgery on Patient B's left eye on May 14, 2001. The operative report made no mention of complications of any sort. Yet, by May 21, 2001, the lens had decentered nasally. By June 25, 2002, the patient was suffering from cystoid macula edema and corneal edema. Respondent failed to document and evaluate the causes of these complications in his office notes, such causes would include capsular tear and vitreous loss.

Respondent last saw Patient B on July 9, 2001. Four days later, Dr. Lahood examined Patient B and noted "marked

disruptions of the posterior capsule," vitreous herniation and vitreous wound incarceration. These are major complications. Respondent testified that he did slit lamp examinations in his office but never observed these complications. He agrees that he should have been able to see these conditions employing the slit lamp examination but testified he saw nothing of the sort. He admitted to observing CME on June 25, 2001 and to observing corneal edema as well.

Respondent's defense rests, in part, upon his assumption that he employs an incision that is self-sealing and does not permit vitreous to ever incarcerate in the wound - "my technique, it never happens" (T.1171). This is an astounding statement in itself. It also ignores the evidence that, in fact, there was vitreous incarceration documented on July 13, 2001 by Dr. Lahood. When confronted with Dr. Lahood's findings of "marked disruption of the posterior capsule" on July 13, 2001, Respondent rejected the idea that his cataract surgery was the cause based on the circular reasoning that Respondent would have seen a disruption in the capsule before implanting the lens. Since he implanted the lens, there could not have been a capsule disruption. In addition, Respondent testified that

the aspiration and irrigation process insured that the lens was secure.

Examining these arguments one at a time: First, Respondent was forced to finally admit that the eye must be incised in order to perform cataract surgery. Any incision wound is, by definition, an opening between the inside of the globe and the outside. If vitreous herniates, one of the places it may migrate to is the wound incision. Regardless of what term the Respondent used of what technique he employed, the wound incision was made and permits a place of egress for the vitreous. Second, mechanical trauma is required to cause damage to zonular and capsular integrity. The most likely source of such trauma was Respondent's surgery in May 2001. Nothing in the office notes of Respondent and Dr. Lahood support the notion of any other cause.

Respondent also argued that the irrigation and aspiration procedures are so turbulent that the lens must have been properly anchored to remain in place during the process. If this were true, then no patient should ever experience dislocation following such a process. However, it is the surgeon who performs the irrigation and aspiration who determines how well the lens survived the turbulence. If the surgeon's observations are faulty, he

may conclude a lens is well placed when it is not. There is no assistant surgeon in these cases, the surgeon operates using a microscope. No one but Respondent is able to see the process. If his judgment is poor, the results will also be poor. In this case, the dislocation occurred in less than one week. Respondent also blamed the MA30 lens for the dislocation. As is discussed elsewhere, the MA30 acrylic lens was not subject to dislocation problems at a disproportionate rate. The reason for dislocation was found in the lack of adequate capsular integrity as noted by Dr. Lahood. That capsular disruption was caused by surgery, not by any lens design flaws, real or imagined.

The most reasonable view of these facts is that the complications occurred during the May 14, 2001 procedure. Attempts to blame the complication on a patient's fall or a lens design highlight Respondent's failure to accept responsibility for surgical and postoperative errors and to try to shift the blame for his mistakes to others.

CONCLUSIONS AS TO PATIENT B

B1. **Respondent performed a phacoemulsification with posterior chamber intraocular lens implant on Patient B's left eye on May 14, 2001. Respondent failed to appropriately perform this procedure.**

This factual allegation was not adequately established to serve as a basis for misconduct. The conditions which developed during/after the surgery are known accepted complications. The occurrence of known complications does not necessarily mean that the procedure was not properly performed (T.218). However, this case represents the first of several cases wherein the issue of lens dislocation has occurred. This will be discussed below.

B2. **Respondent failed to appropriately document the complication(s) that took place during the surgery performed on May 14, 2001.**

There is sufficient evidence to conclude that throughout the postoperative course, there was a charting failure. It is more likely than not, that at least some of the complications would have been visible intraoperatively or more certainly, one week thereafter on May 21, 2001 and again thereafter.

B3 and B4. **Respondent failed to evaluate and/or document the evaluation of the possible causes of the patient's cystoid macular edema and/or corneal edema, noted on a June 25, 2001 visit. Respondent failed to timely evaluate and/or document the evaluation of Patient B's vitreous herniation, wound incarceration and marked disruption of posterior capsule, noted on July 13, 2001.**

There is ample evidence to support these allegations. There is an obvious typographical error in B3 wherein "adequately" should read "evaluate". The Respondent failed to evaluate and document these complications because he negligently failed to recognize them. Respondent's reliance on a logical challenge to Dr. Lahood's finding of a "markedly disrupted" posterior chamber as being impossible because the IOL was still in place is rejected as merely a matter of degree. Dr. Lahood was obviously attempting to convey a remarkable finding. He observed disruption. Would ANY degree of disruption be inconsistent with the concurrent presence of the IOL? This was not suggested by the Respondent, therefore, Respondent's argument fails.

The theory that an uncharted intervening fall by the patient would explain Dr. Lahood's findings is rejected. Not only was there a phantom fall alleged but also a phantom physical (uncharted) which allegedly was unremarkable. This is all too much to believe and it reflects poorly on the Respondent's credibility.

It is fairly certain that Respondent did possess the skill and knowledge to recognize these complications. It was not incompetence. Respondent failed to use ordinary care which is negligence.

PATIENT C - FINDINGS OF FACT

90. Dr. Khan's examination of Patient C on September 8, 1998 noted that the patient had cataracts in both eyes, right eye more than left. Dr. Khan recommended a phacoemulsification of the cataract in the right eye and a posterior chamber intraocular lens implant to be performed on October 7, 1998 (Ex. 6A at 32, T.90).

91. The patient's past medicine history indicated that the patient had diabetes and was hypertensive (Ex. 6A at 26, T.92).

92. Diabetes can cause the onset of a cataract earlier in life than average. Diabetes can also cause diabetic retinopathy. Diabetic retinopathy is a condition in which the vascular permeability of the arteries and veins in the retina is increased. This, in turn, can cause retinal swelling which can cause decreased vision (T.92).

93. Patient C's visual acuity was 20/70 minus as tested with contrast sensitivity. An eye examination showed that the patient had a 3+ posterior subcapsular cataract in the right eye. Funduscopic examination showed that the patient had diabetic retinopathy in both eyes (Ex. 6A at 26, T.92-95).

94. The operative note for the procedure done on October 7, 1998 described an uneventful posterior capsule "in the bag" implant procedure (Ex. 6A at 28, T.95-96).

95. On October 8, 1998, one day postoperatively, the patient's visual acuity in the right eye was "count fingers" (Ex. 6A at 30, T.100-101).

96. In addition, on October 8, 1998, the patient's right eye had striae in the cornea. This means that the cornea was swollen and folds were present due to the swelling. There were also 2 plus cells and flare (Ex. 6A at 30, T.101-102).

97. Dr. Khan's office notes for January 2, 1999 for Patient C indicated that the visual acuity in the right eye could not be ascertained, the lens implant had dislocated nasally and that vitreous phase (sic)[face] had come forward and was touching the cornea. (Ex. 6A at 20, T.102-104).

98. An implant that had dislocated nasally has moved toward the nose. Vitreous does not belong in the anterior chamber (T.103-104).

99. On January 2, 1999, Dr. Khan recommended that Patient C undergo an anterior vitrectomy and the exchange of the intraocular lens in the right eye (Ex. 6A at 20, T.105).

100. Dr. Khan's preoperative history dictated on January 14, 1999 stated that Patient C was suffering from diplopia (double vision) following the October 7, 1998 procedure and that she had some vitreous phase (sic) [face] popping into the anterior chamber. In addition, vitreous was attached to the incision area on the clear cornea (Ex. 6A at 22, T.108).

101. There was a vitreous herniation during the surgery performed by Dr. Khan on October 7, 1998. The vitreous attached to the surgical incision (T.108).

102. Vitreous is a very sticky substance. It is very cohesive and adhesive. The vitreous had come forward and attached to the surgical wound. This is referred to as vitreous wound incarceration (T.108-109).

103. Dr. Khan's examination on January 14, 1995 indicated that the best corrected visual acuity in the right eye was count fingers. The lens had dislocated nasally in the right eye and vitreous phase (sic) [face] was touching the cornea in the right eye (Ex. 6A at 22-23, T.109).

104. On January 15, 1999, Dr. Khan removed the dislocated lens and replaced it with a model MC50 lens which he inserted into the ciliary sulcus of the right eye (Ex. 6A at 24).

105. The goal of this second procedure was to remove the first lens implant in the right eye, remove the vitreous jelly and then put another lens, the MC50, inside the eye (T.110, Ex. 6A at 24).

106. The second procedure involved a sclera incision enlarged to about 5 or 6 millimeters to accommodate the size of the implant. Viscoelastic was injected into the anterior chamber and the old implant was located and removed (Ex. 6A at 24, T.111). Respondent then performed an anterior vitrectomy, removed the vitreous in the anterior chamber and put in the MC50 lens into the ciliary sulcus of the right eye (Ex. 6A at 24, T.111).

107. The dislocation nasally of the first implant, on October 7, 1998, indicated that the support system for the lens was compromised (T.111-112).

108. There was inadequate support for the implant that Dr. Khan placed on January 15, 1999 (T-118).

109. The simplest option concerning the decentered lens was to re-center the lens implant, pass a suture or stitch through it, secure the haptic and pull the implant forward, then remove the vitreous jelly (T.113).

110. There was not sufficient support for the second lens implant. The first lens would have to be removed from a collapsed capsule surrounding the lens. The surgeon would have to maneuver to free up the lens and remove it without further compromising the posterior capsule. This is a very difficult maneuver (T.115-116).

111. There was obviously a rupture of the posterior capsule prior to the January 15, 1999 procedure. The vitreous had already come forward. Once a surgeon goes back into the eye to remove the lens and remove the vitreous there would not be enough support (T.117).

112. In addition, when doing a lens substitution, the surgeon is unable to visualize the zonular support, since the zonules are hidden beneath the iris. It's extremely rare that pupils are so widely dilated that a surgeon can see the zonules themselves. Therefore, the surgeon can never be sure of what zonular support remains. Once the surgeon goes in to remove the original implant and performs a vitrectomy, the chance of a successful implant into the posterior chamber <u>is almost zero</u>. Under these circumstances,

the implant would have to be put into the anterior chamber to provide support (T.118 emphasis added).

113. The ciliary sulcus implant in the second surgery was highly likely to dislocate. Without zonular support and the capsular bag providing additional support, a lens implant into the ciliary sulcus is highly likely to dislocate (T.174).

114. Historically, secondary intraocular lens implant surgeries for aphakic patients were done by anterior chamber lens implants in about 99% of cases. On some occasion, a posterior chamber lens is sewn in with sutures (T.175).

115. It was a deviation from the standard of care to put in a posterior chamber implant in Patient C's right eye on January 15, 1999.

116. On February 3, 1999, Patient C was examined by Dr. Khan. The notes indicated that the intraocular lens implant of the right eye had fallen into the vitreous. Visual acuity in the right eye was noted as "unable". The slit lamp exam indicated "unable to see" (Ex. 6A at 19). The second implant had fallen into the vitreous by February 3, 1999 (T.119).

117. The second lens had fallen into the vitreous, meaning it had fallen into the posterior segment of the eye (T.120).

118. There are dangers to the patient's eye associated with a lens implant falling into the vitreous. In this patient, Dr. Khan had performed a vitrectomy, so that the vitreous within the anterior portion of the eye was removed on January 15, 1999. The back part of the eye (vitreous cavity) still had a vitreous gel. The biggest concern would be the mechanical trauma related to lens movement within the vitreous cavity and damage to the internal structures of the eye, including the retina, from such movement (T.121-122).

119. Dr. Khan ordered Pred Forté 1% solution and anti-inflammatory steroids and told the patient to return in six weeks.

120. Dr. Khan saw Patient C on March 29, 1999. His notes indicated that the patient's visual acuity in the right eye was "light perception only." Dr. Khan noted that the lens had fallen into the vitreous and that he would schedule an IOL exchange of the right eye (Ex. 6A at 17).

121. Dr. Khan's preoperative assessment on April 20, 1999 stated that the intraocular lens was dislocated which was dialer (sic) (dialed) into the capsular bag in January 1999 and could not stay there. However, Dr. Khan's actual operation notes for January 15, 1999 noted that the implant was placed into the ciliary sulcus, not the capsular bag (Ex. 6A at 13 "capsular bag", Ex. 6A at 24 "implanted to the ciliary sulcus", emphasis added).

122. Dr. Khan's assessment on April 20, 1999 indicated that the patient's best visual acuity in the right eye, with correction, was "counting fingers" (Ex. 6A at 13).

123. Diabetic patients are at higher risk of developing cystoid macular edema than non-diabetic patients where the lens is left behind the vitreus (T-137).

124. Respondent, between February 1999 and March 20, 1999, failed to address the risk of Patient C developing cystoid macula edema, this failure was a deviation from the accepted standards of medical care (T.133).

125. A surgeon needs to perform a careful examination when a patient has very poor visual acuity and the patient is at high risk. The patient's retina needs to be thoroughly examined to determine if the retina is

intact and to see if the patient has cystoid macula edema (T.133-134).

126. Respondent failed to perform an adequate retinal examination of Patient C between approximately February 1999 and March 20, 1999 (T.135, Ex. 6A at 12-18). It was below the standard of care to fail to perform such a retinal examination during this period of time (T.134-135). A surgeon must do such an exam because of the possibility of complications from lens movement inside the posterior chamber of the eye (T.135).

127. It is customary practice for an anterior segment specialist, such as a cataract surgeon, to refer the patient out to a retina specialist within a couple of days if a lens has dislocated posteriorly (T.181).

128. Respondent failed to make a timely referral of this patient to a retina specialist (T.135). A referral should have been made after the second surgery when the implant had dislocated posteriorly (T.136). Dr. Khan's notes indicate his knowledge of the dislocation by February 3, 1999 (Ex. 6A at 18).

DISCUSSION: PATIENT C

Patient C was a 64-year-old diabetic female who underwent cataract surgery of her right eye on October 7, 1992. The operative note mentioned no complications. The implant was a posterior chamber intraocular lens. By November 16, 1998, the lens had decentered nasally. On January 14, 1999, Respondent noted that there was vitreous attached to the incision area on the clear cornea. The vitreous incarceration to the wound most likely was exchanged for a second implant placed into the ciliary sulcus. The operative note does not describe what capsular or zonular support was present on January 15, 1999. Obviously, there was not enough support for the second implant since it fell into the vitreous cavity by February 3, 1999. The attempt to retrieve the lens on April 20, 1999 failed and Respondent then inserted an anterior chamber implant. The patient was not referred to see a retina specialist until June 21, 1999. In the meantime, the posterior chamber implant has been a mobile body in the vitreous cavity. Dr. Seligson treated the patient with aggressive steroid treatment and noted vitreous hemorrhage related to the mobile posterior chamber IOL.

Respondent noted no complication during the first surgery in October 1998. He testified that he encountered no

complications. He stated that vitreous could not have come forward to the wound, due to his closed incision technique. He testified he would have seen vitreous if it had come forward during the operation. He saw none. He also testified that the lens was properly placed in the bag and survived the irrigation-aspiration procedure. Accordingly, he argued that the only possible explanation for the first dislocation was the MA30 lens and its small size relative to the lens capsule. He then placed a larger lens, the MC50 into the sulcus, however, this larger lens, also dislocated, and fell into the vitreous.

Examining Respondent's defenses, the inherent flaw in relying upon aspiration-irrigation as the benchmark for lens stability has already been discussed. This procedure is dependent upon the observation and judgment of the surgeon. If he does not check the lens carefully after the irrigation process, decentration may go unnoticed. If the surgeon damages the zonular or posterior capsule during phacoemulsification or removal of cataract contents, aspiration-irrigation will not repair the damage. Aspiration-irrigation provides insight into the centration of the lens inside the bag.

The closed incision technique may be useful, but two separate incisions are made into the eye. Vitreous can

come forward as instruments are removed, thus allowing vitreous incarceration. In this case, Respondent's own notes indicated there was vitreous adherent to the cornea in January 1999. The only reasonable explanation for this condition was Respondent's October surgery. Respondent blamed the dislocation on the MA30 lens design. Yet, if he performed the irrigation and aspiration process and the lens remained in place, how does he then explain a subsequent dislocation? If aspiration and irrigation were a foolproof test of lens stability, it should cause the undersized lens to dislocate during aspiration-irrigation. Yet, Respondent does not note such a dislocation. The most reasonable explanation is that Respondent caused zonular or capsular compromise during the October procedure and vitreous then escaped into the incision wound. As a result, the lens dislocated.

Respondent's implant into the ciliary sulcus failed within three weeks of the procedure. Respondent holds fast to his belief that the sulcus, by itself, is support enough for a lens, provided the lens is 6.0 mm. This belief is contrary to the accepted standards of care in cataract surgery. Without sufficient zonular support and capsular support, a sulcus implant lacks adequate support and lens dislocation is the predictable unhappy result. Dr. Park

testified to this basic premise. Respondent disagreed. Respondent had no explanation for the dislocation from the sulcus in the second surgery because he does not understand or accept the need for zonular/capsular support in sulcus implants. Respondent did not introduce a medical authority to support his portion but introduced an article that stated that zonular support needs to extend to at least 240° of the circumference of the lens-capsule complex.

CONCLUSIONS AS TO PATIENT C

C1. **Respondent performed a phacoemulsification of a cataract in Patient C's right eye followed by a posterior chamber intraocular lens implant on October 7, 1998. Respondent failed to timely document any complication in his operative notes for this surgery, despite vitreous incarceration to the wound later noted on a postoperative history form, dated January 14, 1999.**

This allegation does not sustain a finding of misconduct. The question of whether vitreous incarceration (not herniation) MUST appear intraoperatively in every case was not answered satisfactorily. Therefore, it is not clear whether the complication was present or observable before the surgery was concluded so as to be included in the operative note. Vitreous incarceration is the result of

vitreous herniation. Herniation is a rent of some fashion in the zonular membrane and the lens capsule structure which allows the vitreous to leak from its appointed place in the rear section of the eye, through the capsule structure into the front portion of the eye (anterior chamber). It was explained that the vitreous is a very sticky, pasty-like fluid (T.108,109) which cannot be aspirated out of the eye but must be chopped out with a special tool in a process called a vitrectomy (T.111,282) before it can be removed (T.188). The question not answered was, if the substance is so sticky, would it move immediately forward through any new opening or would it "ooze" forward in a process which could take hours or days? Furthermore, even if it moved immediately, would it be immediately visible since it is a relative clear gel? The testimony seemed to establish that it is visible when it migrates forward and attaches itself to the incision in the cornea. However, the cornea is a cellular membrane of a different, contrasting substance than the vitreous gel so that the phenomenon of contrast might be the mechanism wherein the vitreous becomes visible. It may not be so easily observed if it were merely in transit, gradually filling the anterior chamber, before it found a variegated site to which it could attach.

C2. **Respondent, on January 15, 1999, performed a right eye posterior chamber intraocular lens implant into the ciliary sulcus. Respondent failed to provide adequate support for the implant and/or failed to perform alternative procedures which would have provided such support.**

Respondent's best attempt at explaining his technique of assuring adequate lens support consisted of the use of a bigger lens so that the haptics would attain the longer reach into the ciliary sulcus and to irrigate the lens so that it would settle into place (T.1346, 1347). This explanation was not very illustrative and his cross-examination resulted in total confusion of what the Respondent meant. In the face of the evidence against him, the respondent was unconvincing in his effort to prove that he knew what he was doing and that he possessed the skill to accomplish this very challenging procedure. This constitutes incompetence.

C3. **Respondent's second right eye posterior chamber intraocular lens implant had fallen into vitreous chamber by February 3, 1999. Respondent then treated the patient with steroid drops. Respondent failed to adequately and/or timely treat the patient's lens dislocation and failed to attempt the lens correction procedure until April 20, 1999.**

This allegation consists of two parts: First, the failure to TREAT the lens dislocation. This must mean that the lens implant which had fallen into the vitreous should have been extracted from the vitreous cavity in a more timely fashion. Here there seems to be a difference of opinion between the expert and at least two consultants who treated the patients herein. The Respondent referred this patient to Dr. Seligson (a retinal specialist) and it was not apparent that Dr. Seligson ever removed the lens. A similar situation existed with Patient E, wherein the lens fell into the vitreous and the retinal specialist, Dr. Forgas, recommended leaving the lens in the vitreous cavity (T.971). The standard of care, according to Dr. Park, was to remove the lens (there was no intimation of urgency) or to leave it if the patient was at high risk for surgery (T.975). It is clear that a lens implant which is loose in the vitreous cavity is a significant and dangerous problem but it appears to be a manageable one. This issue is, then, truly one of the evaluation of each individual case. The evidence was not conclusive that this alleged failure to treat constituted misconduct.

The second part of this allegation alleges misconduct for failure to attempt the lens correction procedure until April 20, 1999. There was no evidence to support the

proposition that it violated the standard of care for the Respondent to fail to attempt a new implant within two and one-half months after it was ascertained that the former IOL implant had fallen into the vitreous. This does not constitute misconduct. Therefore, this allegation cannot form the basis to sustain any specification.

C4. **Respondent failed to take adequate steps between February 1999 and March 20, 1999 to address Patient C's risk of developing cystoid edema.**

This allegation is supported by Finding #125 and 126 and constitutes negligence.

C5. **Respondent failed to document an adequate retinal examination of the Patient C between approximately February 1999 and March 20, 1999.**

This allegation is not properly stated in relation to the evidence. The allegation seems to allege negligence while stating only a records violation. The proof established that it was beneath the standard of care to fail to PERFORM a retinal examination, yet there is no specification relating to that evidence. It is not beneath the standard of care to fail to document an exam which never took place. This allegation does not support a finding of misconduct. Allegation C1 and C5 having failed, Specification #12 cannot be sustained.

C6. **Respondent failed to make a timely referral of Patient C to a retinal specialist.**

This allegation is established by Finding #129 and 130 and constitutes negligence.

Charges related to factual allegation C7. were withdrawn by the Department.

PATIENT D - FINDINGS OF FACT

129. Patient D was a 59-year-old male scheduled for phacoemulsification of a cataract in the right eye with posterior chamber intraocular lens implant on February 5, 2001. Patient D had hypertension. His best visual acuity, with correction, was 20/50-2 in the right eye. A slit lamp examination showed the patient had 3+ posterior subcapsular cataracts in both eyes. Dilated funduscopic examination showed that the patient had senile macular degeneration in both eyes and posterior vitreous detachment (PVD) in the right eye (Ex. 7B and 3-4, T. 246-247).

130. Posterior vitreous detachment refers to the vitreous humor contracting away from and detaching from, the lining of the retina (T.248).

131. Dr. Khan's handwritten operative note for the first procedure on February 5, 2001 stated that Dr. Khan performed a phacoemulsification with PCL implant and sutureless closing done in the right eye under periocular anesthesia (Ex. 7B at 5, T.248-249).

132. Dr. Khan's typed operative note also indicated that the first procedure was a routine phacoemulsification and IOL implant (Ex. 7A at 18, T.250). The first procedure indicated a start time of 1245 hours and

end time of 1320 hours, for a total of 35 minutes. The operative record indicated the patient went to the postanesthesia care unit at 1325 hours and was discharged at about 1400 hours (Ex. 7B at 12). The postanesthesia care unit records also indicated an admission time into that unit of 1325 and a discharge time of 1400 (Ex. 7A at 19). The surgeon order sheet showed a discharge order signed by Dr. Khan and timed by nurse Laura K. Becker on at 1440 hours (Ex. 7B at 27).

133. Dr. Khan's office notes for February 5, 2001 stated that Patient D had an IOL (intraocular lens) floating in the A/C (anterior chamber) of the right eye (Ex. 7A at 8, T.252). The note further indicated Dr. Khan's plan: "To Hospital for IOL to PC right away" (Ex. 7A at 9, T.252). Dr. Khan's notes reflected that the patient was status/post cataract surgery in the right eye (Ex. 7A at 9).

134. The handwritten note for the second procedure done on February 5, 2001, stated that the IOL was lying in the A/C (anterior chamber). It was removed and another was put into the capsular bag of the right eye under periocular anesthesia (Ex. 7B at 6).

135. Dr. Khan's preoperative diagnosis for the second procedure on February 5, 2001 stated that there was a dislocated intraocular lens in the anterior chamber immediately after surgery in the right eye (Ex. 7B at 23).

136. A lens dislocated into the anterior chamber would be lying in front of the iris (T.256). This is a very unusual complication in cataract surgery (T.256). Dr. Khan's typed operative note stated that the intraocular lens had a broken haptic, which might have happened during the process of his insertion and folding and releasing the lens into the bag (Ex. 7B at 23). The note further stated that since one of the hepatics (sic) were broken, the lens was removed and a bigger lens, Model MS60 BM, was inserted into the capsular bag of the right eye (Ex. 7B at 23).

137. The operative report for the second procedure done by Dr. Khan on February 5, 2001 indicated that the patient arrived at the outpatient unit at 1630. The operation began at 1715 and ended at 1815. The patient was discharged at 1840 (Ex. 7B at 22).

138. The typed operative notes indicated that the lens had dislocated and was lying in the anterior chamber and touching the endothelium of the cornea (T.257). The

endothelium of the cornea is a single-cell layer of the cornea, behind the back surface of the cornea. This layer is a non-regenerative portion of the eye. Once it is damaged, it does not regenerate. It has only a limited number of cells. If a surgeon compromises the endothelial cell layers of the cornea, it is permanently weakened, making corneal decompensation a possibility later on (T.257-258).

139. It is the surgeon's responsibility to insure that the lens is properly implanted into the eye. An implant is "dialed" or pushed back and forth to make sure it is settling in the right place. If there is a compromise in the haptic, it would be obvious at that time because the implant would not have settled down properly. If one haptic is broken, the implant would be decentered, since one haptic would be pushing against the lens capsule (bag) and one haptic would not (T.260-261). If one haptic was in the capsular bag and one was in the ciliary sulcus, the implant would also not settle down (T.262).

140. Dr. Park had never seen a situation where the surgeon put in an intact IOL and haptic, center it, check it for water tightness and then have the lens fail (T.265).

141. The folding and unfolding of the implant is done under direct visualization. The surgeon grasps the implant, folds it himself as it goes inside the eye and unfolds the lens implant himself. If the lens haptic was broken, the surgeon should be able to know that (T.267-268).

142. The first surgery on February 5, 2001 was not performed correctly if the operative note by Dr. Khan is accurately describing the broken haptic (T.288-289).

143. Dr. Khan noted on February 12, 2001 that the second implant had dislocated by February 12, 2001 (Ex. 7A at 7, T.275).

144. The second surgery done on February 5, 2001 was not successful. The implant was not secured by Dr. Khan appropriately within the globe (T.276).

145. The posterior capsule had to have ruptured in a previous surgery because the implant had fallen into the vitreous cavity. The posterior capsule normally serves as a barrier to the vitreous chamber. That barrier had to be violated for the implant to dislocate posteriorly (T.283). The cause of that rupture was previous surgical intervention (T.283).

146. The posterior capsule had already broken by the time of Dr. Khan's second surgery because the vitreous had come forward as observed on March 21, 2001. The vitreous was plugging up the surgical wound. Some of the iris fibers were also being pushed out through the surgical wound. Iris is very fragile tissue (T.284).

147. By February 26, 2001, the patient complained of blurred vision, the lens had decentered in the right eye and the patient suffered from keratitis (Ex. 7A at 5).

148. By March 12, 2001, the lens implant had fallen into the vitreous in the patient's right eye (Ex. 7A at 3).

149. On March 21, 2001, Dr. Reidy diagnosed Patient D preoperatively as having a dislocated posterior chamber intraocular lens with vitreous prolapse, vitreous to the wound, iris damage with iris sphincter tears. His operative report noted a ruptured posterior capsule and vitreous in the anterior chamber. He further noted a previous temporal clear cornea wound had vitreous incarcerated along with some iris fibers (Ex. 7C at 5-6).

150. Vitreous incarceration to the wound signifies that the vitreous was manipulated during the first or second surgery by Dr. Khan and that vitreous had come forward and was stuck adherent at the surgical wound (T.279).

151. There were multiple tears along the iris aperture (T.280).

152. A vitrectomy was performed by Dr. Reidy to remove the vitreous that had come forward into the anterior chamber. There was also a break in the posterior capsule from previous surgeries (T.282).

153. Dr. Khan failed to provide adequate structural support for the implant of the second lens that was done on February 5, 2001 at approximately 1715 hours (T.286-287).

154. Dr. Khan's operative note concerning the second procedure done on February 5, 2001 lacked detail. It did not detail how the implant was removed. The opening from the previous surgery was about 3.5 mm or so. The optic was 5.5 mm. The optic cannot have come out through the 3.5 mm opening. The implant had to be cut in half or the opening had to be enlarged by the surgeon. These details were not in the operative note. In addition, this implant had a

haptic made of a hard plastic. If there was mechanical damage, it would have a sharp edge if it snapped off. The surgeon needed to be careful not to drag this broken haptic across the inside of the eye and tear the posterior capsule (T.271).

155. The accepted standards of medical care required that a surgeon be specific enough so that the next surgeon can understand what was done (T.272). The second operative note, the report on a complicated case, needed to delineate every single thing that had happened (T.272-273).

156. Dr. Khan failed to adequately document the second operation performed on February 5, 2001 (T.271-274).

157. The MA30 acrylic lens was not more prone to decentration than other types of implants (T.312). In fact, silicone lenses have a higher chance of decentration, not the acrylic lens used here (T.313).

158. The stability of the implant is primarily dependent upon the stability of the zonules, the stability of the capsule, the lack of vitreous in the anterior chamber, intraocular pressure. The size differential between MA30 and MA60 would be low, an almost irrelevant factor in implant stability and support (T.335-336).

159. The reason that the Department's expert stopped using the MA30 lens related to light reflection and reactive issues, not related to the stability of the lens implant (T.384-386). There is no statement in the record that the lens used by Dr. Khan had a manufacturing defect (T.388).

DISCUSSION: Patient D

Patient D was a 59-year-old male suffering from macular degeneration, posterior vitreous detachment of the right eye and a cataract in the right eye. The first posterior chamber implant had a broken haptic and dislocated into the anterior chamber after surgery. Respondent admitted that the haptic may have broken during his insertion and unfolding of the lens. It is incomprehensible why Dr. Khan left a broken or compromised haptic in the eye. Respondent's testimony about the events following the first operation is confusing, at best. The hospital records show that Patient D was discharged home to his wife's care around 1400 hours with a discharge order initiated by Respondent at that time. The hospital records show a second surgery, with the patient arriving in the outpatient unit at 1630 hours. However, Respondent testified that the patient was never really discharged.

Dr. Khan testified Patient D was only discharged on paper, to satisfy some insurance problem. Instead, Respondent testified, under oath, that he examined the patient with a penlight shortly after the first procedure and determined the lens had already dislocated. The hospital records show a routine post-operative course with no mention of lens dislocation. The hospital records reflect a postoperative examination by Respondent stating the patient could be discharged home. There is nothing in the hospital records to support Respondent's testimony on the issue. In fact, Respondent's own office notes reflect a postoperative note on February 5, 2001, noting a lens floating in the anterior chamber. This note must have been written after the first surgery and before the second surgery. Respondent's testimony was at odds with hospital records and his own office notes. It gives rise to serious questions about his credibility in this case. Respondent replaced the MA30 lens that was lying in the anterior chamber with a larger optic, MA60 lens. This was placed in the capsular bag on the theory that a larger optic would not dislocate as easily as a smaller lens. The second larger lens dislocated into the vitreous cavity by March 12, 2001. The details concerning the second operation on February 5, 2001

were sparse indeed. The operation lasted an hour and 15 minutes and the operative note had very few details.

Dr. James Reidy then saw Patient D in March 2001. He diagnosed the patient with vitreous prolapse, vitreous to the wound, iris damage, iris sphincter tears and a dislocated lens. These complications were the results of the previous surgeries done by Respondent. Respondent's counsel tried to blame Dr. Reidy for the ruptured posterior capsule by a tortured parsing of the operative note, while at the same hearing, Respondent claimed he was not blaming Dr. Reidy for the serious complications.

Respondent's defense again centered around the irrigation/aspiration procedure as a 100% guarantee of lens stability. This claim makes no sense, since both lenses dislocated after Respondent employed this procedure. If this process was really fool proof, neither lens should have dislocated. This patient had serious eye problems before these procedures. The two dislocations with vitreous prolapse, iris damage and ruptured capsule made things much worse for Patient D. The attempt to blame Dr. Reidy for Respondent's errors is rejected. Respondent refused to again accept responsibility for his own errors. His testimony in this particular case raises serious doubt

about Respondent's credibility as well as his surgical judgment.

CONCLUSIONS AS TO PATIENT D

D1. **Respondent failed to appropriately perform the phacoemulsification with posterior chamber intraocular lens implant on Patient D's right eye on February 5, 2001 done at approximately 1245 hours.**

It is more likely than not that broken haptic charted by Respondent in the second surgery operative note was broken DURING the first surgery and this should have been observed by the Respondent if he were performing the surgery appropriately (T.261, 267).

The alternative theory that the haptic broke after surgery is markedly less likely. The Respondent himself opined in the note that the break had occurred during the process of insertion and unfolding (T.258). This constitutes negligence.

D2. **Respondent failed to provide adequate structural support for the second lens implant performed on Patient D's right eye on February 5, 2001 at approximately 1715 hours.**

This allegation supports a conclusion of incompetence based on Finding #147 to 155.

D3. **Respondent failed to adequately document the second operation performed on February 5, 2001.**

This allegation supports a conclusion of failure to maintain an adequate medical record.

PATIENT E - FINDINGS OF FACT

160. Dr. Khan, on September 19, 2001, performed a phacoemulsification of Patient E's left crystalline lens and attempted to implant an intraocular lens into the posterior chamber. During this attempt, the intraocular lens fell into the vitreous and Dr. Khan then performed an anterior chamber lens implant (Ex. 8D at 12 and 18, T. 969).

161. Dr. Khan's typed operative note further states that the "patient will be referred to a retinal specialist who can explain the ____ (sic) which fell into the vitreous" (Ex. 8D at 12).

162. On September 21, 2001, Dr. Khan's notes indicate "Referral to Dr. Forgas." The note further stated that Dr. Khan "Discussed about the PCL fell into the vitreous with Dr. Forgas. Recommended that I better leave the PCL there instead of removing it and watch the patient very closely" (emphasis added) (Ex. 8A at 8).

163. On September 28, 2001, Dr. Khan indicated that the patient's vision was a little blurry. The cornea of the left eye had 1+ stria. "Stria" refers to swelling of the cornea. The anterior chamber had 1+ cells and flare (Ex. 8A at 8, T.971).

164. On October 26, 2001, the visual acuity in Patient E's left eye was 20/70.

165. On November 7, 2001, Dr. Khan's notes advised the patient to discontinue the steroid treatment (Pred Forté) and keep a six-month appointment.

166. After November 7, Patient E went on vacation to Florida for a period of four to six months (T.973).

167. The standard of care for a patient who has suffered a dislocated lens that has fallen into the vitreous requires either removal of the implant in the vitreous cavity or close follow-up for the patient (T.975).

168. It is not clear from Dr. Khan's notes what Dr. Forgas' recommendation was and what it meant (T.976).

169. If Dr. Forgas told Dr. Khan to leave the lens in the vitreous, the minimum standard of care required the surgeon to closely follow-up on the patient. The surgeon should see the patient once a week during the immediate postoperative period. He then should see the patient every two to three weeks until the lens had fibrosed completely (T.977).

170. Dr. Khan's follow-up was inadequate for this patient, even in light of her trip to Florida. This patient had a foreign body in her eye that could cause

traumatic damage to the retina and to the retinal blood vessels. The patient was at a higher risk of getting cystoid macular edema, retinal tears and small retinal detachment that could progress to a large retinal detachment. If there was a complete retinal detachment, a surgeon needed to diagnose and treat it early (T.983-984).

171. Dr. Khan should have had the patient see an ophthalmologist in Florida, he could have recommended one to the patient as well (T.984).

172. It was below the minimum standard of care for Dr. Khan to **tell the patient to see a doctor only if she had problems** (emphasis added, T.984-985). The patient needs to see an ophthalmologist because there is a high probability of complication (T.984-985).

173. It was below the standard of care to leave it up to Patient E to decide whether she was having eye problems or not while she was in Florida (T.986).

174. Dr. Khan also needed to inform the surgeon in Florida what had happened to Patient E. Dr. Khan could have forwarded medical information to Patient E's surgeon in Florida (T.985).

175. Dr. Khan's postoperative monitoring of this patient was not within the minimum standard of care. No

complications were noted, there was no mention of how the implants were doing, where the dislocated implant was or what it was doing (T.993).

DISCUSSION: PATIENT E

Patient E was a 68-year-old woman who had cataract surgery on September 19, 2001. The lens fell into the vitreous and Respondent performed an anterior vitrectomy and anterior chamber lens implant. Dr. Park did not fault the procedure done on September 19, 2001. Respondent's notes indicate that he consulted with Dr. Forgas, a retina specialist, on September 21, 2001. The patient was never referred to see Dr. Forgas, nor any other retina specialist from September 21, 2001 through November 7, 2001. There was, therefore, never an examination of this patient's retina during the period November 7 through at least December 2001. Dr. Forgas advised Respondent to watch the patient very closely. However, Respondent discontinued Patient E's Pred Forté steroid medication prior to her Florida vacation. Respondent told Patient E to see an eye doctor only if she had problems. Patient E's condition required the evaluation and follow-up by an ophthalmologist, particularly one knowing about her history. It was below the standard of care to assume

Patient E's retinal status could be self-diagnosed and evaluated by a lay person. Patient E had a foreign body in her eye that could have caused traumatic damage to her retina. Respondent had a duty to advise Patient E to obtain appropriate follow-up care in Florida rather than to rely upon her ability to recognize signs and symptoms of retinal problems. Respondent should have assisted Patient E in obtaining a referral for follow-up in Florida, provided her or her physician with pertinent records and reports. Instead, Respondent provided Patient E advice that placed the burden on her to evaluate her own condition. This was below the minimum standard of care.

CONCLUSIONS AS TO PATIENT E

E1. **Respondent, on September 19, 2001, performed a phacoemulsification of the crystalline lens and attempted to implant an intraocular lens into the posterior chamber. During this attempt, the intraocular lens fell into the vitreous and Respondent then performed an anterior vitrectomy and anterior chamber lens implant. On November 7, 2001, Respondent examined Patient E's left eye and instructed the patient to return in six months. Respondent failed to appropriately and/or timely evaluate and assess**

the status of Patient E's left eye during the period of November 7, 2001 through, at least, December 2001.

It was negligence for the Respondent to allow the patient out of his care without making some arrangements for follow-up. It appears that Respondent failed to recognize the seriousness of the patient's condition. Putting the onus on the patient to seek care in the State of Florida only if she had problems shows a lack of responsibility and laziness.

PATIENT G - FINDINGS OF FACT

176. Patient G was a 48-year-old female who was seen by Dr. Khan on May 6, 1999. She presented with cystoid macular edema of the right eye. Cystoid macula edema is a swelling in the retina of the eye that precludes good visual acuity. The patient had had a prior cataract surgery done by another surgeon. Dr. Khan planned to do a "piggyback implant" of the right eye (Ex. 10A at 22, T. 832).

177. Dr. Khan's notes indicated that he believed that the patient's right eye required a more minus lens than the left eye. A "piggyback" implant signifies a surgeon is putting one lens implant on top of the existing implant, to correct the difference (T.834). The new implant would go in front of the previous implant (T.835).

178. The funduscopic examination on June 16, 1999 by Dr. Khan indicated that the patient's visual acuity was reduced due to the cystoid macula edema in the right eye (Ex. 10B at 6).

179. On June 16, 1999, Dr. Khan performed a piggyback intraocular lens implant on Patient G's right eye.

180. If a surgeon sees CME in a patient from some other practice and does not know what happened from the

previous treatment, he is then obligated to treat CME initially to see if it does respond (T.934). Dr. Khan did not take any steps to treat CME in this patient according to his own medical records (T.934). It is a violation of the minimum standard of care to fail to treat CME prior to performing ophthalmological surgery on Patient G (T.935).

181. Treatment would include steroidal and non-steroidal anti-inflammatory drugs. If that treatment failed, consideration should be given to Diamox or an injection of steroid (T.836-837).

182. The patient needed to have her eye stabilized and visual acuity optimized as much as possible before performing surgery (T.838). By not treating CME, the CME may get worse on its own or it may also get worse following another eye surgery (T.838).

183. CME remained a relative contraindication to doing surgery since CME could be exacerbated by any kind of surgery or any kind of inflammation (T.958-959). Mild cystoid macula edema remained a relative contraindication to surgery (T.959).

184. The procedure done on June 16, 1999 was an <u>elective procedure</u>, not an emergency procedure (emphasis added T.839).

185. A patient such as Patient G should be treated with more conservative measures, including glasses. If glasses failed, contact lenses should then be tried. The purpose of glasses or contact lenses would be to correct an optical problem and maximize vision (T.839).

186. The main indication, alleged by Dr. Khan for this surgery on June 16, 1999 in his History and Physical, was that the patient was suffering from anisometropia. Anisometropia is unevenness between the two eyes. However, according to Dr. Khan's office notes, the patient could not see well and that may have been explained by the untreated cystoid macula edema (T.840-841).

187. A patient with lens implants must wear bifocal lenses. In anisometropia, due to different net powers between the two eyes, images tend to separate when viewed through bifocal lenses. To correct this problem, a prism is employed on the bottom half of the glasses (T.843-844).

188. Dr. Khan's pre-operative History and Physical states that the patient was unable to tolerate the prism in her glasses (Ex. 10B at 6, T.844-845).

189. If the surgeon puts a contact lens on one eye to create equality between the eyes, the patient will not then have problems with anisometropia using the glasses (T.845).

190. There is no mention in Dr. Khan's office notes, prior to June 16, 1999, that he offered the patient more conservative measures, such as glasses or contact lenses (T.850).

191. The original cataract extraction was performed by another surgeon in 1994 (T.851). In the normal course of events, the posterior capsule which is left behind the eye from the surgery would wrap around the implant and secure it. The capsule would contract, just like any other scar tissue. The implant would thus become fully secured or immobilized (T.852). After several years, the adhesions between the artificial lens and the surrounding structure of the eye would become very tight (T.853).

192. The existing intraocular lens implant was within the bag (T.855, Ex. 10B at 15). Dr. Khan's operative note also alleged that the second implant was implanted <u>into the capsular bag</u> of the right eye over the original implant (T.855, Ex. 10B at 15). However, it is not likely that the second implant was

really placed within the capsular bag. The first implant would be secured down very tightly. To open up the bag and put another implant within the bag is technically very difficult (T.856).

193. There was no mention of Dr. Khan's operative report that he undertook the required dissection of lysis of adhesions required to implant the second lens in the capsular bag (T.857, Ex. 10B at 15).

194. On December 1, 1999, Dr. Khan performed the removal of the original intraocular lens, the piggyback intraocular lens, removal of adhesions to the iris, a peripheral iridectomy and the reinsertion of an anterior chamber intraocular lens in the right eye (Ex. 10E at 15).

195. On November 30, 1999, Dr. Khan's funduscopic examination indicated that the patient's right eye had a very mild degree of cystoid macula edema (Ex 10E at 6). Cystoid macula edema is a relative contraindication for surgery (T.870). The procedure done on December 1, 1999 was an elective procedure (T.860).

196. The reasons given by Dr. Khan for that surgery are not adequate indications for the surgery performed (T.863). Patient discomfort and pulling sensation is

a very non-specific complaint (T.863). This type of complaint can be caused by many things, dry eyes, inflammation or inflammation of the eyelid margin. The pupil being "stuck to the lens" was also not adequate grounds for surgery. The assertion that the pupil was the reason for patient discomfort was not correct (T.864). There are many patients who have deformed pupils from prior surgeries but once the eye settles down, they do not experience discomfort (T.864).

197. This patient instead needed to be treated for any possible inflammation. The eye needed to be treated aggressively with steroidal or non-steroidal drops. The eye needed to be well lubricated using artificial tears, if needed (T.865). The patient may have also needed treatment to clear the punctum so that there was adequate tear film. The eyelid margins may have needed cleansing as well (T.865).

198. Dr. Khan's surgery on the iris was inappropriate. The iris is composed of very delicate tissue. Once it becomes deformed or scarred, once it is adherent to the wrong part of the eye, it is almost impossible to correct (T.866). Even if repairs are attempted, the iris would be scarred down all over again

postoperatively because the iris tissue is very fragile (T.866).

199. Furthermore, to remove the piggyback lens, the survival rate for the posterior capsule would be extremely low. There was no way to remove the implant without doing damage to the eye (T.867). To put another implant in would be very difficult technically. The chance of doing it successfully was extremely low (T.867).

200. Performing the December 1, 1999 surgery violated the minimum standards of care for ophthalmology for the reasons outlined above (T.869).

201. Dr. Khan attempted to put in a posterior chamber lens implant on December 1, 1999 even though there was no support for such an implant (T.929).

202. It was inappropriate surgical judgment to attempt to put in yet another posterior chamber lens implant under these circumstances. The surgeon must either sew it in or put in an anterior chamber lens implant (T.930).

203. It is the responsibility of the surgeon to assure that the support structures within the eye needed to maintain centration and stability of the IOL are adequate for the type of lens fixation anticipated.

When capsular support cannot be reasonably assured, alternative methods of securing a posterior chamber IOL, e.g. iris transscleral suture fixation, should be used (T.932-933 from 1995-1996 Basic and Clinical Science Course, Lens and Cataract Section of American Academy of Ophthalmology). **Further, it is contraindicated to put the implant in the eye without adequate support** (emphasis added T.933).

DISCUSSION: PATIENT G

Patient G was a 48-year-old woman who previously had bilateral lens implants performed by another surgeon in 1994. The patient had visual acuity of 20/80 and CME in the right eye. Respondent did not attempt to treat CME first, instead he recommended surgery. Respondent admitted he did not know what treatment, if any, Patient G had received for CME nor what response she had to treatment. He essentially assumed the CME was a chronic condition from the previous surgery and that it was not amenable to treatment. The conclusion was not supported by any documentary evidence in the patient's chart. There was no record of the patient's history of CME, treatment efforts, results or the like.

Respondent raised the six month "window of opportunity" defense. Respondent asserted that within six months some CME gets better and some gets worse, whether treated or not. This view does not seem to be shared by others, since subsequent treating physicians, including Dr. Seligson, treated patients with CME very aggressively with good results. Furthermore, how can Respondent know whether the patient will respond to treatment if treatment is never given? There are many patients with many diseases that do not resolve despite treatment. Physicians still provide treatment to increase the likelihood that their patients will improve, even though some will not. Unless treatment is tried, Dr. Khan could not know if this patient would respond. The failure to treat CME, in the absence of hard data, making such treatment futile is disturbing. The absence of information in his office notes to confirm a trial of glasses or contact lenses to address anisometropia is troubling as well. If the records from the previous treating physician did not detail the trial of glasses or contact lenses, it would seem reasonable for Respondent to document his own efforts to try conservative measures. But this information is also absent from the office notes. Was this a failure of documentation or a failure of Respondent to try these measures? The later is more probable.

Respondent's operative note asserts that the piggyback lens was placed within the capsular bag despite the virtual impossibility of dissecting the adhesions to free up the anterior capsule and insert a second lens into the bag. Respondent's credibility is weakened by such statements.

The indications for the December 1, 1999 surgery were inadequate. Poor vision and discomfort were not adequate indications. Diplopia as an indication for the December 1, 1999 surgery is puzzling, since the previous piggyback implant should have eliminated such a condition. What was the cause of the diplopia? This patient underwent four surgical procedures in a period of six months, her CME was never treated and a serious complication was blamed on a reaction to anesthesia which appears highly unlikely.

CONCLUSIONS AS TO PATIENT G

G1. **Respondent recommended and performed on June 16,1999 a piggyback intraocular lens implant on Patient G's right eye without first treating cystoid macular edema in the same eye.**

Notwithstanding, Dr. Park's forthright admission that there is a difference of expert opinion on the issue of whether CME is an absolute contraindication for surgery (T.889), the issue raised in this allegation concerns the

duty to evaluate and treat CME before surgery is considered in a case where the history is not known as when a patient presents with CME coming from another physician. CME is always a relative contraindication for surgery. It was negligence to fail to treat CME before surgery in this situation.

G2. **Respondent failed to use more conservative measures, including glasses, prior to performing surgery on June 16, 1999, despite the presence of cystoid macular edema in Patient G's right eye.**

The suggestion that the patient refused contact lenses is not supported by the hospital informed consent form (T.891). This form is preprinted and the language presupposes that the patient first knew ALL the alternatives and is now asked to confirm through the consent form that ALL were actually explained. This situation inappropriately resembles a multiple choice test of the patient's knowledge. The only person who knows what alternatives are available is the doctor. It is incumbent upon the doctor to chart exactly what he explained. The burden is on the doctor. The proper place to do this is in the office, before the decision for surgery is made, documented in the office record. The patient was NOT

offered contact lenses because there was no such notation in the chart.

Dr. Park's testimony establishes that a simple contact lens might well have solved the patient's problem and avoided a very complex surgery (T.845). This is yet another example of the Respondent, who possesses alleged "superior surgical technique" (T.893), rushing to judgment to perform the surgery which clouds his assessment of the patient sitting in front of him. The Respondent was negligent in failing to use more conservative measures.

G3. **Respondent failed to adequately document the manner in which the piggyback intraocular lens was supported in the surgery performed on June 16, 1999.**

Dr. Park raised a question about the accuracy of Respondent's operative report. If Respondent really placed the piggyback lens in the bag over the original implant (T.855), then another difficult procedure would be required called lysis of adhesions. It was beneath the standard of care to fail to chart such a significant operative procedure. If this procedure was NOT done, it would be necessary to chart exactly how the second lens was supported. There is no such information in the operative note. This is clearly inadequate record keeping.

G4. **Withdrawn.**

G5. **Respondent performed the removal of the original intraocular lens, the piggyback intraocular lens, removal of adhesions to the iris and peripheral iridectomy and reinsertion of an anterior chamber intraocular lens in the right eye on December 1, 1999. This surgery was performed without adequate indications.**

This allegation emphasizes the rush to judgment to perform surgery. Once again, conservative measures would have been appropriate, at least temporarily, in order to ascertain if improvement would follow from an initially vague complaint. The way that Dr. Park explained the procedure to lyse the IOL from the iris, the result would be permanent damage to the iris (T.866). Respondent indicated that the lyse was not successful but then how could one suggest the removal of the IOL which is stuck to the iris if the adhesion could not be separated? Would one just tear the IOL away from the iris? The Respondent's plan does not make sense.

The Respondent should have known that a posterior capsule IOL implant would not be possible. This allegation supports a conclusion of inappropriate judgment caused by a lack of skill and knowledge. This is incompetence.

G6. **The December 1, 1999 surgery was performed despite documented systoid macular edema in patient G's right eye.**

This allegation is supported by the same rationale as allegation and conclusion G1. This supports a conclusion of negligence.

PATIENT H - FINDINGS OF FACT

208. Patient H was a 78-year-old male scheduled to have phacoemulsification and posterior chamber intraocular lens implant in the left eye on December 4, 2000 at Brooks Memorial Hospital. Patient H had no light perception in the right eye (total blindness). Patient H's visual acuity was 20/70 in the left eye. A slit lamp examination indicated the patient had 3+ posterior capsular cataracts in the left eye. Furthermore, the patient had senile macular degeneration and posterior vitreous detachment (PVD) in the left eye (Ex. 11C at 3-4, T.706-707).

209. Dr. Khan's operative note concerning the cataract surgery performed on December 4, 2000 indicated a normal phacoemulsification with posterior chamber intraocular lens implant. There were no complications noted by Dr. Khan in his operative note (Ex. 11C at 21, T.708).

210. Dr. Khan saw Patient H on December 11, 2000 in his office for a postoperative evaluation. Patient H complained of his left eye being foggy, diplopia and the eye feeling "scratchy". Dr. Khan's slit lamp examination noted that the intraocular lens

had dislocated in a "sunset syndrome" pattern (Ex. 11A at 15-16, T.712-713).

211. There had been a complication in the December 4, 2000 surgery. Dr. Khan did not provide enough support for the implant to be placed adequately. The implant then dislocated (T.713).

212. There was nothing in Dr. Khan's notes to indicate that the patient did anything to cause the dislocation or suffered a trauma which created the dislocation (T.713). On December 11, 2000, Dr. Khan recommended an intraocular lens exchange for Patient H (Ex. 11A at 14).

213. Dr. Khan's History and Physical, dictated on February 2, 2001, for Patient H stated the following:

> "The patient had cataract surgery done in the left eye on December 4, 2000. Postoperative period was uneventful. Then, **six weeks post-op**, the patient got a dislocation of the intraocular lens (sunset syndrome) and started having diplopia in the left eye and blurred vision."

212. In fact, Patient H suffered the sunset syndrome complication on December 11, 2000. This was within

one week of the surgery on December 4, 2000. Dr. Khan's note was therefore misleading and inaccurate (E. 11D at 3, Ex. 11A at 16).

213. "Sunset syndrome" refers to an intraocular lens implant that had dislocated inferiorly. It resembles a sun setting in the sky, hence the term (T.709). The cause of sunset syndrome is lack of support for the implant (T.709).

214. Dr. Khan's operative note on February 5, 2001 indicated that he removed a dislocated lens and inserted a replacement lens that was "sulcus fixated" in the posterior chamber of the left eye (Ex. 11D at 17). The operative note stated that Dr. Khan also performed an anterior vitrectomy on the eye using an automated vitrectomy unit. The vitreous was presenting into the pupillary aperture of the anterior chamber (T.711). Dr. Khan then implanted an MA60 implant to the ciliary sulcus of the left eye (Ex. 11D at 17).

215. A sulcus implant is supported in the ciliary sulcus in the crevice between the ciliary band and the iris root (T.714).

216. On February 12, 2001, the patient saw Dr. Khan with complaints of blurry vision in the left eye.

217. Dr. Khan's notes stated that the patient said he rubbed his eye during sleep and had fuzzy vision since then (Ex. 11D at 6).

218. If a patient rubbed his eye hard enough **and the implant was not situated properly,** a patient can potentially dislocate an implant (emphasis added T.715).

219. On February 26, 2001, the patient saw Dr. Khan with complaints of blurry vision. A slit lamp examination indicated that the second lens implant (MA60 in the ciliary sulcus) had decentered nasally (Ex. 11A at 5, T.715). Dr. Khan's notes indicate the patient should then keep a four-week appointment.

220. There was not sufficient support for the second intraocular lens implant related to the February 5, 2001 procedures (T.716).

221. There was no mention in Dr. Khan's notes that the lens had decentered until February 26, 2001. It is therefore difficult to know whether the dislocation was related to the eye rubbing noted in Dr. Khan's February 12, 2001 notes (T.717).

222. The standard of care required the surgeon to provide adequate support for the lens implant. In

the case of the second surgery on February 5, 2001, the implant could be anchored with McConnel sutures or the suturing of the posterior chamber intraocular lens (T.717). The surgeon could also implant an anterior chamber lens (T.716).

223. The least desirable and most traumatic course of action was to place another posterior chamber implant in without suturing or without other supporting mechanism to be sure of support (T.716).

224. The implanted lens will be adequately held in the ciliary sulcus only if the posterior capsule has enough support (T.720-721). Most times, the surgeon is unable to visualize the exact condition of the posterior capsule remnant during an implant surgery (T.721).

225. Dr. Khan's decision to put in another posterior chamber lens implant during the second surgery was outside the minimum standard of care (T.725). **The ciliary sulcus has to have zonular support or capsular remnant support to hold the implant in position. It is not able to hold the implant in place by itself** (T.735).

226. Lens implants are standardized with 5.5 to 6.0 millimeter optic and two wings that are pulled out

to 13 millimeters. There are different materials but essentially the design is almost identical so that the support issues are not really a problem (T.744).

227. Ophthalmological complication rates are higher in second, third and subsequent surgeries than in a first surgery (T.747). Each time a surgeon goes back into the same eye to operate, the outcome is potentially not as good as the first surgery (T.747).

228. The multiple surgeries performed by Dr. Khan contributed to the patient's corneal decompensation which necessitated a fourth surgery on a patient who was monocular (one-eye) (T.750).

DISCUSSION: PATIENT H

In this case, Respondent demonstrated poor surgical judgment and the willingness to place an implant into the ciliary sulcus without adequate zonular or capsular support. Respondent subscribed to the belief and practice that the sulcus provides adequate implant support even if there is no zonular or capsular support in the eye. Dr. Park testified this was false. The anatomy of the human eye refutes Dr. Khan's belief. This 78-year-old man,

already blind in one eye, suffered consecutive dislocations in his usable eye.

Dr. Khan's testimony and attempts to justify his actions reveal some of the problems in his surgical judgment and disregard for the most basic principles of successful cataract surgery. The "sunset syndrome" complication from the first procedure in December of 2000 can only occur when there is inadequate structural support for the implant. This was the testimony of Dr. Park and the point was conceded by Respondent during cross-examination (T.2198). However, Dr. Khan blamed the MA30 lens for the dislocation (T.2199). He testified that a bigger lens would not have dislocated. However, when he later installed an MA60 lens into the ciliary sulcus, it too dislocated. This subsequent dislocation was blamed, by implication, on Patient H. He rubbed his eyes at night and then he is said to have had fuzzy vision. Respondent failed to understand that adequate structural support is crucial to lens implant stability. The MA30 lens is designed to fit into the lens capsule and exert pressure via the haptics on the inner aspect of the capsule. The lens, when extended inside the capsule, is approximately 13 mm in overall length. The anterior capsule opening is made large enough to accommodate the insertion of the lens only

in its folded state. Once it is unfolded inside the capsule, the likelihood of the lens falling out of the capsule is remote. Further, the "sunset syndrome" refers to a lens that is slowly sinking into the posterior chamber. The only logical cause for this complication must be inadequate zonular or posterior capsule support.

During the first surgery, there must have been a complication affecting the integrity of the zonular and/or posterior capsule. Respondent refused to admit this in his operative note that compromise was iatrogenic. Complications can and do happen in surgery all of the time. It is the surgeon's duty to honestly acknowledge such complications in the patient's chart. If Respondent did not actually perceive the complication in his first surgery, there must have been a failure to monitor the procedure adequately. However, Respondent had the chance to tell the panel of his error, yet refused to do so and instead blamed the dislocation of the lens size.

Concerning the second implant, the Respondent was faced with a patient who had demonstrated zonular/capsular support compromise. Respondent said he feared hemorrhage so he put an implant into the sulcus without sutures. However, Respondent believed sutures were really not necessary for any sulcus implants. He testified, with

great conviction, that ciliary sulcus implants did not require zonular or capsular support to remain in place! Respondent was unable to provide any documentary evidence of valid medical authority to support his view and practice. Dr. Park testified that Respondent's practice was a violation of minimum standards of care and doomed to failure.

Respondent's defense included his view that the turbulent process of irrigation and aspiration was proof positive that the implant was secured. However, despite Respondent's irrigation and aspiration procedures, numerous lenses still have dislocated. Nor does recognized medical authority support the view that a surgeon is free to ignore structural adequacy as long as the lens survives the intraoperative irrigation process. Respondent ignores or does not comprehend the medical and logical fallacies in his surgical thought processes.

A few other observations are pertinent. It has been established that the more repeat surgeries done on the same eye, the greater the likelihood of subsequent complications. It was, therefore, important for Respondent to reduce the risk of injury to Patient H's one good eye by exercising reasonable judgment and technique during the first surgery. The patient's left eye had macular

degeneration and posterior vitreous detachment. A lens dislocation into the posterior chamber causing retinal injury could have disastrous consequences—total blindness. Respondent's willingness to put a second lens into the sulcus exposed the patient to the risk of severe retinal complications in a problematic eye. If Dr. Khan feared hemorrhage, an anterior chamber lens would avoid that issue. In any case, the lens had to have adequate support to be useful and long-lasting.

Issues raised by Respondent's counsel about the patient's age (78) and consent forms are illogical. If a 78-year-old man is at the end of his actuarial life span, why do a procedure at all? Actuarial tables are averages, this patient was an individual whose own lifespan might extend for many more years. He deserved competent surgical decision making. Likewise, a consent form presumes that the patient knows every procedure has risks. Dr. Khan created unnecessary risks by employing questionable methods.

Finally, Dr. Khan's notes related to his patient's retinal examinations are disturbingly inconsistent. The December note (Ex. 11C at 4) describes both macular degeneration and PVD, the February note (Ex. 11D at 4) describes a macula essentially within normal limits. This

gives rise to questions about the accuracy of Respondent's examination results that have direct impact on patient status and care.

CONCLUSIONS AS TO PATIENT H

H1. **Respondent performed an phacoemulsification of the crystalline lens with posterior chamber intraocular lens implant in Patient H's left eye on December 4, 2000. Respondent failed to appropriately assess the risk of complications during this procedure and/or failed to document such complications.**

There is evident, a clear pattern of erroneous judgment in the assessment of the condition of the sight as the surgery continues. The lack of support must be evident, if not before, then surely after the irrigation and aspiration process. This proposition was emphasized by the Respondent. He argues that the support was there or he would not have concluded the surgery. He does not acknowledge the possibility that he did not appropriately observe the lack of support or that he had caused it during the procedure and failed to notice (or worse, to ignore the error and carry on and hope for the best in order to avoid blame). The evidence of the excessive rate of dislocation of the MA30 lens was equivocal and not convincing. It was

too handy an excuse. There is no other credible explanation of a possible intervening cause for the dislocation in this case. There is good medical judgment and inappropriate medical judgment. The disturbing pattern within Respondent's surgeries, as here, indicate inappropriate medical judgment which constitutes incompetence.

However, assuming that Respondent merely failed to appropriately observe the situation (as opposed to fraudulently covering it up) is not misconduct to fail to chart that which one did not observe. Thus, Specification #16 cannot be sustained relating to proper documentation.

H2. **Respondent performed a vitrectomy and replaced the posterior chamber intraocular lens implant on February 5, 2001. By February 26, 2001, the lens had decentered. Respondent failed to provide sufficient support for the lens implant performed on February 5, 2001 and/or failed to perform an alternative procedure that would have provided adequate support for the lens implant.**

The pattern continued with the second surgery. This procedure demonstrated a clear misjudgment and failure to assess the big picture of the patient's perilous vision status. This constitutes incompetence.

PATIENT I - FINDINGS OF FACT

FINDINGS BASED UPON PATIENT I'S TESTIMONY

229. Patient I was a 70-year-old female patient of Dr. Khan's in November 2000. She had worked as a cashier at a college before she retired. She cared for herself and lived alone. Before seeing Dr. Khan, she had been a patient of Dr. Steckmeyer. Dr. Khan took over Dr. Steckmeyer's practice. Patient I lived in Dunkirk, New York. Brooks Hospital is located in Dunkirk, New York and Dr. Khan maintained an office there as well (T.530-532).

230. Patient I first saw her primary care surgeon, Dr. Smith, for what she believe to be a sty in her left eye (T.533).

231. Dr. Smith referred Patient I to Dr. Khan because Dr. Khan was a specialist in ophthalmology (T.533).

232. When Patient I went ot see Dr. Khan, she had fluid draining from the eye. She had not injured her eye, there was a deep line on the lower lid (T.540).

233. Dr. Khan told Patient I that she needed a biopsy to be performed on her left eye (T.533).

234. Dr. Khan performed a biopsy on Patient I's left eye on April 9, 2001, the pre-operative diagnosis was "rule out sebaceous gland carcinoma" (Ex. 12E at 16).

235. Approximately one week later, April 16, 2001, Patient I saw Dr. Khan in his Dunkirk office so she could obtain the results of her biopsy (Ex. 12A at 5, T.534).

236. The biopsy report had been signed electronically by the pathologist on April 11, 2001. The report was transcribed on April 11, 2001. The report was date stamped "Received April 13, 2001" in the Brooks Memorial Hospital records (Ex. 12E at 16).

237. On April 16, 2001, Dr. Khan saw Patient I in his Dunkirk office and told Patient I that her "**eye was doing good**" (T.535).

238. Dr. Khan also told Patient I at this time that the **eye would take a while before it heals** (T.535). Patient I asked Dr. Khan what the biopsy results were. He told her he didn't know because he didn't have anything in his basket at the hospital (T.535).

239. Dr. Khan did not call the patient with the biopsy results in April, May, June, July or August. In

fact, neither Dr. Khan nor his office staff ever initiated contact with Patient I after the April 16, 2001 visit concerning the biopsy report (T.535-536).

240. Patient I thought her left eye seemed to be getting worse by September of 2001. Patient I was going to call another specialist to check her eye out but she decided, in the meantime, to call Dr. Khan and find out what the biopsy showed (T.536).

241. Patient I called Dr. Khan in September 2001 and spoke to his receptionist. The receptionist said he was "very busy right now" but Dr. Khan would get back to Patient I later (T.536).

242. Patient I told the receptionist the reason she was calling was to find out the results of her biopsy (T.537-537). The receptionist said she would relay this message to Dr. Khan (T.537).

243. A couple of days later, Dr. Khan returned Patient I's call and told her she would have to see a specialist because the eye was cancerous and it needed special attention (T.537).

244. Patient I went to see Dr. Schaeffer in October of 2001. He told Patient I she needed surgery on the eye because it was cancerous (T.537). Patient I

went to Erie County Medical Center on October 11, 2001 to have the cancer removed (T.538).

245. Patient I did not call Dr. Khan from April 16 through August 2001 because she took it for granted there was nothing wrong and that the healing would take a long time (T.544). "I took it for granted it was going to heal slowly. That's what he said" (T.544). Dr. Khan did not give Patient I an appointment to see him after April 16, 2001 to either present her with the report of the biopsy or to provide follow-up care (T.544).

246. Dr. Schaffer told Patient I he thought everything (cancer) had been taken out (October 11, 2001) but that Patient I would have to keep coming to see him to have it (cancer) checked out (T.547).

247. Dr. Schaffer told Patient I there was a possibility of recurrence of the cancer (T.547). He said that additional surgery was possible (T.547). This was the reason he wanted Patient I to come in every few months to have her eye checked (T.548).

FINDINGS BASED UPON DR. PARK'S TESTIMONY

248. On September 25, 2000, Patient I visited Dr. Smith, her primary care surgeon, and complained of a "sty"

in her left eye. The physical exam revealed a sty in the lower lid of the left eye (T.775, Ex. 12F at 11).

249. Dr. Khan's office notes for October 2, 2000 stated that Patient I's lump in the left lower lid began 3 months earlier (i.e., July 2000). The patient's left eye was watery and was itchy (T.775-775, Ex. 12A at 8).

250. On October 2, 2000, Dr. Khan wrote a consultation report to Dr. Smith. Dr. Khan diagnosed the patient with a chalazion of the left lower lid. The patient had not improved previously with AK-Sporin ointment. Dr. Khan noted that the patient said she had noticed the lump three months ago (i.e. July, 2000) (Ex. 12A at 23, T.776-777).

251. A chalazion is a small red bump on the eyelid; lay people usually call it a sty. A chalazion is a benign condition (T.777). It is a common condition. A chalazion is caused by blockage in the oil glands along the eyelid margin. The glands become clogged and a sterile abscess forms around it. There is inflammation and swelling (T.778).

252. On October 2, 2000, Dr. Khan recommended TobraDex, a fairly standard treatment for a chalazion (T.779)

253. Dr. Khan saw Patient I on October 16, 2000. He noted a chalazion in the left lower lid getting better (Ex. 12A at 7, T.780).

254. Dr. Khan saw Patient I on March 12, 2001. He noted a recurring chalazion on the left lower lid. He recommended excision and drainage of the left lower lid under local anesthesia (Ex. 12A at 2-3, T.784).

255. Dr. Khan's History and Physical Examination dictated on April 6, 2001 for Patient I's procedure at Brooks Memorial Hospital stated that the patient developed gradual swelling of the left lower lid and mild discomfort in the left lower lid **of about three to four weeks duration.** In fact, Patient I's condition had existed since July 2000, according to Dr. Khan's own records (Ex. 12E at 3, T.787-788, Ex. 12A at 8).

256. The same History and Physical notes that Patient I is scheduled for "**incision** and drainage of the chalazion" of the left lower lid (Ex. 12E at 3). An incision and drainage does not imply a planned biopsy (T.788).

257. The physical examination dictated on April 6, 2001 noted that Dr. Khan planned to perform "Incision and drainage of the chalazion under local

anesthesia of the left lower lid" (Ex. 12E at 4, T.788). Again, an incision and drainage does not imply biopsy (T.788-789).

258. Dr. Khan's impression, as listed in his physical examination report, was "Chalazion of the left lower lid" (Ex. 12E at 4, T. 789).

259. Dr. Khan's handwritten operative note indicated he performed an excision and drainage of chalazion of Patient I's left lower lid and biopsy of lesion (Ex. 12E at 5).

260. Dr. Khan's preoperative diagnosis on his typed operative report stated "Chalazion of the left lower lid, loss of hair at the lid margin of the left lower lid" (Ex. 12E at 15, T.789).

261. The loss of hair in the lower lid heightens suspicion of cancer. Basal cell carcinoma and squamous cell carcinoma are the two most common tumors arising on the eyelid margin. Basal cell being on the lower lid more often. Some malignancies have borders where there is a loss of hair (T.790).

262. UP to the point when the operative note was done (April 9, 2001), there was not a mention of suspected malignancy in Dr. Khan's notes (T.791).

Up to the point when the procedure took place, suspected malignancy was not noted in Dr. Khan's preoperative diagnostic work-up (T.791).

263. The pathology report preoperative diagnosis stated "chalazion left lower lid, rule out sebaceous gland carcinoma" (Ex. 12E at 16). The Brooks Memorial Hospital pathologist diagnosed the specimen as infiltratory sebaceous carcinoma on April 11, 2001 (Ex. 12E at 16).

264. It was the surgeon's responsibility to obtain the biopsy results and contact the patient with the results (T.794).

265. It was a violation of the minimum standard of care for Dr. Khan to fail to contact Patient I during the months of April, May, June, July or August and part of September 2001 with the biopsy results (T.794). It is a very basic obligation on the part of the surgeon to obtain biopsy results and contact the patient with those results (T.794-795).

266. The risk to a patient who has a suspected malignancy and does not receive biopsy results from her surgeon are significant. They include the risk that the tumor may enlarge, it may invade

contiguous tissue or it can become metastatic (T.795).

267. On October 1, 2001, Dr. Schaefer performed a frozen border analysis excision of the basal cell carcinoma, 50% of the left lower lid with involvement of the left inferior puncta and canaculi. He also performed a reconstruction of the left inferior canaculi with cunicular intubation tubing. Finally, he made a myocutaneous advancement flap from the lateral canthal area and temporal area into the left lower lid (Ex, 12C at 29).

268. In a suspected malignancy or a proven malignancy, such as this, the surgeon needs to make certain that the margins of the excision are clear. The surgeon does a frozen section. The section is then sent to the pathologist, they examine it under the microscope and report back to the surgeon immediately. The surgeon finds out if the margins of his excision are clear (T.796-797). If the margins are not clear, the surgeon keeps cutting until he obtains clear margins, as proved by a pathology report. In Patient I's case, about 50%

of the lower lid was involved and the inferior puncta (T.797).

269. Chalazions do not become malignant. Rather, sebaceous cell carcinoma can masquerade as a chalazion (T.811).

270. Incision and drainage meant that Dr. Khan was not thinking of a biopsy. Excision is an element of a biopsy (T.811-812). The loss of hair on the eyelid margin is suggestive of the growth of something other than a chalazion (T.812). There was no mention in Dr. Khan's office notes on March 12, 2001 of the loss of hair on the eyelid margin (T.813).

271. The surgeon, not the pathologist, is the source of the preoperative diagnosis listed on the pathology report done in April of 2001. Dr. Khan must have told the pathologist to rule out carcinoma of the sebaceous gland (T.813).

272. Dr. Khan was fully cognizant and was aware of the high possibility, if not probability, of carcinoma of the sebaceous gland when he excised the growth that day (T.814).

273. It is incumbent upon a surgeon who is excising a mass with a high suspicion of malignancy to follow

though with the patient and not to await faxes in his office (T.814-815). It is his total responsibility. There are no alibis.

274. It is a surgeons responsibility to call the hospital, call the pathology department to find out whether the biopsy specimen was malignant or not. It is immaterial whether the report was on his table in the office (T.815).

275. The earlier such a cancer is detected, the smaller the lesion and the less complex the surgery would likely be. This applies to both basal cell carcinoma and to sebaceous carcinoma (T.817-818).

DISCUSSION: PATIENT I

This case is extremely troubling. The facts are not disputed by Respondent. This patient had a biopsy performed April 9, 2001. She understood that the biopsy was to determine if a sty was cancerous or not. One week later, Dr. Khan told Patient I that he did not have the results yet but that **her eye was doing good but would take a while to heal.** This statement is incomprehensible. It gave Patient I false assurance. Respondent did not provide a rational explanation for his statement. He testified that Patient I was "lucky" that she had non-invasive

carcinoma. He apparently meant Patient I had a cancer which was locally invasive and not metastatic. However, he did not know the biopsy results on April 16, though they were available at the hospital across the street from his office. Giving the patient false assurance of well being for her eye when the Respondent did not know the results of the biopsy is a violation of the most basic and elementary principles of medicine. To compound his error, Respondent did not obtain the biopsy results. He did not schedule Patient I for a follow-up visit to discuss the biopsy results. He did nothing. Patient I relied upon his reassuring words at the office. When she did not receive a phone call or letter and months went by, she assumed all was well. Only the persistence of the pain and some friends persuaded her to call Respondent's office in September. Respondent misstated in the hospital records the duration of the lower lid condition. He blamed Patient I for his error and testified that she must have given him the inaccurate information. He refused to accept responsibility for the error and said he did not have his office chart with him when he dictated his history and physical exam report for the April 9 biopsy procedure.

Respondent tried to minimize the severity of his neglect by characterizing the cancer as "very, very non-

invasive carcinoma" (T.1711). This too is an error since Respondent was forced to admit during panel questions that the cancer was actually locally invasive. Respondent never bothered to obtain the biopsy results until prompted to do so months later by the patient. Had this been an aggressive cancer, the consequences to the patient could have been much more serious than they were. Respondent, during his testimony, sought to minimize the seriousness of the cancer, justify his false reassurances to the patient and blame the patient for errors in his own dictation that understated the duration of the condition. One would expect Respondent to be contrite, devastated by his negligence and humble in apology. Instead, Respondent minimized and blame shifted wherever possible. This does not bespeak a physician who has learned much from the past or who places the health of the patients first. This case by itself merits serious sanctions against the Respondent's license.

CONCLUSIONS AS TO PATIENT I

I1. **Respondent performed a biopsy on Patient I's left eye on April 9, 2001 with a preoperative diagnosis "rule out sebaceous gland carcinoma." A pathology report dated April 11, 2001 indicated an infiltrating carcinoma.**

Respondent failed to take adequate and/or timely steps to obtain the pathology report and notify the patient of the results.

The Respondent's lack of care towards this patient was egregious and constitutes gross negligence.

I2. **Respondent failed to adequately document his office notes and hospital chart concerning Patient I's possible malignancy.**

This allegation was well established and constitutes failure to maintain an adequate medical record.

VOTE OF THE HEARING COMMITTEE

Specification One	SUSTAINED; based on allegations A2, A3, A8(b), A8(c), B3, B4, C4, C6, D1, E1, G1, G2, G6, I1.
Specification Two	SUSTAINED; Based on allegations A1, A6, C2, D2, G5, H1, H2.
Specification Three	NOT SUSTAINED
Specification Four	NOT SUSTAINED
Specification Five	NOT SUSTAINED
Specification Six	SUSTAINED
Specification Seven	NOT SUSTAINED
Specification Eight	NOT SUSTAINED
Specification Nine	NOT SUSTAINED
Specification Ten	SUSTAINED (without allegation A4 and A5.)
Specification Eleven	SUSTAINED
Specification Twelve	NOT SUSTAINED
Specification Thirteen	SUSTAINED
Specification Fourteen	SUSTAINED
Specification Fifteen	SUSTAINED
Specification Sixteen	NOT SUSTAINED
Specification Seventeen	SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE

This was a long, very technical and vigorously contested case. Both counsel distinguished themselves throughout.

The Committee is keenly aware that these charges are a snapshot in time, magnified, sometimes, out of proportion and are based on a cold and sterile analysis of only medical charts from a distant time. There is much to be said about the insistence of all practitioners to "eyeball" the patient, to hear, to see, to feel in order to properly evaluate. There is also much to be said about the overused phrase "20/20 hindsight". Indeed, mistakes were made with these patients but do they a bad doctor make? It is evident that there is considerable room for reasonable disagreement in the field of ophthalmology.

On the one hand, the Committee observed an aspect of the Respondent's person and presentation which garnered a modicum of respect. The Respondent is a gentleman and practices in a very technical and demanding area of microsurgery. The Committee did find some of his statements credible and persuasive. He was well-prepared academically and seemed concerned to keep up his current medical knowledge. He was not reckless or willful, thus the specification of gross incompetence could not be

maintained and only the treatment of Patient I was deemed gross negligence. His errors, rather, seemed errors of obfuscation.

On the other hand, it was observed that the Respondent was too slow to respond to even his own lawyer's questions on direct, appearing, perhaps, absent-minded but certainly NOT what an observer would call sharp. The same phenomenon was observed about the Respondent's preparation (or lack thereof) for the hearing. Granted, nine patients were being discussed, going back as far as 1997, but it would be expected that if a doctor had the will and means to mount a defense, he should also be able to carry it off. However, he appeared, at times, to be lost in confusion. His lawyer was better prepared to discuss the charts than the Respondent who rendered the care and generated most of the records (sparse as they were).

One point of this discussion is to say that while able to convey a positive impression at times, when this quality is weighed against the not so positive observations stated throughout this document, the latter were more frequent and remarkable, exhibiting a possible systemic problem, perhaps of recent and advancing persistence. It seems that he certainly knew better when treating these patients but he could not correct his lax behavior and/or failed or refused

to recognize his shortcomings. There was a major disconnect between his good intentions and his actions.

Thus, it was decided that the Respondent was unsafe for surgery, without any reasonable expectation that his shortcomings would be improved.

Significant consideration was given to the proposition that although not fit to continue surgery, there might be some hope that the Respondent could still practice in a non-surgical setting with a period of observation. However, when considering the non-surgical treatment of Patients E and I and, more importantly, the very grim and obvious laziness regarding medical records, the Committee reluctantly found that the Respondent could not be trusted even in an office practice, if indeed such an endeavor would even be feasible. There is no excuse for sparse medical records. Failure to document shows a lack of concentration and concern for the patient, which attitude, as in his case and in most others, carries over to patient care.

Respondent's license must be revoked.

ORDER

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

This **ORDER** shall be effective upon service upon the Respondent by personal service or certified or registered mail.

DATED: February 5, 2003

New York, New York

KENDRICK A. SEARS, M.D.
(Chairperson)

DATTA WAGLE, M.D.
MS. JEAN KRYM

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
NISARUDDIN KHAN, M.D.

STATEMENT OF CHARGES

NISARUDDIN KHAN, M.D., Respondent, was authorized to practice medicine in New York State on October 30, 1981, by the issuance of license number 148273 by the New York State Education Department, with a registration address of 1504 W. State Street, Olean, New York 14760.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A from approximately December 1996 through at least May 1998. Respondent provided such care at his office and also at Olean General Hospital, located at 515 Main Street, Olean, New York 14760. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Respondent inappropriately performed a YAG membranectomy on Patient A's right crystalline lens on or about January 29, 1997.

2. Respondent failed to timely document the reason that Patient A's visual acuity had declined from 20/80 to "hand motion" in a three day period.

3. Respondent failed to adequately evaluate Patient A's right eye on January 30, 1997 with regard to inflammation, possible retinal detachment and/or other complications.

4. Respondent failed to adequately document the reason for his use of an anterior chamber implant on March 12, 1997.

5. Respondent failed to adequately document and/or maintain an operative report for the procedure he performed on March 12, 1997.

6. Respondent performed a repeat iridectomy on June 6, 1997. On June 25, 1997 he then removed the anterior chamber intraocular lens implant, performed an anterior vitrectomy, membranectomy and removal of epithelial down growth in the anterior chamber. Respondent failed to adequately diagnose and/or document the diagnosis related to epithelial down growth.

7. Respondent failed to document the etiology of corneal scars listed in his office record on December 11, 1997.

8. Respondent attempted to suture in a posterior chamber intraocular lens implant on March 11, 1998. When that attempt failed, Respondent inserted another anterior chamber intraocular lens.

   a. Respondent failed to document the condition of the retina or the optic nerve.

   b. Respondent failed to prescribe appropriate non-surgical alternatives to Patient A, such as aphakic lens, prior to the March 11, 1998 surgery.

c. Respondent inappropriately inserted a second anterior chamber intraocular lens.

9. Respondent, on March 9, 1998, noted the patient's visual acuity as 20/200 with "extensive corneal scar".

a. Respondent inappropriately recommended a corneal transplant without adequate assessment that the corneal scars caused the decreased vision.

b. Respondent failed to adequately evaluate the patient's posterior pole, and/or optic nerve and/or the patient's visual prognosis prior to recommending this additional surgery.

B. Respondent provided medical care to Patient B, a diabetic male, from approximately March 1997 through, at least August 2001. Respondent provided such care at his office and also at Brooks Memorial Hospital, 524 Central Avenue, Dunkirk, New York 14048.

Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Respondent performed a phacoemulsification with posterior chamber intraocular lens implant on Patient B's left eye on May 14, 2001. Respondent failed to appropriately perform this procedure.

2. Respondent failed to appropriately document the complication(s) that took place during the surgery performed on May 14, 2001.

3. Respondent failed to adequately and/or document the evaluation of the possible causes of the patient's cystoid macular edema and/or corneal edema, noted on a June 25, 2001 visit.

4. Respondent failed to timely evaluate and/or document the evaluation of Patient B's vitreous herniation, wound incarceration and marked disruption of posterior capsule, noted on July 13, 2001.

C. Respondent provided medical care to Patient C, a 64 year old diabetic female, from approximately 1988 through, at least, November of 1999. Respondent provided such care at his office and also at Olean General Hospital.

Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in that:

1. Respondent performed a phacoemulsification of a cataract in Patient C's right eye, followed by a posterior chamber intraocular lens implant, on October 7, 1998. Respondent failed to timely document any complication in his operative notes for this surgery, despite vitreous incarceration to the wound later noted on a post-operative history form, dated January 14, 1999.

2. Respondent, on January 15, 1999 performed a right eye posterior chamber intraocular lens implant into the ciliary sulcus. Respondent failed to provide adequate support for the implant and/or failed to perform alternative procedures which would have provided such support.

3. Respondent's second right eye posterior chamber intraocular lens implant had fallen into the vitreous chamber by February 3, 1999. Respondent then treated the patient with steroid drops. Respondent failed to adequately and/or timely treat the patient's lens dislocation and failed to attempt the lens correction procedure until April 20, 1999.

4. Respondent failed to take adequate steps between February 1999 and March 20, 1999 to address Patient C's risk of developing cystoid edema.

5. Respondent failed to document an adequate retinal examination of the Patient C between approximately February 1999 and March 20, 1999.

6. Respondent failed to make a timely referral of Patient C to a retinal specialist.

7. Respondent's operative note of April 21, 1999 failed to adequately describe whether or not the posterior chamber intraocular lens was removed.

D. Respondent provided medical care to Patient D, from approximately June 1989 through at least March 2001. Respondent provided such care at his office and also at Brooks Memorial Hospital. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately perform the phacoemulsification with posterior chamber intraocular lens implant on Patient D's right eye on February 5, 2001 done at approximately 1245 hours.

2. Respondent failed to provide adequate structural support for the second lens implant performed on Patient D's right eye on February 5, 2001 at approximately 1715 hours.

3. Respondent failed to adequately document the second operation performed on February 5, 2001.

E. Respondent provided medical care and treatment to Patient E from approximately September of 1998 through at least November of 2001. Respondent provided such care at his office and also at Olean General Hospital. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care in that:

1. Respondent, on September 19, 2001 performed a phacoemulsification of the crystalline lens and attempted to implant an intraocular lens into the posterior chamber. During this attempt the intraocular lens fell into the vitreous and Respondent then performed an anterior vitrectomy and anterior chamber lens implant. On November 7, 2001, Respondent examined Patient E's left eye and instructed the patient to return in six months. Respondent failed to appropriately and/or timely evaluate and assess the status of Patient E's left eye during the period of November 7, 2001 through, at least, December 2001.

F. Respondent provided medical care to Patient F from approximately April 1993 until at least October of 2001. Respondent provided such care at his office and also at Brooks Memorial Hospital and Olean General Hospital. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care in that:

1. Respondent performed a phacoemulsification of the natural crystalline lens with posterior chamber lens implant of the Patient F's right eye on March 5, 2001. Respondent performed a YAG capsulectomy on Patient F's right eye on June 7, 2001. On June 7, 2001, the posterior chamber intraocular lens was noted to have dislocated temporarily. Respondent failed to adequately assess complications and/or failed to document such complications in his operative notes for the March 5, 2001 procedure and/or the June 7, 2001 procedure.

G. Respondent provided medical care to Patient G from approximately May of 1999 until, at least, December of 1999. Respondent provided such care at his office and also at Olean General Hospital. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care, in that:

1. Respondent recommended and performed on June 16, 1999 a piggyback intraocular lens implant on Patient G's right eye without first treating cystoid macular edema in the same eye.

2. Respondent failed to use more conservative measures, including glasses, prior to performing surgery on June 16, 1999, despite the presence of cystoid macular edema in Patient G's right eye.

3. Respondent failed to adequately document the manner in which the piggyback intraocular lens was supported in the surgery performed on June 16, 1999.

4. Respondent failed to adequately evaluate and/or document his evaluation of Patient G's vitreous hemorrhage and iris prolapse during 1999.

5. Respondent performed the removal of the original intraocular lens, the piggyback intraocular lens, removal of adhesions to the iris and peripheral iridectomy and reinsertion of an anterior chamber intraocular lens in the right eye, on December 1, 1999. This surgery was performed without adequate indications.

6. The December 1, 1999 surgery was performed despite documented cystoid macular edema in Patient G's right eye.

H. Respondent provided medical care to Patient H from approximately 1983 through at least, April of 2001. Respondent provided such care at his office and also at Brooks Memorial Hospital. Respondent's care and treatment of Patient H failed to meet accepted standards of medical care, in that:

1. Respondent performed an phacoemulsification of the crystalline lens with posterior chamber intraocular lens implant in Patient H's left eye on December 4, 2000. Respondent failed to appropriately assess the risk of complications during the procedure and/or failed to document such complications.

2. Respondent performed a vitrectomy and replaced the posterior chamber intraocular lens implant on February 5, 2001, by February 26, 2001 the lens had decentered. Respondent failed to provide sufficient support for the lens implant performed on February 5, 2001 and /or failed to perform an alternative procedure that would have provided adequate support for the lens implant.

I. Respondent provided medical care to Patient I from approximately November, 1995 through at least November, 2001. Respondent provided such care at his office and also at Brooks Memorial Hospital. Respondent's care and treatment of Patient I failed to meet accepted standards of medical care in that:

1. Respondent performed a biopsy on Patient I's left eye on April 9, 2001, with a pre-operative diagnosis "rule out sebacious gland carcinoma." A pathology report dated April 11, 2001 indicated an infiltrating carcinoma. Respondent failed to take adequate and/or timely steps to obtain the pathology report and notify the patient of the results.

2. Respondent failed to adequately document his office notes and hospital chart concerning Patient I's possible malignancy.

SPECIFICATIONS

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A6, A and A.8(b), A and A.8(c), A and A.9(a), A and A.9(b), B and B.1, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.6, C and C.7, D and D.1, D and D.2, E and E.1, F and F.1, G and G.1, G and G.2, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, I and I.1.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A6, A and A.8(b), A and A.8(c), A and A.9(a), A and A.9(b), B and B.1, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, C and C.6, C and C.7, D and D.1, D and D.2, E and E.1, F and F.1, G and G.1, G and G.2, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2.

THIRD THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

3. The facts in Paragraphs C and C.2.

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

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

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

SEVENTH THROUGH NINTH SPECIFICATIONS

GROSS INCOMPETENCE

7. The facts in Paragraphs C and C.2.

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

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

TENTH THROUGH SEVENTEENTH SPECIFICATIONS

RECORDS

10. The facts in Paragraphs A and A.2, A and A.4, A and A.5, A and A.6, A and A.7, A and A8(a).

11. The facts in Paragraphs B and B.2, B and B.3, B and B.4.

12. The facts in Paragraphs C and C.1, C and C.5, C and C.7.

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

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

15. The facts in Paragraphs G and G.3, G and G.4.

16. The facts in Paragraphs H and H.1.

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

DATED: May 14 ,2002
Albany, New York

Peter D. Van Buren

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