STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

June 1, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ralph J. Bavaro, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Amy T. Kulb, Esq.
Jacobson & Goldberg
585 Stewart Avenue
Garden City, NY 11530

David Benjamin, M.D.
209-2 43rd Avenue
Bayside, NY 11361

RE: In the Matter of David Benjamin, M.D.

Dear Mr. Bavaro, Ms. Kulb and Dr. Benjamin:

Enclosed please find the Determination and Order (No. BPMC-93-79) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than 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), "(t)he 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 all action 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
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	DECISION AND ORDER
OF	:	OF THE HEARING
DAVID BENJAMIN, M.D.	:	COMMITTEE
a/k/a/ ELYAS BONROUHI, M.D.	:	ORDER NO. BPMC-93-79

The undersigned Hearing Committee consisting of **LEMUEL A. ROGERS, JR., M.D., Chairperson, JERRY WAISMAN, M.D., and OLIVE M. JACOB,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Administrative Law Judge,** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) of the New York Public Health Law and sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **DAVID BENJAMIN, M.D.** Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Original Notice of Hearing and Statement of Charges dated:	October 15, 1992
Location of Hearing:	5 Penn Plaza New York, New York 10001
Respondents' Answer Served:	None
The State Board for Professional Medical Conduct appeared by:	Ralph J. Bavaro, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, N.Y. 10001
Respondent appeared in person and was represented by:	Jacobson and Goldberg, Esqs., 585 Stewart Avenue Garden City, New York 11530 Amy T. Kulb, Esq., of Counsel
Respondent's Present Mailing Address:	209-2 43rd Avenue Bayside, N.Y. 11361
Hearings Held on:	December 18, 1992 January 19, 1993 February 2, 1993
Conferences Held On:	December 18, 1992
Closing Briefs Received:	March 5, 1993
Record Closed:	March 10, 1993
Deliberations Held:	March 11, 1993

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with either negligence or incompetence, or both, on more than one occasion; that he has practiced the profession fraudulently and that he failed to maintain adequate patient records. The allegations arise from treatment of five patients in 1990 and 1991. The allegations also arise from an application for privileges to the Catholic Medical Center of Brooklyn and Queens, submitted in 1989. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

David L. Gandell, M.D. Expert Witness

Respondent testified in his own behalf and called one witness:

Anthony Giffone, M.D. Expert Witness

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus

consistent with accepted standards of medical practice in this state. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice.

The Committee was instructed that fraudulent practice constituted an intentional misrepresentation or concealment of a known fact. The Committee was further instructed that the intent and knowledge of a Respondent could be inferred from other facts established in the record.

Finally, with regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing entity could read a given chart and be able to understand a practitioner's course of treatment and the basis for same.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

The Committee was further under instructions that with regard to a finding of medical misconduct, it must first assess Respondent's medical care without regard to outcome,

but rather, as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.

The Committee takes official notice of all relevant provisions of the New York State Public Health Law and The New York State Education Law as well as all relevant provisions of the regulations published thereunder.

The findings of fact in this decision were made after review of the entire record. Numbers in parenthesis, refer to transcript pages (T.__) in the transcript of the proceeding or to pages in the exhibits in evidence (EX.__, p.__). These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant.

The State was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. All findings and conclusions herein were unanimous unless otherwise noted.

GENERAL FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State by the issuance of license number 149484 on

September 16, 1982 and is currently licensed to practice medicine with the New York State Department of Education (Ex.2).

FINDINGS OF FACT

WITH REGARD TO

PATIENT A

1. Patient A, a 33 year old female, was admitted to Kingsbrook Jewish Medical Center on December 10, 1990. Patient A had been pregnant four times. She had had 2 prior miscarriages and one child. Her last menstrual period was October 13, 1990. She complained of intermittent vaginal bleeding since October 26, 1990 and lower abdominal pain (Ex. 4, pp. 1, 2, 6, 8, 12).

2. Patient A had a positive pregnancy test on November 24, 1990. A urinary chorionic gonadotropin (UCG) laboratory test taken shortly after admission on December 10th was also positive (Id. pp. 2, 41).

3. An abdominal and pelvic sonogram on December 10th showed no intrauterine pregnancy. However, there was an inhomogeneous echo pattern seen in the uterus. This finding is consistent with the existence of retained tissue in the uterus following a miscarriage (Id. p. 44; T. 19). Respondent proceeded with a laparoscopy (Ex. 4, p. 26). During the laparoscopy Respondent injured Patient A's bladder (Ex. 4, pp. 13, 26; T. 24). (See finding #14 infra regarding discovery of bladder injury).

4. At 2:45 p.m. on December 10th, Respondent rendered a consultation report. He noted the findings described above. His physical examination found a cervix 1/2 centimeter dilated, "small moderately firm uterus" and the left adnexa was described as "tender". Respondent recommended that Patient A have a dilatation and curettage (D & C) and laparoscopy (Ex. 4, p. 2).

5. The 1/2 centimeter dilation of the cervix is consistent with a recent miscarriage (T. 17).

6. On December 10th, Respondent performed a D & C and diagnostic laparoscopy. The pelvic examination again revealed a 1/2 centimeter dilated cervix, "uterus only slightly enlarged". The left adnexa was described as 4 centimeters and "moderately enlarged". A curettage of the uterus obtained a 1/2 centimeter piece of "questionable placenta" (Ex. 4, p. 26). The pathology report confirmed that the removed tissue was placenta (T. 27-28).

7. The finding of tissue by curettage is suggestive that Patient A had suffered a miscarriage (T. 22).

8. In addition the patient reported bleeding. Patient A also had a normal pulse, normal blood pressure (Ex. 4, pp. 120) and a normal hematocrit (Id. p. 36).

9. Subsequent pathological findings included "fragments of gestational endometrium and chorionic villi. These findings confirmed an intra-uterine pregnancy which had spontaneously aborted (miscarried) (Ex. 4, p. 27).

10. Generally accepted principles of medicine establish these procedures to confirm the presence of a uterine pregnancy: Pathological evaluation of the removed tissue in the operating room or analysis by frozen section, or a complete pathological examination to determine whether the tissue was placenta.

11. Both expert witnesses agree that generally accepted principles of medicine indicate that where an ectopic pregnancy is suspected, serial HCG levels should be monitored. This can be done on an outpatient basis (T. 29-31, 34, 35, 427, 446-447).

12. Post-operatively, Patient A was unable to urinate. Respondent noted that the condition was possibly caused by sphincter spasms. Respondent prescribed oral urecholine 25 mgs. On December 11th at 9:00 am and continued it through December 13th (Ex. 4, pp. 15, 47-49, 52).

13. It is not unusual for a patient to have difficulty voiding after surgery. Generally accepted principles of medicine establish that the indicated procedure is to place a catheter and drain the bladder (T. 31-33, 35, 36 and 461).

14. On December 11th, Patient A still could not urinate. Her abdomen became distended. A foley catheter was placed. On December 13, Patient A's bladder injury was discovered (T. 73-74, Ex. 4, p. 15, 19 and 45).

15. Patient consent for treatment must be based upon sufficient information for the patient to make rational

decisions regarding care options. The minimum requisite elements of an adequate informed consent include: apprising the patient of what the illness or condition is; what the proposed treatment is (plan and possible contingencies); what the risks and benefits are; what the alternatives to the proposed treatment are (T. 36-38, 85; see also N.Y. Public Health Law Section 2805-d).

CONCLUSIONS WITH REGARD TO PATIENT A

In factual allegation A.1, Respondent is charged with a failure to monitor the patient's Human Chorionic Growth (HCG) levels. This charge is sustained. Respondent admitted he did not order serial HCG levels. His defense was that they were unnecessary. According to Respondent, the proper management of this patient required a laparoscopy to rule out a possible tubal pregnancy either in lieu of or in addition to a uterine pregnancy. Thus he performed a D & C as well as a laparoscopy. The Committee rejects this course of treatment. It is the finding of the Committee, based upon the testimony of both the expert for the State as well as the expert for Respondent, that upon the capture of tissue during the D & C, Respondent should have concluded that a uterine pregnancy and partial spontaneous abortion had taken place. Whereas the unlikely

event of a simultaneous tubal pregnancy should have been ruled out, this could have been done by the use of serial HCG tests. Had the patient been serially tested for HCG levels, and the test values gone down during the series, Respondent could have been assured that the pregnancy was terminated. If the levels remained steady or increased, it would have been indicative of a continuing pregnancy and further action would have been warranted. The serial HCG tests would have been non-invasive and could have been done on an out patient basis. The risk to the patient would have been minimal. In contrast, the laparoscopy undertaken by Respondent bore, at a minimum, the risks of general anesthesia and the surgical complications associated with any invasive procedure. In so finding, the Committee notes that the patient was in no pain and showed no signs of distress. She should have been closely monitored and could have been re-admitted had conditions so warranted. The Committee again notes that both experts were in general agreement on these points.

Therefore based upon all the above, the Committee finds:

Allegation A.1 is SUSTAINED

Under Allegation A.2 Respondent is charged with a failure to obtain an adequate informed consent from this patient. The Committee has reviewed the consent form signed

by this patient (Ex. 4, p. 17) and finds it entirely inadequate. The standard set forth in finding of fact 15 states both the legal and medical requirements for the establishment of "informed consent." The two primary considerations for establishing "informed consent" are information and permission. While Respondent obtained permission for the procedures performed on Patient A, it cannot be said that he met even the most rudimentary standards requiring that a patient be informed of risks, benefits and alternatives to the procedures undertaken. It would appear, consistent with the conclusions set forth above, that Respondent did not recognize a non-invasive alternative to the procedure performed. However, having elected to perform a laparoscopy, Respondent, at a minimum, should have informed the patient that bladder perforation or bowel injury was a real and possible risk. The words "poor prognosis," which is the totality or Respondent's explanation of the alternatives and prognosis for this patient, do not begin to explain to this or any other patient the benefits or alternatives to the procedures here, undertaken. For these reasons the consent obtained from this patient is not "informed" and therefore sub-standard.

Accordingly:

Allegation A.2 **is SUSTAINED.**

In Allegation A.3, Respondent is alleged to have performed the laparoscopy on Patient A unnecessarily. The Committee sustains this charge. As set forth above, Respondent could have treated this patient well within accepted standards of medicine without subjecting her to the needless risk of general anesthesia and an invasive surgical procedure. Respondent had clear evidence of a uterine miscarriage. While the unlikely possibility of a tubal pregnancy or other complication had to be addressed, the appropriate method would have been to monitor the patient carefully and perform serial HCG tests on an outpatient basis. There was no justification for performing a laparoscopy on this patient under the facts of this case.

Therefore, based upon the above:

Allegation A.3 **is SUSTAINED**

Under Allegation A.4, Respondent is charged with failing to decompress this patient's bladder. There are two elements of proof offered by the State to establish this charge: The operative note, indeed the entire patient record, does not state that the bladder was decompressed, and the bladder was, indeed, injured. The Committee finds that neither offer of proof establishes the necessary preponderance of evidence. The Committee acknowledges that there is no written confirmation that the bladder was decompressed. Yet, Respondent, in his testimony, insists

that he did in fact decompress the bladder. Furthermore, the testimony of the experts indicates that it is possible to injure the bladder when it is appropriately decompressed. In the absence of direct proof that Respondent failed in this elementary procedure, the Committee finds that the State has failed in its burden of proof.

Therefore, based upon all the above:

Allegation A.4 is **NOT SUSTAINED.**

In Allegation five, Respondent is charged with inappropriately administering multiple doses of Urecholine. The Committee sustains this charge. Respondent did not deny that he gave this patient Urecholine. The sole issue was whether under the facts and circumstances of this case, the administration was appropriate. The salient fact is that after surgery, Patient A could not urinate. Respondent, according to his notes, suspected urethral spasm. Urethral spasm is a form of obstruction. Urecholine causes the urinary bladder to contract. Both expert witnesses agreed that the administration of a substance to cause contractions of the bladder in the face of a suspected obstruction was contraindicated. Furthermore, Respondent prescribed this drug in its oral form. Both experts agreed that Urecholine is not effective when given orally. Therefore, the Commitee citing the opinions of both experts,

finds that the administration of oral Urecholine under the facts and circumstances presented by this patient was inappropriate.

Therefore, based upon the above:

Allegation A.5 is **SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Patient B, a 61 year old female, was admitted to Kingsbrook Jewish Medical Center on March 31, 1990. She presented with a two day history of nausea, vomiting and abdominal cramping. Upon admission, she was found to have a tender abdomen. Pelvic examination showed minimal vaginal discharge and an Intra-uterine device (IUD) string protruding from the cervix. The patient disclosed in her history that the IUD was a Dalkon Shield which had been in place since 1973 (Ex. 5, pp. 1, 9-14; T. 102).

2. On April 4, 1990 Respondent rendered an OB/GYN consultation. He found no pelvic pathology, but recommended removal of the IUD and performance of a diagnostic D & C (Ex. 5, p. 46).

3. On April 18, 1990, Respondent performed a D & C and attempted the removal of the Dalkon Shield (IUD). After the cervix was dilated, Respondent "tried to remove the Dalkon

Shield, by pulling on the string which is attached. He was unsuccessful. He then attempted to remove it by uterine forceps. The forceps perforated the uterine fundus (Ex. 5, p. 54). Nevertheless, immediately after the perforation occurred, Respondent, using a large curette, performed a curettage on the anterior and posterior walls of the uterine cavity (Ex. 5, p. 54, 24 {back}; T. 104).

4. Generally accepted principals of medicine dictate that the performance of a curettage after perforation of the uterus is contraindicated because the placement of the curette relative to the perforation, and the size of the perforation, cannot be known with certainty (T. 105-107, 110, 116-117, 124).

5. Following the perforation and curettage, given Respondent's concern about infection generally accepted principles of medicine would have dictated an immediate exploration, under the same anesthesia, to check for bowel injury, assess bleeding and remove the foreign body, that is, the Dalkon Shield (T. 107-108, 11, 122-123; Ex. 5B, p. 6).

6. An abdominal X-ray on April 19th showed dilated loops of small and large bowel. An IUD was noted in the pelvis (Ex. 5, p. 129). Patient A developed fever, abdominal pain and distension and had absent bowel sounds (Id. pp. 24, 25; T. 10).

7. Respondent performed exploratory surgery on April

19th. The uterine perforation was noted to be two centimeters. The IUD was found in the abdominal cavity. A portion of small bowel had the serosa stripped. This is consistent with an injury caused by curette or forceps on April 18th. Respondent removed the IUD, repaired the uterine perforation, and repaired the defect in the bowel (dilated loops) (Ex. 6, p. 67; T. 109, 125-126).

8. Patient B signed a consent form, which does not describe the consequences, risks or alternatives to the procedure undertaken (T. 110-112, 477-8).

CONCLUSIONS WITH REGARD TO PATIENT B

Allegation B.1 charges Respondent with a failure to obtain an adequate informed consent. The Committee makes reference to the standards discussed under Allegation A.2 and sustains this charge. Once again Respondent did not apprise this patient of the risks or alternatives to the treatment undertaken. The document contained in Exhibit 5 at page 148, which is entitled "patient consent", does not fullfill even the basic requirements of information necessary for a patient to make a knowledgeable and meaningful decision to permit an invasive medical procedure.

Therefore, based upon the above:

Allegation B.1 is SUSTAINED.

Allegation B.2 alleges Respondent proceeded with a curettage despite perforation of the uterus. Respondent did not deny that he curetted this patient after he knew he had perforated her uterus. Continuing with a curettage after perforation of the uterus is contrary to accepted standards of medicine because curettage is a blind procedure, that is the practitioner cannot visualize the various structures he may be in contact with. Since the size and location of the perforation could not be known with certainty, Respondent had no way of knowing if he was enlarging the perforation or damaging organs through the perforation. Both experts agreed that there was significant potential for further serious damage to the patient by continuing with the curettage in the face of a perforated uterus. Therefore the continuation of this procedure after perforation was inappropriate as charged.

Therefore, based upon the above:

Allegation B.2 is SUSTAINED

In Allegation B.3 Respondent is charged with failing to perform a surgical exploration in a "timely" manner. It is uncontroverted that Respondent perforated this patient's uterus and continued with the curettage on April 18.

Exploratory surgery was not performed until April 19. Respondent states that he was concerned with infection. He had both perforated the uterus and curetted after the perforation. On such facts, he had a duty to immediately ascertain what, if any, damage had been done to the organs in the body cavity. The possibility of septic shock, which Respondent said he considered, is one which can arise in a very short time. By waiting an entire day, Respondent, by his own definition, subjected this patient to significant risk of irreversible infection, not to mention a second anesthesia. Again, based upon Respondent's analysis of this situation, there was no excuse for not doing an immediate exploratory procedure.

Therefore, based upon the above:

Allegation B.3 is **SUSTAINED**.

FINDINGS OF FACT

REGARDING

PATIENT C

1. Patient C, a 91 year old female, was admitted to Kingsbrook Jewish Medical Center on October 16, 1990. Patient C was a resident of a nursing home and had organic brain syndrome. She was brought to the emergency room for evaluation of vaginal bleeding (Ex. 6, pp. 1, 2, 6, 13). On the evening of October 16th, Patient C was noted to have

recto-vaginal bleeding (Id. p. 3). Patient C was anemic and received blood transfusions (Id. p. 1, 2).

2. Respondent examined Patient C on October 16th, and recommended an ultrasound, CAT scan, barium enema and D & C (Id. p. 2).

3. An abdominal ultrasound of October 18th showed a two centimeter cyst in the left adnexa. The right adnexa was normal (Id. p. 359). A chest X-ray of October 16th was negative (Id. p. 340).

4. On October 19th Respondent performed a D & C. After dilation of the cervix, a first curettage produced a small amount of tissue from the cervix. On a second curettage "some fatty tissue was obtained due to perforation of the uterus". The tissue was sent to pathology (Id. p. 198).

5. The fatty tissue could only have come from an extra-uterine structure (T. 134). The pathology report (Ex. 6, p. 200) showed no endometrial tissue but noted the presence of ganglion cells (T. 134). The pathologist recommended immediate further evaluation (Ex. 6, p. 200).

6. Post-operatively Patient C had a downhill course and expired on January 10, 1991.

7. The "informed consent form" for the surgery of October 19 (Ex. 6, p. 192) does not document that Patient C's proxy was consulted or given an accurate description of Patient C's condition nor the risks or alternatives of

surgery (T. 136-138). The Hearing Committee incorporates by referenced finding #A17 ***supra***.

CONCLUSIONS
WITH REGARD TO
PATIENT C

Under Allegation C.1, Respondent is charged with a failure to obtain an adequate informed consent. The Committee sustains this charge on two grounds: First, citing the previous discussion of the standards for an informed consent, the Committee finds the document in evidence to be lacking in the fundamental elements required for a patient to give a knowledgeable decision regarding care and treatment alternatives. As with the other examples, Respondent did not give even a basic explanation of the risks and alternatives to the treatment rendered. However, in this case there is an additional element as well: This patient was not mentally competent to give her consent. Therefore her guardian should have been consulted. Nevertheless, there is no evidence in the record that the guardian of this patient was ever consulted.

Therefore, based upon all the above:

Allegation C.1 is **SUSTAINED**

In Allegation C.2, Respondent is charged with a failure to perform a surgical exploration in a timely manner after learning he had perforated the patient's uterus and caused an intra-abdominal injury. It was admitted by Respondent that he had perforated this patient's uterus and obtained non-uterine tissue. This warranted immediate action to ascertain the precise nature of the injury. Time was particularly essential because this patient was 91 years old and extremely elderly patients tend to react slowly to adverse conditions. By the time a patient of this age would show symptoms of sepsis or other complications, it would be likely that it would be too late to correct the situation. Notwithstanding the last point, upon discovery of other than uterine tissue, accepted standards of medicine dictated that Respondent immediately perform a laparoscopy to ascertain what, if any injury had occurred. He did not fullfill this requirement.

Therefore, based upon all the above:

Allegation C.2 is **SUSTAINED.**

FINDINGS OF FACT

WITH REGARD TO

PATIENT D

1. Patient D, a 43 year old female, was admitted to Kingsbrook Jewish Medical Center on December 29, 1990. Patient D had a history of fibroid uterus. She presented

with lower abdominal pain and was found to have a large tender mass in her right adnexal region (Ex. 7, pp. 2, 7, 9, 11, 15). An ultrasound revealed a lobulated solid mass in the pelvis consistent with myoma (Id. p. 83).

2. On January 2, 1991, Respondent performed a D & C, exploratory laparotomy, lysis of adhesions, and a total abdominal hysterectomy, bilateral salpingo-oophorectomy. During the operation, Respondent inadvertently transected the left ureter. It was repaired intraoperatively by a urologist (Ex. 7, pp. 41, 43; T. 151, 152).

3. There are several precautionary surgical techniques used to guard against ureteral injury during the performance of a hysterectomy. For example, pushing down the urinary bladder prior to clamping the uterine arteries and cardinal ligaments etc. causes the ureters to retract and avoid possible transection (T. 153).

4. The document entitled "informed consent" for the surgery of January 2, 1991 does not contain an appraisal of the risks and/or alternatives to the surgical procedure contemplated. Furthermore, there is no detailed description of prognosis without the surgery. Finally, the document does not mention the additional surgery which was performed and which was anticipated at the time the consent was signed (Ex. 7, p. 36; T. 147-160, 165-166). The Hearing Committee incorporates by reference finding #A17 supra.

CONCLUSIONS

WITH REGARD TO

PATIENT D

In Allegation D.1, Respondent is again charged with a failure to obtain an adequate informed consent from the patient. The Committee refers to its earlier remarks about the standards for informed consent and finds that the document in this case did not meet those standards. Page 36 of Exhibit 7 is the consent form in question. It lacks any meaningful description of possible risks, citing only "wound infection." The complication which did indeed occur, that is, the inadvertent severing of a ureter is not alluded to, nor are any other reasonably anticipated untoward events. Respondent again relies solely on the words "poor prognosis" in reference to alternatives and potential outcome if the surgery is not performed. Such language does not begin to give a patient sufficient information upon which to base a rational determination. The Committee finds the document in question to be grossly sub-standard in its paucity of necessary information.

Therefore, based upon the above:

Allegation D.1 is **SUSTAINED.**

In Allegation D.2 Respondent is charged with a failure to manipulate the bladder, define and retract the ureters

and skeletonize the uterine vessels to prevent ureteral injury. The only evidence of Respondent's failure to do so is the lack of any notation stating that the precautions were taken and the injury itself. Whereas Respondent acknowledged that the operative report did not reflect the taking of these precautions, he testified that he did indeed do so. Both experts agreed that the injury cited in this charge could have occurred even if the methods stated in the charge had been undertaken. It is noted that this patient had both adhesions and large fibroid masses in the area which the surgery was performed. The existence of adhesions and masses are not insignificant complications to the process. In the absence of any direct evidence that appropriate care was not undertaken by Respondent, it is the conclusion of the Committee that the State has not met its burden to prove, by a preponderance of the evidence that Respondent failed to take the requisite precautions. The Committee finds that the failure by Respondent to note the procedures and the injury itself, are not sufficient to overcome Respondent's unchallenged testimony that he did take the necessary steps to prevent the accident.

Therefore, based upon all the above:

Allegation D.2 is **NOT SUSTAINED.**

FINDINGS OF FACT

WITH REGARD TO

PATIENT E

1. Patient E, a 41 year old female, was admitted to Kingsbrook Jewish Medical Center on October 23, 1990 under Respondent's care. She had presented to the emergency room on October 22nd with a 4 day history of abdominal pain and irregular vaginal discharge (Ex. 8, pp. 1, 2, 10, 13, 14). Abdominal and pelvic ultrasound on October 23rd, and CAT scan on October 24th revealed a 15 X 14 centimeter pelvic mass, a 12 X 10 centimeter mass in the liver, and possible malignant, metastatic cancer of the lymph nodes, spleen and liver (Id. p. 157, 162). Patient E was found to be severely anemic and in response to that, received multiple transfusions (Id. pp. 100-101, 146-155 170). A chest X-ray on October 25th, a barium enema on October 26th, and bone scan on October 26th were negative (Id. pp. 156, 158, 163 respectively).

2. On October 30th Respondent performed a D & C and culdocentesis. Patient E's uterus was found to be enlarged 17 centimeters in depth. (Normal maximum is 10 centimeters). The Pathologist's report showed secretory endometrium and focal adenomatous hyperplasia (Id. p. 72, 73; T. 176).

3. On November 2, 1990, Respondent performed an operation, recorded in the operative report as an exploratory laparotomy and total abdominal hysterectomy and bilateral salpingo-oophorectomy (Ex. 8, 0. 78). However,

pathological examination revealed that, in actuality, removal of the ovary and fallopian tube was only on the right side, not bilateral (Id. p. 79-81; T. 177-178).

4. In the early part of the operation, Dr. Nicholas was consulted and felt that there was a benign mass in the liver, a possible hemangioma (Ex. 8, p. 78).

5. Following removal of the uterus, the ureter was found to have been. A urologist was called to repair the ureter and arrived at approximately 7:20 pm (Ex. 8, p. 78; T. 179). The operative report however, does not describe the portion of the ureter that was cut, or the repair (T. 187).

6. Patient E was under anesthesia from 11:40 am to 9:25 pm on November 2nd. The operation was noted as beginning at 12:25 pm. The uterus was removed at 2:55 pm. The operation finished at approximately 9:10 pm. Patient E lost approximately 2800cc of blood and required 5 units of packed red blood cells (Ex. 8, pp. 27-28, 75-77).

7. There is information recorded on the anesthesia record which does not appear on the operative report, for example attempts to define and locate the ureteral injury through the use of IV dyes. Many hours in the operating room are unaccounted for in the operative report. The operative report does not include the surgical activity between removal of the uterus and termination of the operation, particularly with respect to blood loss,

transfusion, and ureteral injury (T. 125-189, 195). In addition, the operative report makes no mention of the frozen section pathology report obtained intraoperatively (Ex. 8, p. 79). The operative report makes no mention of examination of periaortic lymph nodes or the spleen intraoperatively (T. 198). The description of the operation as a bilateral salpingo-oophorectomy was not accurate, it was actually a right salpingo-oophorectomy (see finding #E3 supra).

8. Patient E was not accurately apprised of the risks and alternatives to surgery (Ex. 8, p. 63; T. 191-192). The Hearing Committee incorporates by reference finding #A17 supra.

CONCLUSIONS
WITH REGARD TO
PATIENT E

Once again, in Allegation E.1, Respondent is charged with a failure to obtain an adequate informed consent for the surgery herein. Again, referring to the standards discussed throughout this decision, the Committee finds the consent document lacking in sufficient information for a patient to make a rational decision prior to having a total hysterectomy and associated procedures. Once again Respondent limits his explanation of possible risks to "wound infection and mild bleeding." He again explains both

the alternatives and possible outcome, if the surgery is not performed, with the words "poor prognosis." Again, as stated before, the Committee finds the document grossly devoid of sufficient information upon which a patient could make a meaningful, rational decision. As the surgery in fact proceeded, there was significant bleeding as evidenced by the loss of 2800 ccs of blood as well as ureteral injury. Neither of these actual consequences were mentioned nor were other reasonably anticipated untoward outcomes.

Furthermore, Respondent never explains what is meant by "poor prognosis." In sum, a patient is entitled to significant, meaningful information prior to agreeing to what amounts to significant and, possibly life threatening surgery. Respondent did not meet the most basic standards.

Therefore, based upon all the above:

Allegation E.1 is **SUSTAINED.**

In Allegation E.2 Respondent is again charged with the failure to manipulate the bladder, define and retract the ureters and skeletonize the uterine vessels intraoperatively to avoid ureteral injury. The evidence consists of the absence of any written reference to precautions being taken, and the existence of an actual injury. Respondent claims he took the necessary precautions but failed to record same. The Committee makes the same findings it made previously: In the absence of any direct proof that

Respondent failed to take the precautions cited, it cannot be said that the State has met its burden of proof in the face of Respondent's essentially uncontroverted testimony.

Therefore, based upon the all the above:

Allegation E.2 is **NOT SUSTAINED.**

In Allegation E.3, Respondent is charged with a failure to adequately investigate this patient's liver during the surgery. The facts established in this case show that a Dr. Nicholas was called in by Respondent and he diagnosed the patient's liver as having a benign lesion, possibly a hemangioma. Such a diagnosis requires no further action on the part of Respondent, as surgeon. Dr. Nicholas did not file a separate report. In the absence of such a report and in the absence of anything more than the most limited reference in the operative report by Respondent, it is impossible for the Committee to fully assess the intraoperative investigation of this patient's liver. Given the known facts without any direct information to work with, the Committee cannot say the State has met its burden of proof with regard to this charge.

Therefore, based upon all the above:

Allegation E.3 is **NOT SUSTAINED**

In Allegation E.4, Respondent is charged with a failure to prepare an adequate operative report. The Committee

sustains this charge. In so finding, the Committee cites these facts: This surgery took place from aproximately 11:40 a.m. to 9:25 p.m. The report filed by Respondent is devoid of any details of what took place in this almost 10 hour time span. Clearly this patient went through a very serious passage as evidenced by the 2800 cc.s of blood loss and the transfusion of 5 units of packed red blood cells. There is simply no explanation for what constitutes a major use of blood. This paucity of information is a serious violation of standards of medicine which would require a physician to document the major events of an operation. The note which appears in this patient's record is insufficient for these reasons and those set forth in finding of fact 7.

Therefore, based upon all the above:

Allegation E.4 is **SUSTAINED**

FINDINGS OF FACT

WITH REGARD TO

THE APPLICATIONS FOR PRIVILEGES

1. Respondent Dr. David Benjamin was formerly known as Dr. Elyas Bonrouhi. He changed his name to Dr. Benjamin subsequent to May 1986 (Ex. 2).

2. In December 1982, Respondent's temporary privileges at St. Luke's Memorial Hospital Center in Utica, New York were terminated (Ex. 11, pertinent excerpt appended).

3. In December 1983, Respondent's privileges at St.

Elizabeth Hospital in Utica, New York were terminated (Ex. 12, pertinent excerpt appended).

4. In May 1986, in the Matter of Elyas C. Bonrouhi, M.D., an Order of the New York State Department of Education was issued. That Order was based upon a report of a hearing committee of the State Board for Professional Medical Conduct, which had held a 7 day hearing concerning misconduct charges against Respondent pursuant to N.Y. Pub. Health Law 230.

The Order suspended Respondent's medical license and placed him on probation based upon findings that he committed professional misconduct. Specifically, Respondent was found guilty of, among other things, gross negligence, gross incompetence, exercising undue influence over patients, abandoning or neglecting a patient and failing to keep accurate medical records. Respondent was ordered to serve an actual suspension of three months and a stayed suspension and probation for two years, nine months (Ex. 9).

5. In October 1989, Respondent applied for privileges at Catholic Medical Center of Brooklyn and Queens, Inc. That application is in evidence as Exhibit 10. On page 12 of that application, Respondent certified that all the information submitted therein was "true, accurate and complete". In his testimony before the present Hearing Committee, Respondent testified that he was familiar with the application, and that he had read the questions before

answering them (T. 386, 388). However, Respondent made several representations in that application as follows:

(a.) "Disciplinary Actions" Exhibit 10, page 7.

The application asked Respondent whether the following had ever been "investigated denied, revoked, suspended, restricted, terminated, reduced, limited, placed on probation, not renewed or voluntarily relinquished?...

101 Medical License in any State...
105 Membership on any Hospital or Other Institutional Medical Staff
106 Clinical privileges
109 Rights Associated with Practice on any Medical Staff
111 Professional Conduct
113 Any other type of Professional Sanction..."

Respondent answered all in the negative, except for 113. Respondent also gave a negative response to question 120, which inquired whether he had ever been the subject of a disciplinary proceeding. Respondent also gave a negative response to question 119, which inquired whether he had ever been found guilty of violating a patient's rights. In the 1986 state disciplinary action Respondent was found guilty of exercising undue influence over patients (Ex. 9).

In a handwritten explanation on page 15 of the application (approximately mid page) Respondent refers to being "involved in a hearing to investigate {his} competency in medicine and surgery". That statement appears between references to Respondent's own complaints to the Health Department about doctors at Herkimer Memorial Hospital, and

about a suspension and possible appeal to the Court of Appeals.

(b.) "Hospital Affiliations" Exhibit 10, page 4.

The application asked Respondent to:

"{l}ist ALL organizations, hospitals and facilities at which you practice, are associated and/or have privileges as a member of the Medical/Dental/Adjunct Staff or have an application pending and those with which you have been previously associated. If such relationship has been discontinued, indicate the reason for the discontinuance".

Respondent failed to list or give any information regarding St. Elizabeth's Hospital or St. Luke's Hospital (See findings #F2 and F3 supra).

CONCLUSIONS

WITH REGARD TO

THE APPLICATIONS FOR PRIVILEGES

The Committee has reviewed the various documents received in evidence with regard to Allegation F.1, in which Respondent is charged with failing to disclose to Catholic Medical Center past discipline by the State, and Allegation F.2 in which Respondent is charged with failing to disclose to the same institution two prior involuntary terminations of affiliation. The way these charges were drafted required the Committee not just to find that Respondent made misrepresentations, which could have been done in good faith error, but rather, that Respondent "knowingly and intentionally made false representations" to Catholic Medical Center, in order to obtain privileges at that

institution. Thus the possibility of mistake or misunderstanding on the part of Respondent had to be overcome by the Committee in order to sustain even the factual allegations, not to mention the specifications arising from them.

One of the defenses raised by Respondent was that English was not his first language and therefore he had difficulty understanding the questions and providing the precise answers necessary. While the Committee acknowledges that Respondent did speak with an accent, they noted no basic difficulty on the part of Respondent to understand and make himself understood. Furthermore, after listening to Respondent's testimony, and reading his responses which were received in evidence, it is the conclusion of this Committee that Respondent understood the questions presented by the documents in issue and that he understood what the correct answers would have been.

Moreover, a review of the handwritten explanation given by Respondent in his application to Catholic Medical Center, and received in evidence as page 15 of exhibit 10, leads this Committee to conclude that Respondent intended his answer to conceal his past discipline before the State. Furthermore, the evidence referenced, leads the Committee to conclude that the obfuscation was intended to induce Catholic Medical Center to grant him privileges, a grant they might have withheld, had the entire truth been known by

them.

In finding that Respondent knowingly and intentionally attempted to mislead the Catholic Medical Center as charged, so that he could obtain staff privileges at that institution, the Committee rejects Respondent's argument that he was not "involuntarily terminated" from St. Elizabeth and St. Luke's hospitals because he did not have permanent privileges with these institutions at the time. A reading of the entire record makes it clear to the Committee that the institutions, not Respondent, were responsible for the change in affiliation status, that Respondent knew this, and that he intentionally attempted to deprive Catholic Medical Center of this relevant and sought after information in order to obtain privileges with that institution.

Therefore, based upon all the above:

Allegation F.1 is **SUSTAINED**

Allegation F.2 is **SUSTAINED**

CONCLUSIONS

WITH REGARD TO

THE FIRST SPECIFICATION

Having sustained a number of factual allegations, the Committee now turns its attention to the specifications of misconduct to decide if any of the factual allegations sustained, rise to the level of professional misconduct. In The First Specification, Respondent is charged with practicing the profession with incompetence on more than one occassion, citing the facts alleged in Allegations A through E. The Committee finds that Allegations A.1, A.2, A.3 and A.5 plus Allegations B.1 and B.2, plus Allegations C.1, and C.2 plus Allegation D.1 plus Allegation E.1 constitute incompetence on more than one occassion. An analysis of the factual allegations and their relationship to the specifications follows:

In Allegation A.1, Respondent is cited for a failure to monitor quantitative HCG (Human Chorionic Growth) hormone levels. The Committee finds that this was an act of incompetence. In so finding, the Commitee considered these facts and circumstances: Respondent made a finding of "possible placenta" during the D & C performed on this patient. This finding was highly suggestive of a uterine pregnancy. Respondent testified that he performed a laparoscopy rather than serial HCG tests to rule out the possibility of a tubal pregnancy. The Committee rejects

this argument. It is the finding of the Committee that in order to rule out the unlikely possibility of a simultaneous tubal pregnancy, HCG levels should have been measured. HCG levels are associated with the presence of fetal development. Therefore, if the HCG level goes down, there is no fetus and the suspected spontaneous abortion is complete. If the HCG level continues to rise or remains the same, then the physician knows that fetal tissue is still present and the possibility of a tubal pregnancy must be addressed. In the absence of any discomfort or other symptoms on the part of the patient, both experts agreed that HCG tests, on an outpatient basis are both efficacious and non-invasive and thus the appropriate choice was to follow this patient as an out patient.

It is the finding of this Committee that any physician demonstrating appropriate levels of knowledge and expertise would have recognized the HCG regimen as the follow-up treatment of choice for this patient. Therefore, based upon the definitions described above, the Committee finds a single occassion of incompetence.

Allegations A.2, B.1, C.1, D.1, and E.1 all concern a failure to obtain informed consent. The Commitee finds that the facts sustained regarding these Allegations form a pattern of sub-standard practice. Thus, the Allegations will be considered together. In each case presented, the Panel finds Respondent demonstrated insufficiency in his

explanations to his patients of alternatives to, and possible risks associated with, the intended surgery. In addition, with specific reference to Allegation C.1, patient C was incompetent and there was no evidence that her guardian was ever contacted regarding permission for the procedure.

By stating that Respondent has violated the standards for informed consent, the Committee is not finding, as Respondent suggested, that they expect a practitioner to specifically list each and every conceivable untoward outcome or alternative to surgery. However, the basis for "informed" consent is information and the Committee accepts the standards described by Dr. Gandell (T. 36-41) and adopts them as their own. In summary, those standards provide that a patient must be given an understanding of the reasonably anticipated risks, benefits and alternatives to a surgical procedure in order to make a rational decision as to whether or not to undergo the procedure contemplated.

The consent forms executed by Respondent violate this standard because they do not disclose basic information necessary for a patient to decide whether or not to undergo a surgical procedure. Furthermore, the information which Respondent listed in the consent forms affirmatively showed he was unaware of the elements of informed consent. Respondent typically relied upon the phrase "poor prognosis" as an explanation for both alternatives to surgery and

possible risks. On no occassion did Respondent record any discussion of options other than surgery. Furthermore, while on some occasions some risks were listed, on no occasion was there a responsible listing of likely complications nor were the complications which did indeed occur ever listed. During questioning by the Committee, Respondent did not demonstrate he knew the necessity for listing likely complications for a patient. Furthermore, Respondent showed no understanding of what the standards for informed consent are. Rather, Respondent defended his consents as adequate, a position which the Committee finds is indefensible.

Having concluded that Respondent did not evidence the standard of knowledge expected of a physician in this State regarding the elements of an appropriate informed consent and utilizing the definitions previously stated, the Committee finds Respondent's acts constitute five separate occassions of incompetence.

In Allegation A.3, Respondent is charged with performing an unnecessary laparoscopy. The Committee finds that this charge supports a finding of incompetence. As alluded to in the discussion of Allegation A.1 above, the appropriate procedure with which to follow-up on the unlikely possibility of a tubal pregnancy in this patient, was serial HCG tests to be performed on an outpatient basis. Both the expert for the State and Respondent agreed that given a patient with no obvious negative signs or symptoms

such as pain or fever, there was no harm in sending the patient home with instructions to return for HCG tests. Furthermore, HCG tests would have been less invasive and would have confirmed a complete abortion or alerted the physician to the need for further studies. Respondent did not seem to be aware of this alternative. In his testimony, he defended his choice of the laparoscopy as the diagnostic tool of choice in these circumstances. The Committee finds that such a position demonstrates a failure to exhibit that level of expertise expected of a physician in this State and thus constitutes an occassion of incompetence.

In Allegation A.5, Respondent is charged with inappropriately prescribing multiple doses of Urecholine orally. The Committee finds that the facts sustained constitute incompetence. Both the expert for the State as well as the expert for Respondent agreed that Urecholine, administered orally, as directed by Respondent, was ineffective. Furthermore, by his own admission, Respondent thought he was treating a urethral spasm. A urethral spasm constitutes an obstruction. Therefore, using Urecholine, which causes the bladder to contract is contra-indicated because it would cause a powerful contraction against an obstructed urethra.

While Urecholine has its usage, it was entirely inappropriate in this case, both as to its selection as the drug of choice as well as the oral route of administration.

The Committee concludes that the use of Urecholine under the facts herein constitutes an occasion of incompetence in that by prescribing it and in directing oral administration, Respondent demonstrated a lack of expertise and knowledge expected of a physician in this State.

Under the facts sustained in Allegation B.2, Respondent was found to have inappropriately proceeded with curettage after noting a perforation of the uterus. As set forth in the findings of fact, it is inappropriate to continue with a curettage after the uterus is perforated because the physician cannot know the precise location or size of the perforation. By continuing with the process, Respondent risked serious damage to the intra-abdominal organs. He thereby violated a fundamental standard of care and demonstrated a failure of that level of skill and knowledge expected of a physician in this state. Therefore, the acts established constitute an occasion of incompetence.

The facts sustained under Allegation B.2 also establish an occasion of incompetence. In this Allegation, Respondent is charged with a failure to perform a surgical exploration in a timely manner after perforating a uterus and discovering an intra-abdominal injury. The facts sustained show Respondent knew he had perforated the uterus. He also knew he had obtained non-uterine tissue. Respondent testified that he delayed the exploration because he could not know precisely where the non-uterine tissue had come

from. However, such an argument establishes the violation of standards: The Committee finds that an immediate exploratory procedure was warranted, if for no other reason than to ascertain the precise location and extent of the damage. To wait for signs and symptoms of distress was particularly inappropriate in this elderly patient because the elderly are often slow to show symptoms and will commonly do so when it is too late to change the course of care. Absent the elderly nature of this patient, there was still a violation of standards of skill and expertise in that Respondent had more than adequate evidence of inter-abdominal injury, yet took no immediate action to ascertain the extent and location of the damage and appropriately correct the situation. Having concluded that Respondent acted with less than an acceptable level of skill and expertise, the Committee finds an occasion of incompetence.

With Regard to Allegation E.4, the Commitee is asked to consider whether the operative note prepared by Respondent evidences, among other charges, incompetence. The Committee finds that the note does indeed constitute an occasion of incompetence. The standard utilized by the Committee is that set forth in the conclusions which follow Allegation E.4: An operative note should record all the important events in a surgery such that a subsequent reviewer, be it a later treating physician or quality assurance entity or for that matter this board, can know with clarity and certainty

what took place during the surgery and why. The procedure here in question lasted aproximately 10 hours. Much of what took place during that ten hours is a mystery. For instance, why did the patient need 5 units of blood and why were 2800 cc.s of blood lost? Obviously, the patient went through a serious passage but the elements of what took place are lost. It is the conclusion of this Committee that such a paucity of information violates the basic standards of medicine. Any physician exhibiting appropriate levels of skill and knowledge, would recognize that the operative note in this case was substandard. Yet Respondent defended his note as adequate. Therefore, having found Respondent to have acted with less than that level of skill and expertise expected of a physician in this state, the Committee finds an occasion of incompetence.

Accordingly, based upon Allegations A.1, A.2, A.3, A.5, B.1, B.2, C.1, C.2, D.1, E.1 and E.4, the committee finds incompetence on more than one occasion.

SPECIFICATION ONE IS SUSTAINED

CONCLUSIONS

WITH REGARD TO

THE SECOND SPECIFICATION

In the Second Specification, Respondent is charged with practicing the profession with negligence on more than one occasion, citing the facts alleged in Allegations A through

F. The Committee finds that Allegations A.2 and A.3 plus Allegations B.1 and B.3 plus Allegation C.1, plus Allegation D.1 plus Allegation E.1 constitute incompetence on more than one occasion. An analysis of the factual allegations and their relationship to the specifications follows:

As noted earlier, Allegations A.2, B.1, C.1, D.1, and E.1 all concern a failure to obtain informed consent. The Committee finds a pattern of sub-standard practice. Thus the allegations will be considered together. Utilizing much of the analysis stated above, but applying it to the definition of negligence set forth in the begining of this decision, the panel finds Respondent demonstrated insufficiency in his explanations to his patients of alternatives to and possible risks from the contemplated procedures. The committee finds that the patient consents in evidence show a deviation from that level of care and diligence expected of a prudent physician and hence constitutes negligence.

The concerns raised by the consents for surgery in evidence are that they fail to inform and they affirmatively show Respondent did not know the basic elements of "informed consent". The Committee finds that a physician entertaining the level of care and dilligence expected of a prudent practitioner would either be conversant with the informed consent procedure, or obtain the training necessary to bring himself into compliance. It

is impossible for the Committee to imagine a physician practicing in this state who would not be familiar with the issues surrounding patient rights and "informed consent." While it is perhaps possible that one would not be familiar with the elements of informed consent it would be a gross departure from accepted standards to perform surgery without obtaining either an adequate informed consent or sufficient consultation to ensure that an adequate informed consent was obtained from another more qualified than oneself. Respondent failed in this regard to avail himself of either alternative. The consents in evidence manifest gross departures from accepted standards, particularly that in Allegation C.1, where the guardian of an incompetent patient was apparently not consulted.

Therefore having found a departure from that level of care and dilligence expected of a prudent physician in this state, based upon factual allegations A.2, B.1, C.1, D.1 and E.1, the Committee finds five occasions of negligence.

In Allegation A.3, Respondent is charged with performing an unnecessary laparoscopy. As stated previously, the Laparoscopy was unnecessary because there was a non-invasive, safer method to rule out the remote possibility that this patient had a tubal pregnancy. Serial HCG tests were the treatment of choice for this patient. However, Respondent defended his choice of the laparoscopy. The Committee finds that a prudent physician, manifesting

that level of care and diligence expected in this state, would have been aware that the HCG tests are less dangerous and at least as definitive as the laparoscopy performed. Having found sub-standard care and dilligence, the Committee finds an occasion of negligence.

In Allegation B.3, Respondent was found to have failed to perform a surgical exploration after he knew he perforated the uterus and continued the curettage. As was stated previously, it was a violation of accepted standards to perform the curettage after perforating the uterus because the chance of further damage to other organs was increased. Respondent stated that he was concerned about the possibility of infection after the perforation and curettage yet he waited until the following day to perform an exploration. It is the finding of the Committee that if Respondent insisted upon continuing the curettage, and considered the very real possibility of infection, accepted standards of medicine warranted an immediate exploration to ensure that no damage to other organs had taken place. By waiting until the following day, Respondent subjected this patient to a second anesthesia and more important, took a significant chance that full scale sepsis would take place and the patient be severely compromised. The Committee finds that Respondent failed to exhibit that level of care and dilligence in his follow-up with this patient expected of a prudent physician. Accordingly, the Committee finds an

occasion of negligence.

The Commitee has found seven occasions of negligence, citing Allegations A.2, A.3, B.1, B.3, C.1, D.1, and E.1. Therefore:

SPECIFICATION TWO IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE THIRD SPECIFICATION

In the third Specification Respondent is charged with practicing the profession fraudulently based upon the factual allegations under Allegation F. To establish fraudulent practice herein, the State must show Respondent filed an application for privileges at the Catholic Medical Center as a part of medical practice and that he knowingly and intentionally made false representations to that institution regarding both a prior state disciplinary action (Allegation F.1) and terminations of hospital affiliations (Allegation F.2). Intent can be inferred by the Committee from Respondent's knowledge.

In this case there was no dispute that Respondent filed an application with Catholic Medical Center for practice privileges. It was also undisputed that at the time he filed the application, Respondent had full knowledge of the prior disciplinary proceedings against him and that he had full knowledge about the facts and circumstances regarding his

prior separation from two Utica hospitals. Therefore, the Committee was asked to consider whether, based upon the knowledge he had at the time of the application, Respondent made false statements in his application and whether he intended those statements to be misleading. The Committee answers both accusations in the affirmative for both charges.

With regard to Allegation F.1, the Committee finds Respondent's answers were purposely misleading and that Respondent intended to mislead the Catholic Medical Center into believing that he was either never disciplined or that the proceeding was less than final, in order that the institution grant him privileges. The Committee further finds that the granting of privileges is an integral part of the practice of medicine and that accepted standards of practice require that a practitioner be truthful and forthright with institutions when applying for privileges or renewing them. Here, Respondent clearly intended to mislead the institution by falsely answering questions 101 and 113 in the application. Both of those questions would have required Respondent to report that he had previously been the subject of a professional medical conduct proceeding before the New York State Board for Professional Medical Conduct and New York State Education Department. In the disciplinary proceedings referred to, Respondent had been found guilty of professional misconduct, having committed

gross negligence, gross incompetence and other significant offenses. However, Respondent checked off answers in the application that assert that he had never been disciplined. Moreover, Respondent's handwritten explanation, which was attached to the application for privileges, does not cure the falsehood because that document contains assertions about other doctors, suggests that an appeal was underway and nowhere clearly states the fact that Respondent had been the subject of prior discipline and penalty.

Based upon Respondent's testimony and the facts available to, and known by, Respondent, the Committee concludes that Respondent attempted to mislead the Catholic Medical Center in that he submitted an application, as a part of his medical practice, which contained falsehoods. Respondent knew the information was false but was motivated to hide his past disciplinary problems in the hope that he would obtain practice privileges at the institution to which he was applying.

With regard to Allegation F.2, the Committee finds Respondent intended to mislead the Catholic Medical Center by failing to disclose he had been terminated from two Utica hospitals. While Respondent defended his answer to the questions in the application by indicating that he was the one who terminated a non-permanent relationship with the institutions and therefore did not have to disclose the relationship, this assertion is belied by the factual

evidence before the Committee. A reading of the plain language in exhibits 11 and 12 indicate that it was the hospitals which ended the relationship. Notwithstanding which party terminated the relationship, the question presented to Respondent in the application, required him to list all institutions and report the circumstances of dissolution of association where applicable. Respondent failed to even list these former associations. The Committee concludes that he did so because he intended to mislead the Catholic Medical Center into granting him privileges, a benefit he would have been less likely to receive had he been candid with the institution.

Therefore, based upon the above discussion, the Committee finds the facts sustained under Allegations F.1 and F.2 constitute practicing the profession fraudulently.

SPECIFICATION THREE IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FOURTH SPECIFICATION

In the Fourth Specification the Committee is asked to consider whether the operative report referred to in Allegation E.4 constitutes a failure to maintain an adequate patient record. Based upon the earlier discussion of this allegation under the First and Second Specifications, the Committee has already expressed its views about the patient

record in issue. As set forth in the first part of this decision, a patient record must give an accurate and complete picture of the care and treatment rendered to each patient. The report in issue is neither accurate nor complete. In fact, it is starkly and seriously deficient such that a future body, such as this Committee can only guess what took place during a lengthy and apparently serious surgical course. The operative report presented to this Committee in this case represents a gross deviation from accepted standards of accurate and appropriate record keeping and as such constitute a failure to maintain an adequate record in violation of Section 6530 (32) of the Education Law.

SPECIFICATION FOUR IS SUSTAINED

CONCLUSIONS
WITH REGARD TO
PENALTY AND ORDER

Respondent in this proceeding has been found guilty of multiple acts of incompetence, negligence, fraud and a failure to maintain adequate records. The Committee notes that the above findings were made without reference to the substance of the report of the prior discipline which was in evidence. In fact, two of the panel members did not read the substantive parts of the prior disciplinary report until the above findings were made at deliberations. Having found

misconduct however, prior discipline may be considered with regard to penalty.

Nevertheless, based solely on the violations in this proceeding, the Committee finds that the only appropriate penalty for this physician is revocation of his license. In so finding, the Committee cites the following considerations: Respondent has demonstrated repeated acts of surgical incompetence, both in the choice of procedure and in performance of the procedures chosen. Respondent elected to perform a laparoscopy on Patient A when a series of outpatient blood tests would have sufficed. He proceeded with curettage despite perforation of the uterus on at least two occasions and then failed to follow-up on further damage. While severing of ureters does occur, the fact that the two cases in this proceeding occurred over such a short time span is significant in that it shows a propensity for this type of error and shows Respondent is not aware of his surgical limitations.

In addition to surgical incompetence, Respondent has demonstrated he has no understanding of the concepts of patient welfare and rights. The violation of patient welfare can be seen in some of the choices Respondent made both in the procedure undertaken and in follow-up to untoward events as discussed above. But the violation is even more evident in the patient consents in this proceeding. Respondent, in the documents themselves and

during his testimony, affirmatively showed he had no understanding of a patient's right to information prior to surgery. He has no concept of how to explain risks or alternatives so that a patient can make a rational decision as to whether to proceed with surgery or not. In the case of Patient C, who was incompetent, Respondent did not even understand the necessity for permission of the guardian.

In a similar vein, Respondent has demonstrated he has no concept of his record keeping duties for the protection of the patient, himself and the institution he is associated with. The incompetence with which the consents were documented is part of this concept. Absent a clear and appropriate consent, the patient, physician and institution are at risk of misunderstanding and acrimonious results. In addition, the operative report cited earlier exemplifies the failure to understand his record keeping duties for the protection of all concerned in that it is grossly substandard and incomplete. As stated earlier, the operative report in question fails to account for hours of what the circumstantial evidence indicates was difficult and dangerous surgery. Those who were not present simply have no way to determine what happened during what the evidence shows to be a very eventful course. Such a situation is intolerable in a physician practicing in this

state.

Based upon the record of the prior proceeding, Respondent has had significant remediation. The evidence in this proceeding clearly demonstrates that there has been no improvement. Respondent, as evidenced by the facts adduced in this proceeding is a significant risk to the community and must therefore be removed from practice.

Therefore, it is hereby **ORDERED:**

That Respondent's license to practice medicine shall be immediately **REVOKED.**

Dated: Rochester, New York
May 11, 1993

SAMUEL A. ROGERS, JR., M.D.
Chairperson

JERRY WAISMAN, M.D.
OLIVE M. JACOB

APPENDIX I

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

IN THE MATTER	:	STATEMENT
OF	:	OF
DAVID BENJAMIN, M.D.	:	CHARGES
a/k/a ELYAS BONROUHI, M.D.	:	

DAVID BENJAMIN, M.D., a/k/a ELYAS BONROUHI, M.D., the Respondent, was authorized to practice medicine in New York State on April 16, 1982 by the issuance of license number 149484 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1992 through December 31, 1992

FACTUAL ALLEGATIONS

A. Patient A (identified along with all other patients mentioned herein in Appendix A), date of birth September 4, 1957, was admitted to Kingsbrook Jewish Medical Center, Brooklyn, New York, from on or about December 10 through 16, 1990, complaining of excessive vaginal bleeding. Respondent performed a dilatation and curettage (D & C) and laparoscopy on Patient A on December 10, 1990. Respondent:

1. Failed to monitor quantitative HCG levels.

2. Failed to obtain adequate informed consent for laparoscopy.

3. Performed laparoscopy unnecessarily.

4. Failed to decompress Patient A's bladder preoperatively.

5. Inappropriately prescribed multiple doses of Urecholine.

B. Patient B, date of birth October 5, 1928, was admitted to Kingsbrook Jewish Medical Center from on or about March 31 through April 29, 1990. Respondent performed a D & C and attempted removal of a Dalcon Shield on Patient B on April 18 and an exploratory laparotomy on April 19, 1990. Respondent:

1. Failed to obtain adequate informed consent for D & C.

2. Inappropriately proceeded with curettage on April 18 despite perforation of uterus.

3. Failed to perform surgical exploration in a timely manner after perforation of uterus on April 18.

C. Patient C, date of birth June 1, 1899, was admitted to Kingsbrook Jewish Medical Center on or about October 16, 1990 for evaluation of possible vaginal and rectal bleeding. Respondent performed a D & C on Patient C on October 19, 1990. Respondent:

1. Failed to obtain adequate informed consent for D & C.

2. Failed to perform surgical exploration in a timely manner following perforation of uterus and discovery of intra-abdominal injury during D & C on October 19th.

D. Patient D, date of birth February 2, 1947, was admitted to Kingsbrook Jewish Medical Center from on or about December 29, 1990 through January 31, 1991. Respondent performed an exploratory laparotomy and a total abdominal hysterectomy and bilateral salpingo-oophorectomy on Patient D on January 2, 1991. Respondent:

1. Failed to obtain adequate informed consent for surgery of January 2, 1991.

2. Failed to manipulate bladder, define and retract ureters, and skeletonize uterine vessels intraoperatively, so as to avoid ureteral injury.

E. Patient E, date of birth June 14, 1949, was admitted to Kingsbrook Jewish Medical Center from on or about October 23 through November 27, 1990. Respondent performed an exploratory laparotomy and total hysterectomy and bilateral salpingo-oophorectomy on Patient E on November 2, 1990. Respondent:

1. Failed to obtain adequate informed consent for the surgery of November 2, 1990.

2. Failed to manipulate bladder, define and retract ureters, and skeletonize uterine vessels intra-operatively, so as to avoid ureteral injury.

3. Failed to adequately investigate liver intra-operatively.

4. Failed to prepare an accurate operative report.

F. On on about October 16, 1989 Respondent made application for privileges at the Catholic Medical Center of Brooklyn and Queens Inc., Jamaica, New York. Respondent knowingly and intentionally made false representations in that application in that:

1. Respondent answered in the negative questions regarding prior disciplinary actions against him, despite the fact that in May 1986 he was found guilty of, among other things, gross negligence and gross incompetence, and was suspended from the practice of medicine by the New York State Board of Regents.

2. In answer to questions regarding present and past hospital affiliations and terminations thereof, Respondent failed to disclose his involuntary terminations from St. Elizabeth Hospital, Utica, New York in November 1983, and St. Lukes Hospital, Utica, New York in December 1982.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1992), in that Petitioner charges at least two of the following:

1. The facts contained in paragraphs A and A(1)-(5), B and B(1)-(3), C and C(1)-(2), D and D(1)-(2), and/or E and E(1)-(4).

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON

MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1992) in that Petitioner charges at least two of the following:

2. The facts contained in paragraphs A and A(1)-(5), B and B(1)-(3), C and C(1)-(2), D and D(1)-(2), and/or E and E(1)-(4).

THIRD SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2)(McKinney Supp. 1992), in that Petitioner charges:

3. The facts contained in Paragraph F and F(1)-(2).

FOURTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1992), in that he failed to maintain records for patients which accurately reflected the evaluation and treatment of the patients. Petitioner charges:

4. The facts contained in paragraph E and E(4).

DATED: New York, New York
October 15, 1992

CHRIS STERN HYMAN
COUNSEL
Bureau of Professional
Medical Conduct