New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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Office of Professional Medical Conduct

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Chair
Denise M. Bolan, R.P.A.
Vice Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

January 4, 2000

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Marc R. Sklar, M.D.
27 Bleeker Street
New York, NY 10012

RE: License No. 169959

Dear Dr. Sklar:

Enclosed please find Order Modifying Hearing Committee Determination and Order #BPMC 99-303 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **January 4, 2000.**

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Anthony Z. Scher, Esq.
Wood & Scher, Esq.
14 Harwood Court
Scarsdale, NY 10583

Silvia P. Finkelstein, Esq.

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

IN THE MATTER

OF

MARC R. SKLAR, M.D.

ORDER MODIFYING HEARING COMMITTEE DETERMINATION AND ORDER # BPMC 99-303

Upon the proposed Stipulation of MARC R. SKLAR, M.D. (Respondent) for a consent order modifying the Determination and Order of the Hearing Committee, which Stipulation is made a part hereof, it is agreed to and

ORDERED, that the stipulation and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 1/4/00

William P. Dillon MD

WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

MARC R. SKLAR, M.D.

STIPULATION

AND

ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

MARC R. SKLAR, M.D., (Respondent) being duly sworn, deposes and says:

That on or about April 30, 1987, I was licensed to practice as a physician in the State of New York, having been issued License No. 169959 by the New York State Education Department.

My current address is 27 Bleeker Street, New York, NY 10012, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I stipulate that the New York State Board for Professional Medical Conduct has charged me with sixteen specifications of professional misconduct, and that after hearing a Hearing Committee has sustained two specifications, and has imposed sanctions, all as more fully set forth in Determination and Order Number BPMC 99-303, annexed hereto, made a part hereof, and marked as Exhibit "A". I further stipulate that Petitioner Department of Health (Petitioner) has filed a Notice of Appeal with the Administrative Review Board of the State Board for Professional Medical Conduct (ARB), seeking review of the sanction imposed by the Hearing Committee.

In consideration of withdrawal by Petitioner of the pending Appeal to the ARB, I stipulate to modification of the sanction imposed by the Determination and Order of the Hearing Committee, which shall in all other respects remain in effect, as follows:

1. The fully stayed two-year suspension imposed by the Hearing Committee shall be modified and I shall be suspended for a period of two years with the final 22 months of said suspension to be stayed. I shall be fully suspended from the practice of medicine for a period of sixty days, said sixty day period to commence upon issuance of this order. As a result of this modification, under the terms of the Order of the Hearing Committee, I shall be subject to terms of probation during the 22 month period of stayed suspension.

I further agree that the Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and

every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance

with same, incorporating Determination and Order Number BPMC 99-260 and Modifying it as set forth herein. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of further litigation on the merits, I knowingly waive any right I may have to contest the Order for which I hereby apply, whether administratively or judicially, ask that the Application be granted, and agree that such final order be issued.

MARC R. SKLAR, M.D.
RESPONDENT

DATED 12/31/99

Sworn to before me
on this 31 day of December
1999

NOTARY

ANTHONY Z. SCHER
Notary Public, State of New York
No. 4840923
Qualified in Westchester County
Commission Expires February 28, 1999
2000

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 12/31/99

ANTHONY Z. SCHER, ESQ.
Attorney for Respondent

DATE: 12/31/99

SILVIA P. FINKELSTEIN Roy Nemerson
DCPMS Associate Counsel
Bureau of Professional
Medical Conduct

DATE: Jan 3, 2000

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

COPY

IN THE MATTER

OF

MARC R. SKLAR, M.D.

DETERMINATION

AND

ORDER

BPMC 99- 303

GERALD S. WEINBERGER, M.D. Chairperson, **STEPHEN A. GETTINGER, M.D.** and **MS. CHARLOTTE S. BUCHANAN**, 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. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee. After consideration of the entire record, the Hearing Committee submits this Determination.

SUMMARY OF PROCEEDINGS

Amended Statement of Charges (Ex. 1A):	February, 1999
Second Amended Statement of Charges (Ex. 1):	May 3, 1999
Pre-hearing Conference:	May 3, 1999
Dates of Hearing:	May 19; June 8, 28; July 14-5, 19-20; August 3-4, 9-10, 1999
Department of Health appeared by:	**HENRY M. GREENBERG, ESQ.**. General Counsel, NYS Dept.of Health

EXHIBIT "A"

BY: SILVIA P. FINKELSTEIN, ESQ

Respondent appeared by: **ANTHONY Z. SCHER, ESQ.**

Witnesses for the Department of Health:

Lillian Cintron, R. N.

Stephen Gonzales, R.N.

Rita Roberts, R.N.

Janice Robbins, R.N.

Winifred Mack, R.N.

Allan Jacobs, M.D.

Richard U. Hausknecht, M.D.

Witnesses for the Respondent:

Michael Baggish, M.D.

Ann Walsh, R.N.

Kurt Christopher, M.D.

Richard J. Traystman, Ph.D.

Anita Shin, R.N.

Andrew Goldstein, M.D.

David H. Schonholz, M.D.

Clyde T. Jacob, M.D.

Steven D. McCarus, M.D.

Marc R. Sklar, M.D. (Respondent)

Close of Record: September 27, 1999

Deliberations held: October 4, 1999

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's exhibits are designated by Letters.

T = Transcript

A copy of the Amended Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix II.

LEGAL ISSUES

Following service of the Amended Statement of Charges (Ex. 1A) in February, 1999, Respondent made a motion to modify those Charges to remove all references to a Consent Order, entered into by Respondent and the Board in 1997. Respondent also moved to delete a Specification alleging a violation of the Terms of Probation contained within said Consent Order.

The Administrative Officer granted such motion based on a determination that references to the earlier disciplinary action would unduly prejudice the Committee. The fact that Respondent had

previously been disciplined by the Board was considered an issue related to penalty only. The Administrative Officer determined that the Committee should not consider the Board's earlier action when evaluating the Charges associated with the current matter. The Department was directed to amend its Charges a second time (Ex. 1) and the Administrative Officer ruled that the Committee members would be informed of the earlier Consent Order only if a Specification of Misconduct was to be sustained. The Committee could then consider the earlier action when determining a penalty and also when deciding whether Respondent violated terms of his probation.

During this proceeding, the Department offered several additional amendments to the Amended Statement of Charges (Ex. 1). Factual Allegations A. 5., B. 3. and Paragraph E. in its entirety were withdrawn. Allegation D. 1. was amended to delete the word "vaginal".

GENERAL FINDINGS OF FACT

1. The Respondent was authorized to practice medicine in New York State on or about April 30, 1987 by the issuance of license number 169959 by the New York State Education Department. (Ex.2)

2. By a Consent Agreement and Order, entered into by Respondent and the Board in June and July, 1997, the parties resolved a Statement of Charges alleging that Respondent was guilty of professional misconduct in his treatment of six patients in relation to his practice of obstetrics. Respondent agreed that he could not successfully defend against three Specifications, which included practicing the profession with negligence on more than one occasion and failing to maintain accurate records with respect to two patients. Respondent agreed to a penalty of a five year

stayed suspension and a five year period of probation. Terms of probation included requirements that Respondent complete a continuing education program in the Management of High-risk Obstetrical Patients and that he manage the labor and delivery of obstetrical patients only when supervised in his medical practice. (Consent Order # BPMC 97-168; hereinafter, Ex. 2A)

FINDINGS OF FACT RELATED TO PATIENT A

3. Patient A, a 29 year old female, had been diagnosed by Respondent's partner, Dr. Robert Klinger, as having a submucous myoma, which is a benign fibrous uterine tumor. A hysteroscopic vaginal myomectomy was scheduled to be performed by Dr. Klinger at the Phillips Ambulatory Care Center of Beth Israel Medical Center (BIMC) on November 20, 1997. (Ex. 3; T. 1242, 1244-5, 1254-5)

4. A hysteroscopic myomectomy is performed by dialating the cervix to admit a hysteroscope, a telescopic instrument which carries a light and fluid source. An inflow tube introduces a distention medium which distends the uterus to permit visualization of the uterine cavity. The electrocautery element, which resects the myoma, is inserted through the inner shaft of the hysteroscope. An outflow tube is also present to enable the fluid to exit the uterine cavity. The surgeon operating the hysteroscope utilizes two stopcock valves to regulate inflow and outflow of the distention medium. (T. 710-12, 921-4)

5. The hysteroscopic procedure performed on Patient A on November 20, 1997 utilized a Johnson & Johnson VersaPoint Bipolar Electrosurgery System (hereinafter referred to as the

"VersaPoint"). This was a bipolar instrument that accepted a high voltage electrical current to vaporize tissue. The fact that bipolar current was generated permitted the use of saline as the distention medium for the surgery instead of the more commonly used glycine. The advantage of the use of saline would be to reduce the possibility of hyponatremia, or sodium imbalance. (Ex. 5; T. 706, 1212)

6. Respondent was present at Patient A's surgery and acted as an Assistant Surgeon to Dr. Klinger primarily to use the new VersaPoint. Respondent had performed approximately 54 total hysteroscopies, 23 of which were operative or simple hysteroscopies, and had performed or assisted at about 14 laparoscopic assisted vaginal hysterectomies prior to Patient A's surgery on November 20, 1997. Respondent had never used the VersaPoint system before Patient A's surgery. (Ex 3, p. 5; T. 1240, 1243-4, 1288-9, 1328-9, 1332,)

7. There is no difference in the technical performance of an operative hysteroscopy or in the monitoring of fluid input and output when utilizing a bipolar, instead of monopolar, system. The mechanical skill necessary to perform the surgery is similar and should be relatively easily transferred from one system to the other. (T. 538-9, 789)

8. In a memo to the Administrative Director of Surgical Services at BIMC dated October 6, 1997, the Chairman of the Department of Obstetrics and Gynecology initiated the process for obtaining the VersaPoint system for use in the hospital. Facility policy for approving the use of new equipment required that a safety approval be secured from the Engineering Department, and when applicable, the Biomedical Engineering Department. The process for obtaining approval

for the use of the equipment was not completed at the time of its use during Patient A's surgery. Two stickers from the hospital's Biomedical Engineering Department were affixed to the equipment on the day of surgery. (Ex. 7; T. 42, 374-5, 465-6)

9. A sales representative from the Ethicon Division of Johnson & Johnson was present in the operating room during Patient A's surgery. It was not uncommon for a sales representative to be present when new equipment was being used in an operating room at BIMC. (T. 45, 246, 360-1, 373-4, 565-6)

10. During the surgical procedure, the sales representative monitored the VersaPoint system, adjusted one or more settings on the machine on at least one occasion and participated in conversations with the Respondent and others in the operating room related to the performance of the medical equipment. At one point and not acting on a request by Respondent to do so, the salesman moved to squeeze a bag of saline that had been hung. It could not be determined whether or not he actually squeezed the bag. He took no role in the surgery beyond those activities. (T. 156-8, 246, 295-7, 361-2, 1171-3, 1227-8)

11. The surgical procedure began at about 3:00 p.m. and lasted approximately two hours. During the procedure, about 9,000 cc's (9 liters) of saline were infused into the patient's uterus via the hysteroscope and approximately 1,000 cc's were recovered as output from the suction cannisters. About 500 cc's were measured as urine output and spillage was calculated as an additional 500 to 1,000 cc's. At the completion of the surgery, the discrepancy between fluid inflow and outflow was approximately six to seven liters. (Ex. 3)

12. Respondent was present in the operating room for about 60-75 minutes. He left at approximately 4:15 p.m., or about 45 minutes before completion of the surgery. During the period he was assisting Dr. Klinger in the operating room, Respondent operated the hysteroscope for a total of approximately 15-20 minutes. (T. 124-5, 210, 1179, 1267-8, 1274-6)

13. When the surgery was completed, the drapes were removed from around Patient A and abdominal distention and severe edema of her upper body was noted. The patient was catheterized, a diuretic was administered and she was transferred to the hospital's recovery room. Patient A suffered cardio-pulmonary arrest while in the recovery room. She was transferred to BIMC's Emergency Department where she died at approximately 8:25 p.m. (Ex. 3; T. 67, 270-2)

14. The responsibilities of the nurses present in the operating room during a hysteroscopic procedure include the measurement and recording of the inflow and outflow of the distension medium and the reporting of such information to the surgeon. (T. 54, 713-4)

15. The operating surgeon retains overall responsibility for fluid intake and output even if the responsibility to monitor and record input and output has been delegated to the nurses. While he may delegate activities such as recording and monitoring fluid levels, the surgeon retains ultimate responsibility to be aware of fluid input and output. (T. 381-2, 714, 721-3, 730, 916, 1937-8)

16. During the period of time that Respondent was operating the hysteroscope, he had a responsibility to monitor the input and output of the distension medium. (T. 720, 742-6)

17. During the time he operated the hysteroscope, Respondent did not specifically ask of the nurses the status of the inflow or outflow of the fluid. (T. 1316)

FINDINGS OF FACT RELATED TO PATIENT B

18. Respondent first treated Patient B, a 51 year old female, in September, 1997 when she presented with a complaint of abnormal vaginal bleeding of about two months duration. The patient had a history of uterine fibroids. A recent pelvic ultrasound reported a submucosal fibroid. Respondent performed a physical examination, a pap smear and an endometrial biopsy which revealed proliferative endometrium and no evidence of malignancy. (Ex. 8; T. 830-1, 1395, 1398-9)

19. The performance of a physical examination, a pap smear, an ultrasound and an endometrial biopsy were adequate and acceptable actions for Respondent to take in investigating Patient B's complaints of post-menopausal bleeding. (T. 1754-6)

20. Respondent recorded in the patient's medical record that he met with Patient B on October 16, 1997 and reviewed risks and alternatives. A laparoscopically assisted vaginal hysterectomy (LAVH) was performed on October 23, 1997. During the procedure, Respondent severed the patient's left ureter. The surgery was converted to a laparotomy and the hysterectomy was completed. (Ex. 8, T. 1403-6, 1411, 1414-6, 1420-1)

21. It was acceptable for Respondent to have performed either an operative hysteroscopy or hysterectomy on Patient B based on her condition. Which procedure should have been performed would have depended on the choice of the patient. (T. 881-2, 1757)

22. The complication of a severed ureter is one that sometimes occurs during the performance of a hysterectomy. (534-5, 1795)

FINDINGS OF FACT RELATED TO PATIENT C

23. Respondent first treated Patient C, a 40 year old female, in November, 1995 for complaints of dysmenorrhea and menorrhagia. A recent ultrasound indicated uterine fibroids. On August 26, 1997, Patient C was seen by Respondent and was found to be pregnant. Respondent performed an elective abortion on September 19, 1997. (Ex. 10; T. 1565, 1572-5)

24. On September 24, 1997, Patient C was seen by Respondent for a complaint of lower abdominal pain. Respondent diagnosed her as having endometritis and prescribed doxcycline. The patient returned the following day without complaints and a vaginal hysterectomy was scheduled for October 9, 1997. (Ex. 10, p. 13; T. 1575-80)

25. The performance of a hysterectomy for a patient with the symptoms demonstrated by Patient C and as a means of addressing the discomfort of pelvic endometriosis was acceptable and appropriate. (T. 1015, 1639-40)

26. Respondent and the Chief Resident who assisted in the surgery performed at least two examinations of the patient in an attempt to identify the appropriate plane to perform a colpotomy incision from the vagina into the peritoneal cavity. Despite these examinations, the presence of adhesions and the obliteration of the cul-de-sac, or the space between the rectum and uterus, were not identified. While performing the colpotomy incision, a laceration of the rectum occurred approximately 12 centimeters from the anal sphincter. (Ex. 10; T.1538-43, 1558-9, 1582-87)

27. Entering the rectum in the presence of an obliterated cul-de-sac is a known complication. In the case of Patient D, it was not a departure from accepted standards of practice to accidently enter the rectum high up in attempting to get into the cul-de-sac. The cul-de-sac, if it was obliterated, would have been higher than the examining finger and therefore not palpable. (T. 1028-9, 1643-4)

28. The medical record maintained by Respondent for Patient C accurately reflected the patient's condition and indications for surgery. (T.1039-40, 1043, 1647-8)

FINDINGS OF FACT RELATED TO PATIENT D

29. Patient D, a 50 year old woman, was seen by Respondent on May 29, 1997 with a complaint of lower left quadrant pain of one month duration. A pelvic ultrasound performed on May 31, 1997 confirmed an earlier study which demonstrated the presence of an enlarged fibroid uterus. Respondent recorded that she was informed of all risks and alternatives and that all questions were answered. A LAVH was scheduled by Respondent to be performed on July 10, 1997. (Ex. 12, 13)

30. The history of fibroids with an exacerbation of pelvic pain and the presence of an enlarged irregular uterus meets accepted criteria for the performance of a hysterectomy. (T. 1078-9, 1805)

31. During the performance of the LAVH, Respondent lacerated a branch of the left uterine artery which produced a blood loss of approximately 2,000 cc's. Four units of packed blood cells were transfused and the procedure was converted to an abdominal hysterectomy. (Ex. 12, pp. 6-9)

32. It is not uncommon for the ureter to be injured while attempting to control a surgical hemorrhage during the performance of a hysterectomy. (T. 1055-7, 1059-60)

33. During the abdominal hysterectomy, once hemostasis was achieved following the surgical hemorrhage, Respondent failed to recognize that he had damaged Patient D's ureter and failed to address said damage. (Ex. 12, T. 1057-60, 1080-1)

34. Post-operatively, Patient D was found to have an obstructed left ureter which required a left uretero-neocystostomy on July 15, 1997. On the following day, a percutaneous nephrostomy was successfully performed. An ureteral neocystotomy was performed on July 18, 1997 and a "J" stent was inserted. The operative report indicated that a catheter could not be passed because it was felt that the ureter was "kinked". The patient was discharged on July 25, 1997. (Ex. 13, Ex. J)

35. Respondent's medical record for Patient D accurately reflected the condition of the patient and the indications for surgery. (Ex. 12, 13; T. 1820-7)

CONCLUSIONS OF LAW

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

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A. :	(3, 5-6, 9, 11, 13);
Paragraph A. 1. :	(13-17);
Paragraph B. :	(18);
Paragraph B. 4. :	(20);
Paragraph C. :	(23-4, 26);
Paragraph C. 3.:	(26);
Pararaph D. :	(29, 31, 34);
Paragraph D. 4. :	(33).

The Hearing Committee determined that all other Factual Allegations should **NOT BE SUSTAINED.**

The Hearing Committee concluded that the **FIRST** Specification of Charges, as it related to Paragraphs A. 1. and D. 4. only, should be **SUSTAINED** and that the **SIXTEENTH** Specification, relating to the violation of the terms and conditions of probation, also be **SUSTAINED.** The Committee determined that all other Specifications should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions for certain types of professional misconduct. The following definitions were utilized by the Hearing Committee during its deliberations:

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

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

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

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

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

PATIENT A

The Committee concluded that there was much less substance to the Department's charges than an initial review would indicate and that, as a result, a great amount of time and effort was needlessly expended. A majority of the Factual Allegations related to Patient A were not sustained for reasons set out below.

The issues of the allegedly unauthorized presence of the VersaPoint system and the sales representative were seen as matters totally unrelated to the surgical complication of the fluid imbalance. Simply put, there was no evidence that the presence, authorized or not, of either the equipment and/or the salesperson contributed in any way to the surgical complication. The VersaPoint, designed to provide a source of electricity to power the hysteroscope, functioned well. The fact that it may not have been fully authorized for use in the operating room was not related to the quality of care provided Patient A. The record demonstrated that the Chair of the Department of Ob/Gyn had requested that the administrative process to obtain the equipment be undertaken. It appeared that such process had not been completed by the date of Patient A's surgery. The equipment was not brought in by the Respondent and appeared in the operating room with the appropriate stickers from the facility's Department of Biomedical Engineering. There was no evidence that Respondent conspired in some manner to bring unauthorized equipment into the operating room. It was being used to verify the purported advantages of performing the surgical procedure with a safer distension medium. The discrepancy between the fluid inflow and outflow was unrelated to the use of the VersaPoint system.

The Committee also concluded that Respondent did not need additional

specialized training and that he had adequate experience to use the VersaPoint. He had experience in performing simple and operative hysteroscopies. The fact that a bipolar, instead of monopolar, system was being used was not considered to be significant. The medical experts for both parties agreed that the technical performance of the procedure would not differ. The Department contended that the resection of a myoma differs from the vaporization of such a fiboid. The Committee viewed that fact as an insignificant technical distinction unrelated to the overall care provided to the patient. Factual Allegation A. 6. was not sustained.

The portion of Factual Allegation A. 4. referring to Respondent's alleged "failure to demonstrate an acceptable level of skill in the management of Patient A's condition during surgery" was interpreted as referring to his level of skill or competency. The Committee believed Respondent possessed the requisite skill to utilize the VersaPoint and to assist in the performance of the surgery. This conclusion was based on his experience in performing hysteroscopies and the similarities in utilizing a monopolar or bipolar cautery system. Factual Allegation A. 4. was not sustained.

The presence, authorized or not, of the salesperson was also seen as not affecting the care rendered Patient A. It was undisputed that BIMC policy permitted sales representatives to be in an operating room when new equipment was being utilized. The record demonstrated that the salesman took no action while present during Patient A's surgery other than adjusting settings on the VersaPoint and conversing with the surgeons. He fuctioned as a type of a technician and the fact that he spoke with Respondent during the procedure would be expected and was not unusual. The surgeons did not "avail themselves of the instructional and participatory support" of the sales representative beyond that point. There was absolutely no

evidence that he operated, or attempted to operate, the hysteroscope.

There was testimony that at one point the representative moved to squeeze a bag of saline that was hanging. While this would have been inappropriate, it could not be established whether he merely moved toward the saline bag or actually squeezed it. In any event, the Respondent did not ask the sales representative to take such an action. There was no evidence that Respondent was responsible for the presence of the salesman in the operating room and it was clear to the Committee that, all other facts remaining the same, the surgical complication would have occurred even if the sales representative had been properly authorized to be in the room. Factual Allegation A.7. was not sustained.

Paragraph A was sustained as a generally accurate statement of fact providing background information. The stated start of the surgical procedure and amount of outflow were considered to be inaccurate. The patient was noted to be massively swollen at the conclusion of the surgery, well after Respondent left the operating room. The paragraph, by itself, did not constitue professional misconduct.

The Committee felt that the most significant issue presented by the Department's charges related to the treatment rendered to Patient A was the question of Respondent's duty to be aware of the inflow and outflow of the distention medium during the surgery. The members wrestled with the extensive testimony of the nurses in an attempt to evaluate the credibility of their contentions that the surgeons were repeatedly warned of the discrepancy between inflow and outflow during the procedure. The Committee was concerned about the absence of any documentation in the nursing notes which would have confirmed the contention that both Respondent and Dr. Klinger were advised of the fluid discrepancy. Although the notes indicated

the amount of input and output, there was no reference recorded such as "M.D. aware" of the discrepancy. The explanation that such a notation would not have been included because it was not "objective" information was held to be unsatisfactory. It was also observed that no other individual present in the operating room during any portion of the surgery corroborated their testimony and that some of the statements made by the nurses were contradicted by other witnesses. At the end, the Committee could not establish, to any degree of certainty, that the Respondent was informed by the nurses of the fluid discrepancy during the course of the procedure and was unable to determine their credibility. It concluded that the Department failed to carry its burden to demonstrate by a preponderance of the evidence that Respondent ignored repeated warnings from the nursing staff and did not sustain Factual Allegation A. 2.

The surgical complication that arose was not recognized until the drapes were removed from around the patient at the conclusion of the procedure and massive edema was observed. The Respondent had left the operating room at least thirty minutes before and the Committee reasoned he could not have possibly responded to the complication of the fluid discrepancy that arose. The Committee again did not conclude that a preponderance of the evidence demonstrated that he was made aware of the fluid discrepancy during the surgery. Factual Allegation A. 2. was not sustained.

The Committee determined to sustain Factual Allegation A. 1. The facts that the patient was Dr. Klinger's and not Respondent's and that Respondent only assisted in the surgery and actually operated the hysteroscope for approximately 15-20 minutes were considered. The Committee believed that it was appropriate for Respondent to delegate the responsibility to monitor the fluids to the nurses, but did not agree with Respondent's contention that he had no

obligation to ensure that the delegated activity was properly carried out during the time he was actually operating. The Committee accepted Dr. Hausknecht's opinion that the surgeon retains ultimate authority to be aware of fluid input and output even if the duty to monitor the fluids is delegated to the nurses. It agreed that Respondent had a responsibility to monitor the fluids by asking the nurses the status of the input and output if he was not being advised of such information. Respondent's failure to inquire, during the 15-20 minutes he was performing the surgery, as to the status of the fluid input and output was considered to be inappropriate and below acceptable standards of practice.

PATIENTS B AND C

The Committee reached similar conclusions about these two cases. Paragraphs B and C were sustained as being accurate statements of fact that did not constitute professional misconduct. Respondent's performance of a physical exam, pap smear, ultrasound and an endometrial biopsy were considered to be adequate and acceptable actions to investigate Patient B's complaint of post-menopausal bleeding. The Committee did not deem it necessary for Respondent to have performed a D & C and hysteroscopy under the circumstances. Respondent recorded that he had reviewed all alternatives with the patient and the Committee agreed with the Department's expert that the choice was appropriately left to her. Factual Allegations B. 1. and B. 2. were not sustained. Factual Allegation B. 4. was sustained as an accurate statement of fact. It was not considered to constitute misconduct because a severed ureter was recognized as a a complication that may occur during the performance of a hysterectomy.

Patient C saw Respondent for treatment of dysmenorrhea and menorrhagia. An ultrasound demonstrated uterine fibroids. Respondent diagnosed Patient C as having endometritis. Dr. Hausknecht agreed that those were appropriate indications for the performance of a hysterectomy. Factual Allegation C. 1. was not sustained.

Respondent and the Chief Resident who assisted in the surgery each examined the patient in an attempt to identify an appropriate plane to perform the colpotomy incision. They each testified that they could not feel evidence of an obliterated cul-de-sac or of endometriosis despite the multiple rectovaginal examinations. The contention of the Department's expert was that the obliteration and endometriosis should have been palpable. The Committee felt that the testimony of the two physicians present at the surgery was credible and that their statements that they conducted several examinations prior to making the incision should be accorded greater weight than that accorded Dr. Hausknecht's opinion. Whether it should have been felt was a judgement call; Dr. Schonholz, testifying for Respondent, opined that the obliteration and endometriosis could have been detected or could have been missed. The Committee felt that the Department was relying on hindsight to expect Respondent to have discovered the abnormal anatomy and that it was more relevant that Respondent and the assisting Chief Resident made diligent and reasonable attempts to establish the proper plane prior to making the incision. Factual Allegation C. 2. was not sustained.

Factual Allegation C. 3. was considered to be an accurate factual statement that did not constitute professional misconduct. The Committee concluded that the medical records maintained for Patient C accurately reflected her condition and the indications for surgery and did not sustain Factual Allegation C. 4.

PATIENT D

Paragraph D. was sustained as an accurate statement of fact that did not constitute misconduct.

The Committee considered Factual Allegations D. 1. and D. 2. to be essentially the same and did not sustain either. The charge would have been different than D. 2. had the former alleged that Respondent "failed to establish the cause of the patient's pain." The complaint of lower left quadrant pain in conjunction with the presence of an enlarged fibroid uterus were determined to be appropriate indications for the performance of a hysterectomy. As with Patient B, the record demonstrated that Patient D was informed of alternatives and risks and the Committee believed that the patient should be given deference in her choice of treatment.

Dr. Hausknecht testified that it was not uncommon for a surgeon to injure a ureter while attempting to control excessive bleeding. He stated that he did not consider the damage to Patient D's ureter to be inappropriate or a deviation from accepted standards of care. Factual Allegation D. 3. was not sustained.

What Dr. Hausknecht concluded was a deviation was Respondent's failure to appreciate that the ureter had been injured and failure to take appropriate action in response. The Respondent testified that the hemorrhage did not occur near the ureter and he did not believe it had been damaged while he was attempting to control the bleeding. Patient D developed a subsequent ureteral obstruction. The operative report of the urologist who performed a ureteral neocystotomy on July 18, 1997 indicated that a catheter could not be passed through the ureter because the ureter was "kinked" and could not be bypassed. Dr. McCarus, testifying on behalf of

the Respondent, indicated that a surgeon may mistakenly feel he is operating far from the ureter when, in fact, he is not. The Committee agreed that Respondent should have exercised greater caution by taking action to confirm the integrity of the left ureter after hemostasis was established. Factual Allegation D. 4. was sustained.

The Committee concluded that the medical record maintained for Patient D did accurately reflect her condition and indications for surgery. Factual Allegation D. 5. was not sustained.

SPECIFICATION OF CHARGES

The Committee concluded that the failures of Respondent to meet accepted standards of practice, as set out in Factual Allegations A. 1. and D. 4. constituted the practice of medicine with negligence on more than one occasion, but were not so egregious as to constitute gross negligence. This decision was made after the Committee members were instructed that they were not to consider either the fact that Patient A died, that Respondent contributed in any manner to the patient's death or that the death was caused by a fluid overload. The Committee made its determination as to whether Respondent had practiced the profession with gross negligence by considering if Respondent's conduct would have been an egregious failure to exercise the care that would have been exercised under the circumstances by a reasonably prudent physician had Patient A fully recovered from the surgical complication and been discharged in good health.

In reaching this decision, the Committee considered the fact that Respondent only assisted in Patient A's surgery and that he performed a small amount of the actual procedure. The Committee felt it important to note that the finding of Respondent's misconduct in his treatment

of Patient A was based on the failure to inquire as to the status of the distension fluid and was completely unrelated to the presence of the VersaPoint and/or the sales representative. The members of the Hearing Committee concluded that Respondent should have asked the nurses as to the status of the fluid inflow and outflow if he were not provided such information during the times he actually operated the hysteroscope. The failure to appreciate the injury to Patient D was also not seen to be so egregious as to be a gross deviation from accepted standards.

The Committee did not consider Respondent's acts or failures to act to constitute practicing with incompetence or with gross incompetence. It felt that he was experienced in the performance of operative hysteroscopies and that he required no additional training to use the VersaPoint or saline to perform the procedure. The surgical complication that arose was the result of negligent, not incompetent, practices. The failure to determine that Patient D's ureter had been damaged was also not believed to indicate that Respondent lacked the requisite amount of skill and knowledge to practice.

Having determined to sustain the Specification that Respondent had practiced with negligence on more than one occasion, the Committee was provided with the original Amended Statement of Charges (Ex. 1A) and the members were made aware of the earlier disciplinary action taken by the Board against Respondent's medical license. The Committee relied on this information in determining the appropriate penalty to impose. A conclusion was made that by having been found to have practiced with negligence on more than one occasion, Respondent violated the general term of his probation that he "conform fully to the professional standards of

conduct and obligations imposed by law and by his profession." The Committee sustained Specification Sixteen and found that Respondent had committed professional misconduct by violating the terms and conditions of his probation.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's license to practice medicine in New York should be suspended for two years, said suspension to be stayed, and that he be placed on probation in accordance with the Terms of Probation as set forth in Appendix I during said period of stayed suspension. Included in the Terms of Probation were requirements that Respondent perform all major gynecological surgeries only when supervised by a licensed physician, board certified in Obstetrics and Gynecology, and that such surgeries only be performed in a supervised practice setting. This decision was made following due consideration of the full spectrum of penalties available pursuant to statute, including license revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee expressly rejected the Department's request that Respondent's license be revoked for several reasons. The earlier disciplinary action by the Board related to Respondent's practice of obstetrics. Of the three Specifications in the 1997 Consent Order to which he agreed he could not defend, two related to violations of record-keeping standards. The instant case was concerned with Respondent's gynecological practice and none of the allegations of record-keeping violations were sustained. Patient A was actually the patient of Dr. Klinger and not

Respondent. It was noted that Respondent testified that he may have made a greater inquiry into the status of the fluid had Patient A been his own, as per his procedure when performing surgery on his own patients.

It was also determined that the fact that Respondent was found to have violated a term of his probation did not justify imposition of a greater penalty than that imposed by the Committee for his having been found to have practiced with negligence on more than one occasion. The finding of a violation was not for failing to comply with specific requirements such as practicing obstetrics only when supervised or failing to participate in continuing medical education courses. Instead, it was based on a general failure to practice in accordance with accepted professional standards. The Committee did not feel any additional penalty was required in such a case.

The Committee concluded that Respondent has the necessary skill and knowledge with which to continue to practice. It therefore felt that further requirements for his participation in continuing medical education would be unnecessary. He appeared sincerely remorseful as to the events which ultimately resulted in Patient A's death. The Committee was convinced that those circumstances were unlikely to reoccur during the course of Respondent's practice. The substandard care rendered Patient D was seen as an error of judgement rather than a deficiency in skills. The members of the Committee believed that the public would be adequately protected if Respondent were to perform major gynecological surgery for a two year period only with the supervision of a practice supervisor and only in a supervised practice setting and concluded that it would be inappropriate to revoke his license to practice medicine.

ORDER

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

1. The First Specification of Charges as set forth in the Amended Statement of Charges (Ex. 1-A), as it relates to Paragraphs A. 1. and D. 4. only, and the Sixteenth Specification of Charges are **SUSTAINED;** and

2. All other Specifications of Charges set forth in the Amended Statement of Charges (Ex. 1-A) are **NOT SUSTAINED** and are hereby **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be hereby **SUSPENDED** for a period of two years, said suspension to be **STAYED**; and

4. Respondent shall be placed on **PROBATION** during the period of the stayed suspension of his license, and he shall comply with all terms of probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order.

5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York

12/6 ,1999

GERALD S. WEINBERGER, M.D. (Chair)

STEPHEN A. GETTINGER, M.D.

MS. CHARLOTTE A. BUCHANAN

TO:

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APPENDIX I

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 4th Floor, 433 River Street, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide periodic written verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients.

7. Respondent shall practice major gynecological surgery only when supervised in his medical practice by a physician board certified in Obstetrics/Gynecology ("practice supervisor"). The practice supervisor shall be on-site at all locations at which Respondent performs major gynecological surgery, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.

a. Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess Respondent's medical practice. Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

b. Respondent shall authorize the practice supervisor to have access to his patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address all aspects Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review and other such on-duty conduct as the supervisor deems appropriate to report.

c. "Major" gynecological surgeries shall include, but shall not be limited to the following procedures:

1. abdominal surgeries;
2. laporascopically assisted vaginal hysterectomies (LAVHs);
3. vaginal hysterectomies and vaginal reconstructions; and
4. operative hysteroscopies.

8. Respondent shall perform gynecological surgeries of any kind only in an Article 28 licensed hospital setting ("supervised setting") where close practice oversight is available on a daily basis and where quality assurance and risk management protocols are in effect. Respondent shall not practice medicine until the supervised setting proposed by Respondent is approved, in writing, by the Director of OPMC.

9. Respondent shall submit semi-annually a signed Compliance Declaration to the Director of OPMC which truthfully attests whether Respondent has been in compliance with the practice supervision and supervised setting requirements.

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.

APPENDIX 2

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

Dept I EV
DATE 5-19-99

IN THE MATTER
OF
MARC R. SKLAR, M.D.

AMENDED
STATEMENT
OF
CHARGES

MARC SKLAR, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 30, 1987, by the issuance of license number 169959 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about November 20, 1997, Respondent, an obstetrician-gynecologist, undertook the care and treatment of Patient A, a 30 year old female, at the Phillips Ambulatory Care Center of Beth Israel Medical Center (BIMC). On that date, Patient A underwent a hysteroscopic vaginal myomectomy because of a demonstrated submucous myoma. (The Patients are identified in the annexed Appendix B). During the hysteroscopic vaginal myomectomy referred to above, a surgical salesman was present in the operating room instructing and/or assisting the surgeons in the use of a new bi-polar cautery unit (Versapoint). During the procedure, which began at 2:00 p.m. and lasted until 5:10 p.m. Patient A received 9000 cc of normal saline infused into the uterus. Only 1000 cc were measured as output. Respondent left the O.R. at 4:30 p.m. The patient was noted to be massively swollen. In the recovery room she suffered cardio-pulmonary arrest.

Despite various resuscitative efforts the patient expired. The autopsy is consistent with fluid overload. Respondent engaged in conduct as follows:

1. Respondent failed to appropriately act in response to the dangerous condition created by the discrepancy in the amount of fluid infused into the uterus versus the fluid output;

2. Respondent failed to appropriately act in response to repeated warnings from the nursing staff regarding the unusual disproportion in the Patient's fluid output;

3. Respondent did not appropriately act in response to the complications that arose during the surgery;

4. Respondent failed to demonstrated an acceptable level of knowledge in the management of Patient A's condition during surgery, the use of the instrumentality involved and in the performance of the procedure;

5. Respondent failed to maintain a medical record for Patient A which accurately reflects the condition of the Patient during surgery and the circumstances surrounding the surgery.

withdrawn JA

6. Respondent inappropriately participated in the surgical procedure performed on Patient A knowing that neither he, nor the other participants in the surgery, were adequately trained and/or experienced in the performance of an operative hysteroscopy procedure using an unauthorized electrocautery unit (Versapoint) that

utilized saline, instead of glycine. as the fluid distension medium.

7. Respondent inappropriately participated in the surgical procedure performed on Patient A in that he facilitated and/or availed himself of the instructional and participatory support of a medical equipment salesman who was not a licensed health care provider and who was not authorized by the hospital to be present in the operating room and/or to participate in the surgery.

B. Respondent, an obstetrician-gynecologist, undertook the care and treatment of Patient B, a 51 year old female, at his office located at 461 Park Avenue South, New York, N.Y. 10016. Commencing on or about September 8, 1997 Patient B presented for evaluation of abnormal vaginal bleeding for 2 months. On or about September 15, 1997, Respondent diagnosed a small subserosa intramural myoma by ultrasound, an endometrial biopsy revealed benign proliferative endometrium and a physical exam revealed a uterus 14 cm in size. On or about October 23, 1997, Respondent performed a laparoscopically assisted vaginal hysterectomy (LAVH) on Patient B at Beth Israel Medical Center . During the procedure, which lasted 7 hours, Respondent severed the left ureter. This was noted, the surgery was converted to a laparotomy and the left ureter was reimplanted in the bladder. The hysterectomy was completed. The pathology report indicated a 120 gram uterus and an endometrial polyp. Respondent engaged in conduct as follows:

1. Respondent failed to properly investigate Patient B's post-menopausal bleeding;

2. Respondent failed to perform a D& C and hysteroscopy which were indicated to address Patient B's symptoms;

withdrawn 7/14/99 JA

3. Respondent inappropriately performed a hysterectomy which was unwarranted by Patient B's symptoms;

4. Respondent severed Patient B's left ureter during the surgery;

C. Respondent, an obstetrician-gynecologist, undertook the care and treatment of Patient C, a 42 year old female, at his office located at 461 Park Avenue South, New York, N.Y. 10016. Commencing on or about November 16, 1995, Patient C presented with a long history of dysmenorrhea and menorrhagia. A pelvic ultrasound revealed uterine fibroids. Respondent noted the recommendation of a vaginal hysterectomy. Patient C was seen on August 26, 1997 and found to have an early pregnancy. Respondent performed an elective abortion on September 15, 1997. On or about September 24, 1997, Patient C was seen by Respondent, diagnosed with endometritis and doxycline for 10 days was prescribed. On September 25, 1997, the exam was negative and Patient C was scheduled for a vaginal hysterectomy on October 10, 1997, at Beth Israel Medical Center. The indication for surgery was stated by Respondent to be pelvic pain. In performing the vaginal hysterectomy, Respondent entered the rectum at about 12 cm above the anal sphincter. Because of the rectal laceration the hysterectomy was converted to an abdominal hysterectomy and repair of the laceration and a temporary loop colostomy were performed. The operative note indicates dense pelvic adhesions and an obliterated cul the sac. Respondent engaged in conduct as follows:

1. Respondent failed to establish the indications for a vaginal

hysterectomy;

2. Respondent failed to appropriately act in response to the surgical complications presented by an obliterated cul de sac which should have been obvious to him as soon as the procedure began;

3. Respondent created a rectal laceration in the performance of a vaginal hysterectomy;

4. Respondent failed to maintain a medical record for Patient C which accurately reflects the condition of the Patient or the indications for surgery.

D. Respondent, an obstetrician-gynecologist, undertook the care and treatment of Patient D, a 51 year old female, at his office located at 461 Park Avenue South, Ne York, N.Y. 10016. Patient D presented for evaluation of fibroids and left lower quadrant pain of one month's duration. A pelvic ultrasound performed on May 31, 1997 revealed no significant change from one performed on June 6, 1994. On Jul 10, 1997, a laparoscopic assisted vaginal hysterectomy (LAVH) was attempted an Respondent lacerated a branch of the left uterine artery which produced bleeding estimated a 2000-2500 cc's and 4 units of packed cells were transfused. Difficulty was encountered in attempts to remove the uterus laparoscopically. The procedur was converted to an abdominal hysterectomy. The surgery lasted approximately 5 hours. Post-operatively Patient D was found to have an obstructed left ureter whic required a left uretero-neocystostomy on July 15, 1998. On July 16, 1997 a percutaneous nephrostomy was successfully performed. On July 18, 1997, surger was performed again and a "J" stent was inserted. Patient D was discharged on

July 25, 1997. Respondent engaged in conduct as follows:

1. Respondent failed to establish the indications for a vaginal hysterectomy;

2. Respondent performed a surgical procedure on Patient D (LAVH) which was unwarranted by the condition of the patient;

3. Respondent inappropriately damaged the left ureter during attempt to control a surgical hemorrhage;

4. During an open abdominal hysterectomy Respondent failed to recognize that he had damaged Patient D's left ureter and failed to address said damage;

5. Respondent failed to maintain a medical record for Patient D which accurately reflects the condition of the Patient or the indications for surgery.

E. On or about December 9, 1997, the Departmental Credentials Committee of Beth Israel Medical Center had advised Respondent that the cases involving Patient B, Patient C and Patient D had been reviewed and instructed him to have another physician present when performing vaginal hysterectomies and laparoscopically assisted vaginal hysterectomies and to seek intraoperative consults in the event of a disagreement between him and the senior resident regarding a procedure. Thereafter, on or about January 26, 1998, Respondent resigned from Beth Israel Medical Center in contemplation of disciplinary action being taken by BIMC against

withdrawn 3/4/99

him. Respondent engaged in conduct as follows:

1. On or about February 22, 1998, Respondent filled out an Application for Appointment to the Voluntary Medical Staff of New York Methodist Hospital wherein was asked, under the section: "Professional Sanctions" the following: "3. Has your medical staff membership and/or clinical privileges at any health care institution ever been suspended, revoked or voluntarily or involuntarily reduced, limited, or relinquished?" Respondent knowingly and with intent to deceive falsely answered: "No".

2. In the same document, Respondent was asked: "4. Are there currently or have there been any past challenges to your medical staff membership and/or clinical privileges at any health care institution?" Respondent knowingly and with intent to deceive falsely answered: "No".

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, B, B.1, B.2, B.3, B.4, C, C.1, C.2, C.3, C.4, D, D.1, D.2, D.3, D.4, and D.5.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, B, B.1, B.2, B.3, B.4, C, C.1, C.2, C.3, C.4, D, D.1, D.2, D.3, D.4, and D.5.

THIRD THROUGH SIXTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. The facts in paragraphs A, A.1 through A.4, A.6 and A.7;
4. The facts in paragraphs B, B.1 through B.4;
5. The facts in paragraphs C, C.1 through C.3;
6. The facts in paragraphs D, D.1 through D.4.

SEVENTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. The facts in paragraphs A, A.1 through A.4, A.6 and A.7;
8. The facts in paragraphs B, B.1 through B.4;
9. The facts in paragraphs C, C.1 through C.3;
10. The facts in paragraphs D, D.1 through D.4;

ELEVENTH SPECIFICATION

FRAUDULENT PRACTICE

withdrawn 8/4 JA

Respondent is charged with committing professional misconduct as defined by N.Y Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

11. The facts in paragraphs E, E.1 and E.2.

TWELFTH SPECIFICATION

VIOLATING SECTION 2805(K) OF THE PUBLIC HEALTH LAW

withdrawn 8/4 JA

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(14)(McKinney Supp. 1999) by violating § 2805(k) of the Public Health Law, as alleged in the facts of:

12. Paragraph E, E.1 and E.2.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

13. The facts in paragraph A.5.

14. The facts in paragraph C.4.

15. The facts in paragraph D.5.

DATED: May , 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduc