STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

January 6, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Claudia Morales Block, Esq.
NYS Department of Health
145 Huguenot Street
New Rochelle, New York 10801

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123 William Street
New York, New York 10038

Edward Lee Saxler, M.D.
c/o Alan Lambert, Esq.
McAloon & Friedman, P.C.
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New York, New York 10038

RE: In the Matter of Edward Lee Saxer, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 04-01) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien/cah

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah
Enclosure

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

COPY

IN THE MATTER OF EDWARD LEE SAXER, M.D.	DETERMINATION AND ORDER BPMC #04-01

CALVIN J. SIMONS, M.D., Chairperson, **MARVIN HARTSTEIN, M.D.** and **ALAN KOPMAN,** 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. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.,** General Counsel, **CLAUDIA MORALES BLOCK, ESQ.** Associate Counsel, of Counsel. The Respondent appeared by **McALOON & FRIEDMAN, P.C., ALAN LAMBERT, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged thirteen (13) specifications of professional misconduct, including allegations of negligence, incompetence, gross negligence, gross incompetence and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated April 1, 2003, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	April 1, 2003
Pre-Hearing Conference	May 19, 2003
Hearing Dates:	May 27, 2003
	June 25 , 2003
	July 8, 2003
	July 15, 2003
	July 22, 2003
	August 19, 2003
	September 9, 2003
	September 23, 2003
	October 28, 2003

WITNESSES

For the Petitioner:	Michael Leitman, M.D. Joan Ferrara, RN
For the Respondent:	Edward Lee Saxer, M.D. James C. Rosser, Jr., M.D. Mehran Mansouri,, M.D. Jeffrey Novak, M.D.

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on or about January 4, 1995 by issuance of license number 198153 by the New York State Education Department. (Ex.2)

PATIENT A

2. Patient A was admitted to New Island hospital (hereinafter referred to as "NIH") through the emergency room ("ER"), at or about 9:35 p.m., on November 20, 2000, with complaints of abdominal pain and lower grade fever. The patient had been sent to the ER by his private medical doctor after a CAT scan was reported as showing appendicitis. Physical examination findings of the patient's abdomen, by the ER physician, of tenderness and guarding in the right lower quadrant, along with the CAT scan results, confirmed a diagnosis of acute appendicitis. (Ex. 3, pp. 6-7; T. 20-23)

3. A surgery page was issued at 10:00 p.m., responded to by Respondent at or about 11:15 p.m. A nurse's note in the ER record documents that by the time Respondent was present and evaluating the patient, x-rays and an EKG had already been done, and the patient's abdominal pain was worsening since his arrival in the ER (10:15 note: "Complains of increased pain while flat in bed"). (Ex. 3, p. 7; T.23-24)

T. ___ and Ex. ____ indicate a reference to the transcript of the hearing or to an exhibit in evidence.

4. Respondent recorded his understanding of the patients's history and present illness in the hospital record as that of a 66 year old male who began having left low back pain the day prior to admission, progressing to the left lower abdominal quadrant, across the abdomen to the right lower quadrant and upper back. The patient reported no nausea or vomiting, but anorexia, with no bowel movement the day of admission. Respondent was also fully aware of the results of the CAT scan. The patient's white blood count ("WBC") was elevated to 15,800 with a shift to the left, indicating inflammation and/or infection, and Respondent's physical examination was also remarkable for a temperature of 100.6 and distension, tympany and tenderness in the right lower quadrant of the abdomen with guarding and rebound. All of the findings were consistent with a diagnosis of acute appendicitis, which Respondent also made, and that the patient required admission to the hospital and an appendectomy. (Ex.3. pp. 91-94, 96-97, 151-152; T. 30-33)

5. Respondent, after making a diagnosis, at or about 11:30 p.m. on the night of admission, wrote an order and recorded a plan to keep the patient NPO, give him IV fluids and antibiotics, obtain a medical evaluation and to take the patient to the operating room the next day. (Ex. 3)

6. Respondent failed to obtain medical clearance, which he claims was necessary within a reasonably accepted time period. (Ex. 3, pp. 1, 96-97; T. 34-39)

7. Dr. Leitman, Petitioner's expert, admitted that the diagnosis of appendicitis was made by the ER physician prior to Respondent's evaluation of the patient and that said diagnosis was timely. (Ex. 3, p.6; T. 61-62) He also agreed that Respondent's consult was timely. (T. 62)

8. Patient A however, was not taken to the operating room until 12:30 p.m. on November 21, 2000, and surgery did not start until 1:15 p.m. over 15 hours after arriving at the hospital and over 13 hours after Respondent had seen Patient A and arrived at a diagnosis of acute appendicitis, and approximately 39 hours after his symptoms began. (Ex 3, pp. 6-7; T. 195)

9. It is perfectly reasonable to prescribe intravenous fluids and intravenous antibiotics. It however is not appropriate to delay the surgery to give more fluid or to give additional doses of antibiotics, other than what was ordered and administered at around 11:30 on the 20th of November. (T. 45)

10. An appendectomy should be performed as soon as possible, certainly within a matter of a couple of hours, as long as it would take to get an operating room ready, an anesthesiologist in the hospital and the patient prepared for surgery. (T. 32-33)

11. If medical clearance were necessary, then medical clearance has to be done immediately in order to prepare the patient for emergency surgery. (T. 35)

12. Postponing emergent surgery for the next day for no medical reason is not within the standard of care.(T. 40)

13. Joan Ferrara, RN, Director of Perioperative Nursing Services at NIH testified that, in 2000, NIH had six operating rooms with a mobile laparoscopy tower able to be used in any of the suites. Therefore, nothing precluded the scheduling of Patient A's appendectomy. (T.1975)

14. NIH had a full surgical team present in the hospital from 7 a.m. to 11 p.m. Monday through Friday and 7 a.m. to 3 p.m. on Saturday. During the remaining hours of the day and on Sundays, an on-call team, assigned on a monthly basis and made up of a surgical tech, an RN and an anesthesiologist are available. The on-call schedule was published every two weeks. (T. 1979-1980, 2015)

15. During the on-call hours, an administrative nursing supervisor is always present in the hospital to call the full team who are expected to be immediately available and come into the hospital. (T. 1981-1983)

16. During the night hours, patients are recovered in one of the critical care units. The nursing supervisor assesses the acuity of the patient, the staffing levels to determine which unit the patient will be sent to. Further, the anesthesiologist accompanies the

patient to the critical care unit and is required, by Hospital policy, to stay until the patient is through the recovery period. (T. 1983-1984)

17. Prior to her testimony before this Committee, Mrs. Ferrara, at the Department's request, reviewed hospital records and testified that, from July 2000 through December 2000, the on call staff had been activated 29 times. Of those 29 activations, 10 were for appendectomies. Further Mrs. Ferrara cited a number of occasions when the team was activated several nights in a row. (T. 1984- 1986)

18. Most patients who end up ventilated and with invasive lines would go directly to the ICU following the surgery and bypass the recovery room.(T. 2016-2017)

19. Mrs. Ferrara testified that a surgeon could easily schedule a case, asking the on call team to come in at 6:00 a.m., so that by the time the surgery was completed, the recovery room staff would be available. In fact, this has been done by Respondent in the past. (T. 1987-1988)

20. Specifically with regard to Patient A, Mrs. Ferrara testified that there would have been absolutely no problem to have called the staff in at 2 or 3 a.m., or even 6 a.m., if Respondent wanted to give the patient a period of hydration and IV antibiotics prior to operating. (T. 1988-1989)

21. On the morning of November 21, 2000, if Respondent had called at 7 a.m. and expressed the need for Patient A, with an acute appendicitis, to go to surgery quickly, asking that another case be bumped, this could have been done. The records for that day document that the scheduled operations in the early morning were cataract extraction, tonsillectomy, removal of a lipoma, an anterior cruciate ligament repair, colonoscopy and a breast biopsy. Mrs. Ferrara testified that the cataract surgeries could have easily been bumped (testifying that: [She] "really, quite frankly, never [has] seen a cataract we couldn't bump") and, more importantly, in all of her experience at NIH, there has never been a case where a surgeon would not yield time for an acute appendicitis with a possible perforation. (T. 1991, 1993, 1995, 2003-2004)

PATIENT B

22. Patient B, an 87 year old male, presented in the ER of NIH on October 29, 2000, at or about midnight, with fever, shaking chills, a rash and a cough. A physical examination was significant for a temperature of 100.2, a heart rate of 120, a blood pressure of 156 over 72 and crackling in the base of the lungs. There were no abdominal complaints, and his abdomen was nontender. The patient's white blood count was 19,200. The patient was admitted to the hospital with a provisional diagnosis of pneumonia or sepsis or dehydration. (Ex. 4, pp. 3-4; T.186-187, 190)

23. Initial blood cultures grew gram negative rods identified as E. coli. However, as of November 5, 2000, all blood cultures taken were reported as negative. Additionally,

there were no pathogens identified on urinalysis or on urine culture.(Ex. 4 pp. 198-199, 202,205; T. 187-189)

24. The patient's medical history, on admission, was significant for emphysema, COPD and a polypectomy performed a few months prior to the current admission which, on biopsy, was found to be positive for adenocarcinoma. The family refused any further surgical intervention or chemotherapy for the patient's cancer. The patient also had a history of a pulmonary embolus five years prior.(Ex. 4, pp. 12& 47; T. 189-192)

25. Patient B, on admission, was started on intravenous antibiotic therapy. He responded to treatment demonstrating improvement, as his white blood count approached normal. (Ex. 4, pp. 89, 167; T. 193)

26. Physical examination of the abdomen, as on admission, remained benign; reported as soft and nontender with bowel sounds present. The patient was tolerating a normal diet. (Ex. 4, pp. 47,91;T. 193-194)

27. Findings from an abdominal and pelvic CAT scan performed on November 3, 2000 included that of a small amount of fluid in the right chest, a small mass in the liver, described as possibly either a hemangioma or neoplastic lesion; several small gallstones in the neck of the gall bladder and a small diverticulum in the urinary gall bladder (Ex. 4, pp.212-213)

28. Through on or about November 8, 2000, approximately 9 days into admission, the patient was reported to have a good appetite.(Ex. 4, p. 107; T. 195)

29. A GI consultation was also ordered. The gastroenterologist's assessment, upon recounting the history of colon cancer with extension into some mucosa, was that surgery was indicated to remove a portion of the colon and treat the cancer, however, again the family refused further surgical intervention. (Ex. 4, p. 107)

30. As of November 11, 2000, the record indicates that the patient began complaining of occasional nausea without vomiting. The abdominal examination remained benign. The white blood count was reported as 18,100. As a result, the intravenous antibiotic was changed and further tests, including stool cultures, were ordered. (Ex. 4, pp. 114, 171)

31. The hospital record for November 12, 2000 documents that the patient's appetite was good and the abdomen was completely normal. On November 14, 2000, the nurses reported some complaint of nausea. A follow-up GI consult on that date reported that the patient has no history of abdominal pain, no vomiting, no hematochezia and that the examination of the abdomen was nontender, without masses. A question was raised by the consultant of hiatus hernia or reflux, and rule out gallbladder disease or metastasis to the liver. The plan was to get a CAT scan of the liver and chest, ultrasound of the gallbladder with HIDA scan, and to change some of the antacid medications and

antibiotics which may have contributed to the nausea. (Ex. 4, pp. 116,120-123, 164-166; T. 196-199)

32. The report of the HIDA scan performed on Patient B on November 15, 2000 indicated that there was no evidence of a cystic duct obstruction. (Ex. 4, pp. 19, 20, 214)

33. A sonogram of the gallbladder and right upper quadrant was reported as showing a mass in the right lobe of the liver and, consistent with the previously reported findings, gallstones within the gallbladder as well as some fluid around the gallbladder. (Ex. 4, pp. 213-215)

34. On November 16, 2000, the GI consultant ordered a surgical consultation with the Respondent. At this time, the GI consultant notes nausea. (Ex. 4, p. 129)

35. Respondent first saw the patient on November 16, 2000 at noontime. (Ex. 4, p.130)

36. Dr. Novak, Patient B's internist and gastroenterologist, explained that the ultrasound test revealed multiple stones in the neck of the gallbladder and pericholecystic fluid so that the first conclusion on his assessment was E Coli Bacteremia secondary to a biliary source which based on the ultrasound results is pathopneumonic for cholecystitis. (Ex. 4, pp. 127, 215; T. 1740-1742)

37. Cholecystitis will respond to antibiotics if the stone which is obstructing the cystic duct falls away and the cystic duct is no longer obstructed, thus resulting in a reduction of pain but that same does not get rid of the inciting problem which is that there are still multiple stones in the gallbladder with a few in the region of the cystic duct which means the risk for recurrent obstruction and complication still exists. (T. 1742-1743)

38. In elderly patients, cholecystitis can have multiple presentations from pain to changes in mental status to fever with no identifiable pain and that elderly patients do not present as frequently as 30 to 40 year olds with pain.(T. 1743)

39. There still remained an issue surrounding the gallbladder which had a significant percentage chance of recurring with a life threatening condition. (T. 1783-1785)

40. Dr. Novak further explained that the patient had been idealized from a medical and gastroenterological perspective to have surgery at that time, that you do not want to do surgery unnecessarily, but that it was clear to him that the gallbladder was the problem and it had to be removed. (T. 1759-1760, 1794, 1796)

41. Dr. Novak noted that we still do not know if the lesion in the liver was benign or malignant and that the patient could have lived for years. (T. 1760)

42. The resolution of the patient's nausea just prior to surgery simply meant that the patient had been treated medically, that he would likely have a follow-up complication which could be fatal since he was not cured of the disease and removal of the gallbladder was the logical move at that time. (T. 1760-1761)

43. Dr. Leitman testified that with respect to Patient B's alleged respiratory issues that arose after Respondent left the recovery room, same would be appropriately managed by the anesthesiologist. (T. 366-367)

44. Dr. Leitman agreed that the blood gas drawn at 1:56 p.m. was drawn at the direction of Dr. Tsu and that Dr. Tsu would have the responsibility to follow up on same. (Ex. 4, pp. 25, 94; T.325-326)

45. Dr. Leitman agreed that there was documentation of an evaluation of Patient B and orders by the primary care physician (Dr. Saif) prior to the patient leaving the recovery room and that Dr. Saif would have had a duty to intervene if he thought Patient B was unable to leave the recovery room. (Ex. 4 pp. 27,237; T. 326-328)

46. The floor nurse did not note any problem with Patient B upon arrival on the floor (T. 330-331)

47. Dr. Leitman agreed that between 4:45 p.m. and 7:00 p.m. the infectious disease physician and oncologist both saw Patient B, both would be trained to note if a patient was in distress and have a duty to intervene or obtain appropriate intervention, and that neither physician saw the need for any such intervention. (Ex. 4,pp. 151-152);.T. 331)

PATIENT C

48. Patient C was triaged and first seen in the ER at NIH at 3:20 p.m., on November 14, 2000. The ER record indicates that the patient presented with complaints of lower right sided pain and tenderness accompanied by nausea, fever and chills for 2 days prior to admission and, on admission, a temperature of 100.3. He had been seen, earlier the same day, by his medical doctor, Corina Serer, M.D., who referred the patient from her office to the ER. Patient C had a past medical history of diabetes and coronary disease requiring a cardiac devascularization procedure. (Ex. 5, pp. 7, 9-10 , 186; T. 120-121)

49. Findings on physical examination by an ER doctor at or about 5:50 p.m., were of right lower quadrant tenderness, right at McBurney's point, and acute pain. The patient's WBC was reported at 21,200 with abnormal poly% of 85.9 and lymph% of 5.4 (Ex. 5, pp. ,9, 225; T.122-124)

50. While the report of the CAT scan findings is not timed, the references in the patient's medical record clearly indicate that the findings were reported sometime after 8:30 p.m. and prior to 10:30 p.m. on the night of admission, November 14, 2000, and that a

definitive diagnosis of acute appendicitis had been made. Telephoned admitting orders were received from Dr. Serer at 8:30 p.m., which included orders for a surgical consult with Dr. Miller, Respondent's employer at the time, and a medical consult. The report of consultation from the medical consultation, Dr. Melcher, notes a time of consult at 10:30 p.m. and states the reason for consultation as "medical clearance for surgery." In his report, Dr. Melcher states that the patient has been diagnosed with acute appendicitis, documents a complete and extensive physical examination and assessment of laboratory work and EKG and finds that "the patient is in optimal condition for laparotomy/appendectomy." (Ex. 5,p p. 12, 190 247-248; T. 124-127, 147-148)

51. Patient C did not have surgery to remove his appendix until approximately 2:40 p.m. on November 15, 2000 ; some 16 hours after medical clearance and 21 hours after presenting to the ER. (Ex. 5, p.259; T. 128-130)

52. Respondent's first progress note in the chart is an entry for 10:00 a.m. on November 15, 2000. (Ex. 5 pp. 117, 122; T. 127)

PATIENT E

(Note: Patient E discussed before Patient D because Patient E's surgery occurred on the same date but before Patient D's surgery)

53. On February 12, 2001, at 2:40 p.m., Respondent undertook to perform an elective laparoscopic cholecystecomy on Patient E. The indications for the procedure were justified and are not at issue in the instant matter. (Ex. 7, pp. 5, 48; T. 370-371)

54. During the course of the operation, Respondent incorrectly identified the cystic duct, and in doing so, completely transected the common bile duct. (Ex. 7, pp. 66-67; T. 373, 375-376)

55. There was dissection and a structure was transected. A bile duct injury was suspected. At this point, the decision was made to convert to an open procedure. Dr. William Miller was asked to come in for an intraoperative consultation. (Ex. 7, p. 67)

56. An intraoperative cholangiogram was obtained which revealed that a common bile duct transection had occurred (Ex. 7, p. 67)

57. As the injury to the hepatic duct was somewhat proximal, the surgery was terminated and reconstruction was deferred to a specialist in hepatic surgery and reconstruction. (Ex. 7, p. 67)

PATIENT D

58. On February 12, 2001 at approximately 7:43 p.m., Respondent performed a laparoscopic cholecystectomy on Patient D. Patient D had come into the hospital the prior day, symptomatic, and had been diagnosed with acute cholecystitis. (Ex. 6, pp. 6, 41 77)

59. Patient D was a 79 year old woman with known cardiac related medical problems, presenting with an acute phase fo cholecystitis. (Ex. 6, pp. 81-82)

60. Respondent's operative report indicates that, on entering the operative field, he found the gallbladder to be very tense, distended, with thicken wall, purulent bile, with several tiny stones within the gallbladder and that the gallbladder fossa was quite inflamed, (as borne out by the pathology report) with part of the gallbladder adherent to the common bile duct. (Ex. 6, pp. 81-82, 84; T. 434)

61. Respondent inappropriately identified the common bile duct as the cystic duct and transected it. After the transection he was able to visualize the true cystic duct. (Ex. 6, p. 82)

62. Respondent transected the common bile duct. A cholangiogram was performed and the case was converted to an open procedure. A second cholangiogram was performed. Drains were placed, the incision was closed and Patient D was transferred to another facility for hepatic reconstruction. (Ex. 6, pp. 82-83)

63. Respondent's records for Patients A through E met accepted standards of care. (T. 452)

CONCLUSIONS OF LAW

Respondent is charged with thirteen (13) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types 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 gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

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

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician 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.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that one (1) of the thirteen (13) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Michael Leitman, M.D., testified as the Department's expert. He is board certified and currently a Senior Attending Surgeon at Lenox Hill Hospital. He is also Program Director for the Lenox Hill Hospital's General Surgery Residency Program and the Director of Surgical Critical Care. (Ex. 8) The Hearing Committee found Dr. Leitman to be credible and beleivable on medical issues. He analyzed and assessed the charts well. They note, however, that he had some problems in establishing the informed consent allegations and in missing the definition of the triangle of Calot. (T. 453-454) The Department also called Joan Ferrara, RN, the Director of Perioperative Nursing Services at NIH. The Hearing Committee found her to be a credible witness who gave straight forward answers.

James Rosser, Jr. testified as Respondent's witness. Dr. Rosser is board certified and is currently the Chief of minimally invasive surgery at Beth Israel Medical Center and the Director of the Advanced Medical Technology Institute. (Ex. B) The Hearing Committee found Dr. Rosser to have an impressive background and that he was

a credible witness. The Committee notes, however, that Dr. Rosser often gave a wordy preamble to his statements. He gave "fuzzy" answers about when emergent situations end and urgent ones begin. They also found that he danced around the 14 hour delay of surgery for Patient A until he was pinned down by Committee questions and then provided more specific information.

Jeffrey Novak, M.D., is a board certified internist and gastroenterologist who holds medical staff appointments at NIH, Mercy Medical Center and Northshore University Hospital. He testified with respect to his care and treatment of Patient B. The Hearing Committee found Dr. Novak to be very credible, knowledgeable and straightforward. Dr. Novak answered all questions presented and explained thoroughly his care for Patient B.

Respondent also offered the testimony of Mehran Mansouri, M.D., a board certified surgeon who was the former Associate Director of Surgery at NIH and is presently Chief of General Surgery at North Shore University Hospital at Plainview. The Hearing Committee found Dr. Mansouri credible as a character witness but not particularly helpful with respect to the allegations against Respondent.

Respondent also took the stand on his own behalf. The Hearing Committee found Respondent to be arrogant, unrepentant and misleading in his testimony. They believe that he did not accept the fact that he had done anything wrong. They note that a lot of his answers were prompted by his attorney. The Committee further notes that Respondent denied that he had ever arranged for early morning surgery when Ms. Ferrara testified that he had done so in the past. (T. 1987-1988)

PATIENT A

Factual Allegations A, and A.2: SUSTAINED

Factual Allegations A. 1 and A.3 : NOT SUSTAINED

Charge A. 1 is not sustained by the Hearing Committee because Dr. Leitman admitted that the diagnosis of appendicitis was made by the ER physician prior to Respondent's evaluation of the patient and that said diagnosis was timely. (Ex. 3, p. 6;T. 61) Dr. Leitman also acknowledged that Respondent's response to the surgical consult was timely and that Respondent concurred with the ER physician's diagnosis of appendicitis. (T. 25, 62-63)

Charge A. 2 is sustained by the Hearing Committee as an instance of neglect and a departure from acceptable standards of care. (T. 44-45) The Hearing Committee believes this was an urgent matter and concurs with Dr. Leitman who stated that the surgery needed to be performed within a matter of a couple of hours and that a time delay of 14 and one-quarter hours is not within the standard of care. (T. 32, 44) Even Dr. Rosser acknowledged the risk involved because you cannot predict when the appendix is going to rupture. (T. 1030) The Hearing Committee believes that there was no justification for Patient A to see another physician and that any medical clearance had to be done immediately in order to prepare for emergency surgery. (T. 35)

The Hearing Committee notes that Patient A became more toxic at approximately 10:30 a..m., several hours before the surgery was actually performed. (Ex. 3, p. 150)

They find that Respondent had access and opportunity to schedule surgery during the night or at least by 6 or 7 a.m. the next morning. Nurse Ferrara's testimony dispelled Respondent's excuses for not scheduling nighttime or early morning surgery. She explicitly stated that she has "never seen a cataract we couldn't bump." (T. 2004)

The Hearing Committee finds Respondent to be negligent for delaying Patient A's surgery for an unreasonable length of time. They further find that these actions do not rise to the level of gross negligence, gross incompetence or basic incompetence.

With respect to Charge A. 3, the Hearing Committee finds that Respondent's medical records for Patient A were adequate. As a result, the Hearing Committee sustains one act of negligence.

PATIENT B

Factual Allegations B and B.1, B.2, B.3 and B.4: NOT SUSTAINED

Charge B. 1 alleges that Respondent inappropriately recommended a cholecystectomy without reasonably accepted medical justification. Charge B. 2 alleges that Respondent performed the cholecystecomy without reasonably accepted medical justification. The Hearing Committee finds that both the recommendation and the performance were medically justified. The Hearing Committee finds Dr. Novak's opinion compelling , i.e. ,that it was clear that the gallbladder was the problem and had to be removed. (T. 1759-1760,1794-1796) The Hearing Committee also concurs with Dr. Rosser's opinion that from a review of the medical record, the infectious disease, oncology and primary care physicians all concurred with the conclusion that Patient B

had a gallbladder problem that required a cholecystectomy. (Ex. 4,pp.131,134,158-160; T. 1239-1241, 1243-1244)

The Hearing Committee believes that E. Coli septicemia in an 87 year old patient is a lethal disease. They further note that Patient B had been a very vigorous man who had just returned from Italy and he had no current symptoms of colon cancer. (T.1761) The Hearing Committee concurs that the medical team believed that the acute cholecystitis posed a real threat. This was appropriately balanced against the hypothetical possibility that the alleged lesion in the liver was metastatic colon cancer. Thus, the Hearing Committee concludes that the surgery was necessary.

Charge B.3 alleges that Respondent failed to properly monitor and follow Patient B post operatively and/or to note the same. Respondent testified that he was never called back in about Patient B and that he was notified about the patient 's death shortly before 11:00 p.m. . (T. 830-833,845) The Hearing Committee finds it difficult to blame Respondent for Patient B's change in condition after surgery when he was also treated by Dr. Saif and Dr. Tsu in the recovery room. The Hearing Committee further finds that Respondent's documentation of the record fell within the standard of care. As a result, the Hearing Committee sustains no charges with respect to Patient B.

PATIENT C

Factual Allegations C and C.1, C.2 , C.3 and C.4: NOT SUSTAINED

Charge C.1 alleges that Respondent failed to make a timely diagnosis of appendicitis. Charge C.2 alleges that Respondent inappropriately delayed performing

the appendectomy without reasonable medical indication or justification. The Hearing Committee notes that the patient's record indicates that Dr. Miller was called twice on the evening of admission and that Respondent's first progress note was not until 10 a.m. on the following day. The Hearing Committee finds that the Department failed to prove any delay by Respondent in diagnosing or performing surgery on this patient. They further note that Dr. Miller was not called as a witness to testify about his involvement in this matter. Even Dr. Leitman testified that if Respondent was completely unaware of Patient C prior to 9:00 a.m. on November 15, 2000, he would not allege that Respondent delayed the care and treatment of this patient. (T. 154) Dr. Leitman further admitted that there was no indication in Patient C's medical record that prior to 10:00 a.m. on November 15, 2000 that any physician or nurse thought that Respondent was the surgeon taking care of the patient. (T. 155)

With respect to Charges C. 3 and C. 4 , the Hearing Committee finds that all consents obtained from the patient authorized both procedures and that the documentation was within the standard of adequate record keeping. As a result, the Hearing Committee sustained no charges with respect to Patient C.

PATIENTS D and E

Factual Allegations D and D.1: SUSTAINED

Factual Allegations D.2 through D.4: NOT SUSTAINED

Factual Allegations E and E.1: SUSTAINED

Factual Allegations E.2 through E.4: NOT SUSTAINED

Since both surgeries were similar procedures that were performed on the same day, they will be discussed together. Also the allegations for both Patients D and E are identical. The Hearing Committee sustains Charges D.1 and E.1 because in both instances, Respondent transected the common bile duct which should not have been cut. Dr. Leitman stated that if Respondent had performed the necessary dissection to trace out the structure before dividing it, this injury would not have occurred. (T. 408, 420) The Hearing Committee concurs and finds that Respondent failed to delineate the appropriate anatomy.

Respondent argued that these instances might be accepted as a complication of surgery and thus not negligence. The Hearing Committee however, finds that these two cases cannot be taken in isolation because they occurred on the same day. The Hearing Committee believes that Respondent should have been far more cautious going into the second surgery, (Patient D) but he was not. They note that neither of the expert witnesses knew of this occurrence happening twice in one day. The Hearing Committee is troubled by this. On that particular day, Respondent placed two patients at risk while performing the same procedure. The Hearing Committee further finds that Respondent offered no explanation to them why these injuries occurred on the same day. As a result, the Hearing Committee sustains Charges D.1 and E. 1 as acts of negligence.

With respect to Charges D.2 and E.2, and except as discussed above, the Hearing Committee finds that the laparoscopic cholecystectomy was performed according to accepted and appropriate surgical techniques.

Charges D.3 and E.3 allege that Respondent failed to appropriately convert the laparoscopic procedure to an open procedure once unable to clarify the anatomy. The Hearing Committee believes that Respondent was never aware that the anatomies of these patients were not clarified. By good faith effort Respondent had clarified these anatomies in his mind, even though he was wrong. The Hearing Committee, therefore, does not sustain Charges D.3 and E.3. Charges D.4 and E.4 are not sustained as all of Respondents records were deemed adequate.

As a result of the above discussion , the Hearing Committee sustains the First Specification for negligence on more than one occasion.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for a period of two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on probation with a practice monitor. The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for a two year stayed suspension with probation and a practice monitor because they do not believe that revocation is commensurate with the level of professional misconduct in this instance. The Hearing Committee notes that while there are clearly three instances of negligence, none of the other specifications alleged against Respondent were sustained. In conclusion, the Hearing Committee believes that a two year stayed probation with a practice monitor of Respondent's surgical records effectively safeguards the public health in this instance. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

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

1. The First Specification of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) is **SUSTAINED**; and

2. The Second through Thirteenth of the Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED;**

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **TWO (2) YEARS,** said suspension to be **STAYED in its entirety;** and

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

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: New York, New York

January 5, 2004

CALVIN J. SIMONS, M.D.

(Chairperson)

MARVIN HARTSTEIN, M.D.

ALAN KOPMAN

TO: Claudia Morales Block, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, NY 10801

Alan Lambert, Esq.
McAloon & Friedman, P.C.
123 William Street
New York, NY 10038

Edward Lee Saxer, M.D.
c/o Alan Lambert, Esq.

APPENDIX I

Petitioner's 1 In Chief
5/19/03

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

IN THE MATTER OF EDWARD LEE SAXER, M.D.	NOTICE OF HEARING

TO: EDWARD LEE SAXER, M.D.
c/o: LaBarbera & Lambert
Lincoln Building
60 East 42nd Street, Suite 3401
New York, N.Y. 10165

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 27, 2003, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, 6th Floor, New York, N.Y. 10001, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth

"Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 2003) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT

YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
April / , 2003

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: CLAUDIA MORALES BLOCH
Associate Counsel
Bureau of Professional
Medical Conduct
145 Huguenot Street, 6th Floor
New Rochelle, N.Y. 10801
914-654-7047

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

IN THE MATTER

OF

EDWARD LEE SAXER, M.D.

STATEMENT

OF

CHARGES

EDWARD LEE SAXER, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 4, 1995, by the issuance of license number 198153 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about November 20, 2000, Patient A was admitted to New Island Hospital (hereinafter referred to as "the Hospital"), under the care and treatment of Respondent, with, inter alia, a 24 hour history of lower abdominal pain. On or about November 21, 2000, Respondent performed an appendectomy on Patient A. In his care and treatment of the patient, Respondent:

1. Failed to make a timely diagnosis of appendicitis.
2. Inappropriately delayed performing the appendectomy without reasonable medical indication nor justification.
3. Failed to maintain a hospital record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Patient B was admitted to the Hospital on or about October 29, 2000. On or about November 16, 2000, Respondent saw Patient B in surgical consult with regard to findings reported from a sonogram performed on the previous day. On or about November 20, 2000, Respondent performed a laparoscopic

cholecystectomy on Patient B. In his care and treatment of the patient, Respondent:

1. Inappropriately recommended cholecystectomy for the patient without having a reasonably accepted medical indication and/or justification to do so.
2. Performed laparoscopic cholecystectomy without medical indication nor justification.
3. Failed to properly monitor and follow the patient post operatively and/or to note same.
4. Failed to maintain a hospital record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

C. On or about November 14, 2000, Patient C was admitted to the Hospital, with, inter alia, complaints of right-sided abdominal pain of several day's duration. Patient C came under the care and treatment of Respondent, in surgical consultation, on the day of admission. On or about November 15, 2000, Respondent performed an open appendectomy on Patient C. In his care and treatment of the patient, Respondent:

1. Failed to make a timely diagnosis of appendicitis.
2. Inappropriately delayed performing the appendectomy without reasonable medical indication nor justification.
3. Failed to appropriately obtain and/or note a consent from the patient for the surgery he performed.
4. Failed to maintain a hospital record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Patient D was admitted to the Hospital on February 11, 2001 under the care and treatment of Respondent. On or about February 12, 2001, Respondent attempted to perform a laparoscopic cholecystectomy on the patient, when he discovered, during the procedure, that he had transected the common hepatic duct. Respondent:

1. Failed to properly delineate the appropriate anatomy prior to performing any transection, and/or to note his performance of same.
2. Failed to perform the laparoscopic cholecystectomy according to accepted and appropriate surgical techniques.
3. Failed to appropriately convert the laparoscopic procedure to an open procedure once unable to clarify the anatomy.
4. Failed to maintain a hospital record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

E. Patient E was admitted to the Hospital on or about February 12, 2001 under the care and treatment of Respondent. On that day, Respondent attempted to perform a laparoscopic cholecystectomy on the patient, when he discovered, during the procedure, that he had transected the common hepatic duct. Respondent:

1. Failed to properly delineate the appropriate anatomy prior to performing any transecting, and/or to note his performance of said delineation.
2. Failed to perform the laparoscopic cholecystectomy according to accepted and appropriate surgical techniques.

3. Failed to appropriately convert the laparoscopic procedure to an open procedure once unable to clarify the anatomy.

4. Failed to maintain a hospital record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

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) 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 of paragraphs A, A.1 through A.3, B, B.1 through B.4, C, C.1 through C.4, D, D.1 through D.4, E, E.1 through E.4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) 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 of paragraphs A, A.1 through A.3, B, B.1 through B.4, C, C.1 through C.4, D, D.1 through D.4, E, E.1 through E.4.

THIRD THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in

N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. The facts of paragraphs A, A.1 through A.3.
4. The facts of paragraphs B, B.1 through B.4.
5. The facts of paragraphs C, C.1 through C.4.
6. The facts of paragraphs D, D.1 through D.4.
7. The facts of paragraphs E, E.1 through E.4.

EIGHTH SPECIFICATION

GROSS INCOMPETENCE

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

8. The facts of paragraphs A, A.1 through A.3, B, B.1 through B.4, C, C.1 through C.4, D, D.1 through D.4, E, E.1 through E.4.

NINTH THROUGH THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) 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:

9. The facts of paragraphs A.3
10. The facts of paragraphs B.3 and B.4.
11. The facts of paragraphs C.3 and C.4.
12. The facts of paragraphs D.1 and D.4.
13. The facts of paragraphs E.1 and E.4.

DATED: April / , 2003
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct him/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession. Respondent acknowledges that if s/he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

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, 433 River Street, Suite 303,Troy, New York12180-2299; 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 written periodic 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. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not

limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law Section 32].

5. 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.

6. 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.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. An approved practice monitor shall be in place within thirty (30) days of the effective date of this Order.

a. Respondent shall make available to the monitor any and all records or access to the practice

requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, including all Article 28 Facilities on a random unaccounted basis at least monthly and shall examine a selection (no less than twenty per cent(20%)of all **surgical** records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and all 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 any/or any such other proceeding against Respondent as may be authorized pursuant to the law.