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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

January 6, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
Associate Counsel
New York State Department of Health
Corning Tower – Room 2509
Empire State Plaza
Albany, New York 12237

Michael J. Gianturco, M.D.

REDACTED

Thomas C. D'Agostino, Esq.
Mattar & D'Agostino, LLP
17 Court Street – Suite 600
Buffalo, New York 14202

RE: In the Matter of Michael J. Gianturco, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.00-7) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said

license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

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

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER	DETERMINATION
OF	AND
MICHAEL J. GIANTURCO, M.D.	ORDER

ORDER #00-7

A Notice of Hearing and Statement of Charges, both dated January 28, 1999, were served upon the Respondent, Michael J. Gianturco, M.D. **STEVEN V. GRABIEC, M.D. (Chair), JOHN H. MORTON, M.D., and PETER S. KOENIG,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Timothy J. Mahar, Esq., Associate Counsel. The Respondent appeared by Mattar & D'Agostino, LLP, Thomas C. D'Agostino, 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 issues this Determination and Order.

STATEMENT OF CASE

Respondent is a board certified surgeon, who practices general surgery, vascular surgery and an office-based family practice. Petitioner served Respondent with a Notice of Hearing and Statement of charges alleging forty-six specifications of professional misconduct regarding his medical care and treatment of thirteen patients. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, inadequate records, fraudulent practice, moral unfitness, willfully making or filing false reports, and excessive testing.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Michael J. Gianturco, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State on September 26, 1956 by the issuance of license number 078527 by the New York State Education Department. (Pet. Ex. #2).

Thrombectomy Procedures

2. Respondent mischaracterized thrombectomy procedures as thromboendarterectomy procedures in operative reports, hospital records and billing statements when he knew that the procedure performed in each instance was a thrombectomy. (T. 647-648, 690, 705, 755-756, 970, 1037). Respondent admitted that each of the procedures charged by Petitioner were in fact thrombectomies, although he had incorrectly identified them and billed for them as thromboendarterectomies. (T. 1037).

3. The thrombectomy procedures which were identified by Respondent as thromboendarterectomies were performed on the following dates for the named patients:

(a) Patient A - August 23, 1994 (Ex. #5, p. 32)

(b) Patient B - August 3, 1994 (Ex. #12, p. 37)

(c) Patient B - December 22, 1994 (Ex. #14, p. 23)

(d) Patient C - July 17, 1982 (Ex. #18, p. 137)

(e) Patient C - March 28, 1995 (Ex. #19, p. 17)

(f) Patient G - June 26, 1996 (Ex. #29, p. 21

(g) Patient H - March 16, 1993 (Ex. #32, p. 31)

(h) Patient I - May 9, 1992 (Ex. #36, p. 14)

4. Respondent's expert, Joseph M. Anain, M.D., testified that an experienced vascular surgeon would know the difference between a thrombectomy procedure and a thromboendarterectomy procedure and correctly designate a thrombectomy as such in a hospital record. (T. 647-648, 705).

5. Respondent and the experts testified that thromboendarterectomy procedures are more labor intensive and require more surgical time than do thrombectomies. (T. 62, 648, 1027). The arterial intima is removed in a thromboendarterectomy, but not in a thrombectomy. (T. 1027). Dr. Anain testified that an experienced vascular surgeon would recognize that a thromboendarterectomy procedure is billed at a higher rate. (T. 648).

6. The billing procedures followed in Respondent's office provided that the staff person preparing the bill would obtain the dictated operative report from the hospital and bill for the procedures identified in the caption of the report under "name of operation". (T. 385-387). The Physician's Current Procedural Terminology (hereinafter "CPT Code") would be consulted for the correct billing code number for the procedure identified by Respondent. (T. 387).

7. There was a code for thrombectomy in the CPT Code for each of the years in which the subject procedures were performed. (Ex. #45).

8. The subject thrombectomy procedures were incorrectly billed as thromboendarterectomy procedures because Respondent had identified them as such. He testified that he had identified the procedures as thromboendarterectomies knowing that his staff would bill them as such and that he had intended that they bill the procedures as thromboendarterectomies. (T. 1032-1033).

9. Respondent testified that he did not know that there was a difference in the billing codes for thrombectomy and thromboendarterectomy, yet he admitted that he never looked in the CPT Code manual, nor did he otherwise determine that there was not a code for thromboendarterectomies. (T. 968, 1033).

10. Respondent submitted bills for thromboendarterectomy procedures when the procedure performed was a thrombectomy and was overpaid in the sums listed:

(a) Patient A - $490.58

(b) Patient B (8/3/94) - $305.92

(c) Patient B (12/22/94) - $479.46

(d) Patient C - $517.55

(e) Patient G - $491.04

(f) Patient H - $952.13

(Ex. ##8, 15, 20, 30, 33, 37 [bills]; Ex. ##53A-F [billing summaries]).

11. Respondent admitted that he was overpaid for these procedures, and that he has made no efforts to repay the insurance companies or Medicare program. (T. 1037-1038).

Carotid Duplex Scans

12. Respondent purchased carotid duplex ultrasound equipment in the mid-1990s as part of an effort to establish a vascular laboratory. He testified that the company and the salespeople from whom he purchased the equipment represented that the indications for carotid duplex scans included headaches, dizziness, and neck injuries, in addition to transient ischemic attacks. Respondent maintains that he followed the recommendations of these salespeople in determining which patients received carotid scans. (T. 1331-1333, 1339-1340).

13. The medical indications for carotid duplex scans in 1989 included focal neurologic symptoms suggesting carotid narrowing or plaque. The relevant neurologic symptoms included transient ischemic attacks, paralysis, sudden loss of vision, carotid bruit and fainting episodes in older patients. (T. 358-359).

14. Respondent performed a carotid duplex scan on Patient J on February 13, 1989. Patient J was then 32 years old, and was being evaluated for injuries sustained in a car accident. The patient had no carotid artery symptomology and there was no documented evaluation for bruits, which should be evaluated prior

to ordering a carotid duplex scan. There was no medical indication for the scan. Therefore, such testing was excessive. (T. 359-360).

15. Respondent billed the no-fault insurance company $300.00 for the procedure. (Ex. #39, pp. 32-33).

16. Respondent performed a carotid duplex scan on Patient K on September 11, 1987. Patient K was then 40 years old, and was being evaluated for injuries sustained in a car accident. The patient's complaints of dizziness and memory loss did not provide an indication for a carotid duplex scan as they were nonfocal, and the pain in her arm was non-episodic and therefore not of the type related to transient ischemic attacks. The carotid duplex scan was excessive. (T. 363-364).

17. Respondent performed a second carotid duplex scan on Patient K on September 30, 1998. There was no change in Patient K's condition from the time of the earlier scan, which had been normal. There were no indications for a repeat study. (Ex. #40, p. 102; T. 364-366).

18. Respondent billed the no-fault insurance carrier $300.00 for the scan performed in September, 1987 and $300.00 for the scan performed in September, 1988. (Ex. #40, pp. 137-138, 1164).

19. Respondent performed a carotid duplex scan on Patient L on December 1, 1986. Patient L was then 45 years old,

and was being evaluated for injuries sustained in a car accident. The patient's complaints of dizziness, memory loss and unusual headaches were non-specific and not suggestive of carotid artery disease. No bruit was heard. Carotid duplex scanning was excessive. (T. 366-368).

20. A second carotid duplex scan was performed on Patient L on June 19, 1987, and a third scan was performed on October 18, 1988. There were no medical indications for the repeat scans. All three scans were negative. (Ex. #41, pp. 64, 64; T. 368-370).

21. Respondent billed the no-fault insurance carrier $250.00 for the December, 1986 scan, $300.00 for the June, 1987 scan, and $300.00 for the October, 1988 scan. (Ex. #41, pp. 69-70, 96-97, 110-111).

22. Respondent performed a carotid duplex scan on Patient M, then 58 years old on February 2, 1987. Patient M was being evaluated for injuries sustained in a car accident. A low bruit is recorded as being heard, but there is no indication as to whether the bruit is carotid in origin or has originated in the heart. The performance of a carotid duplex scan on Patient M at that time was excessive. (Ex. #42, p. 258; T. 370-371).

23. A second scan was performed on July 27, 1987, and a third scan was performed on January 13, 1988. There were no indications for carotid duplex studies on these dates and the

scans were excessive. All three scans performed on Patient M were reported to be negative. (Ex. #42, pp. 262, 301; T. 371-372).

24. Respondent billed the no-fault insurance carrier $300.00 for the second scan and $300.00 for the third scan. (Ex. #42, pp. 319-322).

25. Respondent admitted that he had overutilized his carotid duplex ultrasound equipment. (T. 1342).

Patient A

26. On August 23, 1994, Respondent performed an elective resection of an abdominal aortic aneurysm and placed a bypass graft on Patient A's aorta to the common iliac arteries on both the right and left sides. (T. 15).

27. Patient A was then 68 years old and had undergone a six-vessel coronary bypass procedure in July, 1994. (T. 16).

28. Prior to the August 23, 1994 surgery, an abdominal aortogram and bilateral leg angiogram were performed by Dr. Chu. Dr. Chu reported a 90% stenosis to the mid-right external iliac artery. This is the only reference in the records of any stenosis in this area. Dr. Chu had difficulty in passing the guide wire into the right external iliac artery. He injected contrast dye and found that although the common femoral artery and the right external iliac artery were torturous and narrow, they were patent. These findings indicate that there was no

stenosis present. (Ex. #4, p. 18; T. 586-587).

29. Dr. Chu also noted that the catheter appeared to pass outside the lumen of the right external iliac artery, through a mural thrombus. If the catheter dissected the wall of the vessel, it would cause the artery to appear to be stenosed. Dr. Chu discussed his findings with Respondent. (Ex. #4, pp. 18-19; T. 86-87, 568, 948-949, 951).

30. The ultimate determination as to whether the vessel was, in fact, 90% stenosed rests with the operating surgeon. It is a clinical determination. (T. 73, 569, 589).

31. Respondent was aware of the findings on the aortogram performed by Dr. Chu. He was also aware of the results of a Doppler pressure study which indicated that the patient's thigh pressure was equal on both sides. This made it unlikely that the vessel on the right side was 90% stenosed. (Ex. #4, pp.1-2, 18; T. 590).

32. Upon examination at surgery, Respondent found that the patient had a good femoral pulse. (T. 945).

33. An aortogram performed a month before the August 23, 1994 surgery showed no indication of a stenosis in the right external iliac artery. (T. 592-594).

34. Following surgery, there was evidence of acute ischemia to Patient A's legs. The patient's feet were cyanotic and no pedal pulses were heard by Doppler ultrasound. (T. 34-

36).

35. Patient A's right leg was "very mottled", indicating severe vascular compromise likely due to clotting of the right limb of the graft. (T. 35-36).

36. Acute ischemia causes a breakdown of tissues and muscle, and a release of the cell contents into the circulation. This includes potassium, which can be dangerous at elevated levels. (T. 36).

37. At 4:36 p.m., approximately three hours after surgery, Patient A's pH was 7.22. This is a markedly acidotic level. Severe acidosis is a life-threatening condition. (Ex. #5, p. 70; T. 37-38).

38. Patient A was returned to surgery at 9:45 p.m. on August 23, 1994. Respondent performed a femoral-femoral bypass, with the left femoral artery supplying blood to the right femoral artery, bypassing the right external iliac artery. (Ex. #5, p. 32, 34; T. 39-40, 42).

39. Pre-operatively, Patient A was judged to be a poor anesthesia risk, given a score of 4 on the ASA scale. The second surgery was performed as an emergency procedure. (Ex. #5, p. 41; T. 41).

40. During surgery, a pH of 7.07 was obtained, demonstrating marked acidosis. An uncorrected acidosis of this magnitude would be fatal. During the one hour course of the

surgery, Patient A was given seven ampules of sodium bicarbonate to attempt to correct the acidosis. (Ex. #5, p. 70; T. 43-45).

41. At 1:00 a.m., the patient was taken back to the ICU, accompanied by Respondent. At that time he was able to move his arms, but not his legs, indicating acute ischemia to the legs which had caused a loss of motor function. Further, there was difficulty in assessing pulses by Doppler, and the patient's legs were described as cool to touch, with mottling. A pulse oximeter did not register, indicating poor oxygen perfusion. Dr. Anain testified that these findings indicate an absence of blood supply to the legs and significant ischemia. Respondent testified that he was aware of all of these findings. (Ex. #5, p. 125; T. 46-48, 640-642, 1018-1019).

42. Patient A's overall status was poor as of August 24, 1994 at 1:00 a.m. He had inadequate oxygen perfusion. His pH (7.166) was markedly abnormal. There was evidence of severe ischemia which was not corrected by the second surgery. Dr. Anain testified that the patient's marked acidosis was a consequence of acute leg ischemia or muscle necrosis. The patient required an assessment by the vascular surgeon for a decision return to surgery, or to forego further treatment and accept limb loss. (Ex. #5, p. 71; T. 48, 50, 642-643).

43. Respondent left the hospital sometime after the patient's return to the ICU at 1:00 a.m. and 1:25 a.m. when he

was telephoned at home with the patient's prothrombin time. (Ex. #5).

44. There are no physician progress notes after Respondent's operative note for the second surgery and the note of the house officer at 7:00 a.m. on August 24, 1994, following Patient A's demise. (Ex. #5, pp. 48-49, 56).

45. Respondent's failure to remain at the hospital and evaluate Patient A during the second post-operative period was a gross deviation from accepted standards of medical care. Patient A's condition was progressively deteriorating. As the surgeon, it was Respondent's responsibility to address the complications resulting from the surgery. Voice orders from the anesthesiologist and cardiologist appear in the physicians' orders after 1:00 a.m. until approximately 5:00 a.m. A number of orders are for sodium bicarbonate. The involvement of the physicians did not abrogate Respondent's ultimate responsibility to oversee Patient A's treatment. The patient experienced profound acidosis caused by muscle necrosis due to an inadequate blood supply. The management of this condition was the responsibility of the vascular surgeon. (Ex. #5, pp. 60-62; T. 54-55).

Patient B

46. Patient B, a then 76 year old female, was admitted to St. Joseph's Hospital by Respondent on August 1, 1994. In the

spring of that year, she developed pain in her left foot which had increased. There had been a bluish-purple discoloration of the toes over the previous two weeks. (Ex. #12, p. 8; T. 107).

47. An aortogram and bilateral femoral arteriogram was performed on August 1, which showed thrombus of the superficial femoral artery from its origin to the abductor canal. (Ex. #12, pp. 9, 83; T. 108, 1054).

48. On August 2, 1994, Respondent performed a left femoral-popliteal bypass with thin-wall Gortex graft. (Ex. #12, p. 18; T. 108-109, 1055).

49. The day following surgery, Respondent noted that the patient began to have pain in the left leg and had a cold foot. There was no flow beneath the graft site and re-exploration was necessary. (Ex. #12, p. 55; T. 108, 1055-1056).

50. On August 3, 1994, Respondent resected the graft, and removed a clot from the graft by thrombectomy with a Fogarty catheter. (T. 108-109).

51. Respondent called the thrombectomy a thromboendarterectomy in the operative report, the admission sheet and in the discharge summary. Respondent billed Medicare and Blue Cross/Blue Shield for a thromboendarterectomy. (Ex. #12, p. 2, 7, 37; Ex. #15, p. 1).

52. Respondent designated the resection of the femoral-popliteal graft in the operative report as a "femoral-

femoral" graft. This term describes a new graft from the proximal to distal end of the femoral artery or a graft which crosses the groin from the femoral artery on one side of the body to the femoral artery on the other. (T. 111, 689).

53. Respondent's description of the resection of the bypass as a femoral-femoral graft was not accurate and a vascular surgeon with adequate knowledge of the principles of vascular surgery would not describe it as such. (T. 112, 690).

54. On August 10, 1994, Patient B was discharged from the hospital. She was readmitted two days later. On readmission, Respondent found that the graft had re-occluded. (Ex. #13, p. 2; T. 112, 1056-1057).

55. There were four options for the care and treatment of the patient at this time. Respondent could initiate thrombolytic therapy; perform a thrombectomy; harvest a vein and use that for a graft, or begin heparin therapy. Respondent chose thrombolytic therapy. (T. 670, 676, 1063).

56. Immediately upon the patient's readmission to the hospital, she had a catheter inserted and an infusion of urokinase was begun. The infusion of urokinase was an appropriate measure. A follow-up arteriogram was performed on August 12, 1994. The findings of this arteriogram indicated that the "Fem-pop graft is well opacified... There is some mural thrombus, but there is contrast filling of the graft into the

popliteal arteries. There is extravasation from the distal portion of the graft, however, the patient is hemodynamically stable." These findings confirm that the thrombolytic therapy was working. (Ex. #13, pp. 54, 56; T. 113-114, 673-675, 1059-1060).

57. On December 18, 1994, Patient B was readmitted to the hospital with an occluded left femoral-popliteal graft. Patient B complained of pain, coldness and discoloration of the left leg and foot. The pain which had been episodic was more severe that day and for the first time her foot was cold and her toes numb. The findings on physical examination included a cyanotic left foot, with no pulses in the left leg below the femoral. (Ex. #14, pp. 6, 9; T. 116-119).

58. An arteriogram showed graft occlusion and progression of the clot below the graft. (Ex. #14, p. 87; T. 120).

59. Urokinase was attempted on December 19, 1994, but was aborted when the catheter could not satisfactorily be placed. Further treatment was indicated at that time. Patient B was in jeopardy of losing her left leg. (Ex. #14, p.87; T. 120-121).

60. Unable to perform the urokinase therapy, Respondent had the options of a thrombectomy or an open bypass procedure. One of these alternative procedures should have been performed as soon as possible following the angiogram. (T. 121).

61. Respondent waited until December 22, 1994 - four days following the admission - before performing a thrombectomy, which he called a thromboendarterectomy in the record. (Ex. #14, p. 23; T. 121-122).

62. The standard of care required that the surgery be performed as soon as possible following the failure to insert the catheter for the urokinase therapy. Patient B had suffered numerous occlusions of her left leg, and with each occlusion, more of her vascular system was lost. The decreased and stagnated blood flow resulting from the occlusion created a risk of propagation of thrombus to the smaller vessels. Clots in terminal arterial branches create a risk of limb loss because the clots cannot be easily removed. (T.124-126).

63. By the time of her surgery on December 22, 1994, Patient B had signs of clotting in the smaller vessels, including blue toes symptomatic of a marked decrease in flow, as well as the loss of Doppler signals of flow heard earlier in the admission. (T. 125).

64. Respondent's failure to perform surgery as soon as possible after the inability to pass the catheter was a gross deviation from accepted standards of medical care, as there was a clear risk of limb loss. (T. 124, 126).

Patient C

65. Patient C, then 70 years old, was admitted to St. Joseph's Hospital on March 24, 1995 with increasing discomfort, coldness and numbness in his left leg. He had no pulse in his left femoral artery and distally. He had previously had a right above-the-knee amputation. (Ex. #19, pp. 4-5; T. 159).

66. An arteriogram was performed on March 25, 1995. Patient C had severe occlusions of both external iliac and common femoral arteries. The left superficial femoral artery was occluded and the profunda femoris was reconstituted from collateral flow. The left popliteal artery was also reconstituted and gave two vessel runoff. (Ex. #19, p. 81; T. 159-160).

67. Given the clinical and diagnostic findings, Patient C had severe occlusive disease of his remaining leg and was at significant risk for limb loss. Respondent recognized this fact. (T. 160, 1128).

68. On March 25, 1995, a cardiologist examined Patient C, who had a history of, among other things, congestive heart failure, carotid artery disease, hypertension, diabetes, and chronic atrial fibrillation. The cardiologist, Dr. Issa, reported that Patient C was not presently in congestive heart failure, and had no evidence of recent infarction, but questioned the patient's ejection fraction. Dr. Issa recommended an

echocardiogram, which was performed two days later on March 27, 1995 at 8:45 a.m. A Swan-Ganz catheter was also placed on that date. (Ex. #19, pp. 6, 35, 40).

69. Respondent performed a thrombectomy to remove the leg clots on March 28, 1995. The delay in surgery for four days from the date of admission deviated from accepted standards of medical care. Surgery should have been performed following the cardiology consultation on March 25, and within a day of admission. (Ex. #19, p. 17; T. 164-165).

70. The delay in surgery posed a risk of propagation of the clot in the leg as it was unknown whether the patient had a fresh clot or acute thrombosis superimposed upon chronic occlusive disease. With inadequate blood flow to the left leg, there was a risk of ischemia and limb loss. Patient C had no pedal pulse prior to surgery and was using a foot cradle on the day prior to surgery, which indicates ischemic pain. (Ex. #19, pp. 122-123; T. 164-165, 185).

71. The delay in surgery also risked embolization of the clot or the trashing of small fragments of the clots into distal vessels, which could not be retrieved. (T. 181-182).

72. Surgery should not have been delayed by the completion of the cardiology consultation. The Swan-Ganz catheter can be inserted pre-operatively and some of the readings sought could have been obtained at that time. Further,

Respondent acknowledged that the echocardiogram could be obtained in one hour. (T. 162, 1117).

73. Respondent, in a progress note written on March 26, 1995, determined that surgery would be performed on March 28, 1995. There is no documentary evidence that Respondent requested the cardiologist complete his evaluation earlier to accommodate surgery prior to March 28, 1995. ((Ex. #19, p. 37).

74. Patient C was discharged from the hospital on April 4, 1995. There was evidence of small vessel occlusion in the left foot, including reports of a cyanotic small toe on April 1 through 3, 1995. (Ex. #19, pp. 44-46).

75. In May, 1995, Patient C required amputation of his left small toe. In July, 1995, amputation of gangrenous portions of his left foot was performed. In August, 1995, Patient C underwent a left above-the-knee amputation, when he could not straighten his left knee. (Ex. #18, pp. 4, 5, 7).

76. Following the March 28, 1995 surgery, Patient C's cyanotic toes were likely the result of the embolization of clots and the trashing of little fragments into the distal vessels. These fragments can be produced from clot or plaque and travel to distal vessels from which they cannot be retrieved. With the delay in restoring normal blood flow, the natural lytic activity of the blood is reduced. (T. 181-182).

Patient D

77. Patient D was a 50 year old man who was admitted to St. Joseph's Hospital on April 27, 1992. Upon admission, the patient's bilirubin was 3.5, but it gradually returned to normal by April 30, 1992. Patient D was diagnosed as having acute cholecystitis with a common bile duct stone. (Ex. #22, p.3; T. 194, 800-801, 1151-1153).

78. A CT scan of the abdomen was performed on April 28, 1992. The CT scan showed the pancreas to be within the upper limits of normal. An ERCP was conducted and found inflammation in the area of the ampulla. During the procedure, the catheter could not be advanced and the common duct could not be visualized to obtain a cholangiogram. (Ex. #22, pp. 12, 78; T. 196, 1156-1157).

79. On May 1, 1992, Respondent performed a laparoscopic cholecystectomy. He also performed a cholangiogram during the course of the surgery. The cholangiogram was normal. The patient was discharged from the hospital on May 2, 1992. (Ex. #22, pp. 3,27; T. 196-197; 1157).

80. Following the patient's discharge from the hospital, he was followed by Respondent in his office. On May 13, 1992, the patient was seen by Respondent and was doing well. (Ex. #21).

81. On June 29, 1992, the patient was put on Zantac

and a bland diet. On July 1, 1992, the patient reported that his indigestion and stomach pain had decreased since he began taking Zantac, but he still had a feeling of pressure. Based upon this information, it was Respondent's opinion that the patient had either gastritis or was developing a peptic ulcer. He ordered an upper GI series, which was performed on July 6, 1992. (Ex. #21).

82. The upper GI series showed some inflammation in the second part of the duodenum, but showed no evidence of ulcer disease. Based upon the test results, it was Respondent's impression that the patient had gastritis, duodenitis, or hyperacidity. (Ex. #21, p. 65; T. 1160-1161).

83. The radiologist noted that he could not exclude the possibility of some prominence of the head of the pancreas or pancreatic pathology being responsible for the changes noted. He further indicated that "if clinically indicated, follow-up studies and CT examination may be of aid in further evaluation". (Ex. #21, p. 65).

84. Based upon the symptoms exhibited by the patient in July, 1992, as well as the results of the upper GI series, a CT scan was not clinically indicated. On July 15, 1992 (nine days after the test), the patient reported that he was feeling better since starting on Zantac and a bland diet. The inflammation seen on the upper GI series was consistent with the results of the April, 1992 ERCP. Moreover, there had already

been a normal CT scan as well as a normal cholangiogram. Consequently, another CT scan was not indicated as of July 6, 1992. (Ex. #21, p. 4; T. 813-814, 820-821, 841-842, 1157-1158, 1162-1163).

85. Patient D returned to Respondent's office on August 12, 1992. The patient complained of dark urine, pain in the lower back and abdomen, and frequent urination. The patient was also jaundiced and reported that the jaundice began on August 10, 1992. (Ex. #21, p. 4; T. 1163-1164).

86. Respondent ordered an ERCP. The procedure was performed on August 13, 1992. A tumor of the ampulla, which was suggestive of either a villus adenoma or carcinoma was noted. Multiple biopsies were taken. The pathology reported that no malignancy was identified. (Ex. #23, pp. 27-28).

87. A CT scan of the abdomen was ordered and performed on August 13, 1992. The scan showed a mass at the head of the pancreas measuring 7.5 centimeters in diameter, and marked dilatation of the bile ducts measuring up to 3.5 centimeters in diameter. The report further stated that "the possibility that the mass in the head of the pancreas actually represents an ampullary carcinoma rather than a primary pancreatic carcinoma cannot be excluded, but would appear less likely as the source of the mass." (Ex. #23, p. 278).

88. On August 18, 1992, Respondent operated on Patient

D. He exposed the ampullary lesion, excised the tumor and sent it to pathology. He also sent a lymph node and several needle biopsies of the pancreas as well. The biopsy of the Ampulla of Vader was benign. The needle biopsies showed that the pancreas was inflamed. There was a pathology thatthree or four cells exhibited signs of carcinoma, but all of the doctors who testified at the hearing agreed that it was unlikely that the patient had carcinoma. (Ex. #23; T. 227, 822, 1170, 1172).

89. There was no mass at the head of the pancreas. Rather, the head of the pancreas was enlarged due to chronic pancreatitis. (T. 1170-1171; 1211-1212).

90. During the August 18, 1992 surgery, Respondent performed a roux-en-y hepaticojejunostomy, and a jejunojejunostomy. These procedures were medically appropriate. (Ex. #23, p. 47; T. 821, 1172).

91. On August 27, 1992, Respondent performed a second operation on Patient D for perforation of the jejunojejunostomy performed on August 13, and drainage of a pancreatic abscess. Respondent revised the jejunojejunostomy and performed a gastrojejunostomy. A sump drain was placed down to the pancreas. (Ex. #23, p. 66; T. 1199-1200, 1214-1215).

92. On September 1, 1992, the patient's progress record notes that the patient had intra-abdominal sepsis and was being treated with fluids and antibiotics. This treatment was

medically appropriate. (Ex. #23, p. 111; T. 824-825, 1174).

93. On September 1, Respondent found the patient's abdomen to be soft, although he also had an elevated temperature. Respondent was concerned about the sepsis and ordered a CT scan, which was done on September 3, 1992. The findings were compatible with diffused pancreatitis and diffuse inflammatory changes within the right mid and lower abdomen. A fluid collection was noted in the right lower quadrant which was of unknown etiology. It could not be determined whether this was an abscess, as there were no air bubbles noted, nor was there a well-defined wall present. The patient's treatment for sepsis continued. (Ex. #23, p. 286; T. 1175-1176).

94. On September 8, 1992, another CT scan was performed. This showed that the fluid collection appeared to have minimally increased in size since September 3. Based upon this finding, Respondent attempted CT aspiration. On September 8, 1992, A CT-guided aspiration was attempted and approximately 7 cc's of fluid was removed. The procedure was not completed because the patient could not tolerate it. The attempted aspiration was a medically appropriate procedure. (Ex. #23, pp. 287-288; T. 826, 1213-1214).

95. On September 10, 1992, Respondent noted a large amount of spontaneous drainage of yellow fluid from the sump drain and around the drain. Respondent's progress note on

September 10 also indicated that the patient stated that "a lot of pressure has been relieved". (Ex. #23, p.126).

96. On September 10, another CT scan was performed and it showed that the fluid collection on the right side of the mid-abdomen appeared to have somewhat decreased in size. (Ex. #23, p. 9; T. 829-830, 1181-1182).

97. On September 11, 1992, Respondent noted that there was yellow drainage around the Foley and Penrose drain sites and that the abdomen was soft. A nursing note recorded on that date noted that a large amount of drainage persists. (Ex. #23, p. 129; T. 831, 1182-1183).

98. On September 11, 1992, Respondent considered surgery, but decided against it. He weighed the risks of further surgery on this patient versus the possible benefit. The patient's abscess was draining and he elected to treat the patient conservatively. (T. 1185).

99. Patient D died on September 15, 1992 from the effects of sepsis. (Ex. #23; T. 220).

100. All of the physicians who testified regarding this patient agreed that this was an extraordinarily unusual and complex case. (T. 228, 799, 1149).

Patient E

101. Patient E, then a 54 year old female, was admitted to St. Joseph's Hospital on October 31, 1996 with abdominal pain

and tenderness. The emergency room record indicated that Patient E woke at 5:15 a.m. with a cough and felt pain in her right lower quadrant. Respondent performed an emergency laparotomy on November 1, 1996 for an "excision of aneurysm of abdominal wall with ligation and evacuation of intra-abdominal hemorrhage". (Ex. #25, pp. 3, 14, 31).

102. Patient E's condition was inaccurately described in the operative report and hospital chart as an "abdominal wall aneurysm". Aneurysms occur in blood vessels, and while the abdominal wall has blood vessels, the wall itself cannot be said to have an aneurysm. Patient E had a ruptured epigastric artery. (Ex. #25, p. 14; T. 265-266).

103. The procedure mis-identified by Respondent as an abdominal wall aneurysm was later mistakenly billed as an abdominal aortic aneurysm, and was mis-identified by a physician consulting during Patient E's November 19, 1996 admission as a ruptured abdominal aortic aneurysm. (Ex. #26, p. 13; T. 1253-1254).

104. The laparotomy procedure performed on November 1, 1996 went down to the peritoneal cavity. A Jackson-Pratt drain was inserted in the rectus sheath and was brought to the skin surface through a separate stab wound to the right of the incision line. (Ex. #25, p. 14; T. 1244, 1259-1260).

105. Following surgery on November 1, 1996, and until

the removal of the Jackson-Pratt drain by Respondent on November 3, 1996, bloody drainage was recorded as having come from the drain. (ex. #25, p. 32-35).

106. Nursing notes recorded after 2:00 p.m. on November 3, 1996 through the patient's discharge on November 6, 1996, periodically record large or copious amounts of serosanguinous drainage and numerous dressing changes. (Ex. #25, pp. 36-39).

107. In a patient with an abdominal incision such as Patient E, the reports of large amounts of serosanguinous drainage over several days are very significant and indicate wound breakdown and a risk of an impending evisceration. (T. 257-259).

108. Patient E was at further risk for wound dehiscence as she had a history of asthma and was on steroids. Steroids can delay wound healing. Further, a patient with asthma and who coughs can greatly increase intra-abdominal pressure; thereby placing excessive tension on the wound. (T. 259, 263-264).

109. On November 5, 1996, the nursing notes recorded at 12:30 a.m. indicate that a large amount of serosanguinous drainage is noted from the distal incision line. Respondent acknowledges that a large amount of serosanguinous drainage from the incision line would present a risk of dehiscence and evisceration. (Ex. #25, p. 37; T. 1248-1249).

110. Respondent testified that he observed drainage

from the drain site and not from the incision line. Nevertheless, Respondent acknowledged that serosanguinous drainage from the drain site could be a sign of dehiscence and present a risk of evisceration. (T. 1233, 1245, 1249-1250, 1258).

111. Respondent did not record any observations of the incision on November 4, 5 and 6, 1996. (T. 1250-1252).

112. Given the indications of dehiscence and the concomitant risk of evisceration, Respondent should have taken Patient E back to the operating room for wound exploration and reclosure. Respondent's failure to do so was a gross deviation from accepted standards of medical care. Patient E was at risk to eviscerate at the time of her discharge on November 6, 1996. Eviscerations which occur outside of the hospital pose a substantial risk of infection, peritonitis, and significant fluid loss. (T. 258-262).

113. Patient E continued to have drainage from the drain site at the time of the removal of one-half of the skin staples on November 11, 1996, according to Respondent's office medical record. Respondent testified that he recognized that there was a risk of dehiscence and an associated risk of evisceration at that time. (Ex. #24, p. 7; T. 1252).

114. On November 19, 1996, the day after the removal of the remaining skin staples, Patient E eviscerated at home and was

admitted to the hospital for emergency surgery. (Ex. #26, p. 25).

Patient F

115. Patient F was first seen by Respondent at the emergency room at St. Joseph's Hospital on October 31, 1983. He had been in an automobile accident and his complaints at the time were injury to the left side of neck and chest, right arm and elbow, numbness of left arm and elbow, contusion of the chest with swelling of the left side of his neck. (Ex. #27, p. 185; T. 1265-1266).

116. When Respondent first saw this patient, thoracic outlet syndrome was not a consideration, although the patient's complaints of pain and numbness in his left arm and elbow were consistent with thoracic outlet syndrome. (T. 485, 1271).

117. In December, 1983, the patient was still complaining of pain radiating into the left arm. Respondent referred Patient F to Dr. Silvers for a neurological evaluation. At this time, the patient was being treated with cervical traction, heat, massage, analgesics and muscle relaxants. (Ex. #27, p. 205; T. 1271-1273).

118. Dr. Silvers saw the patient on December 19, 1983. At that time, the patient continued to complain of pain in his left neck, radiating into his shoulder and down his arm to his hand. He also complained of numbness in the left arm and hand.

These symptoms are consistent with a number of conditions, including thoracic outlet syndrome. (Ex. #27, p. 220; T. 486-487, 1271).

119. Thereafter, the patient continued to complain of pain radiating down his left arm each time he visited the doctor's office on January 6, 1984, February 6, 1984 and February 27, 1984. On February 27, Respondent for the first time considered the possibility of a brachial plexus injury and thoracic outlet syndrome. He decided to obtain another consultation. (Ex. #27, pp. 200, 202, 204).

120. On March 27, 1984, Dr. McHugh of the Dent Neurological Institute rendered his report. Dr. McHugh related that the patient remembered that immediately after the accident, his arm was numb and weak and he had difficulty in picking up fine objects. These symptoms are consistent with thoracic outlet syndrome. The patient had been treated with conservative therapy which included traction. The traction had worsened the reported numbness and pain. This worsening of symptoms with traction was consistent with thoracic outlet syndrome. (Ex. #27, pp. 268-269; T. 488-489, 503, 1273).

121. At the time of the consultation, the patient complained of pain in the jaw and neck; episodes of arm numbness, especially when the arm was being used or while driving and sometimes when sleeping. The neck pain and episodic numbness of

the arm were consistent with a diagnosis of thoracic outlet syndrome. (Ex. #27, p. 268; T. 489-490, 1273).

122. In his report, Dr. McHugh stated that "I suspect he probably suffered a brachial plexus injury due to downward traction on the shoulder affecting the upper trunk and probably the lower trunk as well. The symptoms that he experiences now are probably related to some form of compression of the brachial plexus possibly due to post-traumatic changes." (Ex. #27, p. 269).

123. Dr. McHugh recommended maneuvers designed to increase flexibility and range of motion in the shoulder area. (Ex. #27, p. 269).

124. On June 20, 1984, the patient was again seen by Dr. McHugh. In his report dated June 26, 1984, Dr. McHugh stated that the patient had not worked since his accident and has had no marked improvement. When at rest, he was relatively symptom-free but had increasing pain when he attempt to use his arm. (Ex. #27, p. 267).

125. The patient was next seen at the Dent Neurologic Institute on August 28, 1984 by Dr. Bates. In his report, Dr. Bates noted that the patient still had pain in his left neck, shoulder and arm. The pain occurred principally with any use of the left arm such as lifting or any sustained movement. These symptoms are consistent with thoracic outlet syndrome. (Ex. #27,

p. 266; T. 498-499, 1281).

126. Dr. Bates also noted that although the patient had been on physical therapy since June, 1984, he had not noticed any permanent benefit, although he did experience some decrease in symptoms immediately following therapy. (Ex. #27, p. 266).

127. Dr. Bates ordered that the physical therapy be continued, and placed the patient on a trial of Inderal. The Inderal was not helpful and was subsequently discontinued. (Ex. #27, p. 266; T. 500-501, 1282-1283).

128. On September 16, 1984, Patient F was admitted to the Dent Neurologic Institute for further evaluation. Both the admitting and discharge diagnoses were possible thoracic outlet syndrome. In a report dated October 18, 1984, Dr. Bates noted that the patient's pain worsened upon abduction of his arms. This finding was consistent with thoracic outlet syndrome. (Ex. #27, pp. 128-129).

129. On September 16, 1985, Patient F was admitted to the Altoona Hospital for evaluation. A cervical myelogram was performed and the results were negative. This ruled out a cervical disc problem. The final diagnoses by the physicians at the Altoona Hospital were thoracic outlet syndrome and chronic cervical and thoracic strain. (Ex. #27, p. 222).

130. Respondent saw Patient F regularly over the nearly two and one-half years that elapsed between the date of his

accident and the date of his surgery in March, 1986. During that period of time, the patient regularly reported that he had pain, numbness and tingling in the left shoulder, arm and hand. (Ex. #27, pp. 178, 179, 181, 182, 187, 188, 189, 190, 191, 193, 195, 198, 200, 202, 204, 205, 207, 209).

131. All of the doctors that testified in this case agreed that with few exceptions, the complaints related by the patient were consistent with thoracic outlet syndrome. (T. 321, 323, 325-328, 330-336, 515-521, 1293-1294).

132. More often than not there is no objective evidence of thoracic outlet syndrome. However, the lack of such objective evidence does not rule out the syndrome. Clinical evaluation is the most important tool in diagnosing thoracic outlet syndrome. Radiologic and EMG studies have little value in diagnosing thoracic outlet syndrome; rather, these studies are used to rule out other causes of the patient's problem. (T. 476, 479, 481-482, 1267-1270).

133. On March 18, 1986, Respondent performed a transaxillary resection of the first rib. Prior to surgery, Respondent explained the various treatment options to the patient. The patient was advised of the possible complications, as well as the possibility that the surgery would not improve his condition. (Ex. #27, p. 176, 178; T. 1294-1297).

134. Following the first rib resection, Respondent

wrote letters to Nationwide Insurance, dated June 23, 1987; Francis Whitcher, Esq., dated August 18, 1986; and the New York Department of Social Services, dated January 28, 1987, in which he represented that a subclavian venogram "showed blockage of the vein between the first rib and clavicle". These representations as to the findings of the venogram performed on September 17, 1984 are not consistent with the radiologist's findings and are not accurate. Patient F's subclavian vein was not blocked and the description of a slight compression of the axillary vein with the arm in the adducted position is consistent with a normal study. A blocked subclavian vein would be diagnostically significant. However, Patient F's surgery was not performed on a finding of any vascular pathology. (Ex. #27, pp. 258, 276, 281; T. 297-298, 313-314, 1306-1308).

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 unless noted otherwise.

Respondent is charged with forty-six[1] specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct

1 Three additional specifications regarding Patient E (fraudulent practice, moral unfitness and willfully making or filing a false report) were withdrawn

which constitute professional misconduct, but does 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 Henry M. Greenberg, Esq., 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:

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

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

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by Petitioner during the course of the proceedings.

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 the profession.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the First through Sixth, Eighth through Ninth, Thirteenth through Twenty-Fourth, Twenty-Sixth through Thirty-Second, Thirty-Fourth through Fortieth, and Forty-Second through Forty-Ninth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) should be sustained. The Committee further concluded that the Seventh and Tenth through Twelfth Specifications should be dismissed. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee considered the credibility of the various witnesses presented by both parties. Petitioner presented expert testimony by Jesse A. Blumenthal, M.D. Dr. Blumenthal is a vascular surgeon and the chief of trauma services at St. Vincent's Hospital, in New York City. He

has no personal connection to Respondent, and testified in an impartial manner. Although his testimony was generally credible, he did contradict himself on several occasions. In addition, the Committee found that his testimony on some issues tended to be rather dogmatic (e.g., regarding thoracic outlet syndrome). This tended to diminish his credibility somewhat, in the opinion of this Committee.

Respondent presented two experts. The first was Kenneth H. Eckhert, Jr., M.D. Dr. Eckhert is a board-certified surgeon. Dr. Eckhert is now primarily a breast surgeon, but has broad surgical experience. Although Dr. Eckhert is a long-time acquaintance of Respondent's, the Hearing Committee found that he gave very measured, careful testimony, especially with regard to Patient F and thoracic outlet syndrome. The Committee found Dr. Eckhert's testimony to be entirely credible.

Respondent also presented Joseph M. Anain, M.D. Dr. Anain is a board-certified vascular surgeon, who is also of long acquaintance with Respondent. The Hearing Committee was troubled by several contradictions in his testimony. In particular, Dr. Anain's testimony regarding Patient A at the hearing appeared to directly contradict the opinions which he expressed in writing to the Island Peer Review Organization (IPRO). This tended to diminish his credibility.

Respondent also testified in his own behalf.

Respondent has an obvious stake in the outcome of this hearing. The Committee found his testimony to be generally self-serving, and gave it little credibility, except where supported by credible testimony from another expert.

Petitioner also presented fact testimony from three witnesses. Bonnie Trala, a medical assistant employed by Respondent, testified as to the billing practices followed in Respondent's office. Susan McIvor and Patricia Manning, both employees of Blue Cross & Blue Shield of Western New York, testified regarding their practices in terms of reviewing and paying physician claims for surgical procedures. The Hearing Committee found the testimony of all three fact witnesses to be, on the whole, credible.

The charges brought against Respondent fall into several distinct groupings. Petitioner has alleged that Respondent is guilty of fraud, willfully filing false reports, and maintaining inaccurate records with regard to thrombectomy procedures performed on Patients A, B, C, G, H, and I. Petitioner further alleged that Respondent's medical care and treatment of Patients A through I constituted, variously, gross negligence, gross incompetence, negligence on more than one occasion and/or incompetence on more than one occasion. Lastly, Petitioner has charged that Respondent ordered and performed carotid duplex scans on Patients J, K, L and M without adequate

medical justification.

Thrombectomy Cases

The record clearly established that Respondent repeatedly mischaracterized thrombectomy procedures as thromboendarterectomy procedures in operative reports, hospital records and billing statements. Following the testimony of his own expert, Dr. Anain, that the procedures which Respondent had designated as thromboendarterectomies were actually thrombectomies, Respondent acknowledged the mischaracterizations. Moreover, Respondent testified that he designated the procedures as thromboendarterectomies knowing that his secretary would bill them as such. He also admitted that he had intended that the procedures be billed as thromboendarterectomies. (*See*, T. 1031-1032). Respondent attempted to explain this billing windfall by contending that, for reasons he could not identify, he fell into the "habit" early in his practice of calling thrombectomies thromboendarterectomies, although he was well aware that they are different procedures. (*See*, T. 968, 970-971). He also claimed that he may have picked up the practice from another physician (a Dr. Barone).

Petitioner has charged Respondent with fraud concerning his misrepresentation of thrombectomy procedures as thromboendarterectomies. As noted previously, the intentional

misrepresentation or concealment of a known fact, made in connection with the practice of medicine, constitutes fraud. Choudhry v. Sobol, 170 AD2d 893 (3rd Dept. 1991). In order to sustain a charge that a licensee was engaged in the fraudulent practice of medicine, the Hearing Committee must find that (1) a false representation was made, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 AD2d 315 (3rd Dept. 1966), aff'd, 19 NY2d 679(1967). The Hearing Committee may infer a Respondent's guilty knowledge and intent to deceive from the circumstances in which the misrepresentation was made. Matter of Van Gaasbeek v. Chassin, 198 AD2d 527, 574.

The Hearing Committee unanimously concluded that Respondent's repeated mischaracterization of thrombectomy procedures and subsequent billing for thromboendarterectomy procedures constituted the fraudulent practice of medicine. We infer this from the circumstances in this case for several reasons. Respondent was unable to provide a credible explanation as to why he decided to label thrombectomies as thromboendarterectomies. He could not explain why he did not know there was a difference in the procedure codes, and never sought to find out. Respondent received hundreds of dollars in

reimbursement per procedure by misidentifying the surgery as thromboendarterectomies.

Based upon the above, the Hearing Committee concluded that Respondent intentionally mischaracterized the thrombectomy procedures in order to obtain additional income - income to which he was not entitled. Accordingly, the Committee concluded that Respondent was guilty of engaging in the fraudulent practice of medicine, and voted to sustain the Twenty-Second through Twenty-Fourth, and Twenty-Seventh through Twenty-Ninth specifications of professional misconduct.

By seeking to defraud insurance carriers through false billings, Respondent has also violated the moral and ethical standards of the medical profession. Therefore, the Committee further concluded that Respondent's conduct in this regard also evidenced moral unfitness to practice medicine, and voted to sustain the Thirtieth through Thirty-Second, and Thirty-Fifth through Thirty-Seventh specifications.

Respondent admitted that he had falsely identified thrombectomy procedures as thromboendarterectomy procedures knowing that his staff would bill them as such and that he had intended that they bill the procedures as thromboendarterectomies. The Hearing Committee concluded that such actions constituted the willful making or filing of false reports within the meaning of Education Law § 6530(21) and voted

to sustain the Thirty-Eighth through Fortieth, and Forty-Third through Forty-Fifth Specifications of professional misconduct.

Carotid Duplex Scans

The Forty-Sixth through Forty-Ninth Specifications charge Respondent with professional misconduct in violation of Education Law § 6530(32) by reason of his having ordered excessive tests not warranted by the condition of the patient. These specifications all concern carotid duplex ultrasound scanning performed on Patients J, K, L and M, respectively.

Respondent offered no independent expert testimony either supporting his use of the carotid scans in these cases, or refuting the testimony of Dr. Blumenthal that the testing had been excessive. Moreover, in his own testimony, Respondent did not attempt to justify his use of this study for any specific patient charged, nor did he attempt to defend any of the bills he submitted to the patients' insurance carriers.

Respondent's management of Patients J, K, L, and M was the subject of an administrative warning, dated February 21, 1990. (*See*, Administrative Law Judge Ex. #1). Pursuant to Public Health Law § 230(10)(m)(ii), an administrative warning may be issued where there is substantial evidence of professional misconduct of a minor or technical nature, or of substandard medical practice which does not constitute professional

misconduct. Administrative warnings shall be confidential and shall not constitute an adjudication of guilt, or be used as evidence that the licensee is guilty of the alleged misconduct. However, in the event of a further allegation of similar misconduct by the same licensee, the matter may be re-opened and further proceedings instituted. Petitioner alleges that Respondent's conduct in the performance of carotid duplex scans is similar to his conduct in mischaracterizing thrombectomy procedures as thromboendarterectomies.

Prior to our deliberations on these charges, Administrative Law Judge Storch instructed the Hearing Committee that insofar as Patients J,K, L and M were the subject of the prior administrative warning, we could only consider the merits of the excessive testing charges upon making a finding that the conduct involved is similar to other misconduct allegedly committed by Respondent. For the purposes of these deliberations, Judge Storch further instructed us that the definition of the word "similar" to be used provides that the conduct to be compared must be "nearly corresponding; resembling in many respects". (*See*, Black's Law Dictionary, 5th Ed. 1979, p. 1240).

Upon careful review of the evidence in this matter, the Hearing Committee unanimously concluded that the conduct involved in the carotid duplex scan cases was sufficiently similar to

other misconduct alleged as to warrant further consideration. The unifying characteristic overlaying Respondent's actions is the repeated attempt to obtain unjust enrichment at the expense of his patients, or their insurance carriers. In billing for procedures not performed, or performing tests not medically indicated and seeking payment thereafter, Respondent was attempting to gain a financial advantage. As a result, the Committee concluded that we have jurisdiction to consider the merits of the charges brought concerning the performance of the carotid duplex scans.

Petitioner presented uncontraverted testimony by Dr. Blumenthal which established that the carotid duplex scans ordered and performed for Patients J, K, L and M were without adequate medical indications. Accordingly, the Hearing Committee concluded that Respondent's conduct violated Education Law § 6530(32) by reason of his having ordered excessive tests not warranted by the condition of the patient. Therefore, the Committee voted to sustain the Forty-Sixth through Forty-Ninth Specifications of professional misconduct.

Patient A

On August 23, 1994, Respondent performed an elective resection of an abdominal aortic aneurysm and placed a bypass graft on Patient A's aorta to the common iliac arteries on both the right and left sides. At the time of surgery, Patient A was

a 68 year old male who had undergone a six-vessel coronary bypass procedure one month earlier. In Paragraph A.1 of the Statement of Charges, Petitioner alleged that Respondent inappropriately placed the distal end of the aortoiliac graft proximal to a portion of the right external iliac artery which was 90% stenosed.

This allegation is based upon the report of an abdominal aortogram and bilateral leg angiogram performed on August 16, 1994. The radiologist, Dr. Chu, reported a 90% stenosis to the mid-right external iliac. This is the only reference to a stenosis in that area in all of the patient's medical records. However, the report also noted that Dr. Chu had experienced difficulty in passing the guide wire into the right external iliac artery. He found that although the common femoral artery and right external iliac artery were tortuous and narrow, they were patent. This indicates an absence of stenosis. Further, Dr. Chu noted that the catheter appeared to pass outside the lumen of the right external iliac artery, through mural thrombus. If the catheter dissected the wall of the artery, it could cause the artery to appear stenosed.

Dr. Blumenthal acknowledged that his opinion on this issue was based upon the assumption that the artery was actually 90% stenosed. Ultimately, the determination as to whether the vessel was, in fact, stenosed, was a clinical judgement call

exercised by the operating surgeon. Respondent was the only witness testifying who was present at the surgery. He testified that Doppler studies indicated equal thigh pressure on both sides (*See, Ex. #4,* pp. 1-2), and that upon examination the patient had a good femoral pulse. These factors tend to indicate the absence of a significant stenosis.

Based on the foregoing, the Hearing Committee concluded that Petitioner had failed to prove by a preponderance of the evidence that the right external iliac artery was 90% stenosed. Accordingly, the Committee voted to dismiss Factual Allegation A.1.

Following the surgery, Patient A's right leg was "very mottled", indicating severe vascular compromise. Further, approximately three hours after surgery, Patient A's pH was 7.22, indicating severe acidosis. Patient A was returned to surgery at 9:45 p.m. on August 23, 1994. Respondent performed a femoral-femoral bypass. However, the record clearly established that Respondent failed to adequately evaluate and treat Patient A following the femoral-femoral bypass surgery performed (Allegation A.2).

Respondent and his own expert have a significant difference of opinion as to Patient A's status following the second surgery. While Respondent claimed that the patient had improved, both Dr. Anain and Dr. Blumenthal testified that the

findings in the ICU indicated re-occlusion and that further surgery was indicated.

All acknowledged that Patient A was markedly acidotic from the effects of arterial occlusions both prior to and during the second surgery. The surgery was concluded at 11:45 p.m. and the patient returned to the ICU at 1:00 a.m. Respondent testified that he accompanied Patient A to the ICU and that he was aware of the nurse's findings at that time, including that the bilateral lower extremities were cool to the touch, with mottling, that there was difficulty in assessing palpable or Doppler pulses, and an inability to register oxygen saturation.

Respondent testified that the patient was improved at this time, that there was adequate perfusion to the legs and he thereafter left the hospital. (T. 1019-1020). However, Respondent made no progress notes documenting his claim that the patient was improved, as of 1:00 a.m. Moreover, Dr. Anain testified that the 1:00 a.m. findings indicated that the patient's legs were very ischemic. His testimony essentially concurred with the opinions expressed by Dr. Blumenthal. Both experts agreed that Patient A's ischemia required management by a vascular surgeon, and that neither the anesthesiologist nor the cardiologist who were attempting to treat the patient's acidosis by ordering sodium bicarbonate could treat the ischemia.

Respondent testified that he had been called by the ICU

nurse at 1:20 a.m. and told that the patient's condition had not changed. However, Respondent never returned to the hospital and was notified of Patient A's death by telephone at 7:00 a.m.

The Hearing Committee unanimously concluded that Respondent's actions represent a particularly egregious breach of his obligation to this patient. Given the grave nature of the 1:00 a.m. findings, Respondent should not have left the hospital. Having left, he should have returned following the nurse's call at 1:20 a.m. indicating that the patient's condition had not improved. Respondent callously attempted to shift responsibility for this patient to the nursing staff, as well as the cardiologist and anesthesiologist on the case. Nevertheless, as the operating surgeon, the care and treatment of Patient A was Respondent's responsibility. The Hearing Committee strongly believes that Respondent's conduct in this case verged on abandonment. The Committee unanimously concluded that Factual Allegation A.2 has been proved by a preponderance of the evidence, and that Respondent's conduct demonstrated both gross negligence and gross incompetence, as defined above. Accordingly, the Hearing Committee voted to sustain the First and Fifth Specifications of professional misconduct.

Patient B

Respondent provided medical care and treatment to Patient B during a period including August 1, 1994 through March

15, 1995 at his office and at St. Joseph's Hospital. Respondent's surgical treatment of the patient included a left femoropopliteal arterial bypass on August 2, 1994, a subsequent revision of the length of the graft and the removal of blood clots in the left leg on August 3, 1994, among other procedures.

Respondent designated the resection of the femoral-popliteal graft in the operative report for the August 3, 1994 procedure as a "femoral-femoral" graft. This term describes a new graft from the proximal to distal end of the femoral artery or a graft which crossed the groin from the femoral artery on one side of the body to the femoral artery on the other. This was inaccurate, and both Dr. Blumenthal and Dr. Anain noted that a competent vascular surgeon would not describe it as such. Thus, the Hearing Committee voted to sustain Factual Allegation B.4.

Patient B was discharged from the hospital on August 10, 1994. However, two days later, she was readmitted following a re-occlusion of the graft. There were essentially four treatment options available to Respondent at that point. He could initiate thrombolytic therapy; perform a thrombectomy; harvest a vein use that for a graft, or begin heparin therapy. Respondent chose thrombolytic therapy, using an infusion of urokinase. This was a reasoned, and reasonable approach to the patient's condition. Accordingly, the Hearing Committee did not vote to sustain Factual Allegation B.1.

Patient B was admitted to the hospital again on December 18, 1994 with evidence of acute ischemia, including complaints of leg numbness and discomfort, and an absence of pulses below the femoral. The arteriogram performed on December 19, 1994 demonstrated that the clot had progressed from the graft and into the reconstituted popliteal artery. An attempt was made to lyse the clot with urokinase at that time but was aborted due to an inability to insert the catheter. Respondent delayed performing a thrombectomy until December 22, 1994.

The delay in surgery increased the risk of clot propagation and further embolization into the smaller vessels, significantly altering the outflow and reducing the chance of limb survival. By the time of the December 22, 1994 surgery, the Doppler flow heard earlier in the admission was absent, indicating compromised flow.

Following the failure to lyse the clot on December 19, Respondent wrote a progress note dated December 20, 1994 in which he states that the patient is to have surgery. Inexplicably, the surgery was delayed for two days. By delaying the surgery for two days, Respondent significantly increased the risk of limb loss.

Based on the foregoing, the Committee voted to sustain Factual Allegation B.2. The Hearing Committee considers this to be a gross deviation from accepted medical standards.

Consequently, the Committee voted to sustain the Second Specification [gross negligence], as well as the Sixth Specification [gross incompetence]. Petitioner also alleged gross incompetence with regard to the description of the revised femoropopliteal bypass on August 3, 1994 and the description of the December 22, 1994 thrombectomy as a thromboendarterectomy [the Seventh Specification]. These are more accurately addressed as record-keeping and fraud charges, respectively, and are addressed elsewhere. Accordingly, the Seventh Specification was dismissed.

Patient C

Patient C, a 70 year old male, was admitted to St. Joseph's Hospital on March 24, 1995 with increasing discomfort, coldness and numbness in his left leg. He had no pulse in his left femoral artery, or distally. Patient C had previously undergone a right above-the-knee amputation. An arteriogram performed on March 25, 1995 showed severe occlusions of both external iliac and common femoral arteries. Patient C had severe occlusive disease of his remaining leg and was at significant risk for limb loss.

Respondent requested a cardiology consultation, which was performed on March 25, 1995. The cardiologist, Dr. Issa, noted the patient's extensive cardiac history, but found that the patient was not presently in congestive heart failure and had no

evidence of recent infarction. Dr. Issa questioned the patient's ejection fraction and recommended placement of a Swan Ganz catheter as well as an echocardiogram, which was performed on March 27, 1995.

Respondent performed a thrombectomy to remove the leg clots on March 28, 1995 - four days from the date of admission. This delay in surgery was a gross deviation from accepted standards of practice. As in the case of Patient B, Respondent cannot reasonably explain the delay in removing the clots from Patient C's severely compromised leg. Although Respondent claimed that he recognized the patient's serious risk of limb loss, he failed to appropriately respond to that condition by aggressively working to revascularize the leg.

Respondent attempted to cast responsibility for the delay in surgery upon the cardiologist, Dr. Issa. An order written by the cardiologist on March 25 scheduled the echocardiogram for March 27. However, on March 26, Respondent wrote a progress note stating that the patient would have surgery on March 28. Respondent attributed the delay to so-called "foot dragging" by Dr. Issa (*See*, T. 1117-1118, 1131). However, he was unable to provide a credible explanation as to why Dr. Issa would withhold his recommendations.

The Hearing Committee concludes that it is far more likely that there was no delay by the cardiologist, and that

Respondent failed to recognize the severity of the patient's condition. On March 26, Respondent selected the surgery date of March 28, and the cardiologist's evaluation was performed within that period. The Hearing Committee unanimously concluded that Factual Allegation C.1 should be sustained. Further, the Committee concluded that Respondent's failure to timely treat Patient C's acute arterial occlusions demonstrated both gross negligence and gross incompetence, as defined above. The Committee accordingly voted to sustain the Third and Eighth Specifications of professional misconduct.

Patient D

Petitioner raised two specific allegations regarding Respondent's medical care and treatment of Patient D. First, Petitioner alleged that Respondent failed to timely obtain a CT evaluation of the patient's abdomen following the abnormal findings of an upper GI series performed on July 6, 1992. Second, Petitioner charged that Respondent failed to adequately treat an abdominal abscess after September 8, 1992. For the reasons set forth below, the Hearing Committee determined that both allegations should be dismissed, and that all specifications of professional misconduct regarding this patient should be dismissed as well.

Patient D was a 50 year old male who was admitted to St. Joseph's Hospital on April 27, 1992. The patient was diagnosed

as having acute cholecystitis with a common bile duct stone. A CT scan of the abdomen was performed on April 28, 1992. The scan showed the pancreas to be within the upper limits of normal. An ERCP was performed and found inflammation in the area of the ampulla. On May 1, 1992, Respondent performed a laparoscopic cholecystectomy. He also performed a cholangiogram, which was negative. The patient was discharged from the hospital on May2, 1992.

Patient D was subsequently followed by Respondent at his office. On June 29, 1992, the patient was put on Zantac and a bland diet, due to complaints of indigestion and stomach pain. On July 1, Respondent ordered an upper GI series, which was performed on July 6, 1992.

The upper GI series showed some inflammation in the second part of the duodenum, but no evidence of ulcer disease. The radiologist also noted that he could not exclude the possibility of some prominence of the head of the pancreas or pancreatic pathology being responsible for the changes noted. He wrote that "**if clinically indicated**, follow-up studies and CT examination **may** be of aid in further evaluation". (emphasis supplied).

The radiologist's note appears to be the primary reason for Dr. Blumenthal's opinion that Respondent should have ordered

CT examination of Patient D's abdomen, following the July 6, 1992 upper GI series. The Hearing Committee considers this to be an unnecessarily rigid opinion. The decision to order a CT scan was, as noted by the radiologist, a clinical judgement.

Based upon the symptoms exhibited by the patient in July, 1992, as well as the results of the upper GI series, a CT scan was not clinically indicated. The inflammation seen on the upper GI series was consistent with that seen on the ERCP in April. Further, the CT scan performed in April had shown the pancreas to be normal. Finally, nine days after the upper GI series, the patient reported that he was feeling better since starting on Zantac and a bland diet. Under these circumstances, the Hearing Committee concluded that the decision not to order a CT scan was not a deviation from accepted medical standards.

Patient D returned to Respondent's office on August 12, 1992, with complaints of dark urine, pain in the lower back and abdomen, and frequent urination. The patient was also jaundiced. Following an ERCP and CT scan, Respondent performed exploratory surgery on August 18, 1992. Respondent excised an ampullary lesion, performed a roux-en-y hepaticojejunosotomy, and a jejunojejunosotomy. On August 27, 1992, Respondent performed a second operation to repair a perforation of the jejunojejunostomy, and drainage of a pancreatic abscess.

On September 1, 1992, the patient was found to have

intra-abdominal sepsis. Respondent treated the patient appropriately with fluids and antibiotics. A CT scan performed on September 3, 1992 resulted in findings compatible with diffuse pancreatitis and diffuse inflammatory changes within the right, mid and lower abdomen. A fluid collection was noted in the right lower quadrant.

On September 8, 1992 Respondent attempted a CT-guided aspiration of the fluid. Approximately 7 cc's of fluid was removed, but the procedure had to be terminated because the patient could not tolerate it. On September 10, 1992, Respondent noted a large amount of spontaneous yellow drainage from in and around the sump drain. A CT scan indicated some decrease in the size of the fluid collection. Ultimately, the patient expired on September 15, 1992.

All of the physicians who testified regarding Patient D acknowledged that it was a very difficult and complex case. In Dr. Blumenthal's opinion, Respondent should have treated the patient more aggressively, and taken him back to surgery. However, he admitted that the patient was a poor surgical risk, and that while more aggressive drainage and re-operation may have been helpful, such decisions could only be made in a clinical setting on examination of the patient. (*See*, T. 244).

In making the determination to treat the patient surgically or conservatively, one must look at the entire

clinical picture. In this case, Respondent determined that the patient's overall status pointed toward continued medical treatment, rather than surgical intervention. Under the totality of the circumstances, the Hearing Committee concluded that this course of action did not constitute a deviation from accepted medical standards. Consequently, the Committee voted to dismiss all charges and specifications of professional misconduct as applied to the care and treatment of Patient D.

Patient E

Patient E, a 54 year old female, was admitted to St. Joseph's Hospital on October 31, 1996 with abdominal pain and tenderness. Respondent performed an emergency laparotomy on November 1, 1996. In the operative note, Respondent described the surgery as an "excision of aneurysm of abdominal wall with ligation and evacuation of intra-abdominal hemorrhage". This was an inaccurate and misleading description. There is no such thing as an aneurysm of the abdominal wall. In fact, Respondent repaired a ruptured epigastric vessel. This mis-identification led to a subsequent consulting physician's erroneous description of the surgery as repair of a "ruptured aortic aneurysm".

Respondent's inability to correctly use vascular surgery terminology and to correctly identify the surgery he has performed represents a lack of fundamental knowledge. The Hearing Committee voted to sustain Factual Allegation E.2 as well

as that portion of the Fourteenth Specification [incompetence on more than one occasion] as pertains to this allegation.

Of far greater concern to the Hearing Committee was Respondent's failure to appropriately evaluate and treat Patient E's signs and symptoms of the impending dehiscence and subsequent evisceration following the November 1, 1996 surgery. Following the surgery, and until the removal of the Jackson-Pratt drain on November 3, 1996, bloody drainage was recorded as having come from the drain. Nursing notes recorded from November 3, 1996 and continuing through the patient's discharge on November indicate large or copious amounts of serosanguinous drainage from the incision line as well as the drain site, and numerous dressing changes. Such findings over a period of several days indicate wound breakdown. Respondent testified that he observed drainage only from the drain site. However, he failed to record any observations of the incision on during the period November 4-6, 1996.

Respondent was also aware that Patient E was at greater risk for wound dehiscence because she had a history of asthma and was taking steroids. Steroids can delay wound healing. Further, a patient with asthma and who coughs can greatly increase intra-abdominal pressure. This would place excessive tension on the wound.

Given the indications of dehiscence and the significant

risk of evisceration, Respondent should have taken Patient E bac to the operating room for wound exploration and reclosure, rathe than simply discharging the patient. His failure to do so was a gross deviation from accepted standards of practice.

On November 11, 1996 Respondent removed one-half of the skin staples despite the fact that the patient continued to have drainage from the drain site. On November 18, 1996, he removed the remaining staples. One day later, on November 19, 1996, Patient E eviscerated at home and was admitted to the hospital for emergency surgery. The Hearing Committee unanimously concluded that Respondent's failure to appropriately manage and treat the patient's impending wound dehiscence represented both gross negligence and gross incompetence, as defined previously. Accordingly, the Committee voted to sustain the Fourth and Ninth Specifications of professional misconduct.

Patient F

Petitioner has alleged that Respondent performed a transaxillary resection of the first rib for a purported thoracic outlet obstruction without adequate surgical indications. We disagree. Patient F was first seen by Respondent at the emergency room at St. Joseph's Hospital on October 31, 1983. He had been in an automobile accident, and had complaints of injury to the left side of neck and chest, right arm and elbow, numbness of left arm and elbow, contusion of the chest and swelling of the

left side of the neck. For nearly two and one-half years, Respondent treated the patient's ongoing symptoms with a conservative approach. Numerous consultations and evaluations by neurological specialists were obtained. As noted by virtually all of the consulting physicians, the patient's continuing complaints of numbness in the left arm and hand were consistent with thoracic outlet syndrome. Thoracic outlet syndrome is a difficult condition to diagnose. Clinical evaluation is the most important tool in reaching a diagnosis of thoracic outlet syndrome. Laboratory studies such as x-ray and EMG studies can merely rule out other causes for the patient's symptoms.

Respondent saw Patient F regularly for nearly two and one-half years following the accident. During that period time, the patient repeatedly reported pain, numbness and tingling in the left shoulder, arm and hand - despite the various therapies instituted by Respondent and the consulting neurologists. It was not until March 18, 1986 that Respondent attempted to relieve the patient's symptoms by the resection of the first rib. Prior to the surgery, Respondent explained the treatment options to Patient F, and advised him of the possible complications, as well as the possibility that the surgery would not improve his condition.

The Hearing Committee unanimously concluded that the record established at the hearing does not support the allegation

that Respondent performed a transaxillary resection of the first rib without adequate surgical indication. Accordingly, the Committee voted to dismiss Factual Allegation F.1 as well as those portions of the Thirteenth and Fourteenth Specifications pertaining to this patient.

Following the rib resection, Respondent wrote letters to Nationwide Insurance, the New York State Department of Social Services, as well as to a private attorney, in which he represented that a subclavian venogram showed blockage of the vein between the first rib and clavicle. These representations as to the findings of the venogram (performed on September 17, 1984) were not consistent with the findings reported by the radiologist. In fact, the radiologist reported an essentially normal venogram.

Respondent admitted that a finding of blockage on the venogram would be an objective and diagnostically significant finding. In a case where there were no objective findings which could confirm the diagnosis, or more importantly, provide documented indications for surgery, Respondent's mischaracterization of the venogram findings provided a purportedly objective measure by which to justify the surgery.

Under the circumstances, the Hearing Committee inferred that Respondent intentionally misrepresented the findings of the venogram in an attempt to obtain payment for the surgery

performed on Patient F. The Committee voted to sustain Factual Allegation F.2. Further, the Hearing Committee concluded that Respondent's actions in making these intentional misrepresentations constituted fraud, moral unfitness, and the willful filing of false reports. Accordingly, the Committee voted to sustain the Twenty-Sixth, Thirty-Fourth and Forty-Second Specifications of professional misconduct.

Negligence on More than one Occasion

Incompetence on More than one Occasion

As noted above, the Hearing Committee has concluded that Respondent is guilty of both gross negligence and gross incompetence with regard to his treatment of Patients A, B, C and E. It is axiomatic, therefore, that he also stands guilty of negligence on more than one occasion and incompetence on more than one occasion. Accordingly, the Hearing Committee voted to sustain the Thirteenth and Fourteenth Specifications of professional misconduct.

Failure to Maintain Accurate Medical Records

Petitioner has charged Respondent with seven specifications of failing to maintain records which accurately reflect the evaluation and treatment of the patient, in violation of Education Law § 6530(32). The record clearly established that on multiple occasions, Respondent falsely recorded that he had

performed thromboendarterectomy procedures when, if fact, he performed thrombectomies. (Patients A, B, C, G, H and I). Moreover, he misidentified the surgical procedure performed on Patient E. Therefore, the Hearing Committee concluded that Respondent did fail to maintain accurate records with regard to each of these seven patients, and voted to sustain the Fifteenth through Twenty-First Specifications of professional misconduct.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be revoked. In addition, a civil penalty in the amount of $10,000.00 should also be imposed upon Respondent. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent's conduct in the case of Patient A alone warrants the revocation of his medical license. The same signs and symptoms which indicated re-occlusion and acute ischemia to both Dr. Blumenthal and Dr. Anain were interpreted by Respondent

as demonstrating ***improvement*** in the patient's condition. At the very time Respondent should have been preparing to take the patient back to surgery, he was leaving the hospital believing that there was adequate perfusion. This represented either a gross lack of understanding of the severity of the patient's condition, or a reckless disregard for his welfare.

Respondent's management of Patient's B and C, where he delayed surgical treatment without valid medical indications also demonstrate that Respondent's judgment and clinical skills can not be trusted. With regard to Patient E, Respondent disregarded clear signs and symptoms of impending disaster, with predictable results. Respondent has repeatedly attempted to pass the blame for these situations onto others. Whether he is attempting to blame a cardiologist for delaying a surgical clearance, or blaming nurses for failure to report the patient's condition accurately, Respondent always sought to deflect blame away from himself. He never acknowledged any mistakes in the care of these patients. Without a clear recognition of his own deficiencies, it is apparent that retraining, and/or practice monitoring would be of no value in protecting the public. Each of the specifications of gross negligence and gross incompetence warrant revocation.

Each of the specifications of fraud, moral unfitness, and filing of false reports which were sustained also warrant the sanction of revocation. With regard to the thrombectomy issues, Respondent repeatedly mis-identified thrombectomies as thromboendarterectomies, knowing that the insurance carriers would be billed for the more expensive procedures. He performed multiple carotid duplex scans without any medical justification. He ceased the practice only when caught. As with the surgical cases, Respondent again tried to deflect blame away from himself. He attempted to blame another physician for teaching him the "habit" of labeling thrombectomies as thromboendarterectomies. He also tried to blame the ultrasound salesman for misleading him as to the proper indications for duplex scans.

Under the totality of the circumstances, the Hearing Committee unanimously determined that no sanction short of revocation will adequately protect the people of this state from further misfortune at the hands of Respondent. In addition, the Committee determined that insofar as Respondent profited from the fraudulent claims which were submitted to insurance carriers, a civil penalty in the amount of $10,000 should also be imposed.

ORDER

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

1. The First through Sixth, Eighth through Ninth, Thirteenth through Twenty-Fourth, Twenty-Sixth through Thirty-Second, Thirty-Fourth through Fortieth, and Forty-Second through Forty-Ninth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. The Seventh and Tenth through Twelfth Specifications are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order;

4. A civil penalty in the amount of **TEN THOUSAND DOLLARS ($10,000.00)** shall be, and hereby is imposed upon Respondent. This penalty shall be forwarded to the New York State Department of Health, Bureau of Accounts Management, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237 within thirty (30) days from the effective date of this Determination and Order. Any civil penalty not paid by the date prescribed herein shall be subject to all provision of law relating to debt collection by the State of New York. 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 nonrenewal of permits or licenses (Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32).

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: **Troy, New York**
1/4/ , **2000**

REDACTED

STEVEN V. GRABIEC, M.D. (CHAIR)

JOHN H. MORTON, M.D.
PETER S. KOENIG

TO: Timothy J. Mahar, Esq.
Associate Counsel
New York State Department of Health
Corning Tower - Room 2509
Empire State Plaza
Albany, New York 12237

Michael J. Gianturco, M.D.

REDACTED

Thomas C. D'Agostino, Esq.
Mattar & D'Agostino, LLP
17 Court Street - Suite 600
Buffalo, New York 14202

APPENDIX I

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

IN THE MATTER : NOTICE
OF : OF
MICHAEL J. GIANTURCO, M.D. : HEARING

TO: Michael J. Gianturco, M.D.
REDACTED

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 24th day of February, 1999, at 10:00 in the forenoon of that day at the Radisson Hotel, 4243 Genesee Street, Buffalo, New York, 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 Rule 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 Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (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 Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and 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 Section 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.

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 THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
January 28, 1999

REDACTED

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Timothy J. Mahar
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

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

IN THE MATTER : STATEMENT
OF : OF
MICHAEL J. GIANTURCO, M.D. : CHARGES

MICHAEL J. GIANTURCO, M.D., the Respondent, was authorized to practice medicine in New York State on September 26, 1956 by the issuance of license number 078527 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period August 1, 1997, through July 31, 1999, with a registration address of 2503 Kensington Avenue, Snyder, New York 14226.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in the Appendix A hereto) during a period including April, 1994 until Patient A's death on August 24, 1994 at St. Joseph's Hospital in Cheektowaga, New York, and at Respondent's office located at 2503 Kensington Avenue, Snyder, New York (office). Respondent's surgical treatment of Patient A included resection of an abdominal aortic aneurysm, an aortoiliac arterial bypass, and the removal of clots from the bypass graft and from arteries in the lower extremities, among other procedures. Respondent's care and treatment of

Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent failed to adequately treat Patient A's right external iliac artery during the aortoiliac bypass surgery performed on August 23, 1994. Respondent placed the distal end of the aortoiliac graft proximal to that portion of the right external iliac artery which was 90% stenosed.

2. Respondent failed to adequately evaluate and/or treat Patient A following the femoral-femoral by-pass surgery performed on August 23, 1994.

3. Respondent documented in the hospital chart and/or billed for performing a thromboendarterectomy on August 23, 1994 when in fact Respondent knew or should have known that he had performed a thrombectomy procedure.

B. Respondent provided medical care and treatment to Patient B during a period including August 1, 1994 through March 15, 1995 at his office and at St. Joseph's Hospital. Respondent's surgical treatment of Patient B included a left femoropopliteal arterial bypass, a subsequent revision of the length of the graft, and the removal of blood clots in the left leg, among other procedures. Respondent's care and treatment of Patient B deviated from accepted standards of care in the following respects:

1. Respondent failed to adequately treat a thrombus in the femoropopliteal graft in the left leg during an August 12, 1994 hospital admission.

2. Respondent failed to timely treat arterial occlusions of the left leg during a December 18, 1994 hospital admission in circumstances in which there were signs and/or symptoms suggestive of an acute ischemia of the left leg.

3. Respondent documented in the hospital chart and/or billed for performing a thromboendarterectomy procedure on August 3, 1994, when in fact Respondent knew or should have known that the procedure he had performed was a thrombectomy.

4. Respondent documented in the hospital chart that he performed a femoral - femoral bypass procedure on August 3, 1994, when in fact Respondent knew or should have known that he had only revised femoropopliteal by pass performed on August 2, 1994.

5. Respondent documented in the hospital chart and/or billed for performing a thromboendarterectomy procedur on December 22, 1994, when in fact Respondent knew or should have known that the procedure he had performed was a thrombectomy.

C. Respondent provided medical care and treatment to Patient C during the period including February, 1981 through August 11, 1995 at his office and at St. Joseph's Hospital. Respondent's surgical care of Patient C included an aortoiliofemoral thrombectomy on March 28, 1995 and an above the knee amputation of the left leg on August 11, 1995. Respondent's medical care and treatment of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely treat by thrombectomy, other surgical procedure, or lysis, Patient C's acute arterial occlusions of his left leg during a March 24, 1995 hospital admission.

2. Respondent documented in Patient C's hospital records thromboendarterectomy procedures had been performed on the dates listed below, when in fact Respondent knew or should have known that the procedure he had performed in each instance was a thrombectomy:

withdrawn by Pet. 3/25/99 SLB ~~a) November 13, 1981;~~

b) July 17, 1982;

c) March 28, 1995.

3. Respondent billed for performing a thromboendarterectomy procedure on March 28, 1995 when in fact Respondent knew or should have known that the procedure he had performed was a thrombectomy.

D. Respondent provided medical care and treatment to Patient D during a period including April 27, 1992 until his

death on September 15, 1992 at St. Joseph's Hospital and at Respondent's office. Respondent's surgical treatment of Patient D included a laproscopic cholecystectomy biopsy of a mas in the Ampulla of Vater, trans- duodenal needle biopsies of the pancreas, hepaticojejunostomy roux-en-y, jejunojejunostomy, reconstruction of the jejunojejunostomy and drainage of a pancreatic abscess, among other procedures. Respondent's medica care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely obtain a CT evaluation of Patient D's abdomen following the abnormal findings of an upper G.I. series performed on July 6, 1992.

2. Respondent failed to adequately treat Patient D's abdominal abscess after September 8, 1992.

E. Respondent provided medical care and treatment to Patient E at his office and at St. Joseph's Hospital during the period including October 31, 1996 through July 18, 1997. Respondent's surgical treatment of Patient E included repair of an intra-abdominal hemorrhage on November 1, 1996 and repair of an abdominal wound dehiscence and evisceration on November 19, 1996, among other procedures. Sero-sanguinous drainage from the wound site was noted, including on November 3, 4, 5, and 6, 1996. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to timely diagnose and/or treat an impending dishiscence/evisceration of the wound site following the repair of the intra-abdominal hemorrhage on November 1, 1996.

2. Respondent documented in the hospital chart that he had repaired a ruptured abdominal wall aneurysm on November 1, 1996 ~~and/or billed for the repair of a ruptured aortic aneurysm~~, when in fact Respondent knew or should have known that the procedure he had performed was the

withdrawn by Pet. 3/26/99

repair of an epigastric vessel.

F. Respondent provided medical care and treatment to Patient F during a period including October 31, 1983 through March, 1990 at his office and St. Joseph's Hospital. Respondent's surgical treatment of Patient F included a transaxillary resection of the first rib on March 18, 1986 for a thoracic outlet syndrome. Respondent's medical care and treatment of Patient F constituted professional misconduct in th following respects:

1. Respondent performed a transaxillary resection of the first rib for a purported thoracic outlet obstruction without adequate surgical indications.

2. Respondent in correspondence to Francis R. Whitcher, Esq. (8/18/86) the New York State Department of Sccial Services (1/28/87) and Nationwide Insurance (6/23/87), represented that a left subclavian venogram and arteriogram of Patient F "showed blockage of the vein between the first rib and clavicle", or used words of similar effect, when in fact Respondent knew or should have known that such a representation was false and/or misleading, as the subject arteriogram and venogram were reported as essentially normal.

G. Respondent provided medical care and treatment to Patient G during a period including June 26, 1996 through May 30, 1997 at his office and at St. Joseph's Hospital. Respondent's surgical treatment of Patient G included a femoral embolectomy procedure on June 26, 1996, among other procedures. Respondent's care and treatment of Patient G constituted professional misconduct in the following respects:

1. Respondent documented in the hospital chart and/or billed for performing a endarterectomy procedure, when in fact Respondent knew or should have known that the procedure performed was a embolectomy.

H. Respondent provided medical care and treatment to Patient H during a period including March 9, 1993 until Patient H's death on February 16, 1994. Respondent's surgical treatment of Patient H included a thrombectomy of a clot in the aorta on March 16, 1993, among other procedures. Respondent's care and treatment of Patient H constituted professional misconduct in th following respects:

1. Respondent documented in the hospital chart and/or billed for performing a thromboendarterectomy procedure on March 16, 1993, when in fact Respondent knew or should have known that the procedure performed was a thrombectomy or embolectomy procedure.

I. Respondent provided medical care and treatment to Patient I during a period including May 9, 1992 through May 18, 1992 at St. Joseph's Hospital, for a right femoral artery occlusion, among other conditions. On May 9, 1992, Respondent performed a thrombectomy of the right common femoral artery, among other procedures. Respondent's medical care and treatment of Patient I constituted professional misconduct in the following respects:

1. Respondent documented in the hospital chart and/or billed for a thromboendarterectomy procedure of the right common femoral artery, when in fact Respondent knew or should have known that the procedure performed was a thrombectomy procedure.

J. Respondent provided medical care and treatment to Patient J during the period from January 28, 1989 through August 2, 1989 at his office for injuries sustained in a motor vehicle accident, including a cervical sprain. Respondent's medical care and treatment of Patient J constituted professional misconduct in the following respects:

1. On February 13, 1989, Respondent performed, and subsequently billed for, a carotid duplex scan on Patient J, which testing was excessive and/or without medical indication.

K. Respondent provided medical care and treatment to Patient K during the period from September 4, 1987 to March 20, 1991 at his offices for injuries sustained in a motor vehicle accident, including a lumbosacral sprain and left shoulder injury. Respondent's medical care and treatment of Patient K constituted professional misconduct in the following respects:

1. On September 11, 1987, Respondent performed, and subsequently billed for, a carotid duplex scan on Patient K, which testing was excessive and/or without adequate medical indication.

2. On September 30, 1988, Respondent performed, and subsequently billed for, a carotid duplex scan on Patient K, which testing was excessive and/or without adequate medical indication.

L. Respondent provided medical care and treatment to Patient L during the period from April 14, 1986 through April, 1990 at his offices for injuries sustained in a motor vehicle accident, including cervical sprain. Respondent's medical care and treatment of Patient L constituted professional misconduct in the following respects:

1. On December 1, 1986, Respondent performed, and subsequently billed for, a carotid duplex scan on Patient L, which testing was excessive and/or without medical indication.

2. On June 19, 1987, Respondent performed, and subsequently bill for, a carotid duplex scan on Patient L, which testing was excessive and/or without adequate medical indication.

3. On October 18, 1988, Respondent performed, and subsequently bill for, a carotid duplex scan on

Patient L, which testing was excessive and/or without adequate medical indication.

M. Respondent provided medical care and treatment to Patient M during the period from November 8, 1982 through May 20, 1996 at his office, including care for injuries sustained in a motor vehicle accident on January 22, 1987. Respondent's medical care and treatment of Patient M constituted professional misconduct in the following respects:

1. On February 2, 1987, Respondent performed a carotid duplex scan on Patient M, which testing was excessive and/or without medical indication.

2. On July 27, 1987, Respondent performed, and subsequently bill for, a carotid duplex scan on Patient M, which testing was excessive and/or without adequate medical indication.

3. On January 13, 1988, Respondent performed, and subsequently bill for, a carotid duplex scan on Patient M, which testing was excessive and/or without adequate medical indication.

SPECIFICATIONS

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts in paragraphs A and A.1 and/or A and A.2.

2. The facts in paragraphs B and B.2.

3. The facts in paragraphs C and C.1.

4. The facts in paragraphs E and E.1.

FIFTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence on a particular occasion, in that Petitioner charges the following:

5. The facts in paragraphs A and A.1 and/or A and A.2 and/or A and A.3.

6. The facts in paragraphs B and B.2.

7. The facts in paragraphs B and B.4 and/or B and B.6.

8. The facts in paragraphs C and C.1, C and C.3, C and C.4.

9. The facts in paragraphs E and E.1.

10. The facts in paragraphs G and G.1.

11. The facts in paragraphs H and H.1.

12. The facts in paragraphs I and I.1.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

13. The facts set forth in paragraphs A and A.1, A and A.2, and/or B and B.1, and/or B and B.2 and/or C and C.1, and/or D and D.1, and/or D and D.2, and/or E and E.1, and/or F and F.1.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

14. The facts set forth in paragraphs A and A.1, and/or A and A.2, A and A.3, and/or B and B.1, and/or B and B.2 and/or B and B.3, and/or B and B.4, and/or B and B.5, and/or C and C.1, and/or C and C.2, and/or C and C.3, and/or D and D.1, and/or D and D.2, and/or E and E.1, and/or E and E.2, and/or F and F.1, and/or G and G.1, and/or H and H.1, and/or I and I.1.

FIFTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

15. The facts in paragraphs A and A.3.

16. The facts in paragraphs B and B.3 and/or B and B.4, and/or B and B.5.

17. The facts in paragraphs C and C.2.

18. The facts in paragraphs E and E.2.

19. The facts in paragraphs G and G.1.

20. The facts in paragraphs H and H.1.

21. The facts in paragraphs I and I.1.

TWENTY-SECOND THROUGH TWENTY-NINTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) by reason of his practicing the profession fraudulently, in that Petitioner charges:

22. The facts in paragraphs A and A.3.

23. The facts in paragraphs B and B.3, and/or B and B.5.

24. The facts in paragraphs C and C.3.

withdrawn by Pet 7/21/99 jgg

25. ~~The facts in paragraphs E and E.2~~.

26. The facts in paragraphs F and F.2.

27. The facts in paragraphs G and G.1.

28. The facts in paragraphs H and H.1.

29. The facts in paragraphs I and I.1.

THIRTIETH THROUGH THIRTY-SEVENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) by reason of his having engaged in conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

30. The facts in paragraphs A and A.3.

31. The facts in paragraphs B and B.4, and/or B and B.5.

32. The facts in paragraphs C and C.3.

withdrawn by Pet 7/21/99 jgg

33. ~~The facts in paragraphs E and E.2~~

34. The facts in paragraphs F and F.2.

35. The facts in paragraphs G and G.1.

36. The facts in paragraphs H and H.1.

37. The facts in paragraphs I and I.1.

THIRTY-EIGHTH THROUGH FORTY-FIFTH SPECIFICATIONS

WILFULLY MAKING OR FILING A FALSE REPORT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(21) by reason of his having wilfully made and filed a false report, in that Petitioner charges:

38. The facts in paragraphs A and A.3.

39. The facts in paragraphs B and B.3, and/or B and B.5.

40. The facts in paragraphs C and C.2 and/or C and C.5.

withdrawn by Pet 7/21/99 JHS

41. ~~The facts in paragraphs E and E.2~~

42. The facts in paragraphs F and F.2.

43. The facts in paragraphs G and G.1.

44. The facts in paragraphs H and H.1.

45. The facts in paragraphs I and I.1.

FORTY-SIXTH THROUGH FORTY-NINTH SPECIFICATIONS

EXCESSIVE TESTING

Amended by Pet 5/4/99 JHS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(~~20~~ 35) by reason of his having ordered excessive tests not warranted by the condition of the patient, in that Petitioner charges:

46. The facts in paragraphs J and J.1.

47. The facts in paragraphs K and K.1, and/or K and K.2.

48. The facts in paragraphs L and L.1, and/or L and L.2, and/or L and L.3.

49. The facts in paragraphs M and M.1, and/or M and M.2,

and/or M and M.3.

DATED: January 28, 1998
Albany, New York

REDACTED

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