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

October 19, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Moshe Hachamovitch, M.D.
2070 Eastchester Road
Bronx, New York 10461

Anthony Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

RE: In the Matter of Moshe Hachamovitch

Dear Parties:

Enclosed please find the Determination and Order (No. 99-261) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

MOSHE HACHAMOVITZ

DECISION
AND
ORDER

BPMC-99-261

A Notice of Hearing and Statement of Charges, both dated December 7, 1998, were served upon the Respondent, **MOSHE HACHAMOVITZ, M.D. THEA GRAVES PELLMAN (Chair), JOHN CHOATE, M.D. AND ERWIN LEAR, M.D.,** duly designated members of the State Board of Professional medical Conduct, served as the Hearing Committee in this matter pursuant to Section 2301(10)(e) of the Public Health Law. **RALPH A. ERBAIO, Administrative Law Judge,** served as the Administrative Officer.

The Department of Health appeared by **DIANE ABELOFF, Esq.,** Associate Counsel. The Respondent appeared by **SCHER & WOOD, ANTHONY F. SCHER, Esq.,** of Counsel.

Evidence was received and witness sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Decision Order.

STATEMENT OF THE CASE

Petitioner has charged Respondent with eight specifications of professional misconduct. Included within these eight specifications are 68 specific charges of misconduct. These charges relate to the care and treatment of Patient A and also to the staffing and equipping of the Respondent's recovery room. The allegations include gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, inaccurate records and fraudulent practice. Respondent filed an Answer in which he denied the charges. A copy of the Notice of Hearing and Statement of Charges is attached to this Decision and Order as Appendix.

AFFIRMATION OF MEMBER OF THE HEARING COMMITTEE

John Choate, M.D., a duly appointed member of the State Board for Professional Medical Conduct and of its Hearing Committee designated to hear the matter of Moshe Hachamovitz, M.D., hereby affirms that he was absent from the hearing session conducted on March 23, 1999. Dr. Choate affirms that he has read and considered the transcripts of the proceedings of, and the evidence received at such hearing day prior to the deliberations of the Hearing Committee beginning on July 13, 1999.

FINDINGS OF FACT

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

1. Respondent, Moshe Hachamovitz was authorized to practice medicine in the State of New York on or about September 20, 1966 by the issuance of license number 097500 by the New York State Education Department.
2. Patient A went to Respondent's office on September 6, 1996 for a termination of an early second trimester abortion. On that day Laminaria were inserted and she was told to return the next day for an abortion. (Pet. Ex. 3)
3. On September 7, 1996, Patient A returned to Respondent's office. At or about 11:00 a.m.Patient A was given Valium 10 mg. (Pet. Ex. 3)
4. The administration of Valium 10 mg. Was not in the record given to CRNA Gori prior to her administration of Brevital at or about 1:50 p.m. (Pet. Ex. 3)
5. On September 7, 1996, at or about 1:50 p.m., the CRNA administered 150 mg. of Brevital to Patient A. Respondent then performed the abortion. (Pet. Ex. 3)
6. 150 mg. of Brevital causes loss of consciousness and also potentially decreases the patient's respiratory rate and blood pressure. (Tr. 130, 449)

7. The amount of Brevital administered to this patient would cause respiratory depression for approximately 30 minutes. The majority of that time Patient A was in the recovery room. (Tr. 131)

8. The level of respiratory depression is tied into the amount of stimulation of the patient. Surgery is a very strong stimulus, once that is removed the respiratory depression increases. (Tr. 131)

9. At 1:53 p.m., the CRNA gave Patient A 20 units of Pitocin IV, at 1:54 p.m. the CRNA gave her 2 mg. of Methergine IV. The Respondent, according to his handwritten summary, gave Patient A 2 mg. of Methergine intracervically at 1:55 p.m. (Pet. Ex. 3)

10. There was no conclusive evidence presented at the hearing as to the cause of the retroperitoneal hemorrhage found on autopsy. (Pet. Ex. 6)

11. The CRNA wrote her notes concerning the patient's status in the recovery room before the patient was transferred. (Tr. 540)

12. When Patient A was transferred from the operating room table to the gurney for transfer to the recovery room she was still anesthetized. She was unable to move herself from the operating table to the gurney. (Tr. 543, 558, 559)

13. Patient A never responded verbally to the CRNA. (Tr. 559)

14. Shortly after Patient A was transferred to the recovery room, her pulse and oxygen saturation levels were taken and the pulse oximeter was removed from her finger. (Pet. Ex. 3, Tr. 507, 508)

22. At this point, a patient without an obtainable blood pressure and a barely palpable pulse was functionally in cardiac arrest.

23. Respondent was notified of the problem with Patient A at approximately 2:15 p.m. (Pet. Ex. 3, Tr. 504)

24. Respondent arrived in the recovery room and examined Patient A. He started a new IV angiocath with D5W and Ephedrine. He then directed the recovery room nurse to begin CPR and someone to call EMS. (Tr. 657)

25. The EMS Advanced Cardiac Life Support (ACLS) team was notified of the call at 14:40 and arrived at Respondent's office at 14:41. (Pet. Ex. 4, Tr. 21, 22)

26. When the EMS (ACLS) team arrived at Respondent's office Patient A was cyanotic, non-responsive, pulseless, apneic and her pupils were fixed and dilated. (Pet. Ex. 4, Tr. 24-26)

27. After Lt. Bayreuther took the vital signs, his partner hooked up an EKG to Patient A and Lt. Bayreuther intubated the patient. Lt. Bayreuther knew he had successfully intubated Patient A because he visualized the cords as the tube pass through the cords. (tr. 28)

28. Lt. Bayreuther then hooked up the Respondent's equipment which the CRNA had been using to ventilate the patient to the intubation tube. He checked for lung sounds and abdominal sounds. There were not lung sounds nor were there any abdominal sounds. By that time the EMTs (basic life support team) arrived and one came over with the EMS BVM (bag valve mask). Lt. Bayreuther switched the endotracheal tube to the EMS equipment. He heard bilateral breath sound and no sounds in the stomach; therefore, the tube was in the trachea. (Tr. 28, 29)

29. Nothing that Lt. Bayreuther did while intubating Patient A would cause Respondent's equipment to malfunction. (Tr. 30)

30. An ob/gyn routinely obtains blood pressure and pulse. He should be able to obtain these vital signs quickly. (Tr. 206, 289-291, 762)

31. When Respondent arrived in the recovery room, he should have immediately ascertained the patient's pulse, blood pressure, and if there were vaginal bleeding. This should have taken between 20 seconds, and, at the outside, two to three minutes. He should have realized that the patient was in cardiac arrest and started ACLS. The cause of the arrest was not relevant at that point; the immediate treatment was the same. (Tr. 188, 189, 190, 205, 206, 318, 219, 435, 762)

32. Given the clinical picture of this patient at 2:15 p.m. when Respondent was called to the recovery room EMS should have been called immediately and the patient intubated. (Tr. 163, 177, 183)

33. Even if Patient A were only in a near arrest situation Respondent should have immediately call EMS and instituted the rest of ACLS protocol. (Tr. 157, 202, 203, 425, 763)

34. Advanced Cardiac Life Support (ACLS) consists of immediate call to EMS for transfer to hospital, intubation, EKG monitoring so that if the patient requires defibrillation, the rhythm and appropriate ACLS drugs are known. (Tr. 154, 158, 160, 189, 421)

35. This patient's condition had to be treated in a hospital setting, the sooner the patient were to get to hospital, the better her chances of survival. (Tr. 157, 202, 203, 420)

36. Endotracheal intubation was the only way to making sure that whatever gas was being supplied went directly into the patient's lungs. It is very difficult to maintain adequate ventilation with a fact mask. There is a tendency for air or oxygen to be introduced into the stomach. Respondent never intubated Patient A. (Pet. Ex. 3, Tr. 155)

37. Epinephrine and Atropine were the appropriate ACLS drugs to administer. These drugs help to restore cardiac function. Respondent had these drugs in his office but failed to given them to Patient A. Respondent instead administered Ephedrine. Ephedrine is not sufficient to restore cardiac function. The failure to administer appropriate ACLS drugs deviated from accepted medical standards. (Tr. 159, 160)

38. At no time during Patient A's stay in the recovery room did Respondent or any of his staff monitor the patient with an EKG. (Pet. Ex. 3, Tr. 357)

39. Respondent had an EKG and a cardiac defibrillator available, which he never used on Patient A. (Pet. Ex. 3, Tr. 498, 499, 614)

40. Respondent failed to follow ACLS guidelines in a patient in cardiac arrest. (Tr. 160, 161, 425, 426)

41. Such a failure deviated from accepted medical standards. (Tr. 160)

42. An oxygen saturation reading of 96% or 98% when there is no blood pressure and a thready pulse is very unlikely. The pulse oximeter depends upon adequate peripheral perfusion. That is an adequate blood flow to the finger or the periphery wherever that pulse oximeter probe was located. One of the body's responses in cardiac arrest is to preferentially shunt blood to the heart

and the brain, and that decreases the blood flow to the periphery. (Tr. 161, 319)

43. A reasonably prudent physician would not have relied on the pulse oximeter reading in the face of all the evidence to the contrary, in assessing the patient's condition. (Tr. 161, 162, 176)

44. Patient A suffered from progressive hypoxia. Progressive hypoxia means that over the duration of time there is a constant decrease in the level of oxygen in the blood stream, and at the same time an increase in the level of carbon dioxide. This lead to cardiac arrhythmia and cardiac arrest. (Tr. 149, 150)

45. Hypoxia is observable visually. The patient has labored breathing. A normally functioning pulse oximeter would display a decrease in the oxygen saturation. (Tr. 152, 153, 192, 193, 196, 197)

46. According to the chart, Patient A was responsive when she entered the recovery room and at 2:00 p.m. she was stable. By 2:10 p.m., the patient developed hypotension, bradycardia and probable respiratory depression. Hypoxia is a decreased amount of blood in the bloodstream. This developed because the tissues in the body depend upon a constant supply of oxygen; hypoxia can lead to failure of those tissues to function. The brain and the heart are the most sensitive to hypoxia, which explains decreased level of consciousness and cardiac abnormalities, in particular cardiac arrythmia, bradycardia and hypotension. (Tr. 147, 148, 192)

47. The treatment of progressive hypoxia is endotracheal intubation and administration of supplemental oxygen. Early observation is essential. The

earlier the treatment the better the chance of recovery. The longer the period of hypoxia persists, the more likely that there will be irreversible damage to the heart and the brain, and that resuscitation would be impossible. (Tr. 150, 151, 320, 321)

48. The most reasonable clinical diagnosis to Patient's A condition was a respiratory depression, which led to cardiac arrest. (Tr. 449, 450)

49. The most accurate way to ascertain the type of cardiac arrhythmia is with an EKG. (Tr. 149)

50. A physician who performs surgical procedures, i.e. abortions, under general anesthesia in free standing outpatient facilities, has an obligation to recognize when a patient is in cardiac arrest and to know ho to resuscitate the patient. (Tr. 163, 164, 310, 430, 765)

51. Respondent did not recognize that patient A was in cardiac arrest. (Tr. 700)

52. Respondent did not carry out generally recognized resuscitation measures in this patient.

53. The body responds to anesthesia in the same way whether the anesthesia is administered in a hospital or free-standing clinic; therefore, post-anesthesia recovery monitoring requirements are the same whether the termination was performed in the hospital or an outpatient facility. (Tr. 166, 167, 168, 202, 312, 431, 761)

54. The New York Department of Health regulations dealing with anesthesia services administered at Ambulatory surgery Center Sec. 755.4(b) requires that anesthesia be administered in accordance with current standards of

professional practice. Sec. 756.1(a) of the New York State Department of Health Regulations deals with anesthesia in abortion practices. This section cites back to Sec. 755.4(b) of the Regulations. The Standards for Abortion Care published by the National Abortion Federation require practitioners to provide abortions with the same attention to standards of safety and regard for patient rights as other health services; therefore, anesthesia care and post anesthesia care must meet the standards of care for any procedure in which general anesthesia is given. Different anesthesia and post anesthesia care standards do not exist for women receiving abortions. (Resp. Ex. C, ALJ Ex. 1, ALJ Ex. 2)

55. The purpose of a recovery room is to monitor the period when the patient has not yet recovered vital functions to their normal preoperative, preanesthetic level, which with Brevital 150 mg. can last up to 30 minutes. (Tr. 137, 145, 417, 429, 761)

56. For patient's following general anesthesia, monitoring in a recovery room consists of the following: electrocardiogram monitoring and pulse oximeter for the initial stage of recovery-the initial period where the patient is not yet fully responsive to stimuli, or when the patient is not completely awake. It may be in that initial period that the patient, when questioned, or when stimulated, will be responsive. But during the initial period, if the patient is not stimulated, they may become more depressed and have depressed respiratory function. (Tr. 137, 138, 305)

57. Each patient, in the primary stages of recovery from general anesthesia should have available an individual EKG, a pulse oximeter and a blood pressure cuff. (Tr. 142, 143, 313-315)

58. The vital signs must be documented every five minutes until the patient is fully responsive to stimuli and the patient must be observed by staff for respiratory rate and effort, cardiac rate and rhythm, as well as color. (Tr. 138, 139, 305, 306, 429)

59. The recovery room should be staffed by nurses and other medical personnel who have specific training in recovery room cases. They should be oriented to that setting and they should be familiar with the events that occur in the patient recovering from anesthesia. (Tr. 140, 146, 184, 315)

60. On Saturday, September 7, 1996, Respondent had one R.N. in the recovery room, a medical assistant, a sonographer and a receptionist from the front who went to the recovery room to help when the recovery room was busy. (Tr. 210, 211)

61. The sonographer who checked the uterus to ensure that it was fully evacuated was not trained to observe patients recovering from anesthesia. The receptionist who was in the recovery room when Patient A was brought in had taken a medical secretary course, she did not have any special training in caring for patients covering from general anesthesia. (Tr. 140, 210, 211)

62. At the time Patient A was brought into the recovery room there were nine other patients in the room and another patient was brought in a few minutes after patient A. One of the nine patients already in the recovery room was shaking and almost convulsing. (Pet. Ex. 7, Pet. Ex. 8Tr. 548, 549)

63. Respondent's recovery room was not sufficiently staffed to adequately monitor patients recovering from general anesthesia.

64. Patient A was not sufficiently monitored while she was in the recovery room.

65. The opiates were found in the bile, not the brain, therefore, there would not be an effect from the opiate on Patient A's respiration. (Tr. 199)

66. Respondent's medical record did not accurately reflect the care and treatment rendered to Patient A. Respondent failed to note in the concurrent record that Valium was administered to Patient A, that information appeared only appeared in his narrative summary. The narrative reports that Valium 10 mg. was given. Respondent testified that 5 mg. was administered. The CRNA testified that she administered 10 units of Pitocin and the record indicates 20 units. The CRNA completed the condition on arrival in the recovery room before the patient was transferred to the recovery room. The 2 mg. Methergine administered intercivically was not listed in the record. (Pet. Ex. 3, Tr. 497, 682)

CONCLUSIONS OF LAW

Respondent is charged with eight specifications alleging professional misconduct within the meaning of the Education Law Section 6530 with 68 specific instances of misconduct. The statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations, the Hearing Committee consulted a

memorandum prepared by Henry M. Greenberg, Esq., General Counsel for Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", set forth suggested definitions for Gross Negligence On More Than One Occasion, Gross Incompetence, Incompetence On More Than One Occasion, Inaccurate Records and the Fraudulent Practice of Medicine.

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

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

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

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.

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

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.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that thirty-one of the specifications of misconduct had been sustained. The Committee further

concluded that the specifications alleging Negligence and Incompetence on more than one occasion should be dismissed for reasons explained below and that the charge of Fraudulent practice of medicine was also not supported by the evidence. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

NEGLIGENCE AND INCOMPETENCE ON MORE THAN ONE OCCASION

The Department charged 32 specific instances of Negligence On More Than One Occasion and Incompetence On More Than One Occasion. The Respondent asserted in his post hearing submission that a finding of Negligence or Gross Incompetence on more than one occasion requires separate events occurring at distinct time and places and that one occurrence cannot form the basis for a charge of negligence or incompetence on more than one occasion. The Respondent cites the case of Matter of Rho v. Ambach, 74 N>Y> 2d 318, 546 N.Y.S. 2D 1005 (1998), in support of his position. The Respondent's position is well taken. The Rho case, supra, provides that in order to support a finding of negligence on more than one occasion there must be separate occasions.

Since the Department failed to present persuasive evidence to support its charge that the Respondent's recovery room was not adequately staffed or equipped, for the period January 1, 1995 through September 7, 1996, it has not established that the negligence or incompetence occurred on more than one occasion. Therefore, those charges cannot be sustained. Therefore Specifications Third and Specification Sixth are reversed.

REMAINING SPECIFICATIONS

At the outset, the Hearing Committee assessed the credibility of the witnesses presented by the parties. The Committee found the Petitioner's witness, Dr. David Wlody, to be well credentialed and his testimony to be clear, lucid and very persuasive. Although entitled to some weight, the Committee found the testimony of Dr. Griggs and Dr. Shulman to be much less persuasive than that of Dr. Wlody because of their lack of experience in performing abortions under general anesthesia in an outpatient facility. The Committee gave less weight to the testimony of Dr. Goldiner since much of his testimony was based on an assumption, that Patient A was awake and talking upon arrival in the recovery room. The Committee was particularly troubled by the testimony of CRNA Gori. The Committee found particularly incredible her testimony that she held the patient's nose and listened for breath sounds.

The Specific factual allegations of deviation from medical standards made by the Department will be discussed separately below.

The Department alleged that the Respondent failed to appropriately monitor or provide for the appropriate monitoring of Patient A's vital signs in the recovery room, including but not limited to EKG and blood oxygen saturation.

The Committee unanimously upheld this factual allegation. It is clear from the testimony of the Respondent himself that the recovery room was not adequately staffed either in numbers or in training. Monitoring of patients recovering from general anesthesia should consist of electrocardiogram monitoring and a pulse oximeter for the initial stage of recovery and these patients should be stimulated during the initial stage of recovery. There

was no evidence presented on the Respondent's behalf that this was done. To the contrary, the evidence establishes that the Respondent did not follow this protocol. Specifically, the patient was not observed other than at five-minute intervals to take vital signs. There is no evidence that the Respondent ever attempted to stimulate the patient. The Hearing Committee concluded that Respondent's failure to properly monitor the patient in the recovery room demonstrated Gross Negligence, (Specification First, A, A1) and Gross Incompetence (Specification Fourth, A, A1)

The Committee also found that the Respondent failed to run a continuous IV line in the Patient A's arm until she was free of the effects of the anesthesia. The Respondent's own testimony indicates that he had to run another IV line in order give the patient the medications more rapidly. This testimony establishes that the patient did not have a patent I.V. line that was sufficient for the administration of the medications that would have been required in an emergency, such as the instant situation. This factual specification is affirmed. The Hearing Committee concluded that the Respondent's failure to run an I.V. Line constituted Gross Negligence (First Specification, A2) and Gross Incompetence (Fourth Specification, A2).

The Committee found that the Respondent failed to provide EKG monitoring and Advanced Cardiac Life Support (ACLS) during the patient's cardiac arrest. The Committee found the testimony of Dr. Wlody that at 2:11 p.m. when the patient was without an obtainable blood pressure and a barely palpable pulse she was in functional cardiac arrest to be persuasive. The Respondent should have initiated ACLS on Patient A, intubation, an immediate call to EMS for transfer to hospital, and EKG monitoring. The Committee was very disturbed by the Respondent's failure to institute the protocols of

ACLS. At no time did the Respondent or any of his staff monitor Patient A with an EKG even though according to Respondent's own testimony (Tr. 614) an EKG machine was available. The Respondent also delayed at least 20 minutes before calling EMS, although it was apparent from the patient's condition that she required immediate transport to a hospital. The Committee specifically did not find credible Respondent's assertion that he called EMS much sooner, within approximately seven to eight minutes.

The Hearing Committee unanimously concluded that the Respondent's failure to provided EKG monitoring, failure to perform Advanced Cardiac Life Support and failure to call or arrange for someone to call EMS in a timely fashion constituted Gross Negligence (First Specification A3, A4, and A5) and Gross Incompetence (Fourth Specification, A6) have not been sustained.

The Committee also unanimously concluded that the Respondent failed to adequately staff his recovery room on September 6, 1996 with appropriately trained personnel. At the time that Patient A was brought into the recovery room the staff consisted of one R.N., a medical assistant, a sonographer and a receptionist. The Committee found the testimony of Dr. Wlody and Dr. Griggs that the recovery room must be staffed by individuals able to take the patient's vital signs, who posses the ability to observe a patient and clinically assess the patient, persuasive. The Respondent simply failed to meet this requirement. The Respondent failed to present any evidence that the sonographer was trained in recovery room care, specifically, training concerning patients recovering from general anesthesia. The receptionist had no training concerning the care of patient's recovering from general anesthesia. The Committee found this lack of properly trained staff to be particularly disturbing.

The Hearing Committee also unanimously concluded that the Respondent failed to adequately equip his recovery room. The Respondent's recovery room lacked an individual EKG machine for each patient recovering from general anesthesia as well as an individual pulse oximeter and blood pressure cuff for each recovering patient. The Hearing Committee found this failure to adequately equip the recovery room disturbingly negligent.

The Hearing Committee unanimously concluded that the Respondent's failure to adequately staff and equip his recovery room constituted Gross Negligence (First Specification A7, A8) and Gross Incompetence (Fourth Specification A7, A8)

The Hearing Committee unanimously concluded that the Department failed to prove that the Respondent knowingly, falsely and with the intent to deceive, stated that during the period of Patient A's cardiac arrest her oxygen saturation level was 98% and that there were faint breath sounds. Therefore neither Gross Negligence (First Specification, A9) nor Gross Incompetence (Fourth Specification, A9) is affirmed.

The Hearing Committee unanimously concluded that is impossible to determine from this record if the cause of the blood found in the right retroperitoneal space on autopsy was caused by the Respondent's penetrating the right retroperitoneal space or the mini laparotomy performed during autopsy. Dr. Griggs conceded that a mini laparotomy performed on the patient at Jacobi Hospital could have been the cause of this blood. Therefore Gross Negligence (Specification First, A11) and Gross Incompetence (Specification Fourth, A11) are reversed.

The Hearing Committee also unanimously concluded that the Department failed to prove that Patient A received an excessive dose of Methergine. The hearing record establishes that divided doses of Methergine were given by different routes. The

Department failed to present any persuasive evidence that the administration of this dose of Methergine in this manner constituted an excessive dosage. Therefore, the charges of Gross Negligence (First Specification, A11) and Gross Incompetence (Fourth Specification, A11) have not been proved and are reversed.

The Hearing Committee unanimously concluded that the Respondent's chart for Patient A failed to accurately reflect his care and treatment of Patient A. Among other shortcomings, the narrative chart reports that Valium 10 mg. was given while the Respondent testified that he gave 5 mg. of Valium. CRNA Gori testified that she administered 10 units of Pitocin where the record indicates that 20 units of Pitocin were given. Also, and disturbingly, CRNA Gori wrote her notes concerning the patient's condition upon arrival in the recovery room while the patient was still in the operating room. The Respondent's records evince a pervasive failure to accurately reflect the care and treatment of Patient A. This failure constitutes Inaccurate Records (Seventh Specification, Paragraph A, A12).

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent license to practice medicine as a physician in New York State should be suspended. 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. The evidence established that the care provided to Patient A in the

Respondent's recovery room was grossly substandard. The Respondent's recovery room was also not properly staffed either in terms of numbers or training. The Respondent's recovery room was not adequately equipped. The record also establishes that the Respondent's chart did not accurately reflect the patient's care and treatment. Most disturbingly, the Respondent failed to initiate Advance Cardiac Life Support when the situation clearly called for such measures. Such actions clearly call for a severe penalty. Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines that the sanction of suspension for three years, stayed for 2 years and three months is appropriate. The Respondent will also be placed on probation for the 2 years and 3 months for which the suspension is stayed.

The Hearing Committee feels that Respondent should have a practice supervisor, an anesthesiologist on site to supervise the administration of general anesthesia, and that the Respondent himself, must be ACLS certified and that at all time at least one of the medical personnel in the recovery room must be ACLS certified.

The Hearing Committee believes that this penalty will adequately protect the public.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby ORDERED that:

1. The First Specification from the Statement of Charges (Department Exhibit #1 is **SUSTAINED**

   Paragraphs A, A1, A2, A3, A4, A5, A7, A8, A12

   Paragraphs A6, A9, A10, A11, B, B1, B2, are **NOT SUSTAINED**

2. The Second Specification from the Statement of Charges (Department Exhibit #1) is **SUSTAINED**

   Paragraphs A, A1, A2, A3, A4, A5, A7, A8, A12

   Paragraphs A6, A9, A10, A11, B, B1, B2 are **NOT SUSTAINED**

3. The Third Specification from the Statement of Charges (Department Exhibit #1) is **NOT SUSTAINED**

4. The Fourth Specification from Statement of Charges (Department Exhibit #1) is **SUSTAINED**

   Paragraphs A, A1, A2, A3, A4, A5, A7, A8, A12

   Paragraphs A6, A9, A10, A11, B, B1, B2 are **NOT SUSTAINED**

5. The Fifth Specification from the Statement of Charges (Department Exhibit #1) is **SUSTAINED**

   Paragraphs A, A1, A2, A3, A4, A5, A7, A8, A12

   Paragraphs A6, A9, A10, A11, B, B1, B2 are **NOT SUSTAINED**

6. The Sixth Specification is **NOT SUSTAINED**

7. The Seventh Specification is **SUSTAINED**

8. The Eighth Specification is **NOT SUSTAINED**

9. The Respondent's license to practice medicine is **SUSPENDED** for three years with two years and three months of the suspension stayed. During the time period for which the suspension is stayed the Respondent shall be on probation.

10. For the period of probation the Respondent, in the performance of procedures using general anesthesia, must have a practice supervisor, a board certified

anesthesiologist, on site during all procedures for which general anesthesia is used. This board-certified anesthesiologist will supervise the Respondent's practice relating to the administration of and recovery from general anesthesia. This anesthesiologist shall not be a family member or personal friend, or be in a professional relationship, which could pose a conflict with supervision responsibilities.

Respondent shall ensure that the practice supervisor is familiar with the order and terms of probation, and willing to report to OPMC. Respondent shall cause the practice supervisor to report with in 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

Respondent shall authorize the practice supervisor to have access to his/her patient records and to submit quarterly written reports, to the Director of OPMC, regarding Respondent's practice. These narrative reports shall address the administration of general anesthesia in connection with the Respondent's practice including, but limited to the supervisor's assessment of patient records.

11. The Respondent must maintain a current Advanced Cardiac Life Support certification.

12. There must be present in the recovery room, on each shift, one recovery room staff member who is certified in Advanced Cardiac Life Support.

13. 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 day after

mailing by certified mail, wherever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: West Hempstead, New York
October 14, 1999

THEA GRAVES PELLMAN (CHAIR)

ERWIN LEAR, M.D.
JOHN CHOATE, M.D.

TO: Diane Abeloff, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001

Moshe Hachamovitch, M.M.
2070 Eastchester Road
Bronx, New York 10461

Anthony Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

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

IN THE MATTER

OF

MOSHE HACHAMOVITCH, M.D.

NOTICE
OF
HEARING

TO: MOSHE HACHAMOVITCH, M.D.
2070 Eastchester Road
Bronx, N.Y. 10461

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1998) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1998). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 19, 1999, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, 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 Rules is enclosed.

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

12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1998) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1998). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
December 7, 1998

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

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

IN THE MATTER

OF

MOSHE HACHAMOVITCH, M.D.

STATEMENT

OF

CHARGES

MOSHE HACHAMOVITCH, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 20,1966, by the issuance of license number 097500 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 6, 1996, Patient A (her identity appears in the attached appendix), a pregnant woman with an EGA (estimated gestational age) of 13 6/7 weeks, went to Respondent's office, 2070 Eastchester Road, Bronx, N.Y., for an abortion. At or about 1:50 p.m. on September 7, 1996, a C.R.N.A. (certified registered nurse anesthetist), in Respondent's office administered 150 mg. of Brevital to Patient A, and Respondent performed the abortion. At the end of the procedure Respondent administered .2 mg of Methergine intracervically. At or about 1:53 p.m. the C.R.N.A. administered 20 units of Pitocin, and at or about 1:54 p.m. she administered .2 mg of Methergine IV. Patient A arrived in the recovery room at 1:55 p.m. According to the record, Patient A's blood pressure after five minutes in the recovery room was 96/60 with a pulse of 68. At 15 minutes she had a recorded blood pressure of 60/40 and a pulse of 52 with shallow respirations. At 2:11 p.m. the record revealed that Patient A had a thready pulse and a blood pressure that could not be measured. 911 was called at 2:40 p.m.. EMS (emergency

medical services) arrived at or about 2:41 p.m. Patient A was transferred to the emergency room of Jacobi Hospital, Bronx, New York; but, she was dead upon arrival at the hospital.

Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent failed to appropriately monitor or provide for the appropriate monitoring of Patient A's vital signs in the recovery room, including, but not limited to, EKG and blood oxygen saturation.

2. Respondent failed to run an IV line or arrange for an IV line in Patient A's arm until she was free of the effects of the anesthesia.

3. Respondent failed to provide EKG monitoring during the patient's cardiac arrest.

4. Respondent failed to perform Advanced Cardiac Life Support (ACLS) on a patient in cardiac arrest.

5. Respondent failed to call or arrange for someone to call an ambulance in a timely fashion.

6. Respondent failed to maintain functional resuscitative equipment in his office.

7. Respondent failed to adequately staff his recovery room.

8. Respondent failed to adequately equip his recovery room.

9. Respondent, in his chart for Patient A, knowingly, falsely and with the intent to deceive, stated that during the period of Patient A's cardiac arrest her oxygen saturation level was 98% and that there were faint breath sounds.

10. Respondent penetrated the right retroperitoneal space when he administered the intracervical injection of Methergine.

11. Patient A received an excessive dose of Methergine.

12. Respondent's chart for Patient A failed to accurately reflect his care and treatment of Patient A.

B. From on or about January 1, 1995, and continuing through September 7, 1996, Respondent performed first and second trimester abortions in his office.

Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent failed to adequately staff his recovery room.

2. Respondent failed to adequately equip his recovery room.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraph A, A1, A2, A3, A4, A5, A6, A7, A8 , A9, A 10, A 11 and/or A 12.

2. Paragraph B, B1 and/or B2.

THIRD SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

3. Paragraph A, A1, A2, A3, A4, A5, A6, A7, A8 , A9, A 10, A 11, A12, B, B1 and/or B2.

FOURTH AND FIFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

4. Paragraph A, A1, A2, A3, A4, A5, A6, A7, A8 , A9, A 10, A 11 and/or A 12.

5. Paragraph B, B1 and/or B2.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraph A, A1, A2, A3, A4, A5, A6, A7, A8 , A9, A 10, A 11,A12, B, B1 and/or B2.

SEVENTH SPECIFICATION

INACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record which accurately reflected the evaluation and treatment of Patient A, as alleged in

the facts of:

7. Paragraph A, A 12.

EIGHTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

8. Paragraph A , A 8.

DATED: December 1, 1998
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct