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

May 12, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Shafiq Hazboun, M.D.
414 South Fourth Street
Fulton, New York 13069

Bradley Mohr, Esq.
NYS Department of Health
Corning Tower – ESP – Room 2509
Albany, New York 12237

RE: In the Matter of Shafiq Bishara Hazboun, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-150) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

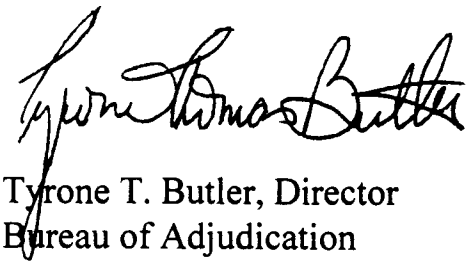
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER OF

OF

SHAFIQ BISHARA HAZBOUN, M.D.

DETERMINATION

AND

ORDER

BPMC 00-150

ANDREW J. MERRITT, M.D., Chairperson, **J. LaRUE WILEY, M.D.**, and **DEANNA L. WOODHAMS, M.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with gross negligence on a particular occasion (six specifications) and gross incompetence (six specifications), with negligence on more than one occasion (one specification) and incompetence on more than one occasion (one specification), and by failing to maintain a record for a patient which accurately

reflects the evaluation and treatment of the patient (six specifications).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	November 16, 1999 and November 17, 1999 respectively
Date of Service of Notice of Hearing and Statement of Charges:	December 9, 1999
Answer to Charges Dated:	December 19, 1999
Prehearing Conference Date:	December 30, 1999
Hearing Date:	January 12, 2000
Deliberation Date:	March 1, 2000
Place of Hearing:	Holiday Inn – Carrier Circle 6555 Old Collamer Road South East Syracuse, New York
Petitioner Appeared By:	Bradley Mohr, Esq. Senior Attorney NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Shafiq Bishara Hazboun, M.D. Respondent Pro Se

WITNESSES

For the Petitioner:	Fredric M. Hirsh, M.D.
For the Respondent:	Shafiq Bishara Hazboun, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Shafiq Bishara Hazboun, M.D. ["the Respondent"] was authorized to practice medicine in New York State on November 18, 1974 by the issuance of license number 122485 by the New York State Education Department (Tr. 155; Ex 3).
2. The Respondent has been practicing medicine since 1961 (Tr. 155-156). He has been engaged in a general practice for most of his professional career, except for a four year period when he practiced general and clinical pathology (Tr. 152-153 and 155).
3. The Respondent currently has a small office practice in Fulton, New York. He works alone as a single general practitioner. He is not a specialist and considers himself a general practitioner of the old-fashioned kind. (Tr. 153-154).
4. The Respondent had been affiliated with A. L. Lee Memorial Hospital ["ALLMH"] in Fulton, New York, until 1987. However, in 1987 the Respondent dropped his malpractice insurance and his hospital privileges were then terminated. (Tr. 153 and 154-155).

5. The Respondent does not belong to any medical organizations. He does not attend any medical conferences. He tries to keep current with medical developments by reading medical journals. (Tr. 155 and 156).

FINDINGS AS TO PATIENT A

6. Patient A, a 22 year old individual, was seen by the Respondent in the Respondent's office ["the office"] on November 25, 1997, which was the only time the Respondent ever saw this patient (Tr. 165-166; Ex. 5).

7. Patient A presented with a sore throat and a history of depression. The patient had been previously treated by another physician with Prozac, an antidepressant medication, and was requesting a resumption of that medication. (Tr. 30; Ex. 5).

8. The Respondent prescribed Amoxil, a penicillin derivative antibiotic, for the sore throat and Prozac, 20 mg. daily for 30 days, for the depression (Tr. 36-38; Ex. 5).

9. The Respondent's medical record for Patient A contains no documentation of a physical examination (Tr. 32-34 and 166; Ex. 5).

10. The Respondent's medical record for Patient A does not document an adequate psychiatric history (Tr. 31; Ex. 5).

11. The Respondent's medical record for Patient A does not document an adequate history for the patient's complaint of a sore throat (Tr. 31-31 and 168; Ex. 5).

12. The Respondent failed to obtain a throat culture to determine the cause of Patient A's sore throat (Tr. 33-34 and 42-43; Ex. 5).

13. The diagnosis of a bacterial infection for which an antibiotic would be indicated is not

justified due to the absence of a physical examination or a throat culture (Tr. 33 and 36-38).

14. The initial physical examination of Patient A should have included a mental status examination, an evaluation of the patient's suicide risk, and the patient's need for medication. The medical record should have documented recommendations for a follow-up visit and recommendations for other mental health care. (Tr. 33).

15. Since the Respondent claims to have taken a more complete history and to have performed a physical examination, but did not document either on this patient, the Respondent failed to maintain a record which accurately reflects his evaluation and treatment of the patient (Tr. 162-163, 164-165, 166 and 168; Ex. 5).

FINDINGS AT TO PATIENT B

16. Patient B was a 44 year old male when he was first seen by the Respondent in the office on January 29, 1991. At that time he presented with an elevated blood pressure and a history of hypertension and chronic pulmonary disease with an apparent asthmatic component. (Tr. 50-52; Ex. 6, p. 1). Thereafter, he was treated by the Respondent in the office on numerous occasions until October 22, 1997. (Ex. 6, pp. 1-11 and 17).

17. Patient B's age, height and particularly weight are not recorded on any of the medical records made by the Respondent (Ex. 6). This basic information appears in several records in the Respondent's possession which were generated by other medical providers more than six years after the Respondent first saw this patient. These other records include a Social Services disability evaluation, a radiology report, and pulmonary funtion

test results, all performed on April 25, 1997. (Ex. 6, pp. 15-18).

18. The Respondent's initial history of Patient B met acceptable medical standards (Tr. 51; Ex. 6, p. 1).

19. The Respondent's initial physical examination of Patient B was inadequate since there was no documentation that the patient's arteries in the neck, extremities, or eyegrounds were evaluated or that the patient's abdomen was examined (Tr. 51-53 and 62; Ex. 6, p. 1).

20. Although the Respondent adequately monitored Patient B's hypertension and adequately treated the hypertension with medication, he failed to evaluate the patient's cardiac and renal functions (Tr. 54-55; Ex. 6).

21. The Respondent also failed to include diet and exercise counseling in his treatment of the hypertension (Tr. 57-59; Ex. 6).

22. There is no indication in Patient B's medical records that the Respondent cautioned the patient to stop smoking and this failure was a deviation in the proper care of the patient's respiratory disease (Tr. 60 and 64; Ex. 6).

23. The Respondent treated the patient's respiratory disease with the use of inhaled bronchodilators and systemic bronchodilators on a daily basis as well as a home nebulizer (Tr. 60; Ex. 6, pp. 1, 2 and 10).

24. The Respondent's treatment of Patient B's respiratory disease was below minimally accepted standards (Tr. 59-60). This patient had chronic pulmonary and reactive airway disease (Tr. 65). The Respondent did not use inhaled steroid agents, which at the time was the recommended method of therapy for reactive airway disease or asthma (Tr. 59-60 and 190-191). The use of inhaled steroid agents is especially appropriate for a patient

with significant pulmonary disease who requires daily bronchodilator therapy (Tr. 61 and 66-68).

25. The Respondent's claim that he counseled Patient B regarding weight and smoking is not supported by the Respondent's medical records for Patient B (Tr. 183 and 189-190; Ex. 6).

FINDINGS AS TO PATIENT C

26. Patient C was a 68 year old female when she was first seen by the Respondent in the office on March 2, 1981. Thereafter, she was treated by the Respondent in the office on numerous occasions until May 11, 1998. (Ex. 7, pp. 1-6).

27. On each of the first three visits, which occurred on March 2, 1981, March 31, 1981 and April 2, 1984, the Respondent attributed Patient C's complaints to acute bronchitis and he prescribed antibiotics on two of the visits (Tr. 74; Ex. 7, p. 1).

28. Up until a cardiac episode which occurred in May 1996, the Respondent's medical records for Patient C were adequate (Tr. 73; Ex. 7, pp. 1-2).

29. The Respondent failed to perform an initial physical examination on Patient C and such failure constitutes a deviation from acceptable standards of medical care (Tr. 73-76; Ex. 7, p. 1).

30. The Respondent's medical records for Patient C are unclear as to whether the patient had a truly elevated blood pressure (Tr. 77-78; Ex. 7).

31. On May 10, 1996 Patient C presented to the office with a new complaint – chest tightness and difficulty breathing (Tr. 81; Ex. 7, p. 2).

32. Patient C was then transferred by private vehicle to the Emergency Room of ALLMH (Tr. 86-88; Ex. 7, pp. 6-10), which was a distance of approximately one city block from the office (Tr. 91-92; Ex. 7, pp. 6 and 11).

33. Patient C was admitted to the hospital and was under the care of Dr. Zaeem Ansari, a cardiologist. On or about May 31, 1996 Patient C was discharged from the hospital with a diagnosis of unstable angina pectoris. (Ex. 7, p. 11).

34. Dr. Ansari believed that Patient C would not tolerate a treadmill exercise test (Ex. 7, p. 11). However, on June 13, 1996 Dr. Ansari did follow Patient C with cardiac ultrasound studies (Ex. 7, pp. 12-13).

FINDINGS AS TO PATIENT D

35. Patient D was a 48 year old male (DOB 12/19/47) when he was first seen by the Respondent in the office on April 12, 1996 (Ex. 8, p 7). Thereafter, he was frequently treated by the Respondent in the office until April 20, 1998 (Tr. 96; Ex. 8, pp. 7-20).

36. Patient D had been previously treated by Dr. David J. Batt (Ex. 8, pp. 1-2).

37. On April 12, 1996 Patient D presented with a history of severe headaches, hypertension, obesity and an elevated blood pressure of 185/110 (Tr. 96-97; Ex. 8, pp. 1 and 7). He was also on antihypertensive medication, two different narcotics and an injectable medication (Tr. 97; Ex. 8, pp. 1-2 and 7). At the time of this visit the Respondent prescribed high doses of Lorcet, a narcotic medication (Tr. 101; Ex. 8, p. 7).

38. The Respondent's initial physical examination of Patient D was below acceptable standards of medical care since it failed to include a neurological examination and

diagnostic testing (Tr. 96-97).

39. In addition, the Respondent failed to document a complete medical history of Patient D during the patient's first visit (Ex. 8, p. 7). The Respondent's failure to obtain a current history from the patient was below acceptable standards of medical care (Tr. 96-98).

40. Patient D was also being seen by Dr. Kingston, a neurologist, who prescribed several medications for headache control (Tr. 106, 212-213 and 218-219; Ex. 8, pp. 1, 8 and 9).

41. Patient D's headaches were not controlled and the Respondent continued to prescribe high daily dosages of narcotics (Tr. 221; Ex. 8, pp. 7-20).

42. Although the Respondent claims that he told Patient D to go to a pain clinic, there is no documentation to support this claim (Tr. 222; Ex. 8).

FINDINGS AS TO PATIENT E

43. Patient E is a male who was approximately 31 years old when he was seen by the Respondent in the office on November 12, 1996.[1] At that time he presented with hypertension and a pain in the right knee (Tr. 115-116; Ex. 9, p. 1).

44. The medical history the Respondent documented for the patient is below acceptable medical standards since it failed to include the patient's age, height, weight, previous history of hypertension and/or previous history of an evaluation for hypertension (Tr. 115-117 and 133-134; Ex. 9).

45. The initial physical examination performed and documented by the Respondent is below acceptable standards of medical care. It does not meet the minimal medical standards for

[1] The approximate age of Patient E was ascertained from the consultation report of Lesly Germain, M.D., dated August 9, 1998, which appears in Exhibit A after page 10.

an evaluation of the patient's hypertension. In addition, it lacks a thorough examination of the cause and/or possible complications of hypertension. (Tr. 117-118 and 122; Ex. 9, p. 1). If the patient, as claimed by the Respondent, refused an examination, then the medical record should document this fact. (Tr. 119-121 and 235; Ex. 9 and Ex. A, p. 9).

46. The evaluation of Patient E's hypertension was inadequate because there was no examination of the patient's organ systems which were or could be affected by the patient's hypertension (Tr. 118, 121-122; Ex. 9). Additionally, there was no examination of the circulatory system involving the palpable or audible arteries, such as the arteries in the neck and in the extremities; there was no examination of the abdomen to determine if there were any significant bruits or vascular abnormalities with respect to the aorta or kidneys; there was no examination to determine if there were any palpable abdominal masses or an enlarged kidney; there was no examination of the arteries in the eyegrounds; and, there is no evidence of any diagnostic work-up of the etiology of the patient's hypertension. (Tr. 52-54 and 117-118; Ex. 9).

47. There is no documentation of any recommendations for lifestyle modification to assist in the control of the patient's blood pressure, such as diet, stress factors, obesity and smoking (Tr. 63-64 and 117; Ex. 9).

48. The treatment of Patient E's hypertension was also below acceptable standards of medical care because the patient's blood pressure was never normotensive (Tr. 118-119; Ex. 9).

49. The Respondent's evaluation and monitoring of Patient E's knee injury was below acceptable standards of medical care due to the Respondent's failure to perform and document a knee examination (Tr. 122-123; Ex. 9).

FINDINGS AS TO PATIENT F

50. Patient F was a 30 year old male (DOB 8/11/56) when he was seen by the Respondent in the office on January 26, 1987 (Ex. 10, pp. 1 and 19). Thereafter, he was treated by the Respondent for over 11 years, until May 5, 1998 (Ex. 10, pp. 1-15). He initially presented with genital herpes (Ex. 10, p. 1). It was later determined that he had an elevated blood pressure. He also developed a cardiac arrhythmia for which he was seeing a cardiologist. (Tr. 137).

51. During the first few years that the Respondent treated the patient, the patient's age, height, weight, family history, lifestyle and other background information were not recorded on any of the patient's medical records made by the Respondent (Ex. 10, pp. 1-5). Although the initial medical history might be acceptable for the treatment of the genital herpes that the patient presented with, it was below acceptable medical standards for the treatment of the patient's hypertension and cardiac condition which were discovered later (Tr. 137-140).

52. The initial physical examination performed by the Respondent on Patient F was adequate for the genital herpes that the patient presented with (Tr. 138).

53. The Respondent's evaluation, treatment and monitoring of the patient's hypertension were below acceptable standards of medical care because the Respondent did not evaluate the causes and possible complications of the hypertension (Tr. 138-139).

54. The initial physical examination of Patient F performed and documented by the Respondent was below acceptable standards of medical care because it failed to include

an evaluation and examination of the parts of the body that can be affected by an elevated blood pressure (Tr. 51-53 and 138-139; Ex. 10, p. 1).

55. There was no examination of the circulatory system involving the palpable or audible arteries, such as the arteries in the neck and in the extremities; there was no examination of the abdomen to determine if there were any significant bruits or vascular abnormalities with respect to the aorta or kidneys; there was no examination to determine if there were any palpable abdominal masses or an enlarged kidney; there was no examination of the arteries in the eyegrounds; and, there is no evidence of any diagnostic work-up of the etiology of the patient's hypertension. (Tr. 52-54 and 138-139; Ex. 10, pp. 1-15).

56. There is no documentation of any recommendations for lifestyle modification to assist in the control of the patient's blood pressure, such as diet, stress factors, obesity and smoking (Tr. 63-64 and 138-139; Ex. 10, pp. 1-15).

57. The Respondent's evaluation, monitoring and treatment of Patient F's hypertension were below minimally acceptable standards of medical care because there was an inadequate physical examination. The Respondent should have examined the patient's blood pressure in both arms. He should have examined the patient's eyegrounds. He should have listened to the neck and abdomen for bruits, and checked peripheral vasculature for evidence of peripheral vascular disease. He should have performed a cardiac examination, listening for abnormal heart sounds or heart movement. He should have ordered a urinalysis to rule out proteinuria, hematuria and intrinsic renal disease. He should have ordered a serum potassium to rule out any significant adrenal disease. (Tr. 62-63). There was no evaluation of other problems associated with an elevated blood pressure, such as an end organ examination and/or an examination of the eyes,

extremities and cerebral vascular system (Tr. 53-54). In addition, the Respondent failed to perform and/or order an adequate examination and appropriate diagnostic tests to determine whether those functions which would most likely be adversely affected by the hypertension, such as kidney and cardiac functions, had, in fact, been affected by the hypertension. There was no electrocardiogram or chest X-ray for cardiac function and heart size. (Tr. 62-63 and 138-139).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless otherwise specified.

The Respondent did practice medicine with gross negligence on a particular occasion. The Petitioner has proved by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients B and E, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did not practice medicine with gross incompetence. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E and/or F.

The Respondent did practice medicine with negligence on more than one

occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of Patients A, B, C, D, E and F, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E and/or F.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of the Patients A, B, C, D and F, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of each of these patients.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as

whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of Fredric M. Hirsh, M.D., in its efforts to establish its case against the Respondent. Dr. Hirsh, an expert in the field of Family Practice, testified to the Respondent's medical care and treatment of Patients A, B, C, D, E and F.

Dr. Hirsh is Board Certified in Family Practice and has an impressive medical background. He is currently a partner and the medical director of Highgate Medical Group, a group medical practice located in western New York, where he also sees patients on a regular basis. In addition, he is the Associate Medical Director for Managed Care at KALEIDA Health, a large hospital-based delivery system in western New York. He is also an Associate Professor of Family Medicine at the State University of New York at Buffalo School of Medicine and he is affiliated with Millard Fillmore Hospital, Millard Fillmore Suburban Hospital and Lockport Memorial Hospital. (Tr. 23-27; Ex. 4).

The Hearing Committee found Dr. Hirsh to be a convincing and credible witness with an appropriate medical background in Family Practice. He was straightforward and non-evasive and his testimony was balanced and unbiased.

The only witness to testify in support of the Respondent's case, was the Respondent himself. The Respondent has been practicing medicine since 1961 and has been engaged in a general practice for most of his professional career. He currently has a small office practice in Fulton, New York, where he works alone as a single general practitioner. (Tr. 153-154 and 155-156).

The Hearing Committee was not impressed with the Respondent's testimony and had various concerns about his credibility. He did not maintain a consistent level of believability throughout his testimony. For example, at different times during his testimony, he willingly conceded obvious mistakes that he had made. However, at other times during his testimony, he made unconvincing attempts to justify or minimize other mistakes. Consequently, while he appeared sincere and certain portions of his testimony appeared forthright and truthful, other portions of his testimony appeared self-serving and questionable.

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

The resolution of the recordkeeping issues required an examination of the entries made by the Respondent in the medical records for each patient as well as an evaluation of the medical testimony relating to the adequacy of each of these medical records.

Before discussing the Respondent's treatment of each of the patients, the Hearing Committee wishes to point out that it found the wording of many of the factual allegations in the Statement of Charges unnecessarily complicated and confusing. Particularly troubling was the combination of separate allegations linked by the phrase "and/or" which compels the Hearing Committee to sustain a multi-faceted allegation based upon a finding of a single component. Such phrasing is awkward and frequently obscures the salient issues and the actual findings of the Hearing Committee.

Patient A

The Respondent's medical record for Patient A (Ex. 5) does not document an

adequate evaluation or treatment of the patient's presenting problems. Although the Respondent testified that further evaluation was performed but not documented, the Hearing Committee believes that an undocumented evaluation is inappropriate and inadequate. It is very difficult to draw conclusions regarding the appropriateness of the Respondent's treatment of Patient A from the Respondent's medical record for Patient A.

Therefore, the Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient A. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment of Patient A.

Patient B

There was insufficient evaluation of complications and risk factors of the patient's hypertension. The Respondent attempted to justify his failure to perform a complete physical examination by explaining that: the patient wasn't scheduled for a physical (Tr. 184); since the patient was "a known hypertensive" there wasn't "any point of working him up again" (Tr. 182); and, whoever treated the patient before must have worked him up (Tr. 188). These explanations are unacceptable. Furthermore, the Respondent made no effort to communicate with the previous treating physician or even to determine his identity (Tr. 194-195).

In addition, the Respondent made no effort to determine the etiology of the patient's hypertension. In view of the Respondent's claim that "the hypertension at the beginning was not kept down because of the non-compliance of the patient" (Ex. A, p. 3), there should have been documented attempts at modification of the therapy, such as recommending lifestyle modifications involving diet and exercise (Tr. 56-57).

The Respondent failed to record the patient's age, height and weight (Ex. 6). Although the Respondent thinks the patient was overweight, the Hearing Committee does not really know whether the patient was actually overweight and, if so, to what extent, when the patient first presented in 1991, over 9 years ago (Tr. 189-190). Additionally, no diagnostic tests were ordered to assess any of the risk factors for hypertension (Tr. 53-57; Ex. 6).

The Hearing Committee finds the Respondent grossly negligent in connection with the medical care that he provided to Patient B. The Respondent did not appropriately evaluate the patient's hypertension or appropriately monitor for the side effects of the chosen therapy. The patient's respiratory condition worsened during the period of treatment. Furthermore, the Respondent failed to perform an appropriate evaluation and modification of the treatment regimen. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment of Patient B.

Patient C

The Hearing Committee knows very little about this patient when she initially presented on March 2, 1981 (Ex. 7, p. 1). The Respondent did not record the patient's age, height, weight, family history and whether or not the patient had any drug allergies or was a smoker (Ex. 7, pp. 1-5). The first notation of the patient's date of birth (10/8/13) appears in a hospital admission record dated May 10, 1996, more than 15 years after the patient was first seen by the Respondent (Ex. 7, p. 6). Although a diagnosis of bronchitis is noted in the medical record of the patient's initial visit, there is no indication why the patient presented, what the patient's symptoms were, and the specific symptoms upon which the bronchitis diagnosis was based. Furthermore, an initial physical examination was not documented. (Ex. 7, p. 1).

The Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient C. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment of Patient C.

Patient D

Patient D was a 48 year old obese male whose main complaint was migraine headaches when he was first seen by the Respondent on April 12, 1996 (Ex. 8, p. 7). He transferred to the Respondent's practice on high doses of narcotics (Tr. 212 and 221-222; Ex. 8, pp. 1-2). The transfer note references the diagnosis of cluster headaches and an evaluation by Dr. Kingston, a neurologist (Ex. 8, pp. 1-2). The Respondent failed to reevaluate Patient D at the initial visit (Tr. 212; Ex. 8, p. 7). There is no notation in the Respondent's medical records for Patient D of any communications between the Respondent and Dr. Kingston (Tr. 219; Ex. 8). However, there is reference in the medical records to Dr. Kingston adding to the medications prescribed by the Respondent (Tr. 213; Ex. 8, p. 9).

It should be noted that there were no documented attempts by the Respondent to wean the patient from the narcotics that he was taking (Tr. 102-103; Ex. 8). A rapid decrease in the patient's dosage could be dangerous to the patient (Tr. 213-214). It was also noted that the Respondent testified that he told the patient to go to the pain clinic in Syracuse, but the patient refused (Tr. 213 and 222). However, there is no documentation supporting this claim (Ex. 8).

The Hearing Committee also feels that, at the very least, contact should have been made between the Respondent and Dr. Kingston to assure that appropriate medications were prescribed in appropriate amounts.

The Hearing Committee finds the Respondent negligent in connection with the medical care that he provided to Patient D. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment of Patient D.

Patient E

Patient E is a male who was approximately 31 years old when he was first seen by the Respondent. The patient's history is devoid of the basics, such as age, height, weight, family history and whether or not the patient had any drug allergies. (Ex. 9).

The Respondent admitted that he did not perform an initial physical examination when he testified: "I didn't do one because he couldn't afford it. He -- he -- he doesn't have insurance and he can't afford the physical exam." (Tr. 235). The Respondent also admitted that he failed to perform an independent evaluation of the patient's hypertension when he subsequently testified: "Well, he -- I haven't evaluated him because he was already evaluated before by other doctors. He was -- he was hypertensive -- known hypertensive before." (Tr. 236). When the Respondent was asked how long the patient had high blood pressure before the patient came to see the Respondent, the Respondent replied "I don't know." (Tr. 238).

With respect to the patient's knee injury, the Respondent didn't even know when the injury occurred (Tr. 239). Furthermore, the Respondent's treatment of the patient with narcotic analgesics was inappropriate without a diagnosis.

For the reasons set forth above the Hearing Committee finds the Respondent grossly negligent in connection with the medical care that he provided to Patient E. However, the Hearing Committee feels that the medical records maintained by the Respondent for Patient

E accurately reflects the Respondent's evaluation and treatment of Patient E (such as it was).

Patient F

Patient F was a 30 year old male suffering from genital herpes when he was first seen by the Respondent (Ex. 10, p. 1). This patient was treated by the Respondent for over 11 years for various complaints. (Ex. 10, pp. 1-15). Other than the acronym NKDA, the Hearing Committee knows very little about the patient when he first presented (Ex. 10, p. 1). During the first few years that the Respondent treated the patient, the patient's age, height, weight, family history, lifestyle and other background information were not recorded on any of the medical records made by the Respondent (Ex. 10, pp. 1-5).

After several visits, the Respondent finally took the patient's blood pressure. It was then determined that the patient had an elevated blood pressure and a cardiac arrhythmia. While the Respondent treated the patient for the hypertension, the patient saw a cardiologist for the cardiac arrhythmia.

The evaluation, treatment and monitoring of the hypertension by the Respondent were substandard. There is insufficient documentation in the patient's medical records to indicate whether the systems that should have been examined to diagnose the hypertension, had in fact been examined. There were no follow-up examinations on those systems potentially affected by the hypertension, to determine if there were any complications. This is critical since the Respondent knew that the patient was non-compliant with his medications (Tr. 248; Ex. A, p. 12). Furthermore, since the Respondent knew that the patient was non-compliant with his medications, recommendations should have been made to the patient regarding lifestyle modification. (Ex. 10, pp. 1-15).

Finally, the Hearing Committee finds the Respondent negligent in connection

with the medical care that he provided to Patient F. However, the Hearing Committee does not believe that any of the proven allegations rises to the level of gross negligence. In addition, the Hearing Committee finds that the Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment of Patient F.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

A Sustained

A1 Sustained

A2 Sustained

A3 Sustained

A4 Sustained

Factual Allegations relating to the treatment of Patient B

B Sustained

B1 Not Sustained

B2 Sustained

B3 Sustained

B4 Sustained

B5 Sustained

Factual Allegations relating to the treatment of Patient C

C Sustained

C1 Not Sustained

C2 Sustained

C3 Sustained

C4 Not Sustained

Factual Allegations relating to the treatment of Patient D

D Sustained

D1 Sustained

D2 Sustained

D3 Sustained

D4 Sustained (2-1 vote)

D5 Not Sustained

Factual Allegations relating to the treatment of Patient E

E Sustained

E1 Sustained

E2 Sustained

E3 Not Sustained

E4 Sustained

E5 Sustained

Factual Allegations relating to the treatment of Patient F

F Sustained

F1 Sustained

F2 Not Sustained

F3 Sustained

F4 Sustained

F5 Not Sustained

Specifications

Gross Negligence

First Specification	(Treatment of Patient A)	Not Sustained
Second Specification	(Treatment of Patient B)	Sustained

Sustained Factual Allegations in Support of the Second Specification:

B, B2, B3, B4 and B5

Third Specification	(Treatment of Patient C)	Not Sustained
Fourth Specification	(Treatment of Patient D)	Not Sustained
Fifth Specification	(Treatment of Patient E)	Sustained

Sustained Factual Allegations in Support of the Fifth Specification:

E, E1, E2, E4 and E5

Sixth Specification	(Treatment of Patient F)	Not Sustained

Gross Incompetence

Seventh Specification	(Treatment of Patient A)	Not Sustained
Eighth Specification	(Treatment of Patient B)	Not Sustained
Ninth Specification	(Treatment of Patient C)	Not Sustained
Tenth Specification	(Treatment of Patient D)	Not Sustained
Eleventh Specification	(Treatment of Patient E)	Not Sustained
Twelfth Specification	(Treatment of Patient F)	Not Sustained

Negligence on More than One Occasion

Thirteenth Specification (Treatment of Patients A, B, C, D, E and/or F) Sustained

Sustained Factual Allegations in Support of the Thirteenth Specification

Treatment of Patient A: A, A1, A2, A3 and A4

Treatment of Patient B: B, B2, B3, B4 and B5

Treatment of Patient C: C, C2 and C3

Treatment of Patient D: D, D1, D2, D3 and D4

Treatment of Patient E: E, E1, E2, E4 and E5

Treatment of Patient F: F, F1, F3 and F4

Incompetence on More than One Occasion

Fourteenth Specification (Treatment of Patients A, B, C, D, E and/or F) Not Sustained

Failure to Maintain a Patient Record

Fifteenth Specification (Medical Record of Patient A) Sustained

Sustained Factual Allegations in Support of the Fifteenth Specification:

A, A1, A2, A3 and A4

Sixteenth Specification (Medical Record of Patient B) Sustained

Sustained Factual Allegations in Support of the Sixteenth Specification:

B, B2, B3, B4 and B5

Seventeenth Specification (Medical Record of Patient C) Sustained

Sustained Factual Allegations in Support of the Seventeenth Specification:

C, C2 and C3

Eighteenth Specification (Medical Record of Patient D) Sustained

Sustained Factual Allegations in Support of the Eighteenth Specification:

D, D1, D2, D3 and D4

Nineteenth Specification	(Medical Record of Patient E)	Not Sustained
Twentieth Specification	(Medical Record of Patient F)	Sustained

Sustained Factual Allegations in Support of the Twentieth Specification:

F, F1, F3 and F4

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determines, by a vote of two to one, that the Respondent's license to practice medicine in the State of New York should be revoked.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough evaluation of the Respondent's testimony and demeanor during the hearing.

While two members of the Hearing Committee are in favor of the penalty of revocation, the dissenting member favors the imposition of a stayed suspension coupled with probation which would be conditioned upon extensive supervision, retraining and continuing medical education.

The Hearing Committee believes that there is a potential for serious harm to the

public if the Respondent is allowed to continue to practice medicine. The Hearing Committee noted that the Respondent, while testifying, demonstrated a lack of insight into his multiple deficiencies. For example, when the Respondent was asked if he intended to change his practice in any way "as a result of either this hearing or any other circumstances that have come up recently", he replied "Not really." (Tr. 260). It is clear that the Respondent has shown a reluctance to change.

It is this reluctance to change which causes the majority of the Hearing Committee to find that the only acceptable penalty is revocation. In addition, it has been noted that the Respondent has limited contact with other doctors and his only attempt to keep current with medical developments is by reading medical journals. It is for these reasons that the majority of the Hearing Committee believes that the Respondent is not a promising candidate for a stayed suspension with probation conditioned upon extensive supervision, retraining and continuing medical education. However, the dissenting member disagrees and believes that requiring the Respondent to obtain extensive supervision, retraining and continuing medical education not only provides sufficient protection of the public health, but it also provides an opportunity for the Respondent to overcome his deficiencies and become a better doctor.

ORDER

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

1. The Second, Fifth, Thirteenth, Fifteenth, Sixteenth, Seventeenth, Eighteenth and Twentieth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The First, Third, Fourth, Sixth, Seventh, Eighth, Ninth, Tenth, Eleventh, Twelfth, Fourteenth and Nineteenth Specifications of professional misconduct contained within the Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

4. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: Syracuse, New York
May 12, 2000

Andrew J Merritt MD

ANDREW J. MERRITT, M.D.
Chairperson

J. LaRUE WILEY, M.D.
DEANNA L. WOODHAMS, M.A.

TO: **BRADLEY MOHR, ESQ.**
Senior Attorney
NYS Department of Health
Bureau of Professional Medical Conduct
Room 2509 Corning Tower
Empire State Plaza
Albany, New York 12237-0032

SHAFIQ BISHARA HAZBOUN, M.D.
414 South Fourth Street
Fulton, New York 13069

APPENDIX I

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER : STATEMENT

OF : OF

: CHARGES

SHAFIQ BISHARA HAZBOUN, M.D.

----------X

SHAFIQ BISHARA HAZBOUN, M.D., the Respondent, was authorized to practice medicine in New York State on November 18, 1970 by the issuance of license number 122485 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine, with a registration address of 414 South Fourth St. , Fulton, N.Y. 13069.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, (patients are identified in the attached Appendix A) (female age 22), presenting with an upper respiratory infection and depression, at Respondent's medical office at 414 South Fourth St., Fulton, New York on or about November 25, 1997. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history and/or mental health history.

2. Respondent failed to perform and/or document an

adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, monitor and/or treat the patient's upper respiratory infection and/or depression.

B. Respondent treated Patient B, (see attached Appendix A) a 44 year old male, presenting with hypertension and asthma at Respondent's medical office, from on or about January 29, 1991 to October 31, 1997. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.

2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, monitor and/or treat the patient's hypertension.

5. Respondent failed to adequately evaluate, and/or treat the patient's respiratory disease. [redacted]

C. Respondent treated Patient C, (see attached Appendix A) a 68 year old female presenting with acute bronchitis, at Respondent's medical office, from on or about March 2, 1981 to May 11, 1998. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.

2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, monitor and/or treat the patient's elevated blood pressure, coronary artery disease risk factors. [redacted]

D. Respondent treated Patient D,(see attached Appendix A) a 47 year old male presenting with migraine headaches, at Respondent's medical office, from on or about April 12, 1996 to April 20, 1998. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.

2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, monitor and/or treat the patient's migraine headaches.

5. Respondent prescribed the following controlled substances without adequate indication in excessive quantities and for an excessive period of time: Percodan (oxycodone and aspirin),a Schedule II Controlled Substance; Xanex (Alprazolam),a Schedule IV Controlled Substance; Percocet,(oxycodone and acetaminophen),a Schedule II Controlled Substance; Lorcet (hydrocodone and acetaminophen),a Schedule II Controlled Substance; Oxycontin(oxycodone), a Schedule II Controlled Substance,

E. Respondent treated Patient E,(see attached Appendix A) a male, (age unknown) presenting with hypertension, at Respondent's medical office, from on or about November 12, 1996 to May 6, 1998. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.

2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, treat and/ or monitor the patient's hypertension.

5. Respondent failed to adequately evaluate, monitor and/or treat the patient's knee injury.

F. Respondent treated Patient F, (see attached Appendix A) a 31 year old male, presenting with herpes sores, at Respondent's medical office from on or about January 26, 1987 to May 5, 1998. Respondent's care and treatment failed to meet acceptable standards of care, in that:

1. Respondent failed to obtain and/or document an adequate medical history.

2. Respondent failed to perform and/or document an adequate initial physical examination.

3. Respondent failed to maintain a complete and/or accurate medical record.

4. Respondent failed to adequately evaluate, treat and/ or monitor the patient's hypertension.

5. Respondent failed to adequately evaluate, treat and/or monitor the patient's cardiac condition.

SPECIFICATIONS

FIRST THROUGH SIXTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with gross incompetence in violation of New York Education Law 6530 (4) in that, Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

2. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

3. The facts in Paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.

4. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4 and/or D and D.5.

5. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4, and/or E and E.5.

6 The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

SEVENTH THROUGH TWELFTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law 6530 (6) in that, Petitioner charges:

7. The facts in Paragraphs A and A.1, A and A.2, A and A.3,and/or A and A.4.

8. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

9. The facts in Paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.

10. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4 and/or D and D.5.

11. The facts in Paragraphs E and E.1, E and E.2, E and E.3. E and E.4 and/or E and E.5.

12. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

THIRTEENTH SPECIFICATION
PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more that one occasion in violation of New York Education Law §6530(3), in that Petitioner charges two or more of the following:

13. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4; B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5; C and C.1, C and C.2, C and C.3 and/or C and C.4; D and D.1, D and D.2, D and D.3, D and D.4 and/or D and D.5; E and E.1, E and E.2, E and E.3, E and E.4 and/or E and E.5; F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

FOURTEENTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more that one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

14. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4; B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5; C and C.1, C and C.2, C and C.3 and/or C and C.4; D and D.1, D and D.2, D and D.3, D and D.4, and/or D and D.5; E and E.1, E and E.2, E and E.3, E and E.4, and/or E and E.5.; F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

FIFTEENTH THROUGH TWENTIETH SPECIFICATIONS
FAILING TO MAINTAIN MEDICAL RECORDS

Respondent is charged with having failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient, in violation of New York Education Law §6530(32), in that Petitioner charges:

15. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.4.

16. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4, and/or B and B.5.

17. The facts in Paragraphs C and C.1, C and C.2, C and C.3 and/or C and C.4.

18. The facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4 and/or D and D.5.

19. The facts in Paragraphs E and E.1, E and E.2, E and E.3, E and E.4 and/or E and E.5.

20. The facts in Paragraphs F and F.1, F and F.2, F and F.3, F and F.4, and/or F and F.5.

DATED: November 17, 1999
Albany, New York

Peter D. Van Buren

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