STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
*Executive Deputy Commissioner*

January 16, 2001

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Harry Josifidis, M.D.
c/o Gerard J. Heubel, Esq.
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115 Broadway – 19th Floor
New York, New York 10006

Harry Josifidis, M.D.
27-47 Crescent Street
Long Island, New York 11102

Daniel Guenzburger, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

**RE: In the Matter of Harry Josifidis, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 00-258A) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah

Enclosure

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

**In the Matter of**

**Harry Josifidis, M.D. (Respondent)**

**A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)**

**Administrative Review Board (ARB)**

**Determination and Order No. 00-258A**


**Before ARB Members Grossman, Lynch, Pellman, Price and Briber**
**Administrative Law Judge James F. Horan drafted the Determination**

**For the Department of Health (Petitioner):** **Daniel Guenzburger, Esq.**
**For the Respondent:** **Gerard J. Heubel, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent committed professional misconduct by performing unnecessary surgery. The Committee placed a permanent restriction on the Respondent's License to practice medicine in New York State (License) that required the Respondent to practice with a monitor. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 2000), both parties ask the ARB to nullify or modify the Committee's Determination. After considering the record and the submissions by the parties, we affirm the Committee's Determination on the charges, except that we overrule the Committee and dismiss charges that the Respondent's conduct amounted to practicing fraudulently and willfully filing a false report. We also overturn the Committee's Determination on penalty. We suspend the Respondent's License for three years, stay the suspension for all but six months and place the Respondent on probation for two and one-half years.

## Committee Determination on the Charges

In this proceeding, the Petitioner charged that the Respondent, acting in concert with Jamile Peress, M.D., caused medically inappropriate transurethral resections of the prostate (TURP) or transurethral incisions of the prostate (TUIP) to be performed on twenty-four persons, Patients 1-24. A TURP is an invasive surgical procedure to relieve lower urinary tract symptoms that result from enlarged prostate glands [Committee Finding of Fact (FF) 6]. A TUIP is a less invasive surgical procedure for patients with smaller prostates [FF 6]. The record refers to the Patients by number to protect their privacy. The Patients suffered from various mental disabilitites and resided in the Leben Home adult long-term care facility.

The proceeding commenced by a Summary Order from the Commissioner of Health, pursuant to N.Y. Pub. Health Law § 230(12)(a). The Summary Order suspended the Respondent's License summarily, upon the Commissioner's Determination that the Respondent's practice constituted an imminent danger to the public health. The Petitioner's Statement of Charges alleged that the Respondent's violated N. Y. Educ. Law §§ 6530(2-6), (20-21), (32) & (37) (McKinney Supp. 2000), under the following misconduct specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence,
- engaging in conduct that evidences moral unfitness,
- willfully filing false reports,

- failing to maintain accurate records, and,
- ordering excessive tests or treatments unwarranted by the patient's condition.

The fraud and false report charges [Factual Allegations B1-13] specified that the fraudulent conduct and false reporting occurred when the Respondent knowingly and falsely misrepresented the difficulty the Patients experienced in urinating. A joint hearing on the charges and the Summary Order, involving the Respondent and Dr. Peress, ensued before the BPMC Committee who rendered the Determination now on review. The ARB review addresses the Committee's Determination on the charges and penalty only, as the ARB lacks the authority to review Summary Orders [see Pub. Health Law § 230-c (1)]. Prior to the time the Committee rendered their Determination, the Petitioner withdrew the charges concerning Patients 4 and 6.

The Committee sustained all charges against the Respondent, except practicing with gross incompetence and failing to maintain accurate records. The Committee found that the Respondent performed either the TURP or TUIP procedures on referrals from Dr. Peress. The Committee found that nineteen of twenty-two patients, whose care remained at issue in the proceeding, received primary care from Zenaida Santos, M.D. and Yitzhak Twerskey, M.D. Neither physician referred the Patients to the Respondent or Dr. Peress. The Committee determined that the Respondent:

- performed surgery on Patients 12 and 16, but failed to evaluate either Patient prior to surgery and never received preoperative evaluations on the Patients;
- deviated from medically accepted standards by relying inappropriately on inadequate evaluations by Dr. Peress, failing to evaluate out-patient evaluations by Dr. Peress and failing to review medical records from eaeh urological evaluation by Dr. Peress;
- failed to obtain adequate informed consent;

- delegated inappropriately significant elements in the informed consent process to Dr. Peress, such as explaining reasonable alternatives to TURP;
- signed the certification on the informed consent forms for Patients 2 and 17 on the day before the hospital record indicates that the Respondent saw or examined the Patients;
- took an approach to evaluating and treating that precluded the Respondent from giving Patients the care they needed;
- performed TURPs inappropriately on 11 patients with no or only mild urinary tract symptoms; and,
- performed surgery on Patient 14, who underwent a prior TURP that relieved his symptoms.

The Committee found that the Respondent performed unnecessary surgery. Although the Committee sustained the fraud and false reporting charges, the Committee made no findings or conclusions that the Respondent had knowingly and falsely misrepresented the difficulty the Patients experienced in urinating. In making their findings, the Committee assessed credibility between the Respondent's experts, Drs. Kaplan and Vaughn, and the Petitioner's expert, Dr. Mellinger. The Committee found that the experts testified on different aspects in the matter. The Committee found that the Respondent's experts concentrated on medical competence in surgical procedures, while the Petitioner's expert addressed the whole patient care process, including alternative treatments, continuity of patient care and informed consents.

The Committee voted to restrict the Respondent's License, so that the Respondent may practice only under monitoring by a board certified urologist. The terms for the monitor appear at pages 23-24 in the Committee's Determination and include approval for the monitor by the

Director of the Office for Professional Medical Conduct (OPMC) and on-site observation by the monitor.

The Committee also sustained all charges against Dr. Peress, except practicing with gross incompetence. The Committee found that Dr. Perress made referrals to the Respondent for unnecessary surgery, without patient informed consent and without a trial of medical management. The Committee voted to suspend his medical license for five years.

## Review History and Issues

The Committee rendered their Determination on September 29, 2000. This proceeding commenced on October 16, 2000, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the response brief on November 27, 2000.

The Petitioner's brief argues that the Committee imposed a sanction inconsistent with their conclusions that the Respondent posed an imminent danger to the public. The Petitioner argues that a monitor on the Respondent's practice will fail to protect the public, because the monitor would review the Respondent's work after the fact. The Petitioner contends that the Respondent used assembly line techniques to mass-produce unnecessary surgery and deprived patients from individual care. The petitioner contends further that Patients lacked understanding to consent to the procedures and that Patients 14 and 16 underwent surgery without undergoing a preoperative evaluation. The Petitioner also contends that the Respondent lacks insight into his deficiencies. The Petitioner asks the ARB to overturn the Committee and revoke the Respondent's License.

The Respondent argues that the Committee erred in sustaining the fraud, false report and moral unfitness charges. The Respondent contends that no evidence showed that the Respondent knew that Dr. Peress failed to work-up the Patients or explain benefits or alternative treatments to the Patients. The Petitioner asserts that Dr. Peress bears the full responsibility for that conduct. The Respondent contends that he relied properly on Dr. Peress to evaluate the Patients and that he evaluated the Patients sufficiently in the hospital. The Respondent notes that his experts, Drs. Vaughn and Kaplan, testified that the referral procedure at issue here was appropriate. As to the unnecessary surgery findings, the Respondent argues that the Committee erred in finding that 11 Patients lacked symptoms or suffered only mild symptoms. The Respondent states that the record showed that all Patients displayed symptoms that would justify surgery. As to the failure to offer medical management, the Respondent argues that medical management would not work for psychiatric patients, who could not be trusted to take medications. The Respondent asks that the ARB overturn the Committee's Determination and dismiss the charges against the Respondent.

In reply to the Petitioner's brief, the Respondent argues that the Petitioner based the request for a more severe penalty on non-existent findings by the Committee. The Respondent argues that the Committee:

- made no finding that the Respondent posed an imminent danger to the public,
- made a finding that the Respondent had performed unnecessary surgery only on Patients 12, 14 and 16, and,
- made no finding that the Patients lacked the capacity to consent to the procedures.

The Petitioner also pointed out that the Petitioner's brief continually referred to misconduct involving twenty-four Patients, even though the Petitioner dropped the charges concerning

Patients 4 and 6. The Respondent also contends that the Committee made no findings that the Respondent prepared records that inflated the degree of the Patients' urinary difficulties.

## Determination

The ARB has considered the record and the parties' briefs. We overturn the Committee's Determination that the Respondent practiced medicine fraudulently and willfully filed false reports. We affirm the Committee's Determination on the remaining charges. We overturn the Committee's Determination on penalty. We suspend the Respondent's License for three years, stay the suspension for all but six months and place the Respondent on probation for two and one-half years.

**Fraud and False Report Charges:** In order to sustain a charge that a licensee practiced medicine fraudulently, a hearing committee must find that (1) a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation, Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (Third Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). A committee may infer the licensee's knowledge and intent properly from facts that such committee finds, but the committee must state specifically the inferences it draws regarding knowledge and intent, Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (Third Dept. 1991). To prove willfully filing a false report, a committee must establish that a licensee made or filed a false statement willfully, which requires a knowing or deliberate act, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986). Merely making or filing a false report, without intent or knowledge about the falsity fails to constitute professional misconduct, Matter of Brestin v. Comm. of Educ.,(supra). A committee may reject a licensee's explanation for erroneous reports (such as resulting from inadvertence or carelessness) and draw the inference

that the licensee intended or was aware of the misrepresentation, with other evidence as the basis, Matter of Brestin v. Comm. of Educ.,(supra).

The Petitioner's Statement of Charges alleged that the Respondent made knowing and false misrepresentations in the Patient's hospital records about the Patients' urinary difficulties [Factual Allegations B1-B13]. Although the Committee sustained both misconduct specifications, the Committee made no findings that the Respondent knowingly and falsely misrepresented information in the Patients' hospital records. The Committee also dismissed the charge that the Respondent failed to maintain accurate records. We find it inconsistent for the Committee to have dismissed a failure to maintain accurate records charge, if the Committee felt that the Respondent made misrepresentations in those same records. The Petitioner's response brief (page 2) argued that the Committee's FF 46 demonstrated the Committee's intent to sustain the charges in Factual Allegations B1-B13. We disagree. In FF 46, the Committee found that the records for eleven Patients contained no symptoms or only mild symptoms for urinary difficulties. Nothing in FF 46 indicated that the Respondent made any misrepresentations in the records for those Patients. As the Committee made no findings that the Respondent entered misrepresentations knowingly and falsely in the Patients' records, no basis existed for the Committee to sustain the fraud and false reporting charges. We overturn the Committee and we dismiss those charges.

**The Remaining Charges:** On the remaining charges that the Committee sustained, the Respondent argued that other evidence in the record contradicted the Committee's findings and conclusions. The Respondent in effect challenges the Committee's Determination on witness credibility and on which evidence to accord greater weight in assessing conflicting evidence. The ARB owes the Committee, as the fact finder, deference in their judgements about credibility. At page 2 in their Determination, the Committee gave their reasons for making their judgement on credibility in this case. The Committee explained that they found that the Petitioner's expert witness, Dr. Mellinger, testified concerning the whole patient care process, while the Respondent's experts, Drs. Kaplan and Vaughn, concentrated on competence in medical procedures. The Committee also made specific factual findings that challenged testimony by Drs.

Vaughn and Kaplan. The Respondent's experts rejected medical management as a treatment option for the Patients at issue in the case on grounds that people with psychiatric problems refused to take their medications. At FF 40, the Committee found that the medical record for 19 of 22 Patients showed these Patients were not adverse to taking oral medications. We hold that the Committee acted reasonably in making their judgements on credibility and we hold that the proof, on which the Committee relied, provided preponderant evidence to support their Determination on the remaining charges that the Committee sustained.

The Committee found that the Respondent performed unnecessary surgery, that he failed to evaluate patients appropriately, that he failed to discuss treatment options with the Patients, that he failed to attempt medical management with the Patients and that he delegated his responsibilities inappropriately to Dr. Peress. The Committee's findings demonstrated that the Respondent treated the Patients at issue as a class or a group rather than as individuals. In his conduct, the Respondent failed to practice according to accepted medical standards, and in these cases, that failure rose to an egregious level. The Respondent also demonstrated a lack of knowledge or skill necessary to practice medicine. By failing to provide these Patients with the individualized care that any patient should expect, the Respondent violated the medical profession's moral standards. The preponderant credible evidence in the case supported the Specifications that charged the Respondent with performing surgery unwarranted by the Patients' conditions, engaging in conduct that evidences moral unfitness and practicing with gross negligence, negligence on more than one occasion and incompetence on more than one occasion.

**Penalty:** Under our authority from Pub. Health Law § 230-c(4)(a), the Review Board may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 Ad 2d 86, 606 NYS 2d 381 (Third Dept. 1993). We elect to exercise that authority here, because the Committee has failed to impose an appropriate penalty for the Respondent's misconduct. The Respondent subjected several vulnerable people to surgical risk, without adequate reason, and denied those persons individualized care to which all patients are entitled. We hold that the Respondent's repeated egregious conduct warrants a severe sanction that will include actual time on suspension with probation to follow. To assure that the

sanction we impose will deter the Respondent from future misconduct, we place the Respondent under supervision during that probation. Further, during that probation, we limit the Respondent to performing surgery and invasive procedures only in a facility holding a license or operating certificate pursuant to Public Health Law Article 28. The probation terms appear at the Appendix to this Determination.

We reject the Petitioner's request that we revoke the Respondent's License. Although the Respondent bears the responsibility for his misconduct, we agree with the Respondent that the greater blame lies with Dr. Peress, for the treatment that the Patients at issue received. The Committee apparently agreed also, because they imposed a more severe penalty against Dr. Peress. The Petitioner has requested a modification in penalty against Dr. Peress in the companion case to the one now on review (Matter or Peress, ARB # 00-258B). In that companion case, we have voted to overturn the Committee and revoke the license held by Dr. Peress.

## ORDER

**NOW**, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB **AFFIRMS** the Committee's Determination that the Respondent performed surgery unwarranted by the Patients' conditions, engaged in conduct that evidenced moral unfitness and practiced with gross negligence, negligence on more than one occasion and incompetence on more than one occasion.
2. The ARB **OVERTURNS** the Committee's Determination and **DISMISSES** the charges that the Respondent practiced fraudulently and willfully filed false reports.
3. The ARB **OVERTURNS** the penalty that the Committee imposed against the Respondent.
4. The ARB **SUSPENDS** the Respondent's License for three years, **STAYS** the suspension for all but six months and **PLACES** the Respondent on probation for two and one-half years, under the terms that appear in the Appendix to this Determination.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

**In the Matter of Harry Josifidis, M.D.**

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Josifidis.

Dated: December 20, 2000

**Robert M. Briber**

**In the Matter of Harry Josifidis, M.D.**

**Thea Graves Pellman**, an ARB Member concurs in the Determination and Order in the Matter of Dr. Josifidis.

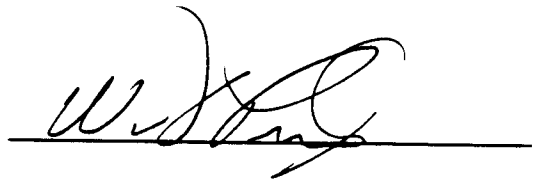
**Dated:** Dec 28, **2000**

**Thea Graves Pellman**

**In the Matter of Harry Josifidis, M.D.**

**Winston S. Price, M.D.**, an ARB Member concurs in the Determination and Order in the Matter of Dr. Josifidis.

**Dated:** 1/12/01, **2000**



**Winston S. Price, M.D.**

**In the Matter of Harry Josifidis, M.D.**

**Stanley L. Grossman**, an ARB Member concurs in the Determination and Order in the Matter of Dr. Josifidis.

Dated: December 22, 2000

S L Grossman M D

**Stanley L Grossman, M.D.**

**In the Matter of Harry Josifidis, M.D.**

**Therese G. Lynch, M.D.**, an ARB Member concurs in the Determination and Order in the Matter of Dr. Josifidis.

**Dated:** Dec 20, **2000**

Therese G Lynch M.D

**Therese G. Lynch, M.D.**

# APPENDIX

Terms of Probation

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

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

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

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

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

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

7. The Respondent shall practice medicine only when supervised in his medical practice. The practice supervisor shall be on-site at all locations at which the Respondent performs surgery or invasive procedures, unless determined otherwise by the Director of OPMC. The practice supervisor shall be proposed by Respondent and subject to the written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship, which could pose a conflict with supervision responsibilities.

8. The Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC. The Respondent shall ensure that the practice supervisor is in a position to regularly observe and assess the Respondent's medical practice. The

Respondent shall cause the practice supervisor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

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

10. The Respondent shall perform surgery or invasive procedures only in a facility holding a license or operating certificate pursuant to Public Health Law Article 28.

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