STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

July 25, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Naji Abumrad, M.D.
5 Dodge Lane
East Setauket, New York 11733

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

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RE: In the Matter of Naji Abumrad, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 97-175) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

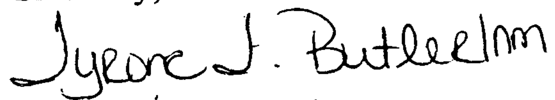
The notice of review served on the Administrative Review Board should be forwarded to:

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:nm
Enclosure

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

COPY

IN THE MATTER OF NAJI ABUMRAD, M.D.	DETERMINATION AND ORDER

BPMC - 97 - 175

DANIEL W. MORRISSEY, O.P., Chairperson, **DANIEL A. SHERBER, M.D.** and **JOSEPH B. CLEARY, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **ELLEN B. SIMON, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Notice of Hearing Dated:	December 11, 1996
Statement of Charges Dated:	December 11, 1996
Prehearing Conference:	December 6, 1996
Hearing Dates:	December 16, 1996 December 17, 1996 January 13, 1997 January 14, 1997 January 17, 1997 January 21, 1997 January 28, 1997 February 4, 1997 February 7, 1997 February 11, 1997 March 10, 1997 March 21, 1997 April 3, 1997

Deliberation Dates:	May 6, 1997 May 9, 1997 May 21, 1997 May 30, 1997 June 2, 1997 June 6, 1997
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Dianne Abeloff, Associate Counsel
Respondent Appeared By:	Heidell, Pittoni, Murphy & Bach, P.C. 99 Park Avenue By: Charles L. Bach, Jr., Esq. Janice K. Lunde, Esq.

WITNESSES

For the Petitioner:	John E. Olson, M.D. John Bennett, M.D.
For the Respondent:	Respondent Patient A Patient E Raquel Ruiz Frank Ernst Gump, M.D. Diane Nannery Patient G's spouse Valerie Marie Parisi, M.D. Josef E. Fischer, M.D. Jordan J. Cohen, M.D. Klaus Schreiber, M.D. Paul Lo Gerfo, M.D. Eugene P. Mohan, M.D. Gerard J. Nuovo, M.D.

AFFIRMATION OF MEMBER OF THE HEARING COMMITTEE

Daniel W. Morrissey, O.P., a duly appointed member of the State Board for Professional Medical Conduct and of its Hearing Committee designated to hear the matter of Naji Abumrad, M.D., hereby affirms that he was absent from a brief part of each of the hearing sessions conducted on December 16, 1996 and February 4 and February 11, 1997. He further affirms that he has read and considered the transcripts of the proceedings of, and the evidence received at, such partial hearing days prior to deliberations of the Hearing Committee beginning on May 6, 1997.

DELIBERATIONS

Although April 3, 1997 was the last hearing date in this matter, the Hearing Committee deferred the start of its deliberations because of the request of counsel for both parties that they be given until April 24th to prepare and submit their proposed findings of fact and conclusions of law for the Committee's consideration. The Hearing Committee received those submissions on or about April 30th, and deliberations began on May 6th.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence on more than one occasion, gross negligence, incompetence on more than one occasion, and gross incompetence.

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

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they 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 evidence cited.

1. Naji Abumrad, M.D., the Respondent, was authorized to practice medicine in New York on June 12, 1976 by the issuance of license number 120178 by the New York State Education Department [Dept.'s Exhibit (hereinafter "Ex") 2].

2. At all times referred to herein, Respondent was a surgeon affiliated with University Hospital at Stony Brook, Stony Brook, New York ("University Hospital") [Transcript pages (hereinafter "T") 891-892].

PATIENT A

Findings of Fact

3. Patient A first visited the Respondent at the obstetrics/gynecology clinic at University Hospital on July 15, 1994 (Ex 3, p. 5).

4. Before seeing the Respondent on July 15, 1994, Patient A reported to her gynecologist the presence of a breast abnormality (T 538).

5. At that July 15th examination a large mass of about 4 to 5 centimeters [hereafter "cm"] in size was palpable in Patient A's left breast (Ex 3, p. 5; T 44).

6. No mammography was performed as part of the Respondent's July 15th workup of Patient A (T 51-52).

7. At the time of that initial visit, Patient A was 20 weeks pregnant, and the Respondent planned to treat her by lumpectomy and axillary dissection followed by chemotherapy, and it was planned that her pregnancy would continue (Ex 3, p. 5; T 570).

8. There is no documentation in the record that the Respondent discussed options for treatment with Patient A (T 45, 1423).

9. Dr. Valerie M. Parisi, Patient A's consulting obstetrician/gynecologist, testified that the Respondent did not discuss treatment options with Patient A in the witness's presence "because he didn't want to hold me up" (T 1796, 1820).

10. Dr. Parisi also testified that the Respondent said that he would take Patient A to another office at University Hospital to have a conversation with her about treatment options (T 1820).

11. The Respondent testified that Patient A never went to his clinic and that she stayed in the ob/gyn clinic all day (T 1424).

12. Patient A stated that the Respondent did not discuss options for treatment with her (T 529).

13. Before Patient A's July 15th visit with the Respondent, she had been told by other doctors that it was necessary to terminate her pregnancy and for her to have a mastectomy (T 526, 527, 552, 1334).

14. It required several telephone calls to get Patient A to speak further with the Respondent for a full explanation that the initial planned surgery would not cause her baby any harm (T 529, 576, 579, 984, 1420, 1421).

15. Patient A testified that she didn't want to have an abortion but had been willing to have a mastectomy (T 527, 530, 554).

16. The Respondent testified that Patient A "categorically refused mastectomy" (T 1437).

17. On July 29, 1994, Patient A signed a consent for the Respondent to perform a left breast lumpectomy with axillary node dissection (Ex 3, p. 103).

18. On August 11, 1994, the Respondent performed a left breast quadrantectomy and left axillary dissection, using two separate incisions (Ex 3, pp. 39-40).

19. The pathology report for the specimen removed at the August 11th surgery indicates that it measured 12 x 8 x 2.5 cm and that all over the sample were isolated indurated areas of approximately 2 cm. The provisional diagnosis notes "br, left mass, biopsy--invasive carcinoma with mixed mucinous and neuroendocrine features" and "axilla, left, excision--four out of 20 axillary lymph nodes positive for metastatic carcinoma." The report also contains the inconsistent note that "There are twelve lymph nodes dissected out and submitted in five cassettes" (Ex 3, pp. 42-44). The pathology report makes no mention of margins, either clear or involved by tumor.

20. The Respondent testified that the pathologist told him that margins were free on the August 11, 1994 surgery specimen (T 1453-1454).

21. Patient A began systemic chemotherapy on or about September 20, 1994 under the care of Dr. Michael V. Viola (Ex 3, p. 125).

22. Patient A was delivered by caesarian section on November 7, 1994 by Dr. Bruce Meyer (Ex 3, p. 195).

23. On or about December 15, 1994, the Respondent felt a mass in Patient A's left breast adjacent to the previous incision/scar (Ex 3, p. 286).

24. On December 27, 1994, the Respondent removed that mass (Ex 3, p. 290).

25. The pathology report for the specimen removed on December 27th shows poorly differentiated carcinoma histologically similar to the previously excised breast cancer (Ex 3, p. 293).

26. The Respondent planned to perform a left mastectomy, as indicated in correspondence to Dr. Viola dated January 5, 1995 (Ex 3, p. 297).

27. There was continued progression of the loco-regional disease, with a large mass appearing in Patient A's clavicle, according to a clinic visit note by Dr. Viola dated February 1, 1995 (Ex 3, p. 301).

28. A left mastectomy was eventually performed by a surgeon other than the Respondent (T 534, 1419).

CONCLUSIONS AS TO PATIENT A

ALLEGATION A: From on or about July 15, 1994 through on or about May 15, 1995, Respondent treated Patient A at the University Hospital at Stony Brook, Stony Brook, N.Y. (University Hospital), Patient A was diagnosed with a very aggressive carcinoma of the left breast during her second trimester of pregnancy.

SUSTAINED

ALLEGATION A1: On or about August 11, 1994, Respondent performed a quadrantectomy and an axillary dissection followed by chemotherapy. Respondent failed to confirm that he had completely excised the cancer from Patient A's left breast.

SUSTAINED

There is no documentation that the Respondent and the pathologist ever discussed the degree and/or extent of local excision. Neither is there any addendum to the pathology report regarding margins. In addition, there is no progress note by the Respondent or any of his staff referring to a review of the pathology.

The Hearing Committee considered the Respondent's testimony that he himself went to the pathology department for the results of his surgery (T 1367); however, the Committee believes that the Respondent ought to have documented that visit and his discussion with the pathologist, especially when the pathologist failed to issue an addendum to his report addressing margins. Therefore, we conclude that the Respondent did not confirm the extent of local excision.

ALLEGATION A2: Respondent failed to ascertain that the carcinoma reported by the pathologist on August 16, 1994 was multifocal and without free margins.

SUSTAINED

The Respondent did fail to ascertain that the carcinoma reported by the pathologist on August 16, 1994 was multifocal and without free margins. (See explanation for the Hearing Committee's conclusion as to Allegation A1 above.) However, since the pathology report did state findings consistent with multifocality, the Hearing Committee must assume that the Respondent was aware of that characteristic of the growth. But the Hearing Committee sustains this allegation with respect to free margins and offers the same explanation as for Allegation A1.

ALLEGATION A3: Respondent failed to perform a mastectomy within a short period of time after the quadrantectomy.

Sustained only as a matter of fact.

Although the Hearing Committee believes that performing a mastectomy would not significantly have delayed treatment of the systemic disease, we accepted testimony that the primary focus of treatment at the time should have been the systemic disease (T 965, 1002-1003, 1452). Therefore, we do not sustain the substance of the charge.

ALLEGATION A4: Respondent failed to perform preoperative mammography prior to the August 11th surgery.

Sustained only as a matter of fact.

The Respondent failed to perform mammography before the August 11th surgery, but the Hearing Committee accepts the testimony of Dr. Frank Gump that mammography was not indicated in this case (T 968-970). Therefore we do not sustain the substance of the charge.

ALLEGATION A5: Respondent failed to offer and/or document in his records that he discussed the various surgical options, including mastectomy, with the patient prior to the August 11th surgery.

SUSTAINED

The Respondent failed to document or have documented in his records that he discussed the various surgical options, including mastectomy, with Patient A before the August 11th surgery.

In view of findings of fact 9-11, the Hearing Committee finds it problematic that, given Patient A's concern for the welfare of her fetus, the Respondent did not discuss treatment options with Dr. Parisi and the patient together. In addition, the Hearing Committee notes Patient A's own testimony that the Respondent never discussed treatment options with her (T 529).

PATIENT B

Findings of Fact

29. Patient B was seen at the University Hospital department of family medicine on March 17, 1994. A lump in her left breast with peau d'orange was noted and the condition was felt to be strongly suspicious for carcinoma (Ex 4, p. 3).

30. The Respondent first saw Patient B on March 18, 1994 at University Hospital. The diagnostic impression then noted was left breast inflammation (Ex 4, p. 15).

31. A mammogram, which was done on March 17, 1994, reported "increased density and architectural distortion of the retroareolar region of the left breast. Likely differential includes infection (mastitis), hemorrhage, and, less likely, inflammatory carcinoma. Please correlate with surgical and clinical evaluation" (ex 4, p. 7).

32. The Respondent saw Patient B again on March 22, 1994, when he noted a 2 cm mass. His diagnostic impression was "resolving inflammation secondary to trauma. . ." (Ex 4, p. 17).

33. The Respondent testified that he himself never felt a mass at the March 22nd visit (T 1149). However, he also testified (T 1148) that "I then felt a distinct mass with or without faint margins."

34. The Respondent testified that he did not make changes in the record after Barbara Smith, his Nurse Practitioner, wrote her findings even if they disagreed with his. The Respondent said that when he disagreed with Barbara Smith, he found it more appropriate to dictate his own opinion to the referring physician (T 1143).

35. The Respondent wrote in a consultant's note dated March 24, 1994 that Patient B had definite evidence of cellulitis, that he would treat her with Cipro, that she should return to the clinic in one week, and that if there were no improvement, he would perform a biopsy of skin and breast tissue (Ex 4, p. 4).

36. The Respondent's progress note dated March 25, 1994 says "Area gives appearance of cellulitis" and that Patient B should return to the clinic in one week; the Respondent prescribed 500 mg of Cipro twice a day (Ex 4, p. 19).

37. A blood count report dated March 25, 1994 shows a normal white blood cell count (8.5) and an elevated erythrocyte sedimentation rate (40; range of normal for the laboratory stated as 0 to 20) (Ex 4, p. 20).

38. The Respondent performed a four-quadrant fine-needle aspiration ("FNA") biopsy on April 1, 1994 [Ex 4, p. 25; Resp.'s Exhibit (hereafter "Ex")C, p. 2].

39. The cytopathology report dated April 5, 1994 indicates that in one of the four sampled areas, the left upper outer quadrant, there was one group of cells with distorted and enlarged nuclei and that the sample was insufficient for further characterization (Ex 4, p. 25).

40. The Respondent testified that he reviewed with the pathologist the slides of the specimen biopsy for all four quadrants (T 1172).

41. Respondent next saw Patient B on April 8, 1994. His relevant progress note states ". . . discoloration resolving--faintly present. Area of erythema persists . . . diagnostic impression was left breast inflammation. Cipro was discontinued, and ibuprofen ordered. Return to clinic in 3 months . . . may biopsy next visit" (Ex 4, p. 27).

42. In response to the question why biopsy would be considered if one were comfortable that there was substantial resolution, the Respondent answered, "it doesn't make sense . . . . It was a result of a dialogue within a teaching setup" (T 1228).

43. The Respondent saw Patient B once more on June 17, 1994. His relevant progress note states " . . .her left breast is edematous and reddened around the nipple, encompassing the majority of the breast . . .". The Respondent indicates that that may be the result of a recent change in the patient's brassiere and that she should return to the clinic in two weeks (Ex 4, p. 29).

44. The Respondent saw Patient B again on July 15, 1994. Ultrasound of the breast and an incisional biopsy was planned (Ex 4, p. 31A).

45. An ultrasound report dated July 19, 1994 shows " . . .impression #1: no evidence of cystic or solid lesion noted . . ." (Ex 4, p. 34).

46. The Respondent performed an incisional biopsy of Patient B's left breast on July 25, 1994 under local anesthesia (Ex 4, p. 45).

47. The pathology report for the July 25th operative procedure shows " . . .A) skin, biopsy--small vessel involvement by ductal carcinoma; B) br, L, biopsy--invasive carcinoma . . ." (Ex 4, pp. 46-48).

48. The Respondent obtained a chemotherapy consultation on August 4, 1994 (Ex 4, pp. 58-60).

49. Patient B obtained another opinion about her care from David Kinne, M.D., who sent an opinion letter dated September 18, 1994 to the Respondent (Ex D).

CONCLUSIONS AS TO PATIENT B

ALLEGATION B: From on or about March 17, 1994 through on or about March 29, 1995, Respondent treated Patient B at University Hospital. On or about March 18, 1994, Patient B presented with a palpable mass, discoloration of the left breast, and a mammogram with a differential diagnosis of infection, hemorrhage from trauma, and inflammatory carcinoma. Until July 25, 1994, Respondent incorrectly diagnosed and treated this condition as if it were mastitis.
SUSTAINED, but see findings of fact 32 and 33 as to the presence of a palpable mass.

ALLEGATION B1: On or about April 1, 1994, a fine-needle aspiration biopsy was performed which revealed a few large and slightly atypical cells. Respondent failed to follow up with an open biopsy.
SUSTAINED except for the description of the biopsy result; see finding of fact 39.

ALLEGATION B2: Respondent inappropriately continued to treat the condition as though it were mastitis, despite the fact that there was no clinical improvement and the pathology findings were suspicious of inflammatory carcinoma. Respondent failed to order or perform an open biopsy until July 25, 1994. Respondent failed to [diagnose] and treat Patient B's inflammatory breast cancer in a timely manner.

SUSTAINED except for the statements that there was no clinical improvement and that the pathology findings were suspicious of inflammatory carcinoma.

The Respondent inappropriately continued to treat Patient B's condition as if it were mastitis. He should have followed up with a more definitive biopsy as of April 8, 1994 and should not have relied on a negative FNA report. Despite the Respondent's impression that the discoloration was resolving, the clinical signs had not completely resolved (Ex 4, p. 27, noting persistent erythema and impression of left breast inflammation), and there were no inflammation cells reported on the biopsy from April 1st (testimony of Dr. John E. Olson T 166, 172).

When a fine-needle aspiration does not show many neutrophils, many cells to suggest an abscess, i.e., mastitis, a physician must be concerned that he is dealing with inflammatory carcinoma and not with mastitis, especially if there are any atypical cells at all (testimony of Gerard J. Nuovo, M.D., T 2064).

The Hearing Committee considered Dr. Klaus Schreiber's testimony that the FNA biopsy report should have both stated more specifically the presence of cells suspicious for cancer and stated the absence of inflammatory cells (T 1718). Nonetheless, the Hearing Committee concludes that the Respondent should not have relied on a negative FNA report.

The Respondent testified that FNA is not only an acceptable biopsy technique but a superior one (T 1162, 1196). The articles that he submitted in evidence to support that opinion simply describe the use of FNA in inflammatory breast cancer; they do not recommend it over other forms of biopsy technique. Indeed, one article states that incisional biopsy is actually preferred over FNA in suspected cases of inflammatory breast cancer: "[A]n incisional biopsy is preferred for the diagnosis of inflammatory breast carcinoma to obtain adequate tumor or samples of the skin and dermal lymphatics" (Ex DD, article 3, Jaiyesimi et al., p. 1015, col. 2).
The articles in evidence do not change the fact that a more definitive type of biopsy should have been done when the FNA was reported as negative for cancer.

The Respondent testified (T 1197) that an incisional biopsy would have increased the chance of infection. The articles that he submitted to support that testimony do indicate an increased possibility of infection when the diagnosis is periductal mastitis; however, none of them even implies that biopsy should be delayed in circumstances in which inflammatory breast cancer is being considered (Ex CC). Moreover, the Hearing Committee notes Dr. Gump's testimony (T 1045) that he did not think that performing a more definitive biopsy would have precipitated an infection.

PATIENT C

Findings of Fact

50. The Respondent first saw Patient C at University Hospital on March 18, 1994, for the evaluation of an abnormal mammogram (Ex 5, p. 22).

51. A mammogram was performed at University Hospital; the relevant report is dated February 2, 1994. A "cluster of microcalcifications" was reported present in the upper outer quadrant of the left breast (Ex 5, p. 5).

52. Magnification views of the left breast were done at University Hospital; the relevant report on those views is dated March 24, 1994 (Ex 5, p. 23).

53. On October 31, 1994, Patient C signed a consent for excision biopsy of left breast microcalcifications with needle localization (Ex 5, p. 53).

54. On November 7, 1994, the Respondent performed excision biopsy of the left breast microcalcifications with needle localization (Ex 5, p. 55).

55. The relevant operative report says that x-rays showed that microcalcification was within the specimen, but the margin was not adequate. The report further indicates that a second specimen was obtained and sent to pathology (Ex 5, pp. 55-57).

56. The only form in evidence of the radiology report for the specimen excised on November 7, 1994 is a computer printout (Ex 5, p. 77). It indicates that the calcifications seen on the preprocedural localization mammogram are not seen in the mammogram of the surgical specimen. The printout also states, "This case was discussed with Dr. Abumrad."

57. There was no x-ray of the second specimen excised on November 7th (T 241).

58. The pathology report for the November 7th surgery indicates the presence of microcalcification in the biopsy as follows (Ex 5, p. 57):

"A) Breast, left, biopsy--foci of markedly atypical ductal hyperplasia in a background of moderate ductal hyperplasia and multifocal adenosis. Microcalcification is present in this biopsy.

"B) Breast, left, biopsy--mildly atypical ductal hyperplasia.

"C) Breast, left, biopsy #3--multifocal markedly atypical ductal hyperplasia associated with extensive sclerosing adenosis, lesser degrees of atypical ductal hyperplasia, and multifocal microcalcification.

"NOTE: A&C) Although markedly atypical, none of the foci of ductal hyperplasia appears to meet the criteria for cribriform ductal carcinoma in situ."

59. On November 17, 1994, the Respondent saw Patient C in follow-up (Ex 5, p. 59); the Respondent's note of that visit makes no mention of either the radiology or the pathology report pertinent to the surgery.

60. On December 22, 1994, the Respondent again saw Patient C, and again he made no written note of either the radiology or the pathology report; he told Patient C to return in one year (Ex 5, p. 61).

61. On April 24, 1995, Nurse Practitioner Barbara Smith and Dr. Gary R. Gecelter saw Patient C for breast evaluation. At that visit a bilateral mammogram was ordered (Ex 5, p. 72).

62. On April 27, 1995, a bilateral mammogram was performed at University Hospital. The relevant report indicates that the previously described cluster of microcalcifications was still present (Ex 5, p. 75). There is no note in the progress records referring to that x-ray finding.

63. On April 12, 1996, another bilateral mammogram was done at University Hospital (Ex P, p. 1; T 1520). This report again notes a cluster of microcalcifications in the upper outer quadrant of Patient C's left breast.

64. On May 17, 1996, Dr. Gecelter performed a needle-localization excision biopsy of Patient C's left breast (Ex P, p. 2). The specimen mammogram report for that procedure indicates that the cluster of microcalcifications was not identified (Ex P, p. 5).

65. The pathology report for the May 17th biopsy indicates (Ex P, pp. 6-7):

"A) Breast, left, needle localization biopsy for microcalcifications--intraductal hyperplasia without atypia, foreign body giant cell reaction and scar. Microcalcifications are seen associated with intraductal hyperplasia with apocrine features.

"B) Breast, left, excisional biopsy of medial margin--two foci of mildly atypical intraductal hyperplasia and focal florid ductal hyperplasia. Rare microcalcifications are seen associated with non-proliferative epithelium."

66. Patient C had another bilateral mammogram at University Hospital on or about November 22, 1996 (Ex P, pp. 8-9). The report for that procedure indicates that a small cluster of microcalcifications is identified in the same location as in the study dated April 12, 1996 (Ex P, pp. 6-7).

CONCLUSIONS AS TO PATIENT C

ALLEGATION C: From on or about March 18, 1994 through on or about April 27, 1995, Respondent treated Patient C at University Hospital. On or about March 25, 1994, at Respondent's direction, Patient C had magnification views of the left breast, which revealed a small cluster of microcalcifications which appeared round and indeterminate at that time. Another mammogram was

performed on October 26, 1994 which revealed a "suspicious cluster of microcalcifications in the two o'clock position spanning an area of 5mm." On or about November 7, 1994, Respondent performed a needle-localization and excisional biopsy. The specimen was submitted for specimen mammography.

Sustained only as a matter of fact.

ALLEGATION C1: The suspicious calcifications visualized on the pre-operative needle-localization mammography were not present on the specimen mammogram. Respondent failed to remove the suspicious microcalcifications from Patient C's left breast.

Sustained only as a matter of fact.

ALLEGATION C2: On or about November 7, 1994, Respondent performed an additional excision. Respondent failed to send that specimen for specimen mammography to confirm that the suspicious microcalcifications were in the specimen.

Sustained only as a matter of fact because the second specimen was not checked by x-ray. The Respondent testified that the second specimen was given to an OR nurse "to process through the adequate procedure, which is to take them back to radiology....I found out later... they were in the pathology department" (T 1532).

ALLEGATION C3: Respondent failed to perform or arrange for the performance of a postoperative mammogram of Patient C's left breast as soon as the healing of the incision from the November 7th surgery permitted.

SUSTAINED by a vote of two to one.

The Hearing Committee concludes by a vote of two to one that the Respondent failed to perform or arrange for the performance of a postoperative mammogram of Patient C's left breast as soon as the healing of the incision from the November 7th surgery permitted.

Dr. Olson testified that the second specimen removed on November 7, 1994 should also have been x-rayed to check for the calcifications and that if some error resulted in the specimen's not being x-rayed, a mammogram should have been done two to three weeks after surgery, when healing permitted (T 242-243).

The Respondent testified that at the end of the November 7th procedure he knew that the second specimen had gone to pathology instead of radiology (T 1542). The Hearing Committee is concerned that the Respondent made no note of that fact either in his operative report or in a postoperative note.

The Respondent further testified that this area of calcification was of very low suspicion for cancer (T 1538). Even if that were so, the majority of the Hearing Committee concludes that that was no justification for avoiding an early follow-up mammogram.

The primary concern of the majority of the Hearing Committee in this case is not that the calcifications were missed but that appropriate simple steps that would have indicated that they had been missed were not taken--i.e., the second specimen x-ray and an early follow-up mammogram.

PATIENT D

Findings of Fact

67. From on or about July 22, 1994 through on or about December 29, 1994, the Respondent treated Patient D at University Hospital (Ex 9).

68. On August 10, 1994, the Respondent performed a parathyroid exploration on Patient D. The postoperative diagnosis was "right inferior parathyroid adenoma and left inferior intrathyroidal parathyroid adenoma" (Ex 9, p. 53).

69. The Respondent did not order a frozen section on the tissue removed during the August 10th procedure; he recognized the parathyroid adenoma grossly as such (Ex 9, pp. 53-55).

70. There are irreconcilable discrepancies in specimen identification among the operative report, the pathology report, and the brief operative note, all concerning the August 10th surgery (Ex 9, pp. 40, 53-57; T 342-344, 346, 379, 393-394).

71. The Respondent testified that there is a discrepancy between the operative report and his testimony regarding the nodule on the left lobe of Patient D's thyroid and that that discrepancy is due to an error in dictation by the surgical resident who transcribed everything that went on during "an academic discussion" that took place in the operating room (T 1747, 1756).

72. On August 18, 1994, the Respondent sent a letter to Dr. Marie Gelato, the referring physician, stating, *inter alia*, that "some ectopic thyroid tissue" was removed during his August 10th surgery on Patient D (Ex G). In addition, the August 19th postoperative follow-up visit note refers to "resection of ectopic thyroid" (Ex 9, p. 99).

73. The Respondent testified that the left thyroid nodule was "most definitely a thyroidal pathology, not a parathyroid pathology" (T 1768).

CONCLUSIONS AS TO PATIENT D

ALLEGATION D: From on or about July 22, 1994 through on or about December 29, 1994, Respondent treated Patient D at University Hospital. On or about August 10, 1994, Respondent performed a parathyroid exploration, an excision of a right inferior parathyroid adenoma, and excision of a left lower lobe thyroid nodule which he thought to be intrathyroid parathyroid adenoma on Patient D.

Sustained as a matter of fact, except that the Respondent testified that he thought that the left thyroid nodule was "most definitely a thyroidal pathology, not a parathyroid pathology" (T 1768).

ALLEGATION D1: Respondent failed to confirm with a frozen section that the tissue removed during the August 10th procedure contained the two parathyroid adenomas he considered to be present on gross examination.

Sustained. **Note:** The Hearing Committee concludes that although this finding denotes poor judgment, it does not rise to the level of incompetence or negligence.

The Respondent testified that the abnormality on the left side of the thyroid was thyroidal pathology. He had earlier reported to the Department of Health that he had palpated and excised a left inferior adenoma mass, part of which appeared grossly like intrathyroidal parathyroid tissue (T 1972-1973).

The pathology report for the August 10th surgery describes a specimen D as labeled "left lower lobe intrathyroidal mass, r/o [rule out] parathyroid adenoma" (Ex 9, p. 57). Dr. Paul Lo Gerfo, after reviewing the cited portion of the pathology report, testified that "it sounds like he was questioning whether that nodule in the thyroid was parathyroid adenoma" (T 1975). Dr. Olson testified that the nodules should have been tested by frozen section to prove whether they were in fact the suspected adenomas (T 333). The Hearing Committee found Dr. Olson to be more persuasive on this point.

ALLEGATION D2: During the course of the August 10th surgery, Respondent failed to biopsy at least one normal parathyroid gland to rule out parathyroid hyperplasia.

Sustained only as a matter of fact.

While considering Dr. Olson's testimony (T 328, 333) regarding the need to biopsy normal-appearing parathyroid(s), particularly to help in detecting asymmetrical four-gland hyperplasia, the Hearing Committee finds more persuasive the testimony of Dr. Lo Gerfo that normal-appearing parathyroids are usually not biopsied (T 1963-1964). Therefore, the Hearing Committee does not sustain the substance of this charge.

ALLEGATION D3: The operative report for the August 10, 1994 surgery failed to completely describe the operation.

SUSTAINED

The Respondent's August 19th letter to Dr. Gelato, the referring physician, states that he had removed "some ectopic thyroid tissue" on August 10th. The August 19th postoperative follow-up visit note refers to "resection of ectopic thyroid." There is no reference at all in the operative report to ectopic thyroid tissue. Moreover, in light of the pathology report, the Hearing Committee notes that there was no documented attempt by the Respondent to annotate his operative report or otherwise to reconcile this discrepancy. See findings of fact 70-72.

PATIENT E

Findings of Fact

74. From on or about January 7, 1994 through on or about May 15, 1995, the Respondent treated Patient E at University Hospital (Ex 6).

75. Patient E was an employee of the University Hospital radiology department (T 772).

76. On January 7, 1994, the Respondent examined Patient E and found a palpable lesion in the left breast and no clinical involvement of the lymph nodes (T 269; Ex 6, p. 2).

77. On January 7, 1994, the Respondent performed a fine-needle aspiration that was reported as positive for adenocarcinoma (Ex 6, p. 8).

78. The Respondent and/or Barbara Smith, N.P., scheduled Patient E for a lumpectomy under local anesthesia and sedation to be performed on January 12, 1994 (Ex 6, p. 18).

79. The January 11, 1994 ambulatory surgery order sheet states that no preoperative lab work or x-rays were required. In fact, there are no orders for such tests in Patient E's record (Ex 6, pp. 18, 23, 51). The January 12, 1994 ambulatory surgery unit nurse note pre-op checklist shows that no lab work or chest x-ray was done (Ex 6, p. 51).

80. On January 12, 1994, the Respondent performed a left lumpectomy and axillary dissection on Patient E under general endotracheal anesthesia (Ex 6, p. 31).

81. University Hospital Archival Result Data (a computer printout) show no preoperative lab or x-ray tests for Patient E, but they do show postoperative blood work on January 13, 1994 (Ex 15).

82. Dr. Glenn Messina, the attending anesthesiologist at the January 12th surgery, stated in his January 3, 1997 affidavit that his January 12, 1994 entry in Patient E's record indicates that he reviewed preoperative lab studies for Patient E (Ex R; Ex 6, p. 20).

83. Blood tests on Patient E were ordered at 1:30 PM on January 12, 1994, following her surgery (Ex 6, p. 43).

84. The Respondent testified that he had seen preoperative lab results for Patient E and that they were normal (T 1309).

85. The Respondent also testified that he was told on the morning of the January 12th surgery that there were no preoperative lab results in the patient's file; he then ordered and received stat labs (T 1315). Neither an order for nor the results of such stat labs appears in the patient record (Ex 6).

86. Patient E testified that the Respondent directed her to have preadmission blood work and that she had her blood drawn on January 10, 1994 (T 781-783, 810).

87. Raquel Ruiz, a co-worker of Patient E, testified that on January 10, 1994 she accompanied Patient E to the University Hospital radiology department and that, afterward, she saw Patient E giving blood (T 822-826).

88. Patient E produced two x-rays of her chest which, she testified, had been taken on January 7, 1994 (Exs N, N-1; T 794, 802). The x-rays were identified with handwritten stick-on labels (T 806). There is no report of those x-rays anywhere in evidence (Ex 6).

CONCLUSIONS AS TO PATIENT E

ALLEGATION E: From on or about January 7, 1994 through on or about May 15, 1995, Respondent treated Patient E at University Hospital.

Sustained only as a matter of fact.

ALLEGATION E1: On or about January 12, 1994, Respondent performed major surgery, a lumpectomy and axillary dissection under general anesthesia, without the necessary preoperative laboratory and radiologic work-up.

SUSTAINED

The Hearing Committee considered the testimony of Patient E and her friend Raquel Ruiz as well as the affidavit of Dr. Messina. The Committee finds them unpersuasive in view of both the absence of pertinent lab and x-ray reports in the record and the presence of notations in the record that no such preoperative labs or x-rays were needed or done.

The Hearing Committee also considered the Respondent's testimony concerning this allegation and finds it unconvincing, because if he had seen results of preoperative tests, his ordering stat labs on the day of surgery would have been redundant. He could simply have written a note that he had seen the existing lab results and that they were normal. No such note appears in the record.

Patient E produced a chest x-ray, which was purported to have been taken preoperatively. However, because of its handwritten stick-on label and the lack of any corresponding order or report, the Hearing Committee did not find it credible evidence.

PATIENT F

Findings of Fact

89. From on or about January 12, 1995 through on or about February 14, 1995, the Respondent treated Patient F at University Hospital (Ex 10).

90. Patient F had several coexisting medical conditions that were investigated and treated during the twelve days prior to surgery on January 18, 1995 (Ex 10, pp. 35-36).

91. On January 18, 1995, the Respondent performed a parathyroid exploration and excision of tissue for the correction of hyperparathyroidism. He identified two glands on the superior and posterior aspect of both lobes of the thyroid gland, which he felt to be the right superior and left superior parathyroid glands. They appeared grossly normal. The Respondent did a thorough neck and upper anterior mediastinal exploration; he removed several pieces of tissue and submitted them for pathology (T 1884-1885; Ex 10, pp. 227-229).

92. The Respondent's operative report makes no reference to frozen sections' having been done, and the Respondent testified that he didn't request any (Ex 10, pp. 227-228; T 1649-1650).

93. The Respondent could not identify the inferior parathyroid gland. He took biopsies from multiple sites and sent them as specimen. (Ex 10, p. 227).

94. The operative report indicates that the Respondent identified and preserved the recurrent laryngeal nerves (Ex 10, p. 228).

95. The pathology report for the January 18th surgery notes receipt of multiple small pieces of tissue, including seven pieces of possible parathyroid tissue, of which five are reported as discrete parathyroid glands and two are reported as benign lymph nodes (Ex 10, p. 230).

96. The specimen received by the pathologist was labeled "evaluate for parathyroid tissue" (Ex 10, p. 230).

97. Postoperatively, Patient F developed hypocalcemia, secondary to hypoparathyroidism (T 1670-1671, 1679-1680).

98. The anesthesia record indicates that at the end of the January 18th surgery a direct laryngoscopy showed equal abduction and adduction of the vocal cords (Ex 10, p. 226).

99. Postoperatively, Patient F had respiratory distress, which required a tracheostomy on January 19th. The anesthesia record for that surgery indicates a diagnosis of vocal cord paralysis (Ex 10, pp. 77-87, 239).

100. By September 14, 1995, Patient F's vocal cords were bilaterally mobile (Ex F).

CONCLUSIONS AS TO PATIENT F

ALLEGATION F: From on or about January 12, 1995 through on or about February 14, 1995, Respondent treated Patient F at University Hospital.

Sustained only as a matter of fact.

ALLEGATION F1: On or about January 18, 1995, Respondent performed a parathyroid exploration. Respondent failed to request a frozen section examination to determine the nature of the tissue removed during the course of that exploration.

Sustained only as a matter of fact.

The Hearing Committee finds as a matter of fact that the Respondent did not order frozen sections of the tissue that he removed during surgery. The Committee also finds no evidence of consensus on the appropriate standard of surgical practice with respect to the use of frozen sections [T 1886-1888, 1908-1909 (Dr. Fischer), 439 (Dr. Olson), 1649-1650 (the Respondent)].

The Hearing Committee finds credible the Respondent's testimony that he believed that he had left Patient F with two normal parathyroid glands. Accordingly, even if he had ordered frozen sections that indicated that all the tissue that he had excised was parathyroid, he still would have believed that he left behind enough functioning parathyroids. The Hearing Committee also finds credible and reasonable, given the Respondent's testimony (T 1654-1655) about the amount of time that it routinely then took at University Hospital to receive results of frozen section examinations, that because of Patient F's age and relatively poor condition (Ex 10), the benefit, if any, of ordering frozen sections was outweighed by the risk of keeping the patient under anesthesia any longer than necessary for the surgery itself.

ALLEGATION F2: During the course of the January 18th procedure, Respondent explored and tentatively identified two normal upper parathyroid glands located on the posterior superior aspect of each lobe of the thyroid, but was unable to identify additional parathyroid tissue in the region of the inferior parathyroid glands. Respondent then took biopsies from multiple sites and submitted seven pieces of tissue to pathology for "evaluation for parathyroid tissue," but failed to label the specimens individually and obtain frozen sections to determine whether any of the tissue was parathyroid gland.

Sustained only as a matter of fact, except as to the number of pieces of tissue submitted to pathology. The Hearing Committee concludes that although the Respondent was careless with respect to accepted standards of protocol and procedure, this finding does not rise to the level of negligence or incompetence. With respect to the charge that the Respondent failed to label the specimens individually, the Hearing Committee finds as a matter of fact that that is true; the Respondent did not himself label the specimens. There is also no evidence--even in the Respondent's own testimony--that he gave any labeling instructions to the staff during the January 18th surgery. The Respondent talks only in generalities about such responsibilities (T 1658).

ALLEGATION F3: Respondent inappropriately removed five discrete parathyroid glands, thereby leaving the patient hypoparathyroid.

NOT SUSTAINED

The Hearing Committee finds that, as noted in the pathology report, the Respondent removed five discrete parathyroid glands. The Committee also finds that after surgery Patient F became hypoparathyroid (T 1688). However, the Hearing Committee concludes that because the Respondent believed that he left the patient with two normal parathyroid glands, his excision of other parathyroid tissue cannot be considered inappropriate.

ALLEGATION F4: Respondent performed the January 18th operation in an inappropriate fashion, injuring the recurrent laryngeal or the vagus nerves bilaterally, causing temporary bilateral vocal cord paralysis.

NOT SUSTAINED

The Respondent's operative report states that he identified and preserved the recurrent laryngeal nerves, and Dr. Olson, the Petitioner's own expert, testified that the January 18th surgery was not performed inappropriately (T 453). Accordingly, the Hearing Committee concludes that the Respondent did not perform the January 18th surgery inappropriately.

PATIENT G

Findings of Fact

101. Respondent first saw Patient G on November 11, 1994 as a referral from Dr. Stuart Seiden (Ex H, p. 2; T 1563-1564).

102. The first note in Patient G's record regarding surgical evaluation at University Hospital is dated November 17, 1994 and is signed only by B. Smith, N.P. (Ex 11, p. 27).

103. A CT scan of Patient G's abdomen done by Long Island Diagnostic Imaging on November 5, 1994 showed a right adrenal mass and a left renal hypodense focus (Ex H, p. 1).

104. On November 14, 1994, the results of a renal sonogram done at University Hospital showed "1. unremarkable bilateral renal sonogram. No cystic mass identified in either kidney. 2. Detection of a 6.2 x 2.7 x 5.4 hypoechoic mass in the region of the right suprarenal gland. Clinical correlation for this finding is recommended" and "The mass causes mild indentation and anterior displacement of the adjacent inferior vena cava" (Ex H, p. 3).

105. There are no preoperative notes by the Respondent in the patient's record; B. Smith's evaluation note on November 17, 1994 was not even countersigned by the Respondent (Ex 11).

106. The following tests on Patient G were ordered and reported on before surgery:

a. CBC, platelets, PT and PTT, serum chemistries, amylase, and lipase (Ex 11, pp. 6, 7, 8, 9, 10, 11-14);

b. a renal sonogram (Ex 11, p. 8; Ex H, p. 3);

c. a Venous Duplex test for deep venous thrombosis of the lower extremities (Ex 11, p. 15);

d. a chest x-ray (Ex 11, p. 18);

e. a skin bleeding time (Ex 11, p. 6); and

f. an electrocardiogram (Ex 11, p. 106).

107. A urinalysis, reported October 24, 1994, showed trace blood (Ex H, p. 5).

108. The following tests were ordered preoperatively, but the relevant official report was dated November 28, 1994: creatinine and 17-ketosteroids (Ex 11, p. 2).

109. On November 21, 1994, the Respondent performed an exploration for a right adrenal mass, using a right flank incision to enter the retroperitoneal space. Findings included a 6 x 7 x 6 cm mass involving the right adrenal gland. There was direct extension of the tumor into the inferior vena cava. During dissection, massive hemorrhage occurred, and the Respondent obtained a vascular consult. After the bleeding was controlled it was decided to abort the procedure, with a plan to go back in two days for adrenalectomy (Ex 11, pp. 110-112).

110. The Respondent testified that at 9:30 A.M. during the operation, "I lost blood pressure in that gentleman" (T 1613).

111. The Respondent said, "I had to seek immediate help with six units of blood" (T 1613).

112. Additional testing was done in the postoperative period, including an inferior venacavagram and the FNA biopsy of both the right adrenal mass and the left renal lesion (Ex 11, pp. 92-94, 97, 99, 119, 121).

CONCLUSIONS AS TO PATIENT G

ALLEGATION G: From in or about November 1994 through in or about March 1995, Respondent treated Patient G at University Hospital.

Sustained only as a matter of fact.

ALLEGATION G1: Respondent failed to perform sufficient preoperative studies and evaluations prior to attempting an adrenalectomy on or about November 21, 1994.

NOT SUSTAINED; see findings of fact 103-108.

The preoperative studies reported in the patient's record were sufficient to permit the Respondent to attempt an adrenalectomy. The Hearing Committee accepts Dr. Fischer's testimony (T 1852) that he would not have done additional tests.

ALLEGATION G2: On or about November 21, 1994, Respondent inappropriately attempted his surgical procedure through a right retroperitoneal flank approach which prevented him from evaluating a lesion in Patient G's left kidney.

NOT SUSTAINED.

The Respondent testified that he was aware of the left kidney lesion and said that he planned to attend to it at a later date. He felt that the primary concern of the surgery was to address the increasing pain caused by the right flank mass (T 1624-1625). The Hearing Committee also notes Dr. Fischer's testimony (T 1853-1854, 1868-1869) that both Respondent's choice of incision and the decision to defer attention to the left kidney were an appropriate exercise of surgical judgment.

ALLEGATION G3: During the November 21, 1994 surgery, Respondent failed to biopsy the right adrenal mass to determine the tumor type.

Sustained only as a matter of fact.

The Respondent did fail to biopsy the right adrenal mass; accordingly, the Hearing Committee sustains this charge as a matter of fact.

Given the massive hemorrhage that the Respondent described, the Hearing Committee believes that his decision not to perform any further procedures--including a biopsy--was understandable.

Nonetheless, the Hearing Committee notes that both the anesthesia record and the operative report suggest that the circumstances were not as dire as those that the Respondent described. The anesthesia report notes no loss of blood pressure, and the operative report notes transfusion of only two units of blood.

The Hearing Committee also notes that although the Respondent testified about the importance of ruling out pheochromocytoma (T 1599, 1602-1603), there are no orders or results or tests for catecholamine metabolites; the only adrenal gland hormone tests were those for *adrenocortical* dysfunction (see finding of fact 108).

PATIENT H

Findings of Fact

113. From in or about November 1992 through in or about December 1993, the Respondent treated Patient H at University Hospital (Ex 13).

114. On November 27, 1992, the Respondent performed a left modified radical mastectomy on Patient H (Ex 13, pp. 67-69).

115. A February 12, 1993 progress note co-signed by the Respondent indicates that Patient H began to receive Tamoxifen at 10 mg a day (Ex 13, p. 25).

116. The recommended effective dose of Tamoxifen is 20 mg a day (T 639).

117. The Respondent testified that he planned to start Patient H with 10 mg a day of Tamoxifen and then to increase the dose to 20 mg (T 854-855, 927-928).

118. The May 14, 1993 progress note indicates that Patient H's Tamoxifen was increased to 20 mg a day (Ex 13, p. 15).

119. The August 13, 1993 progress note indicates that the Tamoxifen was dropped back to 10 mg a day (Ex 13, p. 13).

120. Dr. Bennett stated that 20 mg of Tamoxifen can control the growth of cancer cells; he also testified that there is no conclusive evidence in the literature as to whether 10 mg is a sufficient dose (T 642).

CONCLUSIONS AS TO PATIENT H

ALLEGATION H: From in or about November 21, 1992 through in or about December 1993, Respondent treated Patient H at the University Hospital, Stony Brook, N.Y.
Sustained only as a matter of fact.

ALLEGATION H1: On or about November 21, 1992, Respondent performed a left modified radical mastectomy on Patient H. On or about February 12, 1993, Respondent prescribed Tamoxifen 10 mg/day, which was an insufficient dosage to control micrometastases and prevent recurrence of the cancer.

NOT SUSTAINED

The Respondent was aware that 20 mg per day was the recommended effective dose of Tamoxifen (T 841-842). He began Patient H's dose at 10 mg, intending to increase it to 20 mg, and in fact it was increased to 20 mg at her next clinic visit. The Hearing Committee notes Dr. Gump's testimony that the initial prescription of 10 mg was acceptable and not a departure from accepted standards of medical practice.

Although the weight of the evidence led the Hearing Committee not to sustain this charge, we find it problematic that the Respondent waited for three months before determining whether the initial 10 mg dose was causing side effects.

PATIENT I

Findings of Fact

121. From on or about April 14, 1994 through in or about December 1994, the Respondent treated Patient I at University Hospital (Ex 14).

122. On April 14, 1994, Dr. Eva Chalas excised a 1 cm mass from Patient I's right breast (Ex 14, p. 231).

123. The pathology report for the April 14th surgery shows an infiltrating right breast duct carcinoma measuring 1.4 x 0.7 x 1.5 cm and tumor present at surgical margins (Ex 14, p. 233).

124. On May 12, 1994, the Respondent performed a re-excision of previous excisional biopsy margins and axillary dissection with no residual cancer (Ex 14, pp. 393-395, 397).

125. The Respondent referred Patient I to Dr. Allen G. Mead for radiation therapy to begin in early June 1994. Patient I was placed on Tamoxifen 10 mg per day on May 20, 1994 and told to return to the clinic in three months (Ex 14, pp. 17-19, 24, 26).

CONCLUSIONS AS TO PATIENT I

ALLEGATION I: From on or about April 14, 1994 through in or about December 1994, Respondent treated Patient I at University Hospital.

Sustained only as a matter of fact.

ALLEGATION I1: On or about May 12, 1994, Respondent performed an excisional biopsy and axillary dissection with no residual cancer. The patient was referred for radiation therapy to be started in June and was placed on Tamoxifen 10 mg/day, an insufficient dosage to control micrometastases and prevent recurrence of the cancer.

Sustained only as to the facts that on May 12, 1994, the Respondent performed a *re-excision* of previous excisional surgery on Patient I which showed no residual cancer, that he referred Patient I for radiation therapy to be started in June, and that he placed her on 10 mg per day of Tamoxifen.

Not sustained as to the allegation that the Respondent's prescribed amount of 10 mg per day of Tamoxifen was insufficient to control micrometastases and prevent recurrence of the cancer.

As noted with respect to Patient H, the Respondent was aware that 20 mg of Tamoxifen was the recommended effective dose, but he began with 10 mg to minimize side effects. Again, the Hearing Committee notes Dr. Gump's testimony that the initial prescription of 10 mg per day was acceptable. Once more, although the weight of the evidence led the Hearing Committee not to sustain this charge, we find it problematic that the Respondent waited for three months to have Patient I return to the clinic so that he could determine whether the initial 10 mg dose was causing side effects.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously as follows:

First through Eighth Specifications:

(Gross Negligence)

NOT SUSTAINED

Ninth Specification:

(Negligence on more than one occasion)

SUSTAINED, as to paragraphs A1, A2, A5; C3; D3; and E1

Tenth through Seventeenth Specifications:

(Gross Incompetence)

NOT SUSTAINED

Eighteenth Specification:

(Incompetence on more than one occasion)

SUSTAINED, as to paragraphs B and B1

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee recognizes its obligation to convey the importance of what it alone could observe in the course of thirteen hearing days and understands that no transcript can fulfill that responsibility.

The Committee discussed seriously whether the charges sustained, taken together, constitute either gross negligence or gross incompetence and finds that they do not. We believe, however, that they portray an experienced physician whose practice reflects, from at least eight occasions in two and a half years, both his failure to meet some of the fundamental accepted standards of protocol and practice of his profession and his pattern of carelessness.

In addition, the Hearing Committee notes that the Respondent's stated concern for his patients is not necessarily reflected in his care for them. For example, despite his testimony about his heroic work with Patient A (T 1420-1421), the Respondent failed both to confirm that he had completely excised the cancer in her left breast during the August 11, 1994 surgery and to ascertain that the carcinoma later reported by the pathologist was without free margins. It is not even clear from the record that he discussed Patient A's treatment options with her or made any recommendation prior to surgery.

The Hearing Committee also observed that instead of assuming final responsibility for the care and treatment of his patients, the Respondent is not above blaming others when something goes wrong (see, e.g., findings of fact 42 and 71). In addition, the Respondent apparently delegates responsibility to others and then does not necessarily supervise them adequately, as is evident from some of the operative notes dictated by residents (see finding of fact 71) and progress notes written by Barbara Smith (see, e.g., findings of fact 102 and 105).

Although the Committee has sustained only eight substantive charges in this matter, we deem them serious enough to warrant a substantial penalty. In considering and weighing all the possible penalties, we determined that either revocation or suspension was excessive. On the other hand, neither censure and reprimand nor probation alone would either reflect the seriousness of the charges sustained or adequately protect the public. Accordingly, the Hearing Committee unanimously determines that the Respondent's license to practice medicine in New York shall be suspended for a period of one year, that such period of suspension shall be stayed, and that during such stay, the Respondent shall be placed on probation, subject to the terms and conditions ordered below.

This penalty represents the Determination of the Hearing Committee, as does its unanimous vote, except as to charge C3 as noted above, on the charges and specifications.

ORDER

Based upon the foregoing, it is hereby **ORDERED THAT:**

1. The Respondent's license to practice medicine in New York is hereby **SUSPENDED** for a period of one year;

2. The one-year suspension of Respondent's medical license is hereby **STAYED;**

3. During the stay of suspension, the Respondent is hereby placed on **PROBATION**, subject to the following terms and conditions:

a. 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;

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

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

d. The period of probation shall be tolled for periods during 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 he 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. The Respondent shall then notify the Director again before any change in that status. The period of probation shall resume, and any terms of probation that were not fulfilled shall be fulfilled upon the Respondent's return to practice in New York State;

e. 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, and interviews with or periodic visits with the Respondent and his staff at practice locations or OPMC offices;

f. The Respondent's practice shall be monitored by a licensed physician, who is board certified in surgery and has been practicing for at least ten years ("practice monitor"), proposed by the Respondent and subject to the written approval of the Director of OPMC.

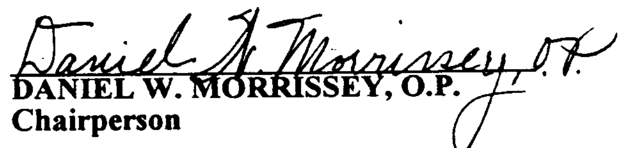
i. The Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit the Respondent's medical practice at each and every location, at random and unannounced, at least monthly and shall examine no fewer than two of the records maintained by the Respondent, including patient records, prescribing information, and office records, if the Respondent's practice is such that there are at least two such records. The review will determine whether the Respondent's medical practice is conducted in accordance with generally accepted standards of professional medical care. The monitor shall report to OPMC within 24 hours any perceived deviation from accepted standards of medical care or refusal to cooperate with the monitor. In addition, the monitor shall submit to OPMC quarterly reports on his or her review of the Respondent's practice;

g. The Respondent shall maintain legible and complete medical records that accurately reflect his evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances. In addition, the Respondent shall dictate and sign all of his own operative reports;

h. In addition to any house staff notes, the Respondent shall write his own preoperative note for each surgery that he performs and write all of his own notes whenever he sees a patient postoperatively;

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

DATED: New York, New York
July 16 , 1997



DANIEL W. MORRISSEY, O.P.
Chairperson

DANIEL A. SHERBER, M.D.
JOSEPH B. CLEARY, M.D.

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

IN THE MATTER OF NAJI ABUMRAD, M.D.	STATEMENT OF CHARGES

NAJI ABUMRAD, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 12, 1976, by the issuance of license number 120178 by the New York State Education Department.

FACTUAL ALLEGATIONS

PATIENT A

A. From on or about July 15, 1994 through on or about May 15, 1995, Respondent treated Patient A (The identity of Patient A and the other patients is contained in the attached appendix) at the University Hospital at Stony Brook, Stony Brook, N.Y. , (University Hospital). Patient A was diagnosed with a very aggressive carcinoma of the left breast during her second trimester of pregnancy.

1. On or about August 11, 1994, Respondent performed a quadrantectomy and an axillary dissection followed by chemotherapy. Respondent failed to confirm that he had completely excised the cancer from Patient A's left breast.

2. Respondent failed to ascertain that the carcinoma reported by the

pathologist on August 16, 1994, was multifocal and without free margins.

3. Respondent failed to perform a mastectomy within a short period of time after the quadrantectomy.

4. Respondent failed to perform preoperative mammography prior to the August 11th surgery.

5. Respondent failed to offer and/ or document in his records that he discussed the various surgical options, including mastectomy with the patient prior to the August 11th surgery.

PATIENT B

B. From on or about March 17, 1994 through on or about March 29, 1995, Respondent treated Patient B, at University Hospital. On or about March 18 1994, Patient B presented with a palpable mass, discoloration of the left breast and a mammogram with a differential diagnosis of infection, hemorrhage from trauma and inflammatory carcinoma. Until July 25, 1994, Respondent incorrectly diagnosed and treated this condition as if it were mastitis.

1. On or about April 1, 1994, a fine-needle aspiration biopsy was performed which revealed a few large and slightly atypical cells. Respondent failed to follow up with an open biopsy.

2. Respondent inappropriately continued to treat the condition as though it were mastitis, despite the fact that there was no clinical improvement and the pathology findings were suspicious of inflammatory carcinoma. Respondent failed to order or perform an open biopsy until July 25, 1994. Respondent failed to diagnosis and treat Patient B's inflammatory breast cancer in a timely manner.

PATIENT C

C. From on or about March 18, 1994 through on or about April 27, 1995, Respondent treated Patient C, at University Hospital. On or about March 25, 1994, at Respondent's direction, Patient C had magnification views of the left breast which revealed a small cluster of microcalcifications which appeared round and indeterminate at that time. Another mammogram was performed on October 26, 1994 which revealed a "suspicious cluster of microcalcifications in the two o'clock position spanning an area of 5mm." On or about November 7, 1994, Respondent performed a needle-localization and excisional biopsy. The specimen was submitted for specimen mammography.

1. The suspicious calcifications visualized on the pre-operative needle localization mammography were not present on the specimen mammogram. Respondent failed to remove the suspicious microcalcifications from Patient C's left breast.

2. On or about November 7, 1994, Respondent performed an additional excision. Respondent failed to send that specimen for specimen mammography to confirm that the suspicious microcalcifications were in the specimen.

3. Respondent failed to perform or arrange for the performance of a postoperative mammogram of Patient C's left breast as soon as the healing of the incision from the November 7th surgery permitted.

PATIENT D

D. From on or about July 22, 1994 through on or about December 29, 1994, Respondent treated Patient D, at University Hospital. On or about August 10, 1994, Respondent performed a parathyroid exploration, an excision of a right inferior parathyroid adenoma and excision of a left lower lobe thyroid nodule which he thought to be intrathyroid parathyroid adenoma on Patient D.

1. Respondent failed to confirm with a frozen section that the tissue removed during the August 10th procedure contained the two parathyroid adenomas he considered to be present on gross examination.

2. During the course of the August 10th surgery, Respondent failed to biopsy at least one normal parathyroid gland to rule out parathyroid hyperplasia.

3. The operative report for the August 10, 1994 surgery failed to completely describe the operation.

PATIENT E

E. From on or about January 7, 1994 through on or about May 15, 1995, Respondent treated Patient E, at University Hospital.

1. On or about January 12, 1994, Respondent performed major surgery, a lumpectomy and axillary dissection under general anesthesia without the necessary preoperative laboratory and radiologic work-up.

PATIENT F

F. From on or about January 12, 1995 through on or about February 14, 1995, Respondent treated Patient F, at University Hospital.

1. On or about January 18, 1995, Respondent performed an parathyroid exploration. Respondent failed to request a frozen section examination to determine the nature of the tissue removed during the course of that exploration.

2. During the course of the January 18th procedure, Respondent explored and tentatively identified two normal upper parathyroid glands located on the posterior superior aspect of each lobe of the thyroid, but was unable to identify additional parathyroid

tissue in the region of the inferior parathyroid glands. Respondent then took biopsies from the multiple sites and submitted seven pieces of tissue to pathology for "evaluation for parathyroid tissue", but failed to label the specimens individually and obtain frozen sections to determine whether any of the tissue was parathyroid gland.

3. Respondent inappropriately removed five discrete parathyroid glands, thereby leaving the patient hypoparathyroid.

4. Respondent performed the January 18th operation in an inappropriate fashion, injuring the recurrent laryngeal or the vagus nerves bilaterally, causing temporary bilateral vocal cord paralysis.

PATIENT G

G. From in or about November 1994 through in or about March 1995, Respondent treated Patient G, at University Hospital.

1. Respondent failed to perform sufficient preoperative studies and evaluations prior to attempting an adrenalectomy on or about November 21, 1994.

2. On or about November 21, 1994, Respondent inappropriately attempted his surgical procedure through a right retroperitoneal flank approach which prevented him from evaluating a lesion in

Patient G's left kidney.

3. During the November 21, 1994 surgery, Respondent failed to biopsy the right adrenal mass to determine the tumor type.

PATIENT H

H. From in or about November 1992 through in or about December 1993, Respondent treated Patient H, at the University Hospital, Stony Brook, N.Y.

1. On or about November 21, 1992, Respondent performed a left modified radical mastectomy on Patient H. On or about February 12, 1993, Respondent prescribed Tamoxifen 10 mg./day which was an insufficient dosage to control micrometastases and prevent recurrence of the cancer.

PATIENT I

I. From on or about April 14, 1994 through in or about December 1994, Respondent treated Patient I, at University Hospital.

1. On or about May 12, 1994 Respondent performed an excisional biopsy and axillary dissection with no residual cancer. The patient was referred for radiation therapy to be started in June and was placed on Tamoxifen 10 mg/day, an insufficient dosage to control micrometastases and prevent recurrence of the

cancer.

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~~J. In or about June 1991, Respondent knowingly and intentionally falsely indicated on a resume he submitted to the search committee for chairman of the department of surgery at University Hospital that he was Board Certified in Surgery when his board certification had expired on or about June 30, 1988.~~

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraph A, A1-A5.
2. Paragraph B, B1- B2.
3. Paragraph C, C1-C3.
4. Paragraph D, D1- D3.
5. Paragraph F, F1 - F4.
6. Paragraph G, G1-G3.
7. Paragraph H, H1.
8. Paragraph I, I1

NINTH 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. 1996) 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:

9. Paragraphs A, A1-A5, B,B1-B2, C, C1-C3, D, D1-3, E, E1, F,F1-F4, G, G1-G3, H, H1, and/or I, I1 .

TENTH THROUGH SEVENTEETH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

10. Paragraph A, A1- A5.
11. Paragraph B, B1- B2.
12. Paragraph C, C1-C3.
13. Paragraph D, D1- D3.
14. Paragraph F, F1 - F4.
15. Paragraph G, G1-G3.
16. Paragraph H, H1.
17. Paragraph I, I1.

EIGHTEENTH 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. 1996) 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:

18. Paragraphs A, A1-A4, B,B1., C, C1.-C3, D, D1-3, E, E1, F,F1-F4, G, G1-G3, H, H1, and/or I, I 1.

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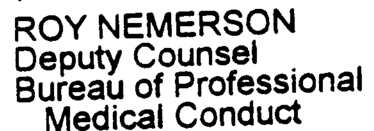
NINETEENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined b N.Y. Educ. Law §6530(2)(McKinney Supp. 1996) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

19. Paragraph J.

DATED: December 11, 1996
New York, New York



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Medical Conduct