STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

April 17, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Peter Adams, M.D.
265 Mountain Road
Engle Wood, New Jersey

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Lee S. Goldsmith, Esq.
Goldsmith & Richman, P.C.
747 Third Avenue
New York, New York 10017

RE: In the Matter of Peter Adams, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-113) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER	:	DETERMINATION
OF	:	AND
PETER ADAMS, M.D.	:	ORDER

Michael Golding, M.D., Chairperson, Naomi Goldstein, M.D. and **Eugenia Herbst,** 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 Sections 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. **Jane B. Levin, 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 THE PROCEEDINGS

Notice of Hearing and Statement of Charges dated:	July 2, 1999
Answer dated:	July 26, 1999
Hearing dates:	September 30, 1999

November 8, 1999
November 15, 1999
December 9, 1999
December 10, 1999
December 13, 1999

Deliberation dates: February 3, 2000
February 28, 2000

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, N.Y.

Petitioner appeared by: Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
By: Terrence Sheehan, Esq.
and Patricia Moro, Esq.

Respondent appeared by: Lee S. Goldsmith, Esq.
Goldsmith & Richman, P.C.

747 Third Avenue
New York, N.Y. 10017

WITNESSES

For the Petitioner:
1) Robert Madden, M.D.

For the Respondent:
1) Peter Adams, M.D.
2) Anthony J. Tortolani, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence, gross negligence, incompetence and gross incompetence, and that he failed to obtain adequate consent, and to maintain adequate medical

records. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers of exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Peter Adams, M.D., the Respondent, is a physician who was duly licensed to practice medicine in New York State by the issuance of license number 108609 by the New York State Education Department (Pet. Ex. 1).

2. Respondent is a board certified thoracic surgeon (Resp. Ex. H).

FINDINGS OF FACT AS TO PATIENT A

1. On September 8, 1994 and September 9, 1994, Respondent operated on Patient A, a 43 year old female with a history of lung cancer, at New York Hospital Center of Queens ("NYHCQ") (Pet. Ex. 2, p.13; T. 16; 108).

2. Patient A had initially been diagnosed with Stage IIIB

disease, and, prior to surgery, had been treated with chemotherapy and radiation (Pet. Ex. 2, p.69; T. 17).

3. The Petitioner's expert witness, Dr. Robert Madden, testified that the five year survival rate in patients with Stage III disease is not improved with surgery, and that surgery was not indicated in this patient (T. 59, 129, 130, 136).

4. Patient A responded to chemotherapy and radiation. The post-operative pathology report dated September 13, 1994 was negative for cancer (T. 69, 631).

5. Bronchoscopies were performed on Patient A on 4/21/94 and 7/20/94 by Dr. Jack Mann, the second of which was nine weeks prior to surgery (Pet. Ex. E).

6. Dr. Madden testified that in order to determine if a patient was a surgical candidate, bronchoscopy should be performed close to the date of surgery, and that even a test performed three weeks prior to surgery would be "stretching it" (T. 109).

7. Patient A underwent pulmonary function testing on July 14, 1994, seven weeks prior to surgery (Pet. Ex. E). Dr. Madden testified that such tests should be performed within three weeks of surgery (T. 132).

8. Although the hospital chart notes that bronchoscopy and pulmonary function tests were done preoperatively, neither the actual reports nor a summary of their contents are in the chart, but rather in auxiliary records of Dr. Mann (Pet. Ex. E).

9. The hospital chart does not contain progress notes written or countersigned by the Respondent (Pet. Ex. 2).

10. The Respondent's expert, Dr. Anthony Tortolani, stated that the attending surgeon is ultimately responsible for including accurate notes and reports in the chart (T. 686).

11. Patient A did not undergo brain and bone scans prior to surgery. Dr. Madden testified that the performance of these tests was a controversial issue in the absence of specific symptoms (T. 132-33).

12. A mediastinoscopy, which would have helped to determine whether or not to operate, was not performed prior to surgery (Pet. Ex. 2; T.668).

13. Dr. Madden testified that prior to making a decision to operate, the patient should have been restaged, by, at a minimum, the performance of a CT scan, to assess whether she was a surgical candidate (T. 113).

14. The Respondent testified that the surgery was part of NYHCQ's tumor board protocol (T. 660-661).

15. A letter from NYHCQ, elicited in response to subpoena, states that there was no lung cancer protocol in existence at the hospital in 1994 (ALJ Ex. 2).

16. On September 8, 1994, the Respondent attempted to perform a sleeve resection of Patient A's right upper lobe. According to the operative report and clinical abstract, during surgery the Respondent divided the arterial and venous supply to the upper lobe before completing the dissection of the bronchus and estimating its resectability. Respondent terminated the procedure without completing the resection (Ex. 2, p.13; T.52).

17. Shortly after the Respondent closed the chest, Patient A began to bleed heavily from the bronchus (Pet. Ex. 2, p.67-68).

18. Respondent testified that he did not compromise the patient's blood supply during surgery, and that the operative report was in error in that the operation did not occur as described therein (Pet. Ex. 2, p.53, 54; T. 607).

19. The Respondent signed both the operative report and the clinical abstract (Pet. Ex. 2, p.13, 52, 67, 68).

20. Dr. Tortolani testified that the operative report could not be accurate, because if in fact the Respondent had ligated the arterial blood supply to the upper lobe, it would have been avascularized, and the patient would not have experienced bleeding in the post-operative period (T. 693, 715).

21. Because of persistent bleeding from the patient's right upper lobe, on September 9, 1994, the Respondent performed a thoracotomy and right pneumonectomy (Pet. Ex. 2, p.67).

22. Dr. Tortolani testified that once the patient began to bleed after the first surgery, this surgery was indicated (T. 686).

23. Patient A died on September 11, 1994 (Pet. Ex. 2, p.4).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient A.

2. Respondent negligently failed to order preoperative tests in a timely fashion to be useful in surgical decision making.

3. Surgery was not indicated in this Stage III cancer

patient, and Respondent was negligent in deciding to operate, which unnecessarily increased her risks for complications and mortality.

4. Under the circumstances, Respondent appropriately decided to terminate the first procedure.

5. Due to the uncontrolled bleeding after the first surgery, the second operation, a pneumonectomy, was indicated.

6. The Respondent failed to meet minimally acceptable standards of medical practice in maintaining Patient A's hospital chart, since it lacked pertinent test results and progress notes, as well as an inaccurate operative report.

FINDINGS OF FACT AS TO PATIENT B

1. Patient B was a 68 year old female with esophageal cancer. On August 28, 1995, the Respondent performed a partial esophago-gastrectomy on this patient at NYHCQ (Pet. Ex. 3, p. 53, 54, 55.

2. Patient B's history included cirrhosis of the liver, history of esophageal varices, high blood pressure, abnormal coagulation factors, heart disease and status post silent myocardial infarction (Pet. Ex. 3, p. 27, 28, 43, 53).

3. Dr. Madden testified that Patient B presented too high a risk to tolerate this surgical procedure because of these various problems (T. 27).

4. Dr. Madden stated that esophageal varices are dilated high pressure veins, and that with liver disease coagulation problems would be expected. Therefore, the chances of major

bleeding during surgery were high (T. 28).

5. The Respondent knew of the patient's risk factors, and signed both the operative report, which delineated an extensively cirrhotic liver, as well as the clinical abstract, which indicated that the patent was a known cirrhotic (Pet. Ex. 3, p. 27, 52).

6. The patient was taking Aldactone, a drug given to cirrhotics who have ascites (T. 574-5).

7. Liver function studies were abnormal and were not repeated prior to surgery (Pet. Ex. 3, p.30).

8. The pre-anesthesia evaluation indicated that the patient had positive esophageal varices (Pet. Ex. 3, p.43).

9. Dr. Adams testified that the patient did not have varices at the time of surgery (T. 542), although it was "possible that she had varices in the past" since they may come and go (T. 543).

10. The Respondent's expert, Dr. Tortolani, testified that esophageal varices represent a heightened risk factor because of the chances of bleeding associated with them (T. 763).

11. Dr. Tortolani further testified that in a patient with liver disease, the liver does not metabolize the anesthetic agents well, and the patient may have to remain intubated. Coagulation problems, poor wound healing and infection are potential complications (T. 763, 765, 770, 771, 797).

12. Dr. Peter J. Heffer, a cardiologist, saw the patient prior to surgery, and his report, dated July 19, 1995, five weeks before the surgery, states that the patient had EKG changes, possible ASHD with suggestion of past myocardial infarction, mitral

valve prolapse, cirrhosis, and a past history of alcoholism. He suggested a pre-op stress test, EKG, and Holter monitoring. Dr. Heffer's report is not mentioned in the hospital chart, but is contained in supplemental records (Resp. Ex. C).

13. Although the hospital chart states there was a hematology consult, there is none in the record (Pet. Ex. 3, p.27). The progress notes did not accurately reflect the patient's condition and/or data which was available outside the chart (Pet. Ex. 3).

14. Dr. Madden testified that a hematology consult would have been helpful since a coagulopathy was a possibility in this patient with liver disease, and a hematologist might have suggested ways to prepare the patient (T. 32).

15. The cure rate for squamous cell carcinoma of the esophagus is very low. Dr. Madden testified that there are alternative modalities to the surgery performed, such as radiation, and esophageal dilation (T. 27, 28, 29, 31). There is no discussion in the chart that alternative modalities were considered (Pet. Ex. 3).

16. During the operation, the patient experienced heavy bleeding, estimated at 8500-9000 cc (Pet. Ex. 3, p. 32). Normal blood volume for a female is 4000 cc (T. 549).

17. During surgery, the patient's body temperature dropped, which can lead to coagulopathy and increased bleeding (T. 29, 30).

18. Dr. Tortolani testified that the patient hemorrhaged due to a coagulopathy (T. 797).

19. After surgery, the operative site was "packed" and sent

to the recovery room, where she expired approximately three hours later (Pet. Ex. 3, p. 32, 36).

20. Despite the extensive operation, the final pathology report states that the proximal margin of resection was positive for tumor (Pet. Ex. 3, p.57).

21. A signed standard hospital consent form is contained in the hospital chart (Pet. Ex. 3, p. 21, 22).

CONCLUSIONS AS TO PATIENT B

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient B.

2. Respondent negligently failed to order preoperative tests in a timely fashion to be useful in surgical decision making.

3. Surgery was not indicated in this high risk patient, and Respondent was negligent in deciding to operate.

4. Respondent negligently failed to obtain a preoperative consult with a hematologist for this patient with known risk factors for excessive bleeding.

5. The Respondent was negligent is his management of the patient's intraoperative and postoperative bleeding.

6. The Respondent failed to meet minimally acceptable standards of medical practice in maintaining Patient B's hospital chart, since it lacked pertinent test results, documentation of the cardiology consultation and progress notes.

7. The Respondent did obtain informed consent for this procedure.

FINDINGS OF FACT AS TO PATIENT C

1. On January 10, 1994, Respondent operated on Patient C, a 65 year old male diagnosed with lung cancer, at NYHCQ.

2. Prior to surgery, the patient had a consultation with a pulmonologist, but his report is contained in supplementary material and not documented in the hospital record (Pet. Ex. 4, Resp. Ex. D).

3. Preoperatively, the patient had a history of COPD, dyspnea, hypertension, stroke, and heart and kidney disease, although the documentation is sparse (Pet. Ex. 4, p. 11). 4 .

The Respondent performed a right pneumonectomy and mediastinal node dissection on January 10, 1994 (Pet. Ex. 4, p. 93, 94, 95).

5. After the first surgery, Patient C became hypotensive in the recovery room (Pet. Ex. 4, p.117, 118).

6. The Respondent testified that he re-operated on Patient C because he believed that despite a negative chest x-ray, there was a hemorrhage in the chest and the patient was hematologically unstable. The Respondent stated that he thought there was probably bleeding in the mediastinal area (T. 440-443).

7. The Respondent did not write any progress notes between the first and second operation (Pet. Ex. 4).

8. Respondent attempted to contact a family member to obtain consent for the second operation, since the patient was incapable of giving consent (T. 810). The chart notes that the second operation was an emergency (Pet. Ex. 4).

9. The patient expired on January 22, 1994.

CONCLUSIONS AS TO PATIENT C

1. The Respondent met minimally acceptable standards of medical practice in his care of Patient C.

2. Patient C had a preoperative consultation with a pulmonologist, and the Respondent should have included documentation of the pulmonolgist's report in the hospital chart and a progress note between the first and second surgeries. The chart was otherwise minimally acceptable.

FINDINGS OF FACT AS TO PATIENT D

1. On or about September 12, 1997 Respondent was called as a consultant surgeon to perform a percutaneous tracheostomy upon Patient D, at St. Vincent's Hospital, New York, N.Y. (Pet. Ex. 5).

2. The Respondent testified that there was a complication during the procedure, resulting in a pneumothorax (T. 419).

3. Patient D's chart did not contain a preoperative note, a history or physical, a signed note regarding the operative procedure and the patient's response, nor an informed consent for the procedure (Ex. 5; T. 81, 82, 91, 367, 408.

CONCLUSIONS AS TO PATIENT D

1. While the Respondent's testimony may not have been credible regarding the performance of the tracheostomy, the

Petitioner did not offer enough evidence to sustain this charge, and therefore it must be concluded that Petitioner met minimal acceptable standards of medical care.

2. The Respondent did not meet the minimum standards of maintaining an accurate medical record for Patient D.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST THROUGH FOURTH SPECIFICATIONS:
(Gross negligence)

A. NOT SUSTAINED
A1. NOT SUSTAINED
A2. NOT SUSTAINED
A3. NOT SUSTAINED
A4. NOT SUSTAINED
A5. NOT SUSTAINED
B. NOT SUSTAINED
B1. NOT SUSTAINED
B2. NOT SUSTAINED
B3. NOT SUSTAINED
B4. NOT SUSTAINED
C. NOT SUSTAINED
C1. NOT SUSTAINED
C2. NOT SUSTAINED
C3. NOT SUSTAINED
D. NOT SUSTAINED
D1. NOT SUSTAINED
D2. WITHDRAWN

FIFTH THROUGH EIGHTH SPECIFICATIONS:
(Gross incompetence)
A. NOT SUSTAINED
A1. NOT SUSTAINED
A2. NOT SUSTAINED
A3. NOT SUSTAINED
A4. NOT SUSTAINED
A5. NOT SUSTAINED
B. NOT SUSTAINED
B1. NOT SUSTAINED
B2. NOT SUSTAINED
B3. NOT SUSTAINED
B4. NOT SUSTAINED

C. NOT SUSTAINED
C1. NOT SUSTAINED
C2. NOT SUSTAINED
C3. NOT SUSTAINED
D. NOT SUSTAINED
D1. NOT SUSTAINED
D2. WITHDRAWN

NINTH SPECIFICATIONS:
(Negligence on more than one occasion)

A. SUSTAINED
A1. SUSTAINED
A2. SUSTAINED
A3. NOT SUSTAINED
A4. SUSTAINED AS TO INADEQUATE PRE-OPERATIVE
A5. NOT SUSTAINED
B. SUSTAINED
B1. SUSTAINED
B2. SUSTAINED
B3. SUSTAINED
B4. SUSTAINED only as to hematologist
C. NOT SUSTAINED
C1. NOT SUSTAINED
C2. NOT SUSTAINED
C3. SUSTAINED
D. NOT SUSTAINED
D1. NOT SUSTAINED
D2. WITHDRAWN

TENTH SPECIFICATION:
(Incompetence)
A. NOT SUSTAINED
A1. NOT SUSTAINED
A2. NOT SUSTAINED
A3. NOT SUSTAINED
A4. NOT SUSTAINED
A5. NOT SUSTAINED
B. NOT SUSTAINED
B1. NOT SUSTAINED
B2. NOT SUSTAINED
B3. NOT SUSTAINED
B4. NOT SUSTAINED
C. NOT SUSTAINED
C1. NOT SUSTAINED
C2. NOT SUSTAINED
C3. NOT SUSTAINED
D. NOT SUSTAINED
D1. NOT SUSTAINED
D2. WITHDRAWN

ELEVENTH AND TWELFTH SPECIFICATIONS:
(Failure to obtain informed consent)
B. NOT SUSTAINED
B5. NOT SUSTAINED

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS:
(Failure to maintain adequate records)

A. SUSTAINED
A6. SUSTAINED, only as to progress notes and accurate operative report
B. SUSTAINED
B6. SUSTAINED ONLY AS TO PROGRESS NOTES
C. NOT SUSTAINED
C5. NOT SUSTAINED
D. SUSTAINED
D3. SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has carefully considered all of the evidence in this matter, and unanimously determined that the Respondent's license to practice medicine in the State of New York should be suspended for five years, with the suspension stayed under the terms of probation, for four and one half years, coupled with a monetary penalty of $20,000.

The Committee believes the Respondent demonstrated a severe lapse in medical judgment by deciding to operate on Patients A and B, for whom adequate preoperative testing, if done thoroughly and in a timely fashion, would have led to a determination that these high risk patients were not surgical candidates. The Respondent's negligence in these cases stems not from poor surgical technique, but from his decision to operate at all.

Further, the Committee felt the Respondent's testimony was not always credible. At the hearing, the Respondent appeared to be

arrogant and without remorse or concern about his poor surgical outcomes. The Committee felt his demeanor reflected his approach to patient care and cavalier attitude about medical record keeping. The Committee felt the Respondent's approach to surgical decision making was troubling and we are deeply concerned about the public's welfare.

Because the Committee feels the Respondent has a sufficient foundation of knowledge and competence as a surgeon, he should be capable of correcting these deficiencies during his period of suspension and probation.

ORDER

Based upon the foregoing IT IS HEREBY ORDERED THAT

1. Respondent's license to practice medicine in the State of New York is hereby suspended for a period of five years, during a five year period of probation, with the suspension stayed for four and one half years.

2. The terms of probation are as follows:

- 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;
- Respondent shall submit written notification to the New York State Department of Health address to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Fourth Floor, Troy, New York 12180; said notice to 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 taken by any local, state or federal agency, institution or facility, within thirty days of each action;

- Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.
- Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law section 32].
- The period of probation shall be tolled during periods in which Responded is not engaged in active practice in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends t 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 Respondent's return to practice in New York State.
- Respondent's professional performance may be reviewed ny 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.
- 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.
- Respondent shall make available for review by OPMC, and/or on OPMC's discretion, by a physician proposed by the Respondent and approved in writing, by the Director of OPMC, complete copies of any and all medical and office records selected by OPMC. Respondent shall fully cooperate in the review process.
- 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 amy be authorized pursuant to the law.

3. A fine in the amount of Twenty Thousand ($20,000) Dollars is imposed upon the Respondent. Payment of the fine shall be made

within thirty (30) days of the effective date of this ORDER to the New York State Department of Health, Bureau of Accounts Management, Revenue and Cash Unit, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York, 12237.

4. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

Dated: New York, New York
March 31 2000

MICHAEL GOLDING, M.D.
Chairperson

NAOMI GOLDSTEIN, M.D.
EUGENIA HERBST

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

IN THE MATTER OF PETER ADAMS, M.D.	STATEMENT OF CHARGES

PETER ADAMS, M.D., the Respondent, was authorized to practice medicine in New York State on or about , by the issuance of license number 108609 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about September 8, 1994, and on or about September 11, 1994, Respondent treated Patient A for lung cancer at New York Hospital Center of Queens, New York, New York. (Patient names are contained in the attached appendix). Respondent's conduct deviated from accepted medical standards in that:

1. Respondent failed to order, perform and document necessary preoperative diagnostics tests and metabolic workup, including bronchoscopy, brain scan and bone scan.

2. On or about September 8, 1994, Respondent attempted to perform a right upper lobectomy, which was not indicated.

3. During this procedure Respondent improperly decided to abandon the operation, which decision left the patient in a worse condition than she was preoperatively.

4. Respondent's inadequate preoperative workup and improper technique, i.e., leaving a devascularized lobe in place, unnecessarily increased the risks for complications and mortality in this patient.

5. On or about September 9, 1994, Respondent performed a right pneumonectomy which was not indicated.

6. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient's complaints, history, physical examination, diagnosis, progress notes, operative reports, treatment plan and discharge summary.

B. On or about August 28, 1995, Respondent treated Patient B for cancer of the esophagus at New York Hospital Center of Queens, New York, N.Y. Respondent's conduct deviated from accepted medical standards, in that:

1. On or about August 28, 1995, Respondent performed a partial esophagogastrectomy which was not indicated in this high risk patient.

2. Respondent failed to appropriately manage the patient's intraoperative and postoperative bleeding and complications.

3. Respondent failed to order appropriate preoperative blood tests and fresh blood in this high risk surgical patient.

4. Respondent improperly failed to obtain preoperative consultations with a hematologist and cardiologist.

5. Respondent failed to obtain Patient B's informed consent for the surgical procedure he performed.

6. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient's complaints, history physical, examination, diagnosis, progress notes, operative reports, treatment plan and discharge summary.

C. On or about January 10, 1994, and on or about January 21, 1994, Respondent treated Patient C for lung cancer at New York Center of Queens, New York, New York. Respondent's conduct deviated from accepted medical standards, in that:

1. On or about January 10, 1994, Respondent performed a right pneumonectomy and mediastinal lymph node dissection. On January 10, 1994, the Respondent reoperated on Patient C which was not indicated in the face of a negative chest X-ray.

2. The Respondent failed to arrange for consultations with an internist or cardiologist in this high risk surgical patient.

3. Respondent failed to document and record any pre-operative notes.

4. Respondent failed to obtain informed consent of Patient C for the re-operation.

5. Respondent failed to maintain a medical record for Patient C which

accurately reflects the patient's complaints, history, physical examination, diagnosis, progress notes, operative reports, treatment plan and discharge summary.

D. On or about September 12, 1997, Respondent treated Patient D for pulmonary disease at St. Vincent's Hospital, New York, N.Y. Respondent's conduct deviates from accepted medical standards in that:

1. Respondent improperly performed a percutaneous tracheostomy upon Patient D which resulted in pneumothorax.

2. Respondent's selection of percutaneous tracheostomy in this patient was inappropriate and resulted in postoperative complications. withdrawn 11/5/99 JBC MRG

3. The Respondent failed to maintain a medical record for Patient D which accurately reflects the patient's complaints, history, physical examination, diagnosis, progress notes, operative reports, treatment plan ~~and discharge summary.~~ withdrawn as to discharge summary 11/5/99 JBC MRG

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following paragraphs:

1. A and A(1) through A(5).
2. B and B(1) through B(4).
3. C and C(1) through C(3).
4. D and D(1) through D(2).

FIFTH THROUGH EIGHTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the following paragraphs:

5. A and A(1) through A(5).
6. B and B(1) through B(4).
7. C and C(1) through C(3).
8. D and D(1) through D(2).

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. 1999) 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 paragraphs:

9. A and A(1) through A(5); B and B(1) through B(4); C and C(1) through C(3); D and D(1) through D(2).

TENTH 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. 1999) 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 paragraphs:

10. A and A(1) through A(5); B and B(1) through B(4); C and C(1) through C(3); D and D(1) through D(2).

ELEVENTH AND TWELFTH SPECIFICATIONS

FAILURE TO OBTAIN INFORMED CONSENT

Respondent is charged with committing professional misconduct under N.Y. Educ. Law §6530(26) in that he performed professional services which had not been duly authorized by the patient or his or her legal representative as alleged in the following paragraphs:

11. B and B(5).
12. C and C(4).

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) in that he failed to maintain records for patients which accurately reflect the evaluation and treatment of the patients, as alleged in the following paragraphs:

13. A and A(6).
14. B and B(6).
15. C and C(5).
16. D and D(3).

DATED: July 2, 1999
New York, New York

ROY NEMERSON
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Bureau of Professional
Medical Conduct