NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

Jeffrey E. Lavigne, Physician
7 East 68th Street
New York, New York 10021

259 South West 193rd Place
Normandy Park, Washington 98166

RECEIVED
OCT 13 1994
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

SEPTEMBER 23, 1994

Re: License No. 114611

Dear Dr. Lavigne:

Enclosed please find Order No. 14391. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR
cc: Andrew Fisher, Esq.
Fisher & Fisher
1 Whitehall Street - 21st Floor
New York, New York 10004

REPORT OF THE
REGENTS REVIEW COMMITTEE

JEFFREY LAVIGNE

CALENDAR NO. 14391

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

JEFFREY LAVIGNE **No. 14391**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

JEFFREY LAVIGNE, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

This disciplinary proceeding was properly commenced and on twenty-nine dates from August 28, 1990 to August 7, 1992 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct.

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, including the statement of charges and respondent's answer, is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee concluded that respondent was guilty of the first and second specifications (having had disciplinary action taken in another state based on conduct which would, if committed

in New York State, constitute professional misconduct); the thirteenth specification (practicing the profession with negligence on more than one occasion); the fifteenth, sixteenth, twenty-third and twenty-fourth specifications (practicing the profession fraudulently); and the twenty-ninth, thirtieth, thirty-second, thirty-third, fortieth, forty-first, forty-second, forty-third, forty-fourth, forty-fifth, forty-sixth and forty-seventh specifications (unprofessional conduct).

The hearing committee unanimously recommended that respondent be fined $10,000 for each of the four sustained charges of practicing the profession fraudulently, for a total fine of $40,000 and that respondent's license to practice medicine in the State of New York be revoked.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted in full. The Commissioner of Health further recommended that the recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "B".

On December 1, 1993 respondent did not appear before us in person and no attorney appeared to represent respondent. Terrence Sheehan, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the penalty to be

imposed, should respondent be found guilty, was a license revocation plus a $40,000 fine.

We have reviewed the record as transferred by the Commissioner of Health in this matter.

We unanimously recommend that the determination of the Board of Regents be as follows:

1. The hearing committee's findings of fact, conclusions and recommendation, as well as the recommendation of the Commissioner of Health as to those findings of fact, conclusions and recommendation be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the first and second specifications (having had disciplinary action taken in another state based on conduct which would, if committed in New York State, constitute professional misconduct); the thirteenth specification (practicing the profession with negligence on more than one occasion); the fifteenth, sixteenth, twenty-third and twenty-fourth specifications (practicing the profession fraudulently); and the twenty-ninth, thirtieth, thirty-second, thirty-third, fortieth, forty-first, forty-second, forty-third, forty-fourth, forty-fifth, forty-sixth and forty-seventh specifications (unprofessional conduct); all of the aforesaid guilt being to the extent set forth in the hearing committee report; and not guilty of all remaining specifications and charges; and

3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges on which respondent has been found guilty and respondent be fined $10,000 upon each of the fifteenth, sixteenth, twenty-third and twenty-fourth specifications, said fines to total $40,000 and to be paid no later than one year from the date of the service of the order in this matter, by certified or bank cashier's check, payable to the order of the New York State Education Department, to be delivered to the Executive Director, Office of Professional Discipline, New York State Education Department, One Park Avenue - Sixth Floor; New York, New York 10016-5802.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

JOHN T. McKENNAN

Chairperson

Dated: 8/18/94

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

IN THE MATTER	:	REPORT OF THE
OF	:	HEARING
JEFFREY LAVIGNE, M.D.	:	COMMITTEE

TO: HONORABLE MARK R. CHASSIN, M.D., COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

THEA GRAVES PELLMAN, Chairperson, PHILLIP I. LEVITAN, M.D., and JAMES W. PHILLIPS, 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 §230(1) of the Public Health Law, served as the hearing committee in this matter pursuant to §230(10)(e) of the Public Health Law. Gerald H. Liepshutz, Esq., served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee submits this report.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the Statement of Charges attached hereto. A copy of Respondent's Answer is also attached.

1. Pursuant to New York Education Law §6509(5)(d) (McKinney Supp. 1990), having had disciplinary action taken against him after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another

state when the conduct resulting in the disciplinary action involving his license would, if committed in New York State, constitute professional misconduct under New York Education Law §6509(2) (McKinney 1985): **FIRST AND SECOND SPECIFICATIONS**

2. Practicing with gross negligence under New York Education Law §6509(2) (McKinney 1985): **THIRD THROUGH SEVENTH SPECIFICATIONS**

3. Practicing with gross incompetence under New York Education Law §6509(2) (McKinney 1985): **EIGHTH THROUGH TWELFTH SPECIFICATIONS**

4. Practicing the profession with negligence on more than one occasion under New York Education Law §6509(2) (McKinney 1985): **THIRTEENTH SPECIFICATION**

5. Practicing the profession with incompetence on more than one occasion under New York Education Law §6509(2) (McKinney 1985): **FOURTEENTH SPECIFICATION**

6. Practicing the profession fraudulently under New York Education Law §6509(2) (McKinney 1985): **FIFTEENTH THROUGH TWENTY-SIXTH SPECIFICATIONS**

7. Pursuant to New York Education Law §6509(9) (McKinney 1985), committing unprofessional conduct by performing professional services which had not been duly authorized by the patient or his or her legal representative within the meaning of 8 NYCRR 29.1(b)(11)(1987): **TWENTY-SEVENTH THROUGH THIRTY-FIRST SPECIFICATIONS**

8. Pursuant to New York Education Law §6509(9) (McKinney 1985), committing unprofessional conduct by willfully making or filing false reports within the meaning of 8 NYCRR 29.1(b)(6)(1987): **THIRTY-SECOND THROUGH FORTY-SECOND SPECIFICATIONS**

9. Pursuant to New York Education Law §6509(9) (McKinney 1985), committing unprofessional conduct by engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of 8 NYCRR 29.1(b)(5)(1987): **FORTY-THIRD SPECIFICATION**

10. Pursuant to New York Education Law §6509(9) (McKinney 1985), committing unprofessional conduct by failing to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient within the meaning of 8 NYCRR 29.2(a)(3)(1989): **FORTY-FOURTH THROUGH FORTY-EIGHTH SPECIFICATIONS**

11. Pursuant to New York Education Law §6509(9) (McKinney 1985), committing unprofessional conduct by creating and/or approving and causing to be disseminated advertising that was false, fraudulent, deceptive or misleading within the meaning of 8 NYCRR 29.1(b)(12)(i)(a) (1987): **FORTY-NINTH SPECIFICATION**

The following **SPECIFICATIONS** were withdrawn by the New York State Department of Health (Petitioner) during this proceeding: **EIGHTEENTH, TWENTIETH, TWENTY-FIRST, THIRTY-**

FIFTH, THIRTY-SEVENTH, THIRTY-EIGHTH, and FORTY-EIGHTH SPECIFICATIONS.

RECORD OF PROCEEDINGS

Service of **NOTICE OF HEARING** and **STATEMENT OF CHARGES**:	July 30, 1990
ANSWER by Respondent dated:	August 24, 1990
Department of Health (Petitioner) appeared by:	Terrence Sheehan, Esq. Associate Counsel Office of Professional Medical Conduct
Respondent appeared by:	Fisher & Fisher Attorneys at Law One Whitehall Street 21st Floor New York, NY 10004 **BY:** Andrew S. Fisher, Esq., P.C. and Pattie E. Evans, Esq., of Counsel
Hearing dates:	1990 August 28 September 11 October 1 October 25 November 14 December 20 1991 January 8 January 15 February 6 March 19 April 2 April 8 May 2 July 9 July 11 July 23 August 12 September 6 October 3

	October 24 October 29 November 15 December 16 1992 January 2 January 9 May 28 June 19 July 17 August 7
Hearing Committee absences:	Dr. Levitan was not present during the hearing days of August 12, 1991 and January 9, 1992. He affirms that he has read and considered evidence introduced at, and transcripts of, the days of his absences.
Witnesses called by Petitioner:	Bruce Gingold, M.D. Jeffrey Lavigne, M.D, Respondent Patient E Martin L. Rudolph Patient J Patient D Patient B Patient C Neil Sadick, M.D. Gary Steven Hitzig, M.D. Patient G Allison Ferry Mark Germaine
Witnesses called by Respondent:	Geroge M. Hollenberg, M.D. James F. Imperiale, Esq. Robert J. Foster, R.N. Albert B. Lewis, Esq. Anthony Paul Geraci Norman Sohn, M.D. Jeffrey Lavigne, M.D. Respondent Joseph Bottino, M.D. Renee Lavigne, R.N.
Adjournments of hearing days:	1. March 21, 1991, due to actual engagement of counsel for Petitioner

2. January 7, 1992 due to unavailability of hearing committee member

Intra-hearing conferences on the record for legal determinations without the presence of the hearing committee:

1990
September 11
October 1
October 25
December 20
1991
January 15
March 19
September 6
September 24
October 3
October 24
1992
June 19
July 17

Post-hearing written submissions received from
Petitioner: September 28, 1992
Respondent: September 28, 1992

Dates of hearing committee deliberations:
September 30, 1992
November 9, 1992
November 16, 1992
December 2, 1992
December 21, 1992

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while numbers or letters preceded by "Ex." refer to an exhibit in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence was considered and rejected in favor of the cited

evidence. All findings of fact were made by a unanimous vote of the hearing committee.

1. Jeffrey Lavigne, M.D., Respondent, was authorized to practice medicine in New York State on December 13, 1972 by the issuance of license number 114611 by the New York State Education Department. He was registered with the Education Department to practice medicine for the period January 1, 1989 to December 31, 1991 at 7 East 68th Street, New York, New York (uncontested).

FIRST SPECIFICATION - PARAGRAPH A OF THE STATEMENT OF CHARGES

2. On June 17, 1988, Respondent entered into a STIPULATION AND AGREED ORDER with the Washington State Medical Disciplinary Board in which the Respondent stipulated that he did not contest that if the matter pending before that Board were to proceed to hearing, the State of Washington would show the following:

a. On or about March 5, 1984, Respondent performed surgery on a patient without obtaining the patient's full informed consent; and

b. On or about March 5, 1984, Respondent performed a left subclavian carotid transposition without first performing a complete evaluation of the patient's cerebral circulation to determine whether the procedure was indicated; and

c. On or about February 24, 1984, Respondent performed revisions of traumatic amputations of the second, third and fourth fingers of a patient's left hand,

and a reduction of the fracture of the patient's right thumb. The patient requested transfer to a medical center which provided specialized services in hand surgery, but Respondent overrode this request. Respondent's initial reduction of the right thumb fracture was not physiologically adequate, nor did Respondent attempt a primary repair or primary nerve graft of a severed digital nerve to the thumb during the surgery (Ex. 18).

3. The Washington State Medical Disciplinary Board revoked Respondent's medical license, stayed the revocation, and prohibited Respondent from performing surgery other than minor in-office procedures. Respondent was required to obtain the Board's approval for the particular minor procedures which he desired to perform. In addition, the Board ordered Respondent to cooperate with a "practice review" to be conducted by the Board (Ex. 18).

SECOND SPECIFICATION - PARAGRAPH B OF THE STATEMENT OF CHARGES

4. On or about August 25, 1989, the New Jersey Board of Medical Examiners took disciplinary action against Respondent. This action was based on the Washington State disciplinary proceeding discussed in Findings of Fact 2 and 3 herein. The New Jersey Order provides that Respondent may perform no surgery in New Jersey other than minor procedures which may be performed in an office setting. The Order also requires Respondent to obtain the New Jersey Board's approval of the particular minor procedures which he desires to perform (Ex. 19).

REGARDING PATIENT A - THIRD THROUGH FOURTEENTH, TWENTY-SEVENTH, AND FORTY-FOURTH SPECIFICATIONS

5. Between on or about July 26, 1988 and on or about September 30, 1988, Respondent treated Patient A for hemorrhoids and other conditions at Respondent's office at 7 East 68th Street, New York, New York (Ex. 3 and Ex. Y).

6. On July 26, 1988, Respondent performed a hemorrhoidectomy on Patient A. During this procedure, Respondent employed an infrared coagulator (Ex. 3 and Ex. Y; T. 3347). The preponderance of the evidence did not show that the coagulator was not indicated, inasmuch as Petitioner's expert witness stated that there were two schools of thought regarding the use of an infrared coagulator (T. 312-313).

7. On both July 26, 1988 and August 4, 1988, Respondent did not diagnose rectal cancer for Patient A, nor did he obtain a biopsy (Ex. 3 and Ex. Y). He should not, however, be faulted for not diagnosing rectal cancer or for not obtaining a biopsy on those dates (T. 80-81, 1830-1831, 2313-2315, 3562-3563). Additionally, the charge of failing to diagnose rectal cancer must fail because Patient A had anal cancer rather than rectal cancer (Ex. R, Ex. 4-p.13; T. 477-478, 1698-1699, 1706, 1708).

8. On August 23, 1988, Respondent ordered an upper GI series and a gallbladder series for Patient A, but there is no evidence that they were performed (Ex. 3, Ex. R; T. 114, 118).

9. Upon Patient A's reported symptomatology, Respondent concluded that radiologic studies were necessary (T. 3375, 3384).

Given the symptoms and circumstances, ordering a GI series and a gallbladder series was "absolutely appropriate" (T: 2843). He referred him to a radiologist (and told him to use either this radiologist or one of his choice), but there is no evidence that the tests were performed (T. 3375, 3390-3394). It is within the standard of care to recommend a gall bladder series and an upper GI series for both diagnostic and screening purposes (T. 4386).

10. Respondent cannot be faulted for not diagnosing cancer or for not obtaining a biopsy or Patient A's visit of August 23, 1988 (T. 80-81, 1830-1831, 2312-2315, 3562-3563).

11. On September 17, 1988, Respondent again examined Patient A (Ex. 3). By this date, Respondent should have diagnosed Patient A's cancer or obtained a biopsy (T. 325-326).

12. On September 17, 1988, Respondent incorrectly diagnosed Patient A's condition as cryptitis (T. 124-125).

13. On September 17, 1988, Respondent prescribed Flagyl which was not indicated (T. 125).

14. On September 27, 1988, Respondent performed an incision and drainage of an anal cancerous mass of Patient A. This procedure was indicated and it did not unnecessarily risk spreading the cancer. On this date, Respondent obtained a biopsy and the subsequent pathology report contained a diagnosis of anaplastic carcinoma (Ex. R, Ex. 5, Ex. Y; T. 2307, 2549).

15. Patient A gave an informed consent for the procedures performed by Respondent on July 26, August 23 and September 27, 1988 (Ex. Y; T. 3361-3362).

16. On or about March 6, 1989, Patient A saw Bruce Gingold, M.D. At that time, the cancerous mass was approximately seven centimeters in diameter. After a trial of chemotherapy and radiation, and an unsuccessful operation by Dr. Gingold to remove the cancer, Patient A was given a diagnosis of inoperable rectal cancer (Ex. 4).

17. Regarding recordkeeping, Respondent had done a comprehensive physical examination on Patient A (T. 3348-3352). This examination was not documented in the patient's record (Ex. Y). Pertinent negative findings such as an examination of the patient's lungs should be stated as well as findings on examination of regional lymph nodes with a known or suspected cancer. Patient A had asthma and, therefore, the record of his visit to Respondent should have indicated an examination of the Patient's heart and lungs which it does not (T. 2461-2462).

18. Patient A's medical record did not indicate where his hemorrhoids were located nor the number of hemorrhoids. The record should have contained this information (Ex. Y; T. 2382).

19. One cannot discern from Patient A's chart what his condition was, what the correct findings were and why Respondent proceeded in the way that he did (Ex. Y; T. 2803).

REGARDING PATIENT B - THIRTEENTH THROUGH FIFTEENTH, TWENTY-EIGHTH, THIRTY-SECOND, FORTY-THIRD AND FORTY-FIFTH SPECIFICATIONS

20. Between on or about October 31, 1989 and on or about December 10, 1989, Respondent treated Patient B for hemorrhoids at Respondent's office (Ex. KK and Ex. 12).

21. Respondent did not fail to order a blood count for Patient B prior to surgery (Ex. KK - inside front cover).

22. On or about November 9, 1989, Respondent performed a hemorrhoidectomy and a sphincterotomy. Respondent's associate, Dr. Rock, not Respondent, performed an endoscopy. Adequate consents signed by Patient B are in the medical record (Ex. KK).

23. On or about November 10, 1989, Respondent billed Patient B's insurance carrier $2,500 for performing a sphincteroplasty. Respondent did not perform this procedure (T. 199-200; Ex. KK).

24. On or about November 10, 1989, Respondent billed Patient B's insurance carrier $1,000 for anesthesia provided to Patient B on November 8, 1989 and November 9, 1989 (Ex. KK and Ex. 13). In fact, no anesthesia was provided on November 8, 1989 as the procedures were performed on November 9, 1989 (T. 832-833, 4224; Ex. KK).

25. Respondent knew when he billed Patient B's insurance carrier for a sphincteroplasty that he had not provided this service and, therefore, was not entitled to payment for it. He had performed, as previously found herein, a sphincterotomy, not a sphincteroplasty. Although Respondent claimed that he had mistakenly checked the incorrect box on the superbill, he in fact added the modifying number "51" next to the number "46760" which is the CPT code number for, and adjacent to, the word "sphincteroplasty." Respondent did indeed sign the superbill which contained this information. In addition, Respondent billed

Patient B's carrier $2,500 for a sphincteroplasty and $2,500 for a hemorrhoidectomy. The charge of $2,500 for a sphincteroplasty is not consistent with the actual procedure performed of a sphincterotomy for which the charge would have been considerably less (Ex. NN - pp. 192-193, Ex. KK, Ex. 12, Ex. 13; T. 198-200).

26. Respondent knew when he billed Patient B's insurance carrier $1,000 for anesthesia that he had not fully provided this service and, therefore, was not entitled to the claimed payment. He billed for anesthesia for a date on which Patient B did not receive anesthesia, November 8, 1989. This hearing committee infers that Respondent intentionally sought to deceive the insurance carrier (T. 832-833, 4224; Ex. KK).

27. After operating on Patient B on November 9, 1989, Respondent failed to provide adequate professional coverage for post-surgical complications. In fact, Patient B experienced significant bleeding in the days after her operation, and she was unable to obtain effective medical assistance from Respondent's office. As a result, Patient B had to be hospitalized for rectal bleeding. Respondent had not returned the patient's phone calls in a timely manner. Only Respondent's associate, Dr. Rock, who is not a surgeon, was available to speak to Patient B. This does not constitute adequate professional coverage for post-surgical complications. In spite of repeated telephone calls to Respondent's office, no one physically examined the patient following her complaints regarding such potentially serious complications (T. 829-830, 847-855, 1348-1350, 4225-4228).

28. After a hemorrhoidectomy and a sphincterotomy are performed on a patient, it is necessary that a surgeon or someone with sufficient training to handle any anticipated problems be available to render post-surgical care and to attend to complications. Respondent's failure to have a surgeon available to respond to this patient's problems post-surgically violated the standards of post-surgical care (T. 204-208). It is the obligation of the surgeon to be available, or to have another competent person available, to treat such complications (T. 2941-2942).

29. Respondent failed to maintain a medical record for Patient B which accurately reflects his treatment of the patient. The record does not note the telephone conversations which Patient B made to the office describing her post-surgical complications (Ex. KK, Ex. 12; T. 206-207).

REGARDING PATIENT C - THIRTEENTH, FOURTEENTH, SIXTEENTH, TWENTY-NINTH, THIRTY-THIRD, FORTY-THIRD AND FORTY-SIXTH SPECIFICATIONS

30. Between on or about April 29, 1989 and on or about May 4, 1989, Respondent treated Patient C for hemorrhoids and other conditions at Respondent's office (Ex. MM).

31. Respondent obtained a sufficient hemoglobin blood count for Patient C on April 29, 1989 (Ex. MM - inside cover; T. 3099).

32. A hemorrhoidectomy and a modified DeLorme anoplasty were performed on the date of Patient C's initial visit to Respondent, April 29, 1989 (Ex. MM). These procedures were

performed without obtaining the patient's informed consent because alternate forms of therapy were not explained to her, and the signed consent form (Ex. 9) was defective in that she signed after being administered sedatives (T. 135-136, 1046-1047, 1052-1053). The written consent was also inadequate because it was not signed by a physician, and it does not mention the anoplasty which was performed according to the medical record (Ex. 9; T. 155-157).

33. It is not proper procedure to take a history from a patient, discuss surgery with the patient, recommend that a certain surgery be done, and then, only at the last minute just before the patient is being brought to the operating room, to introduce another surgeon to the patient while telling the patient that this surgeon is the one who is going to do the operation. This sequence of events occurred here (T. 152-160).

34. Patient C had seen an ad in the New York Daily News which caused her to call to make an appointment to see Respondent. During the telephone conversation, she was not asked about the reason why she wanted to see Respondent, nor was she given any instructions concerning what she could or could not eat prior to coming to the office (T. 1039-1041). Patient C received I.V. sedation during the procedures which were performed on the first visit to Respondent. The lack of pre-operative eating instructions unnecessarily subjected the patient to the risk of vomiting while under sedation (T. 1039-1041; Ex. MM).

35. Respondent advised Patient C to have the modified DeLorme anoplasty performed. During this procedure, Respondent

acted as the surgeon and/or as the anesthesiologist (Ex. MM). A Delorme anoplasty is done to correct a condition of rectal prolapse. Patient C did not have a rectal prolapse. Therefore, a Delorme anoplasty was not indicated for the patient. A rectal prolapse is not the same as a prolapse of a hemorrhoid (T. 162-165).

36. Several days following the procedures, Patient C experienced bleeding. On or about May 4, 1989, the patient returned to Respondent. Respondent determined that the sutures had separated, and he restitched along the previous suture line to control the bleeding (Ex. MM; T. 4298-4304). The hearing committee was not convinced by a preponderance of the evidence that this procedure was not indicated, because the procedure was appropriate if there was bleeding (T. 168).

37. Respondent performed the restitching after obtaining Patient C's informed oral consent. There had not been time to obtain a written consent (T. 4298-4300).

38. On or about November 22, 1989, Patient C underwent surgery performed by Bruce Gingold, M.D., to correct anal stenosis. It was not proved that the anal stenosis had been caused by the procedures performed by Respondent (T. 937-939, 3157-3164).

39. Respondent failed to maintain a medical record for Patient C which accurately reflected his treatment in that there is no anesthesia record present in the chart which states the exact type and dosage of anesthesia given and the patient's

condition and vital signs during the procedure or post-operatively. Also, no operative report for the procedure of May 4, 1989 exists which adequately describes the findings and the actual procedure performed (T. 187, 3179-3180).

40. Included in Patient C's chart is a letter which Respondent sent to her. This letter contains statements which are knowingly false with respect to medical matters. The false claims include the statement that there is a purported statistical association between hemorrhoids, polyps and tumors, and the statement that there is a general rule of thumb among physicians who practice in the Respondent's field that once someone has had anorectal disease or surgery they should have a colonoscopy and fiberoptic sigmoidoscopy on an alternating annual basis. That these claims are not true is so self-evident to physicians that the hearing committee infers that Respondent knew them to be false, and that he made the claims to cause the patient to obtain unwarranted medical services (Ex. 6, p. 11; T. 182-186).

REGARDING PATIENT D - THIRTEENTH, FOURTEENTH, THIRTIETH AND FORTY-SEVENTH SPECIFICATIONS

41. Between on or about May 13, 1989 and on or about September 9, 1989, Respondent treated Patient D for hemorrhoids and other conditions at Respondent's office (Ex. 15, Ex. TT).

42. Respondent performed both a hemorrhoidectomy and an anoplasty on May 13, 1989 and not on separate dates as charged by Petitioner. The anoplasty was not indicated (T. 217), but Patient D did not become incontinent as a result of this operation (T.

783).

43. Although Patient D signed a written consent form (Ex. TT), an informed consent did not exist as evidenced by the fact that the patient was never told that an anoplasty had been performed or even an explanation of the procedure (T. 758).

44. Respondent failed to maintain a medical record for Patient D which accurately reflected his examination of the patient. He performed a comprehensive examination of Patient D (T. 3864) and billed for the examination (Ex. TT), but the medical records do not reflect a comprehensive examination (Ex. 15, Ex. TT).

REGARDING PATIENT E - SEVENTEENTH, THIRTY-FOURTH AND FORTY-THIRD SPECIFICATIONS

45. On or about May 5, 1982, Respondent treated Patient E, an eighty year old man, for a blister on his right forefinger at Vista Medical Center, 529 Beach 20th Street, Far Rockaway, New York (Ex. 16).

46. The hearing committee was not convinced by a preponderance of the evidence that Respondent agreed to accept an assignment of Patient E's Medicare benefits for the procedure performed. Respondent's billing form (Ex. 16) states that he does not accept assignment. The ledger card (Ex. 16) which was periodically copied and sent as a bill to Patient E by Respondent's office staff, told Patient E that the insurance claim had been submitted, that payment would be made by the insurance company directly to him, and that payment should be made to

Respondent "as soon as possible" (Ex. 16). This informed Patient E that there was to be no direct payment by the insurer to the doctor (as there would be in the case of an assignment), and that when the patient received the check from the insurance company he was expected to forward the money to Respondent. This is also consistent with not taking an assignment (T. 3753). Despite receiving periodic statements from Respondent, Patient E never contacted him with a complaint about being obligated for payment (T. 3707).

47. At no time did Patient E indicate that he was unable to pay for the services provided to him (T. 3699).

48. Although Patient E denies that he was paid by an insurance company for the procedure (T. 562-570), he was indeed paid by Blue Cross/Blue Shield (Ex. 16). Respondent received an explanation of benefits from Blue Cross/Blue Shield relating to Patient E's Senior Care benefits (T. 3697-3699) indicating that the checks for both the Medicare and the Senior Care policies had been sent to the patient (T. 3697-3698, 3725; Ex. 16).

REGARDING PATIENT F - THIRTEENTH, FOURTEENTH, EIGHTEENTH, THIRTY-FIFTH, FORTY-THIRD AND FORTY-EIGHTH SPECIFICATIONS

49. All charges relating to Patient F were withdrawn by Petitioner by letter dated October 15, 1992.

REGARDING PATIENT G - THIRTEENTH, FOURTEENTH, NINETEENTH, THIRTY-FIRST, THIRTY-SIXTH AND FORTY-THIRD SPECIFICATIONS

50. On or about June 14, 1988, Respondent performed a hemorrhoidectomy on Patient G at Respondent's office (Ex. N).

Respondent obtained an informed consent prior to surgery (T. 1423-1424, 1491).

51. It has not been proven, as charged, that Respondent represented to Patient G that Respondent would use a laser to treat him. The patient cannot recall such a representation (T. 1404-1405). He was not concerned with what instrument Respondent would use, did not ask him what instrument would be used (T. 1428-1429), and did not ask Respondent if a laser beam would be used (T. 1427-1429). Patient G was not interested in the difference between laser, as referred to in other advertisements, and laser technology as referred to in Respondent's advertisements (T. 1483-1484). Patient G viewed infrared coagulation as a desirable form of treatment (T. 1452-1453).

52. Patient G checked with Respondent to make sure that he was a participating physician in the GHI Program (T. 1405). According to the way the patient interpreted the insurance contract, Respondent was accepting GHI as payment in full for all services (T. 1405), and that Respondent's status as a participating physician was a condition under which he agreed to treatment (T. 1406). Patient G understood that Respondent would accept payment from GHI as payment in full for all covered services, and that he, Patient G, was responsible for payment for any services not covered (T. 1441).

53. Respondent billed $500 for anesthesia separately from the hemorrhoidectomy (Ex. N). However, GHI lumped the two together as "surgery" and paid for surgery only at a rate of $633

(T. 3778; Ex. N). Respondent billed Patient G for the anesthesia in May 1988 (T. 3778; Ex. N) and when he failed to pay, Respondent turned the account over for collection (T. 3778). GHI's clerical error fueled Patient G's desire to avoid paying Respondent, inasmuch as GHI told Patient G that they were never billed for anesthesia (Ex. N -- Patient G's November 4, 1988 letter to Respondent). This appears to be the source of the dispute which escalated into Patient G's complaint to GHI, New York County Medical Society and OPMC (Ex. N -- Patient G's complaint letters).

54. After both GHI and the New York County Medical Society investigated the claim (Ex. N -- letters from Valentine Borroughs and Jack R. Harness; T. 3778), and received documentation and explanations regarding the anesthesia (T. 3778; Ex. N), Respondent was paid and the dispute was resolved.

55. Respondent had provided the anesthesia service for which he billed $500, and he was entitled to payment (Ex. N; T. 1492-1494).

REGARDING PATIENT H - TWENTIETH, THIRTY-SEVENTH AND FORTY-THIRD SPECIFICATIONS

56. All charges relating to Patient H were withdrawn by Petitioner by letter dated March 27, 1991 (Ex. 38).

REGARDING PATIENT I - TWENTY-FIRST, THIRTY-EIGHTH AND FORTY-THIRD SPECIFICATIONS

57. All charges relating to Patient I were withdrawn by Petitioner by letter dated March 27, 1991 (Ex. 38).

REGARDING PATIENT J - TWENTY-SECOND, THIRTY-NINTH AND FORTY-THIRD SPECIFICATIONS

58. On or about February 18, 1988 and March 1, 1988, Respondent treated Patient J for hemorrhoids at Respondent's office (Ex. 22).

59. On March 1, 1988, a hemorrhoidectomy was performed on Patient J. A local anesthetic was administered and I.V. sedation was administered by Robert Foster, CRNA (Ex. 22 - anesthesia record; T. 1981-1985). A determination had been made as to whether the patient had had anything to eat, and an EKG was taken (T. 1984). Mr. Foster spent 20-25 minutes with Patient J (T. 1990). Patient J behaved like a "sloppy drunk" while recovering from the anesthesia (T. 2175, 3643-3644).

REGARDING PATIENT K - TWENTY-THIRD, FORTIETH AND FORTY-THIRD SPECIFICATIONS

60. On April 20, 1988, a patient calling himself Patient K was treated by Respondent's office but not by Respondent (Ex. 36; T. 4077). Respondent never met this patient (T. 4077). This was his sole visit (T. 4078). Patient K was given an insurance form by Respondent's office staff (T. 4079), and he filled it out using the name "Patient K" (T. 4079-4081). A physician employed by Respondent, Kip Burgermeister, M.D., treated Patient K for penile warts (T. 4082). The patient was scheduled for a follow-up visit, but he never returned (T. 4083).

61. Respondent billed the insurance carrier $1,590 for an excision of condylomata, $75 for an EKG and $500 for anesthesia (Ex. P).

62. No record of an EKG or for anesthesia exists in Patient K's medical chart. There is a completely blank anesthesia chart with no anesthesiologist's signature (Ex. P). The hearing committee finds that an EKG was not done and anesthesia was not administered.

63. On or about April 20, 1988, Respondent submitted to Patient K's insurance carrier two bills and one insurance form, each of which contained the alleged signature of Patient K (Ex. P). A post-payment review was conducted of the claims submitted by Respondent for this patient. This review was prompted by the fact that Blue Cross/Blue Shield had discovered evidence that the patient was in the hospital on the day that Respondent claimed he had been treated in his office, April 20, 1988 (T. 1518; Ex. 34, p. 16).

64. The insurance carrier could not determine whether Patient K had signed the claim forms and/or bill (T. 1507-1508), whether someone else signed those documents at Patient K's direction (T. 1508), or whether Patient K was actually in the hospital on April 20, 1988 (T. 1507). The hearing committee, therefore, makes no finding on whether the documents were forged.

65. Respondent knew that an EKG had not been done and that anesthesia had not been administered. He knew that he was not entitled to payments for these services, because the chart

contained no record of these services (Ex. P). The excision was done in Respondent's office (Ex. P).

REGARDING PATIENT L - TWENTY-FOURTH, FORTY-FIRST AND FORTY-THIRD SPECIFICATIONS

66. Between on or about October 16, 1986 and on or about January 20, 1988, Respondent treated Patient L for weight control at Respondent's office (Ex. 37).

67. During this period, Respondent submitted approximately 32 bills to the patient's insurance carrier. Each of these bills contained one or more of the following diagnoses: hiatal hernia, reflux esophagitis, chronic bronchitis, menorrhagia and PMS (Ex. 37). The patient's chart does not substantiate any of these diagnoses. There is no record of a comprehensive examination or history to support these diagnoses (Ex. 37). The hearing committee finds that the diagnoses were knowingly false. Patient L was being treated for obesity, as acknowledged by Respondent (T. 1645-1646).

TWENTY-FIFTH, FORTY-THIRD AND FORTY-NINTH SPECIFICATIONS - PARAGRAPH O OF THE STATEMENT OF CHARGES

68. Between in or about June, 1986 and in or about December, 1988, Respondent advertised his use of laser technology in the treatment of various medical conditions (Ex. 33).

69. Respondent owned an infrared coagulator, or IRC, during that time period, and he referred to it as "laser technology" (T. 2754; Ex. 33).

70. The professional and industrial literature refers

to the IRC as laser technology. After Respondent's then partner, Dr. Hitzig, obtained the advice of counsel that such advertising was not misleading, the partnership used the terminology in the advertisements (T. 2742). The advertisements did not state that a laser would be used. The advertisements specifically used the term "laser technology" (Ex. 33; T. 2754) employed by the medical literature discussing IRC methodology (T. 2729-2730, 2733-2734, 2737-2739, 2743-2744; Ex. FF, Ex. GG, Ex. HH, Ex. II and Ex. JJ).

71. An attorney advised that it was appropriate to advertise in this fashion (T. 1334-1335). As a result, it was believed that the partnership was proceeding in good faith in advertising the infrared coagulator as "laser technology" (T. 1334-1335). Even if the advertisements are considered to be false, it was not proved, as required, that intentional deception existed.

FORTY-THIRD SPECIFICATION - PARAGRAPH P OF THE STATEMENT OF CHARGES

72. Neil Sadick, M.D., was a subtenant at 7 East 68th Street, New York, New York from in or about February, 1986 to March 31, 1987 (Ex. EE; T. 2723-2724) at which time Respondent also leased space in the same suite of offices. Dr. Sadick's subtenancy had ended prior to the time of the alleged misconduct charged in the Statement of Charges (Ex. 1 - paragraph P). Accordingly, the hearing committee finds that the charges are legally insufficient. It is also found that these charges should not be sustained pursuant to the following findings of fact.

73. The evidence does not support the charge that Respondent took biopsy specimens from Dr. Sadick's desk. Dr. Sadick had left the biopsies on his desk, and then he left for several hours (T. 1164). Upon his return, the specimens were gone and they could not be found anywhere on the premises (T. 1164). Dr. Sadick had no specific proof regarding who took the specimens (T. 1170).

74. The evidence does not support the charge that Respondent placed nude and offensive pictures on the walls of the patient waiting room used by Dr. Sadick at the 68th Street location. Petitioner offered only testimonial evidence that nude and offensive pictures were placed on the walls. The sole picture produced during this hearing was submitted by Respondent (Ex. L) which was an example of the "artwork in question" (T. 2194). The hearing committee finds that this picture, Exhibit L, was not offensive. Inasmuch as nothing else was produced by Petitioner for the hearing committee to view and consider, this charge should not be sustained due to a failure of proof.

TWENTY-SIXTH AND FORTY-THIRD SPECIFICATIONS - PARAGRAPH Q OF THE STATEMENT OF CHARGES

75. On October 18, 1989, Respondent gave a sworn deposition as a plaintiff's expert witness in a medical malpractice action entitled Virginia Woods and John Woods vs. Albert L. Rosenthal, M.D., Superior Court of New Jersey. During the deposition, Respondent stated that there "was not a sanction per se" imposed on his medical license by the State of Washington,

and that it was "purely administrative."[4] He stated that as of October 18, 1989 there was "no" restriction on his New Jersey medical license and that the New Jersey license restriction was "a trivial thing" with "no change in functional result." Respondent further stated that the restriction on his New Jersey license "will be in effect for another few months" (Ex. 26).

76. Although Respondent was evasive during his deposition on October 18, 1989, a thorough review of his testimony reveals that he grudgingly admitted, upon questioning, that restrictions had indeed been placed on his license (Ex. 26, p. 65).

77. Respondent's testimony concerning the status of his licenses was based on the information given to him by his attorney, James F. Imperiale, Esq., who is admitted to practice in both the states of Washington and New York (T. 1858). He represented Respondent in the action taken by the Washington State Medical Disciplinary Board which was commenced in or about 1987 (T. 1860). He was involved in drafting the consent order dated June 17, 1988 in which those proceedings culminated (T. 1861).

78. Mr. Imperiale had advised Dr. Lavigne that the Order would only control or limit his ability to practice in the State of Washington, and that it was of "no functional significance" to his practice (T. 1870).

79. He further advised him that this was an administrative action, and that at the expiration of two years, he would be able to remove these restrictions (T. 1871) by utilizing an automatic process of offering a petition to the Washington State Medical Board (T. 1871). He told Respondent that he would not have to come back to the State of Washington (T. 1871). Mr. Imperiale believes that he could have petitioned the Washington State Medical Board for removal of the restrictions as early as June 1990. However, because of his own personal medical problems, he did not file the petition until late 1990 or early 1991 (T. 1872).

80. Between April 1988 and the time he testified in the Woods case in October of 1989, Respondent believed that the restrictions would be lifted as scheduled (T. 1873).

81. Mr. Imperiale was sent a copy of a New Jersey draft administrative action consent order regarding Respondent (T. 1874; Ex. 19). Sometime prior to August 25, 1989, Respondent's counsel, Andrew S. Fisher, called Mr. Imperiale and inquired as to the status of the Washington State matter (T. 1876). Around that time, Mr. Imperiale again told Respondent that there was reason to believe that once the mere fact that two years expired, the restrictions could be lifted (T. 1878).

82. In light of these findings, the hearing committee was not convinced by a preponderance of the evidence that Respondent gave knowingly false testimony during his deposition of October 18, 1989.

FORTY-SECOND SPECIFICATION - PARAGRAPH R[6] OF THE STATEMENT OF CHARGES

83. In 1980, Respondent obtained a disability insurance policy from Provident Life and Casualty Insurance Company (Ex. V). On or about January 17, 1986, Respondent suffered a myocardial infarction. On or about February 14, 1986, Respondent submitted a disability claim in which he incorrectly claimed that, at the time he suffered this heart attack, he practiced general and vascular surgery. In fact, Respondent at that time was engaged in a diet and nutrition practice which he had purchased from another physician in or about October, 1985 (T. 1007-1008, 1215-1217, 1264, 1269-1270).

84. Between on or about March 20, 1986 and on or about December 16, 1987, Respondent submitted to the insurance company twenty-one monthly claim statements (Ex. 28, Ex. 35) in which Respondent stated that he was totally disabled, unable to engage in surgery, and not then performing surgery. In fact, during this period Respondent was not totally disabled. He was actively engaged in a diet and nutritional practice until June, 1986 (T. 1215-1216, 1269-1270), at which time he formed a partnership with Dr. Hitzig and Dr. Handler in general and anorectal surgical practice. In 1987, Respondent personally performed surgery (T. 1220-1225, 1230). It was not proved that Respondent performed surgery during 1986.

85. On or about January 25, 1988, Provident stopped further payments on the policy (Ex. 35, pp. 4-6).

86. No finding is made regarding the amount of disability benefits received by Respondent, inasmuch as no proof was offered by Petitioner.

CONCLUSIONS

Following a review of the memoranda submitted by the parties, the administrative officer, by letter dated August 6, 1992, informed the parties that he had determined that the hearing committee would be instructed as follows regarding the definitions of medical misconduct to be applied in this matter. Neither party objected to these definitions.

1. **Negligence** is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Errors of judgement may or may not constitute negligence depending on whether the judgement in question was reasonably applied under the circumstances.

2. **Gross negligence** is negligent conduct which is egregious or conspicuously bad.

3. **Incompetence** involves the lack of the necessary skill or knowledge to perform a specific act.

4. **Gross incompetence** involves an unmitigated lack of the skill or knowledge necessary to perform a specific act.

5. The phrase **"on more than one occasion"** refers to separate events of some duration occurring at a particular time and place.

6. **Willful** means intentional or deliberate.

7. The charges of medical misconduct containing language not defined herein, nor defined by definition or context in the statute or regulation at issue, are to be defined in accordance with the ordinary meaning of said language.

The following conclusions were reached pursuant to a review of the entire record and the findings of fact herein. All conclusions resulted from a unanimous vote of the hearing committee.

FIRST SPECIFICATION - PARAGRAPH A OF THE STATEMENT OF CHARGES

Findings of Fact 2 and 3 herein relate to the FIRST SPECIFICATION. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraphs A, A(1), A(2), and A(3)	**sustained** (Findings of Fact 2 and 3)

Conclusions Regarding the Commission of Professional Misconduct

Respondent is charged with professional misconduct within the meaning of New York Education Law Section 6509(5)(d) (McKinney Supplement, 1990). Section 6509(5)(d) provided as follows:

> Each of the following is professional misconduct, ...Having his license to practice medicine revoked, suspended or having other disciplinary action taken, or having his application for a license refused, revoked or suspended or having voluntarily or otherwise surrendered his license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or refusal, revocation or suspension of an application for a license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state.

Petitioner alleges that the facts as sustained by the hearing committee (Findings of Fact 2 and 3) constitutes a violation of Education Law Section 6509(5)(d) because the conduct which resulted in disciplinary action being taken against Respondent in Washington would, if committed in New York State, constitute professional misconduct under Education Law Section 6509(2) (McKinney, 1985). Section 6509(2) provided as follows:

> Each of the following is professional misconduct, ...Practicing the profession fraudulently, beyond its authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion,

It is concluded that Respondent's act of performing surgery on a patient in Washington without having obtained the patient's informed consent, as found herein in relation to paragraph A(1) of the Statement of Charges, would not have constituted professional misconduct in New York State under Section 6509(2) as alleged by Petitioner. The lack of an informed consent was the subject matter of another New York statute (Section 6509(9)) which was not alleged by Petitioner.

Respondent's conduct in Washington as sustained herein regarding paragraph (A)(2) of the Statement of Charges would have constituted gross negligence and negligence (one occasion) in New York under Section 6509(2). Respondent's conduct in Washington as sustained herein regarding paragraph A(3) of the Statement of Charges would have constituted negligence (one occasion) in New York under Section 6509(2). Therefore, the FIRST SPECIFICATION should be sustained because the conduct in Washington which

resulted in disciplinary action by that State would have constituted both gross negligence and negligence on more than one occasion under Section 6509(2) as alleged.

Respondent's arguments that the FIRST SPECIFICATION must fail as a matter of law should be rejected. Respondent, on page 9 of his post-hearing "PROPOSED FINDINGS OF FACT, CONCLUSIONS AND RECOMMENDATION", incorrectly argues that a violation of Education Law Section 6509(5)(d) requires that "having been found guilty" by another state was an element of that statute. In fact, Section 6509(5)(d) did not require, as did Section 6509(5)(b), a finding of guilt by the first state. Section 6509(5)(d) required that the conduct which resulted in disciplinary action in the first state would have been, if committed in New York, professional misconduct under New York law. Respondent's medical license was the subject of disciplinary action in Washington resulting from conduct stated in a STIPULATION AND AGREED ORDER under Section II of that document entitled STIPULATION TO AGREED FACTS (Ex. 18). As previously concluded, that conduct included acts which would have been professional misconduct in New York.

Respondent's reliance on the Court of Appeals decision in Halyalkar v. Board of Regents, 72 N.Y. 2d 261, 532 NYS 2d 85 (1988), should also be rejected. Halyalkar dealt with the doctrine of collateral estoppel which gives conclusive effect to findings regarding issues in a prior proceeding or action. The doctrine serves to preclude litigation of issues which are identical to those decided in a prior action where there had been

a full and fair opportunity to contest the issue in the prior action. Here, collateral estoppel is not relevant. Education Law Section 6509(5)(d) does not require that the underlying conduct in Washington be proved in this proceeding. It requires only that the disciplinary action taken by Washington be based on conduct which would have constituted professional misconduct in New York. Exhibit 18 lists the conduct which Respondent agreed that Washington "would show" if the matter had proceeded to hearing. Washington took disciplinary action based on that conduct which, as concluded herein, would have been professional misconduct in New York if committed here. The requirements of Section 6509(5)(d) have been satisfied.

Furthermore, even if Halyalkar and the doctrine of collateral estoppel were considered to be relevant in this matter, that case is distinguishable. In Halyalkar, the Court concluded that the relevant factual issue had not been determined in the previous consent order and, therefore, the necessary identicality of issue with the second proceeding was not established. Here, Respondent had agreed that Washington "would show" the conduct at issue in this later proceeding (Ex. 18).

SECOND SPECIFICATION - PARAGRAPH B OF THE STATEMENT OF CHARGES

Finding of Fact 4 herein relates to the SECOND SPECIFICATION. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph B	**sustained** (Finding of Fact 4)

Conclusions Regarding the Commission of Professional Misconduct

Again, Respondent is charged with professional misconduct pursuant to New York Education Law Section 6509(5)(d) (McKinney Supplement, 1990) and Education Law Section 6509(2) (McKinney, 1985). This SPECIFICATION is based on action taken by New Jersey which in turn had taken disciplinary action against Respondent based on the proceeding in Washington. In effect, this is a repeat of the charge in the FIRST SPECIFICATION. The hearing committee concludes that this charge should be sustained as a technical matter, but it recognizes that it is not, in reality, a separate charge involving a separate act of professional misconduct.

REGARDING PATIENT A - THIRD THROUGH FOURTEENTH, TWENTY-SEVENTH AND FORTY-FOURTH SPECIFICATIONS

Findings of Fact 5 through 19 herein relate to Patient A. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph C	**sustained** (Finding of Fact 5)
paragraph C(1)	**not sustained** (Finding of Fact 6)
paragraphs C(2) and C(3)	**not sustained** (Finding of Fact 7)

paragraph C(4)	**not sustained** (Findings of Fact 8 and 9)
paragraph C(5)	**not sustained** (Finding of Fact 10)
paragraph C(6)	**sustained** (Finding of Fact 11)
paragraph C(7)	**sustained** (Finding of Fact 12)
paragraph C(8)	**sustained** (Finding of Fact 13)
paragraph C(9)	**not sustained** (Finding of Fact 14)
paragraph C(10)	**not sustained** (Finding of Fact 15)
paragraph C(11)	**sustained** (Finding of Fact 16)
paragraph C(12)	**sustained in part** (Findings of Fact 17-19)

Conclusions Regarding the Commission of Professional Misconduct

The following charges of gross negligence should not be sustained because the underlying factual allegations in the Statement of Charges were not sustained:

THIRD SPECIFICATION -- Finding of Fact 7
FOURTH SPECIFICATION -- Finding of Fact 7
FIFTH SPECIFICATION -- Finding of Fact 10
SEVENTH SPECIFICATION -- Findings of Fact 14 and 16

The charge of gross negligence in the SIXTH SPECIFICATION should not be sustained because Respondent's failure to diagnose Patient A's cancer by September 17, 1988 (Finding of Fact 11) did not constitute gross negligence as defined herein. That is, the failure was not egregious or conspicuously bad.

The following charges of gross incompetence should not be sustained because the underlying factual allegations in the

Statement of Charges were not sustained:

EIGHTH SPECIFICATION -- Finding of Fact 7
NINTH SPECIFICATION -- Finding of Fact 7
TENTH SPECIFICATION -- Finding of Fact 10
TWELFTH SPECIFICATION -- **Findings of Fact 14 and 16**

The charge of gross incompetence in the ELEVENTH SPECIFICATION should not be sustained because Respondent's failure to diagnose Patient A's cancer by September 17, 1988 (Finding of Fact 11) did not constitute gross incompetence as defined herein. That is, the failure was not proved to have involved an unmitigated lack of skill or knowledge.

The charge of negligence in the THIRTEENTH SPECIFICATION regarding Patient A should be sustained because Respondent's actions (Findings of Fact 11-13) constituted negligence as defined herein. All other charges of negligence regarding Patient A should not be sustained because the underlying factual allegations were not sustained.

The charge of incompetence in the FOURTEENTH SPECIFICATION regarding Patient A should not be sustained because it was not proved that Respondent's acts (Findings of Fact 11-13) resulted from a lack of skill or knowledge.

The charge of unprofessional conduct in the TWENTY-SEVENTH SPECIFICATION should not be sustained because the underlying factual allegations were not sustained (Finding of Fact 15).

The charge of unprofessional conduct in the FORTY-FOURTH SPECIFICATION for failing to maintain an accurate medical record

for Patient A should be sustained pursuant to Findings of Fact 17-19.

REGARDING PATIENT B - THIRTEENTH THROUGH FIFTEENTH, TWENTY-EIGHTH, THIRTY-SECOND, FORTY-THIRD AND FORTY-FIFTH SPECIFICATIONS

Findings of Fact 20 through 29 herein relate to Patient B. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph D	**sustained** (Finding of Fact 20)
paragraph D(1)	**not sustained** (Finding of Fact 21)
paragraph D(2)	**not sustained** (Finding of Fact 22)
paragraph D(3)	**not sustained** (Finding of Fact 22)
paragraph D(4)	**sustained** (Finding of Fact 23)
paragraph D(5)	**sustained in part** (Finding of Fact 24)
paragraph D(6)	**sustained** (Findings of Fact 25 and 26)
paragraph D(7)	**sustained** (Findings of Fact 27 and 28)
paragraph D(8)	**sustained in part** (Finding of Fact 29)

Conclusions Regarding the Commission of Professional Misconduct

The charge of negligence in the THIRTEENTH SPECIFICATION regarding Patient B should be sustained because Respondent's actions (Findings of Fact 27 and 28) constituted negligence as defined herein. All other charges of negligence regarding Patient

B should not be sustained because the underlying factual allegations were not sustained.

The charge of incompetence in the FOURTEENTH SPECIFICATION regarding Patient B should not be sustained because it was not proved that Respondent's acts (Findings of Fact 27 and 28) resulted from a lack of skill or knowledge.

The charge of practicing the profession fraudulently in the FIFTEENTH SPECIFICATION should be sustained because Respondent's actions (Findings of Fact 23-26) constituted an intent to deceive related to his practice of medicine.

The charge of unprofessional conduct in the TWENTY-EIGHTH SPECIFICATION should not be sustained because the underlying allegations were not sustained.

The charges of unprofessional conduct in the THIRTY-SECOND SPECIFICATION and the FORTY-THIRD SPECIFICATION relating to Patient B should be sustained because Respondent's actions (Findings of Fact 23-26) constituted willfully making or filing false reports and conduct in the practice of medicine which evidences moral unfitness to practice medicine, respectively.

The charge of unprofessional conduct in the FORTY-FIFTH SPECIFICATION should be sustained because Respondent's conduct (Finding of Fact 29) constituted a failure to maintain an accurate medical record for Patient B.

REGARDING PATIENT C - THIRTEENTH, FOURTEENTH, SIXTEENTH, TWENTY-NINTH, THIRTY-THIRD, FORTY-THIRD AND FORTY-SIXTH SPECIFICATIONS

Findings of Fact 30 through 40 herein relate to Patient

C. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph E	**sustained** (Finding of Fact 30)
paragraph E(1)	**not sustained** (Finding of Fact 31)
paragraph E(2)	**sustained** (Findings of Fact 32 and 33)
paragraph E(3)	**sustained** (Finding of Fact 34)
paragraph E(4)	**sustained** (Finding of Fact 35)
paragraph E(5)	**not sustained** (Finding of Fact 36)
paragraph E(6)	**not sustained** (Finding of Fact 37)
paragraph E(7)	**not sustained** (Finding of Fact 38)
paragraph E(8)	**sustained in part** (Finding of Fact 39)
paragraph E(9)	**sustained** (Finding of Fact 40)

Conclusions Regarding the Commission of Professional Misconduct

The charge of negligence in the THIRTEENTH SPECIFICATION regarding Patient C should be sustained because Respondent's actions (Findings of Fact 32-35) constituted negligence as defined herein. All other charges of negligence regarding Patient C should not be sustained because the underlying factual allegations were not sustained.

The charge of incompetence in the FOURTEENTH SPECIFICATION regarding Patient C should not be sustained because

it was not proved that Respondent's acts (Findings of Fact 32-35) resulted from a lack of skill or knowledge.

The charge of practicing the profession fraudulently in the SIXTEENTH SPECIFICATION should be sustained because Respondent's actions (Finding of Fact 40) constituted an intent to deceive related to his practice of medicine.

The charges of unprofessional conduct in the TWENTY-NINTH, THIRTY-THIRD, FORTY-THIRD and FORTY-SIXTH SPECIFICATIONS should be sustained because Respondent's actions constituted performing professional services which had not been duly authorized (Findings of Fact 32 and 33), willfully making or filing false reports (Finding of Fact 40), conduct in the practice of medicine which evidences moral unfitness to practice medicine (Finding of Fact 40), and a failure to maintain an accurate medical record for Patient C (Finding of Fact 39), respectively.

REGARDING PATIENT D - THIRTEENTH, FOURTEENTH, THIRTIETH AND FORTY-SEVENTH SPECIFICATIONS

Findings of Fact 41 through 44 herein relate to Patient D. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph F	**sustained** (Finding of Fact 41)
paragraph F(1)	**sustained in part** (Finding of Fact 42)
paragraph F(2)	**sustained** (Finding of Fact 43)
paragraph F(3)	**sustained in part** (Finding of Fact 44)

Conclusions Regarding the Commission of Professional Misconduct

The charge of negligence in the THIRTEENTH SPECIFICATION regarding Patient D should be sustained because Respondent's actions (Findings of Fact 42 and 43) constituted negligence as defined herein.

The charge of incompetence in the FOURTEENTH SPECIFICATION regarding Patient D should not be sustained because it was not proved that Respondent's acts (Findings of Fact 42 and 43) resulted from a lack of skill or knowledge.

The charges of unprofessional conduct in the THIRTIETH and FORTY-SEVENTH SPECIFICATIONS should be sustained because Respondent's actions constituted performing professional services which had not been duly authorized (Finding of Fact 43) and failing to maintain an accurate record for Patient D (Finding of Fact 44), respectively.

REGARDING PATIENT E - SEVENTEENTH, THIRTY-FOURTH AND FORTY-THIRD SPECIFICATIONS

Findings of Fact 45 through 48 herein relate to Patient E. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph G	**sustained** (Finding of Fact 45)
paragraphs G(1) and G(2)	**not sustained** (Findings of Fact 46-48)

Conclusions Regarding the Commission of Professional Misconduct

The charges of practicing the profession fraudulently in the SEVENTEENTH SPECIFICATION, and unprofessional conduct in the THIRTY-FOURTH and FORTY-THIRD SPECIFICATIONS should not be sustained because the underlying factual allegations were not sustained.

REGARDING PATIENT F - THIRTEENTH, FOURTEENTH, EIGHTEENTH, THIRTY-FIFTH, FORTY-THIRD AND FORTY-EIGHTH SPECIFICATIONS

The SPECIFICATIONS regarding Patient F were withdrawn by Petitioner (Finding of Fact 49).

REGARDING PATIENT G - THIRTEENTH, FOURTEENTH, NINETEENTH, THIRTY-FIRST, THIRTY-SIXTH AND FORTY-THIRD SPECIFICATIONS

Findings of Fact 50 through 55 herein relate to Patient G. The hearing committee reached the following conclusions regarding the factual allegation in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph I	**sustained** (Finding of Fact 50)
paragraph I(1)	**not sustained** (Finding of Fact 50)
paragraph I(2)	**not sustained** (Finding of Fact 51)
paragraph I(3)	**not sustained** (Finding of Fact 52)
paragraphs I(4) and I(5)	**not sustained** (Findings of Fact 53 and 54)

Conclusions Regarding the Commission of Professional Misconduct

The charges of negligence in the THIRTEENTH

SPECIFICATION, incompetence in the FOURTEENTH SPECIFICATION, fraudulent practice in the NINETEENTH SPECIFICATION, and unprofessional conduct in the THIRTY-FIRST, THIRTY-SIXTH and FORTY-THIRD SPECIFICATIONS relating to Patient G should not be sustained because the underlying factual allegations were not sustained.

REGARDING PATIENT H - TWENTIETH, THIRTY-SEVENTH AND FORTY-THIRD SPECIFICATIONS

The SPECIFICATIONS regarding Patient H were withdrawn by Petitioner (Finding of Fact 56).

REGARDING PATIENT I - TWENTY-FIRST, THIRTY-EIGHTH, AND FORTY-THIRD SPECIFICATIONS

The SPECIFICATIONS regarding Patient I were withdrawn by Petitioner (Finding of Fact 57).

REGARDING PATIENT J - TWENTY-SECOND, THIRTY-NINTH AND FORTY-THIRD SPECIFICATIONS

Findings of Fact 58 and 59 herein relate to Patient J. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	**Conclusions as to Factual Allegations**
paragraph L	**sustained** (Finding of Fact 58)
paragraphs L(1) and L(2)	**not sustained** (Finding of Fact 59)

Conclusions Regarding the Commission of Professional Misconduct

The charges of fraudulent practice in the TWENTY-SECOND SPECIFICATION and unprofessional conduct in the THIRTY-NINTH and