STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

December 7, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael A. Hiser, Esq.
Assistant Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Phinehas Z. Makoyo, M.D.
Shirati Hospital
PVT - BAG U2
Musoma
Tanzenia, Africa

RE: In the Matter of Phinehas Z. Makoyo, M.D.

Dear Mr. Hiser and Dr. Makoyo:

Enclosed please find the Determination and Order (No. BPMC-92-105) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must than be delivered to the Office of Professional Medical Conduct in the manner noted above.

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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.

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	
OF	:	DETERMINATION AND ORDER
PHINEAS Z. MAKOYO, M.D.	:	
		ORDER NO. BPMC-92-105

TIMOTHY TRUSCOTT, Chairman, JOSEPH G. CHANATRY, M.D. and ROBERT J. PEARTREE, M.D. duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. MICHAEL P. MCDERMOTT, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	June 19, 1992
Hearing Dates:	October 1, 1992
Place of Hearing:	NYS Department of Health Tower Building Empire State Plaza Albany, New York
Date of Deliberations:	November 2, 1992

Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Michael A. Hiser, Esq. Assistant Counsel
Respondent appeared by:	The Respondent failed to appear

MOTIONS:

On October 1, 1992, the Petitioner made a motion to withdraw the charges specified in paragraph C of the original Statement of Charges. Motion GRANTED - First Amended Statement of Charges accepted in evidence.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, moral unfitness, fraudulent practice and failing to maintain 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.

WITNESSES

For the Petitioner:

Lyle Barlyn, M.D.

Henry Radke

Saundra Barnett-Reyes, M.D.

For the Respondent:

NONE

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or 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. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDING

1. Phinehas Z. Makoyo, M.D., the Respondent, was authorized to practice medicine in New York State on April 20, 1979 by the issuance of license number 137916 by the State Education Department. The Respondent was last registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1990 from 6 Winding Way, Oswego, New York 13126 (Pet's Ex. 10).

2. The Respondent currently lives in Tanzania. He was served with the Notice of Hearing and Statement of Charges in this matter on August 12, 1992 at K.M.T. Shirati Hospital, Musoma Tanzania E.A. (Pet's. Ex. 1).

FINDINGS AS TO PATIENT A

3. Patient A, a 77 year old male, was admitted to the Oswego Hospital, Oswego, New York (hereinafter, "Hospital")

on or about August 1, 1986, with complaints of sudden onset of profuse rectal bleeding (Pet's. Ex. 4, p. 62).

4. The Emergency Room record for Patient A indicates that upon rectal examination by the emergency room physician, the patient was found to have a rectal pedunculated mass left anteriorly and that the hemoccult test from the rectal examination was positive (Pet's. Ex. 4; p. 62).

5. The Respondent was consulted as a general surgeon in the care of Patient A (Pet's. Ex. 4, p. 29).

6. The accepted practice for diagnosing this condition is to first perform a digital rectal examination, then have an anoscopic examination to actually visualize the lesion and thereafter perhaps a biopsy if indicated (Tr. 29).

7. There is no indication in the Respondent's consultant's report that he performed a rectal examination on Patient A (Pet's. Ex. 4, p. 29)

8. Based on the operative note however, it appears that the Respondent performed a flexible sigmoidoscopy on Patient A on August 2, 1986 (Pet's. Ex. 4, p. 36; Tr. 32-33).

9. There is a disadvantage in using the flexible sigmoidoscope in that the instrument is frequently passed into the rectum and the anus and will slide past a lesion or tumor that is immediately adjacent to the sphincter. If a surgeon or gastroenterologist does feel something on a

digital exam, the accepted practice is to use the flexible sigmoidoscope, and also to use an anoscope and/or a rigid sigmoidscope (Tr. 30).

10. On August 2, 1986 the Respondent ordered a barium enema which was performed on that day following the sigmoidoscopy (Pet's. Ex. 4, p. 24).

11. A barium enema will not show lesions in the distal rectum.

12. On August 3, 1986, the Respondent ordered an upper GI series which was performed on August 4, 1986 (Pet's. Ex. 4, p. 58).

13. Neither the sigmoidoscopy, the barium enema nor the upper GI series were diagnostic of the rectal tumor (Pet's. Ex.. 4, 36, 58, 59).

14. Patient A was discharged from the hospital on August 5, 1986 (Pet's. Ex. 4, p.6).

15. Patient A was readmitted to the Oswego Hospital on September 9, 1986, with a complaint of bright red blood per the rectum. A physical examination revealed a lesion at the left rectal wall (Pet's. Ex. 5, pp. 658-659).

16. A biopsy was taken on September 10, 1986 by the Respondent. The pathology report diagnosed the biopsied tissue as "fairly well differentiated adenocarcinoma, rectum" (Pet's. Ex. 5, pp. 224-225, 446).

17. The patient was scheduled to have surgery, an abdominal perineal resection, on September 12, 1986 (Pet's.

Ex. 5, p. 186).

18. The Respondent wrote orders for the patient to receive a bowel prep at approximately 5:00 p.m. on September 11, 1986, which was approximately 18 hours prior to surgery (Pet's. Ex. 5, p. 186).

19. The surgery was performed on Patient A on September 12, 1986, beginning at approximately 10:45 a.m. The procedure described is an abdominal perineal proctosigmoidectomy, which is another name for an abdominal perineal resection (Pet's. Ex. 5, pp. 204-207; Tr. 42).

20. The purpose of the procedure is to remove the rectoidsigmoid and the rectum and sphincter. The procedure requires a colostomy (Tr. 42).

21. The laparotomy sponge count for the patient was noted to be incorrect by one of the nurses, and the Respondent was so notified (Pet's. Ex. 5, p. 216).

22. The fact of an unaccounted for laparotomy sponge in an operative procedure should be reflected in the operative report (Tr. 45).

23. The Respondent's operative report makes no mention of the fact that a laparotomy sponge was unaccounted for in the operative procedure (Pet's. Ex. 5, pp. 204-207).

24. When a surgeon has been apprised that a laparotomy sponge is not accounted for in the operating room, he should first re-explore the wound. If necessary, the abdominal incision is opened up to be re-explored manually. If that

does not reveal the location of the lost item, then an adequate x-ray should be carried out right on the operating table (Tr. 45).

25. The Respondent was apprised of the fact that the sponge was missing. This necessitated an x-ray consultation. The x-ray technician was called and the patient's x-rays were taken in the operating room. The x-rays were read by the radiologist to be negative of foreign body. Additional checks were made to look for the missing sponge. Two additional sets of x-rays were taken of the patient in the recovery room. These were also reported to be normal, i.e. without a sponge (Pet's Ex. 5, pp. 89-90, 458).

26. The first x-ray, Petitioner's Exhibit 6-1, was an x-ray of Patient A's upper abdomen and lower chest. This x-ray is incomplete in that it does not show the lower part of the abdomen nor most of the area where the operation had occurred (Pet's. Ex. 6-1; Tr. 51-52).

27. The second x-ray, Petitioner's Exhibit 6-2, shows Patient A's lower abdomen. This film is of very poor quality and does not give a full view of the operative site (Pet's. Ex. 6-2; Tr. 52-53).

28. The third x-ray, Petitioner's Exhibit 6-3, is an x-ray of Patient A's abdomen and lower pelvis. This x-ray is of extremely poor quality and would not allow for the identification of a foreign body (Pet's. Ex. 6-3; Tr. 53).

29. None of the x-rays represented by Petitioner's Exhibits 6-1, 6-2 and 6-3, would have allowed a surgeon to determine the presence of a foreign body in the patient (Tr. 53).

30. It was the responsibility of the surgeon (the respondent) to review the films with the radiologist to determine if the x-rays were of adequate quality to identify whether or not a foreign body was present (Tr. 53-54).

31. Patient A was returned to surgery on September 24, 1986, and a laparotomy sponge was found in the patient at the "splenic flexture". The laparotomy sponge was determined to be radiographically opaque (Pet's. Ex. 5, pp. 194-195).

32. Patient A lost approximately 3500 cc of blood during the operation of September 12, 1986. This amount of blood loss is out of the range of normal (Pet's. Ex. 5, p. 147; Tr. 54).

33. Following the surgery on September 12, 1986, Patient A bled approximately 1500 cc for the first 24 hours, and 1600 cc the following 12 hours (Pet. Ex. 5, pp. 645, 638).

34. Bleeding in the amount of approximately 3100 cc during the 36 hours following the surgery is excessive and the patient should have been returned to the operating room to find the site of the bleeding (Tr. 56).

35. The Respondent failed to return the patient to the

operating room to determine the site of bleeding (Pet's. Ex. 5).

36. At 10:00 p.m. on September 12, 1986, the Respondent ordered Pitressin 0.4 units per minute for one hour for Patient A (Pet.'s Ex. 5, p. 182).

37. At 12:15 a.m. on September 13, 1986, the Respondent ordered Pitressin 0.2 units per minute during the night for Patient A (Pet.'s Ex. 5; p. 182).

38. Pitressin is a naturally occurring substance which can cause venous and arterial constriction. It is often used for gastrointestinal bleeding related to the portal hypertension of cirrhosis. It is also used to control the bleeding in liver disease. However, it is not a substance which is used to control the bleeding of surgical trauma (Tr. 55).

39. Patient A had a history of arteriosclerotic heart disease and myocardial infarction (Pet's. Ex. 5, pp. 89, 658; Pet. Ex. 4, p. 6).

40. Pitressin is not indicated where a patient has had a history of myocardial infarction because Pitressin is likely to cause constriction of the coronary vessels and might lead to problems with the heart (Tr. 56).

41. The management of the fluid status of a patient is the responsibility of the surgeon, unless the patient were in an intensive care unit and an intensive care unit specialist was available. In this case, the Respondent was

responsible for the fluid status of Patient A (Tr. 58).

42. A patient's fluid status is managed by attempting to keep the patient's vital signs stable and to maintain a balance between fluid intake and output (Tr. 58-59).

43. Diuretics cause a patient to be diuressed, i.e., they force fluids out of a patient (Tr. 59).

44. The Respondent ordered diuretics for Patient A as follows:

9/30/86	9:00 P.M. - Lasix 80 mg. 10:05 P.M. - Lasix 160 mg.
10/02/86	11:50 A.M. - Bumex 2 mg. IV 2:05 P.M. - Edecrin 50 mg. IV 9:25 P.M. - Lasix 120 mg. IV
10/03/86	3:30 A.M. - Lasix 160 mg. IV 7:00 A.M. - Edecrin 50 mg. IV no time indicated - Hydrodiuril 50 mg. IV 10:10 A.M. - Diuril 500 mg. and Lasix 120 mg. every six hours Sometime after 8:00 - Diuril, Lasix and Edecrin
10/04/86	8:45 - Diuril 500 mg. every four hours P.R.N. 8:45 - Lasix 120 mg. every 4 hours P.R.N

(Pet's. Ex. 5, pp. 153-156, 163).

45. Diuretics are not usually used in a patient who is actively bleeding (Tr. 59).

46. Crystalloids are basically water with electrolytes and are used in the fluid management of a patient (Tr. 59-60)

47. Lactated ringers solution is a crystalloid.

48. On September 30, 1986, the Respondent ordered approximately 5500 cc of crystalloids for Patient A (Pet's Ex. 4, p. 11).

49. The Respondent ordered crystalloids for Patient A again on October 1, 1986, and Patient A received approximately 7000 cc of lactated ringer solution on that day (Pet. Ex. 4, p. 13; Tr. 77).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to perform and/or record the performance of a rectal examination of Patient A during the admission of August 1, 1986 to August 5, 1986, despite an emergency room finding and recording that Patient A had a rectal mass.

2. The Respondent failed to obtain adequate diagnostic tests on Patient A during the admission of August 1, 1986 to August 5, 1986.

3. The Respondent prepared Patient A's bowel for an adequate length of time prior to performing surgery on September 12, 1986.

4. The Respondent failed to adequately search for a laparotomy sponge unaccounted for during surgery on Patient A on September 12, 1986, despite being told that the sponge was missing.

5. The Respondent failed to record in his report of the September 12, 1986 surgery that the laparotomy sponge

was unaccounted for.

6. The Respondent's use of Pitressin to stop Patient A's post-operative bleeding following the operation of September 12, 1986 was not indicated and/or was contraindicated.

7. The Respondent failed to re-operate on Patient A to remedy Patient A's excessive bleeding following the operation of September 12, 1986.

8. The Respondent failed to properly control Patient A's fluid intake and output in that he prescribed excessive diuretics and excessive crystalloids for Patient A following the surgery of September 12, 1986.

FINDINGS AS TO PATIENT B

50. Patient B, a 71 year old female, was admitted to the hospital on October 15, 1986, due to complaints of a two week history of constipation. The Respondent was Patient B's attending physician (Pet's. Ex. 7, pp. 4, 26).

51. The Respondent took a personal history of Patient B during which he noted that the patient had undergone "numerous surgical procedures [secondary to] gynecologic cancer" (Pet's. Ex. 7, p. 26).

52. The history taken by the Respondent of this patient relative to her numerous surgical procedures secondary to gynecological cancer is incomplete in that it

fails to list the procedures performed and the reasons for the procedures (Tr. 93-94).

53. A plane x-ray of Patient B's abdomen was taken October 15, 1986. The radiographic findings of the plane x-ray did not indicate any type of obstruction. The radiographic findings did not support the diagnosis of obstruction (Pet's. Ex. 7, p. 106; Tr. 95).

54. A barium enema was performed on Patient B on October 15, 1986. The radiographic findings of the barium enema did not support a diagnosis of colon obstruction (Pet's. Ex. 7, p. 106; Tr. 95-96).

55. A barium enema was performed again on Patient B on October 20, 1986. The radiologic findings of the barium enema indicates that there may be a narrowed area of possible constriction in a segment of the colon, but not that the colon was obstructed (Pet. Ex. 7, p. 102; Tr. 97).

56. A scout film of Patient B's abdomen was performed on October 19, 1986. The radiologic findings for the scout film did not indicate any type of obstruction (Pet.'s Ex. 7, p. 103; Tr. 97).

57. Procedures described by the Respondent as flexible distal colonoscopies (flexible sigmoidoscopy) were performed on Patient B on October 15 and October 20, 1986 (Pet's. Ex. 7, pp. 62, 66)

58. While the two barium enemas and the two flexible colonoscopies did not show evidence of complete bowel

obstruction, there was a suggestion of significant right colon pathology on the barium enema test of October 20, 1986 (Pet. Ex. 7, p. 102).

59. On October 22, 1986, the Respondent performed a right hemicolectomy with ileotransverse colostomy on Patient B (Pet's. Ex. 7, pp. 50-51).

60. The operation was performed not for obstruction but due to a perceived abnormality in the ascending colon, perhaps a tumor. The evidence of the abnormality came mostly from the barium enema of October 20, 1986, which showed the constricted area on the ascending colon (Pet's. Ex. 7, p. 98; Tr. 103-104).

CONCLUSIONS AS TO PATIENT B

1. The Respondent failed to take an adequate history of Patient B to discover the extent and type of prior surgery for gynecological cancer, despite having been informed that Patient B previously had undergone numerous surgical procedures secondary to gynecological cancer.

2. The Respondent performed an exploratory laparotomy on Patient B on October 22, 1986, which appeared to be indicated at the time based on the barium enema study of October 20, 1986.

3. The Respondent performed a right hemicolectomy with ileotransverse colostomy on Patient B on October 22, 1986.

FINDINGS AS TO FRAUD IN THE PRACTICE OF MEDICINE/MORAL UNFITNESS

The Respondent submitted disability insurance claim forms to Paul Revere Life Insurance Company dated August 26, 1989. November 1, 1989, December 6, 1989, and February 1, 1990. On each form the Respondent provided an "Attending Physician's Statement". The statements included dates of treatment, diagnosis, prognosis and other information purporting to represent the Respondent's treatment by Saundra B. Reyes, M.D. Payments totalling $12,000 were made to the Respondent by Paul Revere between the months of August 1989 and April 1990 based on these claims. In fact, Dr. Reyes did not sign or fill out any of the four "Attending Physicians Statements" submitted to the insurance company by the Respondent (Pet's. Ex. 8, p. 4; Pet's. Ex. 9, pp. 22, 48-52, 65-69, 79-80, 82-83, 87-88, 90-91, 133-136, 139; Tr. 101-102, 120-128, 131-133, 136-138, 140-147).

CONCLUSIONS AS TO FRAUD IN THE PRACTICE OF MEDICINE/MORAL UNFITNESS

The Hearing Committee concludes from the evidence that the Respondent knew that the "Attending Physician Statements" had not been filed out and signed by Dr. Reyes, and that the Respondent intended to, and did in fact, mislead the Paul Revere Company through the submission of the forged "Attending Physician Statements".

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous)

FIRST THROUGH SECOND SPECIFICATIONS: (GROSS NEGLIGENCE)

SUSTAINED as to the charges specified in paragraphs A6, A7 and A8 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in paragraphs A1, A2, A3, A4, A5, B1, B2, B3 and B4 of the Statement of Charges.

THIRD THROUGH FOURTH SPECIFICATIONS: (GROSS INCOMPETENCE)

NOT SUSTAINED as to the charges specified in paragraphs A1, A2, A3, A4, A5, A6, A7, A8, B1, B2, B3 and B4 of the Statement of Charges.

FIFTH SPECIFICATION: (NEGLIGENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to the charges specific in paragraphs A1, A2, A4, A5, A6, A7, A8 and B1 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in paragraphs A3, B2, B3 and B4 of the Statement of Charges.

SIXTH SPECIFICATION: (INCOMPETENCE ON MORE THAN ONE OCCASION)

SUSTAINED as to the charges specified in paragraphs A6 and A8 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in

paragraphs A1, A2, A3, A4, A5, A7, B1, B2, B3, and B4 of the Statement of Charges.

SEVENTH SPECIFICATION: (MORAL UNFITNESS)

SUSTAINED as to the charges specified in paragraph C of the Statement of Charges.

EIGHTH SPECIFICATION: (FRAUDULENT PRACTICE)

SUSTAINED as to the charges specified in paragraph C of the Statement of Charges.

DETERMINATION

The Hearing Committee has considered the full spectrum of available penalties, including revocation, suspension, probation, censure and reprimand or the imposition of civil penalties not to exceed $10,000 per violation.

If this case was solely concerned with the Respondent's treatment and care of Patients A and B, the Hearing Committee might have considered placing the Respondent on probation with supervision for a period of two years with an appropriate program of retraining.

However, given the fact that the Hearing Committee has sustained the charges of fraudulent practice and moral unfitness against the Respondent, the only appropriate penalty is **REVOCATION.**

ORDER

ORDERED, that the Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: Albany, New York

12/4, **1992**

TIMOTHY TRUSCOTT,
Chairman

JOSEPH G. CHANATRY, M.D.
ROBERT J. PEARTREE, M.D.

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

	:	FIRST
	:	AMENDED
IN THE MATTER	:	STATEMENT
OF	:	OF
PHINEHAS Z. MAKOYO, M.D.	:	CHARGES

PHINEHAS Z. MAKOYO, M.D., the Respondent, was authorized to practice medicine in New York State on April 20, 1979 by the issuance of license number 137916 by the New York State Education Department. The Respondent was last registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1990 from 6 Winding Way, Oswego, New York 13126.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [all patients are identified in Appendix A] from on or about August 1, 1986 through August 5, 1986, and from September 9, 1986 through October 4, 1986 at the Oswego Hospital, Oswego, New York [hereinafter "Oswego Hospital"]. Patient A was admitted to Oswego Hospital on August 1, 1986 due to rectal bleeding.

Patient A was re-admitted to Oswego Hospital on September 9, 1986 due to rectal bleeding.

1. Respondent failed to perform and/or record the performance of a rectal examination of Patient A during the admission of August 1, 1986 to August 5, 1986, despite an emergency room finding and recording that Patient A had a rectal mass.
2. Respondent failed to obtain adequate diagnostic tests on Patient A during the admission of August 1, 1986 to August 5, 1986.
3. Respondent failed to prepare Patient A's bowel for an adequate length of time prior to performing non-emergency surgery on September 12, 1986.
4. Respondent failed to adequately search for a laparotomy sponge unaccounted for during surgery on Patient A on September 12, 1986, despite being told that the sponge was missing.
5. Respondent failed to record in his report of the September 12, 1986 surgery that the laparotomy sponge was unaccounted for.
6. Respondent's use of Pitressin to stop Patient A's post-operative bleeding was not indicated and/or contra-indicated.
7. Respondent failed to re-operate on Patient A to remedy Patient A's excessive bleeding following the operation of September 12, 1986.
8. Respondent failed to properly control Patient A's fluid intake and output in that he prescribed excessive diuretics and excessive crystalloids for Patient A following the surgery of September 12, 1986.

B. Respondent provided medical care to Patient B from on or about October 15, 1986 through October 29, 1986 at Oswego Hospital. Patient B was admitted to Oswego Hospital due to complaints of a two week history of constipation.

1. Respondent failed to take an adequate history of Patient B to discover the extent and type of prior surgery for gynecological cancer, despite having been told that Patient B previously had undergone numerous surgical procedures secondary to gynecologic cancer.

2. Respondent diagnosed Patient B as having a colon obstruction, which was not indicated.

3. Respondent performed an exploratory laparotomy on Patient B on October 22, 1986, which was not indicated.

4. Respondent performed a right hemicolectomy with ileotransverse colostomy on Patient B on October 22, 1986, without identifying significant disease in the cecum/colon.

C. Respondent submitted disability insurance claim forms to Paul Revere Life Insurance Company dated August 26, 1989, November 1, 1989, December 6, 1989, and February 1, 1990. On each form, Respondent provided an "Attending Physician's Statement". The statements included dates of treatment, diagnosis, prognosis and other information purporting to represent Respondent's treatment by Dr. Saundra B. Reyes. Payments totalling $12,000 were made to Respondent by Paul Revere between the months of August 1989 and April 1990. Respondent prepared and submitted the attending physician's statements with the knowledge that they were without the authorization or knowledge of Dr. Reyes.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Education Law §6530(4), in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, and/or A and A.8.

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

THIRD THROUGH FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Education Law §6530(6), in that Petitioner charges:

3. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7 and/or A and A.8.

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

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Education Law §6530(3), in that Petitioner charges that Respondent committed two or more of the following:

5. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, and/or B and B.4.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Education Law §6530(5), in that Petitioner charges that Respondent committed two or more of the following:

6. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, and/or B and B.4.

SEVENTH SPECIFICATION

UNPROFESSIONAL CONDUCT - MORAL UNFITNESS

The Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice the profession of medicine under N.Y. Education Law §6530(20), in that Petitioner charges:

7. The facts in Paragraph C.

EIGHTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with practicing the profession of medicine fraudulently under N.Y. Education Law §6530(2), in that Petitioner charges:

8. The facts in Paragraph C.

NINTH SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing unprofessional conduct under N.Y. Education Law §6530(32), by failing to maintain records for Patient A which accurately reflect the evaluation and treatment of the patient, in that Petitioner charges:

9. The facts in Paragraphs A and A.1 and/or A and A.5.

DATED: Albany, New York
October 1, 1992

Peter D. Van Buren

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