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.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

August 9, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Ziyad A. Mansur, M.D.

Dear Mr. Loughlin and Ms. Finkelstein :

Enclosed is the Supplemental Determination of the Hearing Committee. The parties shall have thirty days from the receipt of this Determination to submit additional briefs to the Review Board. Only those issues covered in the Supplemental Determination may be addressed in the briefs.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

STATE OR NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER	:	HEARING
OF	:	COMMITTEE'S
	:	SUPPLEMENTAL
ZIYAD A MANSUR, M.D.	:	DETERMINATION

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Stephen A. Gettinger, M.D., Chairperson, **George F. Couperthwait, Jr.**, and **William P. Dillon, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to §230(1) of the Public Health Law of the State of New York, served as the Hearing Committee (hereinafter the "Committee") in this matter pursuant to § 230(10)(e) and §230(12) of the Public Health Law. **Gerald H. Liepshutz, Esq.**, served as Administrative Officer for the Committee.

Pursuant to the Remand Order of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board") recieved by the Committee during the week of June 6, 1994, the Committee issues this Supplemental Determination following its deliberations on July 26, 1994 held at the Offices of the New York State Department of Health, Empire State Plaza, Corning Tower Building, Albany, New York.

QUESTIONS PRESENTED BY THE REVIEW BOARD

The Review Board in its Remand Order directed the Committee to answer the following questions:

1. Do the Committee's Findings of Fact 3, 4, 5, 7, 8, 10, 11 and 14 in its Order dated December 27, 1993 indicate that Respondent's access to Student A's apartment resulted from

his agreement to allow Student A to observe him perform surgical procedures?

2. Was Respondent's failure to perform an adequate evaluation of Patient B for the possibility of ectopic pregnancy (Finding of Fact 34) and/or Respondent's failure to warn Patient B of the possibility of ectopic pregnancy (Finding of Fact 39) negligence that was egregious or conspicuously bad?

3. Was Respondent's failure to warn Patient B of the possibility of ectopic pregnancy a conscious disregard of the consequence of the act or indifference to patient B's rights?

4. Did Respondent's statements in the records of Patients C through S, excluding Patient G, that the patients were suffering from dysplasia when he knew that the pathologist had not found dysplasia in the biopsy (Finding of Fact 74) demonstrate an indifference to these patients' rights or a conscious disregard of the consequences of this act? Did the statements in the records demonstrate intent to misrepresent a known fact?

5. Does the Committee's penalty limiting Respondent from treating cervical disease, in fact, limit Respondent from any practice as an obstetrician/gynecologist during the period of the suspension?

6. If Respondent is permitted to practice general medicine during the period of the limited suspension, how is the penalty to be enforced?

7. Would Respondent be banned from even performing an examination which could lead to a determination of cervical disease?

8. How does the one year probation relate to the partial suspension regarding the Committee's penalty?

ANSWERS

Following are the answers to the Review Board's questions as numbered above:

1. In addition to the Review Board's question 1 above, the Committee is also asked to discuss in greater detail its finding that Student A was not Respondent's student. In response, the Committee submits the following:

Petitioner's Exhibit 3 makes clear that the agency (BOCES) sponsoring Students A's assignment to spend a day with a health facility or a health care provider considered the assignment to be an "observational community clinical experience". BOCES specifically stated that there would "not be an instructor available that day"(Ex. 3, p.2). Student A's role was to observe Respondent. She had other options such as spending the day with a health facility or a health care provider other than Respondent. She was a student of the BOCES Practical Nursing Program. Respondent had no appointment to the faculty of that program. He did not examine or grade Student A. Respondent had no relationship with BOCES at all except that he agreed to allow Student A to observe him at work. He had no duty to speak with her or to instruct her. The relationship between Respondent and Student A was similar to that of a high school student who spends a day with a health provider as part of a "doctor of tomorrow" experience. The student is an observer of the health care provider's work, not that provider's student.

Regarding the Review Board's question whether the Committee's Findings of Fact 3, 4, 5, 7, 8, 10, 11 and 14 indicate that Respondent's access to Student A's apartment resulted from his agreement to allow her to observe him perform surgical procedures: The short

answer to this question is, yes, perhaps Respondent's initial access to Student A's apartment resulted from his agreement to allow her to observe him perform surgical procedures, but the question is not relevant. This would not change the fact that she was not his student which is the issue now being discussed. Those findings of fact indicate that their relationship was virtually exclusively social except for her observational role discussed above. It is important to note that Respondent's visit to Student A's apartment on May 20, 1993 when the incident in question occurred was six days following the BOCES observational experience, and it had no relationship to the observation itself. May 20th was also five days following a brief social encounter during which they had danced together.

In its Order dated December 27, 1993, the Committee specifically addressed the issue of whether Student A was Respondent's student because it was so alleged in the Statement of Charges. As explained herein, the finding was that there did not exist a student-teacher relationship between them. The Committee wishes to emphasize that aside form the student- teacher relationship question, it separately concluded that the FIRST SPECIFICATION should not be sustained in any event because Respondent's conduct (Findings of Fact 14-17) on May 20, 1993 did not occur within the practice of medicine as required by New York Education Law Section 6530(20) and as defined by New York Education Law Section 6521 in that he was not "diagnosing, treating, operating or prescribing for any human disease, pain injury, deformity or physical condition". This applies even if one accepts, as the Committee does not, that Student A was Respondent's student on May 16, 1993 as alleged.

2. and 3. The Committee submits that the answer to the questions posed by the Review Board regarding Patient B in questions 2 and 3 above is no. It was concluded that Respondent's treatment of Patient B was negligent. Respondent's erroneous diagnosis of incomplete abortion was predicated on interpreting a sonogram report from Dr. Toma in Sidney Hospital that

there was "no evidence of (an) ectopic " pregnancy, and on Respondent's belief that Dr. Toma had reported the sonogram indicated an intrauterine sac (Finding of Fact 32). Relying on the sonogram report and ignoring other evidence of ectopic pregnancy constituted negligence, but it did not rise to the level of egregious conduct. Similarly, the failure to warn Patient B of the possibility of an ectopic pregnancy was negligence, but it was not gross negligence because it was not egregious nor did it manifest a conscious disregard of the consequences of the act or indifference to Patient B's rights. This is because Respondent, due to negligence and perhaps incompetence, erroneously thought he had properly ruled out ectopic pregnancy. The necessary element of consciousness was not proved to support a charge of gross negligence. As instructed by the administrative officer, a charge of gross negligence necessitates a showing of egregious conduct which has been defined as "conspicuously bad" conduct. The dictionary definition of "conspicuous" incorporates terms such as "obvious" and "plainly visible". Additionally, the legal dictionary definition of gross negligence states that it involves an intentional failure to perform a duty (Black's Law Dictionary, Sixth Edition, 1990, pp. 1033-1034) and the Department of Health has stated in its widely distributed memorandum of February 5, 1992 that consciousness of impending dangerous consequences is a necessary element of gross negligence. Respondent was in error, but the consciousness element was not proved.

4. Regarding Respondent's statements in patients' records that the patients were suffering from dysplasia when he knew that the pathologist had not found dysplasia in the biopsy: The Committee believes this was based on incompetence, but it was not gross negligence or fraud as charged because the consciousness element of gross negligence and the intentional deception element of fraud were not proved. Respondent's statements in the records did not demonstrate an indifference to the patients' rights or a conscious disregard of the consequences of the act. Furthermore, the statements did not demonstrate an intent to misrepresent a known fact. The Committee found that Respondent had erroneously stated in the records that the patients were

suffering from dysplasia (Finding of Fact 74). It was not found that he had done so knowing it was false, or to intentionly misrepresent or conceal a fact known to him. It was not proved that Respondent did not believe that the patients suffered from dysplasia. He misinterpreted the findings on colposcopic examination, on cervical cytology and on biopsy.

It is noted that all the patients in question, except Patients M and O, had indication for colposcopy. In patients C through R., Respondent made diagnoses of dysplasia through incompetent interpretation of colposcopic findings. Despite a lack of tissue confirmation, he erroneously believed he was treating cervical dysplasia.

5. Respondent is not totally limited from practicing obstetrics/gynecology. He may do visual inspection, palpation and obtain pap smears of the cervix. Any abnormalities of the cervix must be referred to a consultant. Respondent may not perform any other procedure on the cervix including, but not limited to, colposcopy, cervical biopsy, endocervical curettage, cervical cautery by any modality, cervical ablation, cervical conization by any modality, cryosurgery, LEEP (Loop Endocervical Excision Procedure) procedures and laser therapy.

6. The penalty of imposing a partial suspension of a respondent's license to a specified area or type of practice is legally permissible pursuant to Public Health Law Section 230-a. Enforcement of the penalty is within the purview of OPMC and/or BPMC, not this Committee. The Committee suggests, however, that the penalty be enforced by notifying all facilities at which Respondent has privileges and by audits of his office records.

7. Addressed in answer No. 5 above.

8. The Committee clarifies the one year probation requirement as follows: The one year probation is to commence after Respondent completes the retraining ordered by the

Committee. Respondent cannot currently treat cervical disease, except as related to his retraining. Following his successful retraining, Respondent will be allowed to treat cervical disease, but he will be placed on probation for a one year period as contemplated by Section 230-a(9) of the Public Health Law to allow monitoringof this area of his practice by the New York State Department of Health through periodic record inspections if deemed necessary. The condition that Respondent complete the retraining program within a one year probation period as stated on page 28 of the Committee's Order is vacated.

DATED: Halesite, New York
August 4 **,1994**

Stephen A Gettinger MD
STEPHEN A. GETTINGER, M.D.
Chairperson

GEORGE F. COUPERTHWAIT, JR.
WILLIAM P. DILLON, M.D.