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

Paula Wilson
Executive Deputy Commissioner

December 31, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Ziyad A. Mansur, M.D.
400 Main Street
Oneonta, New York 13820

Walter P. Loughlin, Esq.
Mark D. Beckett, Esq.
Mudge, Rose, Guthrie
Alexander & Ferdon
180 Maiden Lane
New York, New York 10038

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

Dear Parties:

Enclosed please find the Determination and Order (No. BPMC-93-215) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

Please note that a copy of this report went to the Commissioner of the New York State Department of Health for purposes of the Committee's Summary Order recommendation.

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:	HEARING COMMITTEE'S RECOMMENDATION ON SUMMARY ORDER AND HEARING COMMITTEE'S FINDINGS OF FACT, CONCLUSIONS, DETERMINATION AND ORDER
IN THE MATTER OF ZIYAD A. MANSUR, M.D.	NO. BPMC-93-215

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 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 hearing committee.

After consideration of the entire record, the hearing committee issues its Recommendation on Summary Order and its Findings of Fact, Conclusions, Determination and Order.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in copies of the

COMMISSIONER'S ORDER AND NOTICE OF HEARING and the **STATEMENT OF CHARGES** attached hereto:

1. Engaging in conduct in the practice of medicine which evidences moral unfitness to practice the profession pursuant to New York Education Law §6530(20) **(FIRST SPECIFICATION)**

2. Practicing the profession with gross negligence pursuant to New York Education Law §6530(4) **(SECOND AND THIRD SPECIFICATIONS)**

3. Practicing the profession with negligence on more than one occasion pursuant to New York Education Law §6530(3) **(FOURTH SPECIFICATION)**

4. Practicing the profession fraudulently pursuant to New York Education Law §6530(2) **(FIFTH SPECIFICATION)**

5. Ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient pursuant to New York Education Law §6530(35) **(SIXTH SPECIFICATION)**

6. Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient pursuant to New York Education Law §6530(32) **(SEVENTH SPECIFICATION)**

SUMMARY ORDER

This matter was initiated on June 29, 1993, by service on Respondent of an Order issued by the New York State Commissioner of Health summarily suspending Respondent's license

to practice medicine in New York State pursuant to Public Health Law §230(12).

Respondent waived the statutory ninety-day time limit for summary suspension, and he stipulated that the summary order will remain in full force and effect until a final decision was rendered by this committee or, if review is sought, by the administrative review board. Attached are copies of letters dated July 16, 1993 and July 15, 1993 from Respondent's attorneys setting forth this waiver and stipulation.

RECORD OF PROCEEDINGS

Service of **COMMISSIONER'S ORDER, NOTICE OF HEARING and STATEMENT OF CHARGES:**	June 29, 1993
Department of Health (Petitioner) appeared by:	Silvia P. Finkelstein, Esq. Associate Counsel Bureau of Professional Medical Conduct
Respondent appeared by:	Walter P. Loughlin, Esq. Mark D. Beckett, Esq. Mudge Rose Guthrie Alexander & Ferdon 180 Maiden Lane New York, New York 10038
Pre-hearing conference:	Cancelled upon request of both parties after determined to be unnecessary

Hearing dates:	1993 July 8 July 9 August 12 August 13 September 10 September 23 September 24 September 30
Hearing committee absences:	None
Adjournments:	September 17, 1993, due to religious holiday
Witnesses called by Petitioner:	Student A Richard A. Cecee, New York State Trooper Timothy J. Vinciguerra, M.D. John Remillard, President, A.O. Fox Memorial Hospital
Witnesses called by Respondent:	Irwin Weiner, M.D. Sabah Toma, M.D. Ziyad A. Mansur, M.D. Respondent
Post-hearing written submissions received from Petitioner: Respondent:	 October 18 and October 22,1993 October 6 and October 25, 1993
Dates of hearing committee's deliberations:	October 29, 1993 November 5, 1993

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 (3-0) of the hearing committee.

1. Ziyad A. Mansur, M.D., Respondent, was authorized to practice medicine in New York State on April 16, 1982, by the issuance of license number 149579 by the New York State Education Department. Respondent is currently registered with the Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 400 Main Street, Oneonta, New York 13820. (Ex. 2)

FIRST SPECIFICATION

Paragraph A of the Statement of Charges

2. Respondent delivered Student A's son about four years ago when she was a patient at a clinic at A.O. Fox Memorial Hospital in Oneonta, New York. The clinic was staffed on a rotation basis by the obstetrician-gynecologists who were on the staff at the hospital. (T. 40-41, 1020)

3. In April, 1993, Respondent and Student A, who was enrolled in a Licensed Practical Nursing program at Fox Hospital, noticed one another in a corridor at the hospital, recognized each other, and chatted briefly. There had been no contact or

communication between the two since the delivery of Student A's son which occurred four years previously. (T. 39-42, 1021)

4. One or two weeks later, Respondent and Student A met by chance in a public park in Oneonta that is near both of their residences. On that day, Student A was accompanied by her son and Respondent was with his two sons. The two spoke about Student A's son, engaged in "small talk," and discussed Student A's nursing program. Student A "mentioned that we had (a) community day experience which we were supposed to go into a hospital or a doctor's office, school or whatever, and observe." The community experience day was scheduled for May 14. (T. 42-43, 80, 84, 1021-1022, 1024)

5. Regardless of who initiated the request that Respondent allow Student A to observe him, the issue arose and was the subject of discussion, and it was agreed that Student A would spend the community day observing Respondent. (T. 43, 1022)

6. A short time later, Student A and Respondent saw each other again in the park. There was a "friendly chat" involving "small talk," the weather, and Babcock's, a local country-western dance hall. The two walked out of the park together past Student A's apartment and parted company. (T. 43-44, 90, 1034)

7. Approximately two days before the observation day, which was scheduled for May 14, 1993, Respondent telephoned Student A to inform her that the hospital required a release form to be signed before she would be permitted to observe him in the

operating room. Respondent also told her that he had completed the BOCES forms that her program required him to sign. Student A volunteered to pick up the forms at Respondent's office, but either because the forms were not in the office, or because she could only stop by the office in the evening when it would be closed, Respondent offered to drop them off at Student A's apartment which was in the same neighborhood only a few blocks from Respondent's home. (T. 45-47, 1025; Ex. 3)

8. Respondent delivered the papers to Student A's apartment on May 13, the evening before the observation day. Student A was expecting the visit which lasted approximately 45 minutes. After completing the forms, which only took several minutes, Respondent and Student A conversed for the remaining time discussing, among other things, Student A's son and his grandparents, and her classes. The two discussed their marital status and spending time with their children. (T. 68, 94, 98-102, 1026-1029)

9. Respondent noticed a group of photographs in the kitchen and asked about them. Student A told Respondent that the photographs were of a New York State Trooper named Anthony Cecee, of a former boyfriend, and of her son. The photograph of Trooper Cecee showed him in uniform. When Respondent asked if the picture of the trooper was a photograph of her boyfriend, she said "No." Student A explained that they were only dating, and that she did not have a boyfriend. (T. 102-103, 120, 1027-1028)

10. On May 14, 1993, Student A observed Respondent

perform five surgical procedures. The community experience day went smoothly, and Respondent behaved in a completely professional manner. (T. 53, 114)

11. Respondent had no responsibility for instructing Student A on that day, or for evaluating or grading her. It is clear from the form that Student A asked Respondent to sign that his role was a passive one involving only his agreement that he could be observed. (T. 1029-1030; Ex. 3)

12. The next day was Saturday, May 15, 1993. That evening both Student A and Respondent went to Babcock's, a country-western place that they had previously told each other that they liked to go to dance. (T. 44, 1028)

13. At Babcock's, they chatted briefly at his table, and they danced at least one slow dance and one fast dance. They talked during the dance. (T. 55, 118-119, 1030)

Paragraphs A.1(a), A.1(b), and A.1(c) of the Statement of Charges

14. On May 20, 1993, at approximately 10:30 P.M., Respondent appeared at Student A's home. When Student A inquired who was at the door, Respondent identified himself as "Dr. Mansur". Student A opened the door. (T. 57-58, 1031, 1053-1054)

15. Student A's 4 year old son was asleep on his bed which was a short distance away. (T. 58, 132, 136)

16. Respondent entered Student A's home, and he walked into the kitchen where she was studying. Respondent asked Student A what she was studying and discussed her books. He then started kissing her. Student A told Respondent that he made her

uncomfortable, and that she did not want to kiss. Respondent kept kissing Student A and telling her that she was beautiful. Student A repeatedly told Respondent "no" and "I don't want to". (T. 61-63, 65, 128-130, 132, 147, 162)

17. Respondent then put his arms around Student A's body while her arms were at her side, and he carried her to the bed which was nearby. Respondent pinned down Student A with his legs and straddled her above her waist. Respondent held Student A's arms above her head by her wrists. Student A kept telling Respondent "No, I don't want to." Respondent put his penis in Student A's mouth while pinning her arms down alongside her body with his legs. Student A resisted by moving her head from side to side. Respondent's weight on top of her prevented her from moving. Respondent ejaculated in her mouth. Student A spit out the semen into the bedspread and was crying. Respondent told Student A that he was sorry and that he did not mean to hurt her. (T. 62-64, 66-67, 137-138, 147)

18. Immediately after Respondent left, Student A telephoned New York State Trooper Anthony Cecce who came to her apartment. When Officer Cecce arrived, Student A was crying uncontrollably. She was holding herself, and her eyes were swollen. Student A reported to Officer Cecee that Respondent had raped her. (T. 67-68, 179-180, 182)

19. Student A spoke with a rape counselor on the following day, May 21, 1993. The counselor suggested that Student A not make a criminal complaint. This advice was what Student A

"wanted to hear". Subsequently, she reported the incident to the nursing school authorities. (T. 70-74, 186)

SECOND AND FOURTH SPECIFICATIONS

Paragraph B of the Statement of Charges

20. Respondent treated Patient B, a 20 year-old female, at his office at A.O. Fox Memorial Hospital between January 1992 and August 1992. (Ex. 4)

21. In January 1992, Patient B was seen by Respondent complaining of infertility for two years with a history of previous pelvic inflammatory disease. (T. 227; Ex. 4)

22. On January 17, 1992, Respondent performed a laparoscopy on Patient B. At the time of that procedure, the presence of adhesions around the fimbriated end of the fallopian tube was noted. The adhesions were lysed, and a D & C was performed. (T. 227-229; Ex. 4)

23. An ectopic pregnancy is any pregnancy outside of the normal intrauterine location. The majority of ectopic pregnancies occur in a fallopian tube. An ectopic pregnancy, if not surgically removed, may continue to grow and may rupture the tissue where it is implanted resulting in bleeding, shock and, if left untreated, death. (T. 222-226)

24. When an ectopic pregnancy is suspected, a reasonable clinician would document that fact in the patient's medical record and order appropriate follow-up. (T. 225)

25. On or about May 14, 1993, Patient B was admitted to A.O. Fox Memorial Hospital at approximately 4-5 weeks gestation with a history of abdominal pain and vaginal bleeding. She had a positive pregnancy test. (Dept. Ex. 4) Ultrasound had been performed at Sidney Hospital which was reported as negative and that ectopic pregnancy could not be ruled out. Respondent assumed that there was an empty gestational sac. (T. 227, 229, 831, 878; Ex. 4)

26. On or about May 15, 1992, Respondent performed a D & C which yielded a scant amount of tissue which was submitted to pathology. (T. 230) Patient B was discharged on that date. The corresponding pathology report dated May 18, 1993 shows no chorionic or decidual tissue. The pathology report confirmed the absence of any intrauterine tissue. (T. 230, 703-704; Ex. 4)

27. On May 24 1992, Patient B reported to another hospital with complaints of severe abdominal pain. She was transferred to A.O. Fox Memorial Hospital where on May 24, 1992 she underwent a surgical procedure by another physician for a ruptured ectopic pregnancy. (T. 234-235)

Paragraph B(1) of the Statement of Charges

28. Patient B had been examined at Sidney Hospital by emergency room physician, Dr. Sabah Toma. Patient B reported to Dr. Toma that a previous pregnancy test was positive. (T. 627; Ex. B)

29. Dr. Toma Performed an abdominal examination that

revealed slight tenderness in the left lower quadrant, but no masses, no distention, and no rigidity. Rebound and guarding tests were negative. (T. 627; Ex. B)

30. Dr. Toma also performed a pelvic examination that revealed some tenderness of the left adnexa, but no sign of a mass. The cervix was closed and there was no bleeding. (T. 627; Ex. B)

31. Respondent called Dr. Toma just after the examinations were completed and together they discussed Dr. Toma's findings, the patient's history, and the possibility of an ectopic pregnancy. Respondent asked Dr. Toma to have an ultrasound performed in order to rule out an ectopic pregnancy. An ultrasound was performed and Dr. Toma called Respondent to report the results he had obtained from the ultrasound technician. (T. 627-630, 829-830; Ex. C)

32. Respondent made an entry in his office records at the time of his conversation with Dr. Toma about the ultrasound results. Respondent's notes show that Respondent interpreted his conversation with Dr. Toma as follows: (1) the ultrasound was within normal limits, (2) the pregnancy was four weeks old and there was a sac, (3) there was "no evidence of [an] ectopic," and (4) there was no bleeding. (T. 830-831, 857-859; Ex. C)

33. Dr. Toma did not recall reporting the presence of a gestational sac. (T. 630)

34. Respondent failed to do an adequate evaluation of Patient B for the possibility of ectopic pregnancy prior to her

discharge on May 15, 1992. (T. 230)

35. Patient B's history, clinical picture, and diagnostic testing suggested the presence of an ectopic pregnancy. (T. 230-231)

36. Respondent failed to order a quantitative BETA HCG blood test, although such testing was indicated. (T. 233-236)

37. Respondent failed to follow up on the results of the pathology lab analysis he had ordered. (T. 706-712) Said results indicated that Respondent had not obtained any chorionic villi or decidual tissue in the D & C. (T. 232-233; Ex. 4).

38. The pathology report was completed on May 18, 1992. The written report was not received in Respondent's office until several months later. He had not previously requested the report nor alerted his covering doctor to request the pathology report. Again, there was no decidual tissue, placental tissue or chorionic villi found among the tissue fragments taken from the D & C. (Ex. 4 - Pathology Report dated May 15; T. 870, 884-886)

Paragraph B(2) of the Statement of Charges

39. Respondent failed to warn Patient B of the possibility of ectopic pregnancy prior to her discharge on May 15, 1992. (T. 231, 236, 838-839)

THIRD, FOURTH, FIFTH, SIXTH, AND SEVENTH SPECIFICATIONS

Paragraph C of the Statement of Charges

40. On March 2, 1993, Respondent performed a laser

vaporization of the cervix, under general anesthesia, on Patient C. (Ex. 6)

41. On or about May 8, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient D. (Ex. 8)

42. On or about May 15, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient E. (Ex. 10)

43. On or about June 1, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient F. (Ex. 12)

44. On or about July 10, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient G. (Ex. 14)

45. On or about July 22, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient H. (Ex. 16)

46. On or about August 28, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient I. (Ex. 18)

47. On or about August 31, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient J. (Ex. 20)

48. On or about September 2, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient K. (Ex. 22)

49. On or about September 11, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient L. (Ex. 24)

50. On or about October 9, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient M. (Ex. 26)

51. On or about October 15, 1992, Respondent performed a laser conization of the cervix, under general anesthesia, on Patient N. (Ex. 28)

52. On or about October 23, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient O. (Ex. 30)

53. On or about October 30, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient P. (Ex. 32)

54. On or about October 30, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient Q. (Ex. 34)

55. On or about November 4, 1992, Respondent performed a laser conization of the cervix, under general anesthesia, on Patient R. (Ex. 36)

56. On or about November 11, 1992, Respondent performed a laser vaporization of the cervix, under general anesthesia, on Patient S. (Ex. 38)

57. A Pap smear is a screening test performed to ascertain the presence or absence of abnormal cervical cells. A

diagnosis of dysplasia cannot be made on the basis of Pap smear results alone. (T. 561)

58. A colposcopy is a procedure in which the cervix is examined with an optical instrument (colposcope) which achieves magnification of the tissues. Certain dyes or solutions are applied to the tissues to highlight abnormal areas. Under magnification, the most abnormal areas of the cervix usually can be identified. In the course of performing a colposcopy, if there is an area that appears suspicious, a biopsy is done. (T. 240-241)

59. Laser vaporization of the cervix is a surgical procedure most often done under general anesthesia in which a portion of the cervix is vaporized by a high power or high intensity laser beam. No surgical specimen is obtained. The "vaporized" tissue is destroyed. (T. 241)

60. Laser vaporization is indicated in a situation where the physician is able to identify the lesion colposcopically, and to identify and biopsy the most abnormal area that is visible on the cervix. Cytology should be consistent with the histology of the biopsy specimen. Under these circumstances, if the lesion is one requiring ablation, laser vaporization of the lesion is acceptable treatment. (T. 247)

61. Low grade squamous intraepithelial lesions (mild dysplasia) may be treated with ablation or excision. Carbon dioxide laser is used to vaporize or ablate cervical lesions. (Ex. D; T. 455)

62. An excisional cone is a surgical procedure in which

a cone-shaped segment of the cervix is removed and the tissue is treated so that it can be examined by the pathologist and evaluated histologically throughout the whole specimen instead of in a localized area as in a punch biopsy. (T. 242)

63. A laser conization may be indicated in a situation where the clinician has evidence of an abnormal Pap smear or an abnormal biopsy and the Pap smear and the biopsy are not consistent with each other, or in a situation where the entire transformation zone cannot be visualized. (T. 248)

Paragraph C(1) of the Statement of Charges

64. There should be an indication for colposcopic examination. A colposcopic examination may be indicated if Pap smear results are negative, or normal and there is a gross lesion of the cervix. Colposcopy is also indicated in situations where the Pap smear implies any type of dysplasia or cervical intraepithelial neoplasia or CIN. (T. 243-244, 459, 764) Other indications for colposcopy of the cervix are: follow-up on previous diagnosis of or treatment for dysplasia; presence of HPV lesions elsewhere in the female genital tract; intrauterine exposure to DES; an abnormal Pap smear other than clearly benign abnormalities; and post-coital bleeding. (T. 227, 459, 528, 548, 597, 765)

65. Patients C, D, G, H, J, and P had abnormal Pap smears. (Exs. 5, 7, 13, 15, 19, 31; T. 244, 539, 563, 569) Patient E had an HPV lesion in the genital tract. (Ex. 9; T. 548) Patients F, I, and L had gross lesions of the cervix. (Exs. 11, 17, 23; T.

553, 566, 574) Patients K, N, and Q had previous cervical disease and treatment. (Exs. 22, 27, 28, 33, 34; T. 574, 586, 593) Patient S had intrauterine DES exposure. (Exs. 37, 38; T. 597) Patient R had post-coital bleeding. (Ex. 35; T. 277, 595)

66. With regard to Patients M and O, Respondent performed colposcopic examinations which were unnecessary and not indicated by the patients' clinical condition and/or Pap smear. (T. 270, 273-274)

67. Cervical biopsy is indicated whenever a lesion is present if the colposcopist is uncertain about the lesion. It is acceptable to biopsy a lesion even if it is erroneously interpreted as being normal. (T. 491-492)

68. With regard to Patients C through S, Respondent thought he saw colposcopically a lesion on the cervix which required histologic diagnosis. He performed a cervical biopsy on each patient. (Exs. 5, 7, 9, 11, 13, 17, 19, 21, 23, 25, 27, 29, 33, 35, 37; T. 245, 342, 349, 355, 357-358, 361, 363-364, 369)

69. The definitive way to make the diagnosis of dysplasia is by histologic evaluation. (T. 462, 476, 534)

70. With regard to Patients C through S, the pathologist did not make the diagnosis of dysplasia in any patient prior to treatment. Subsequent review by a consultant pathologist found dysplasia in Patient S (T. 246, 534, 721, 742; Ex. 5) For Patients C through S, the admitting, operative and discharge diagnoses in the hospital records were cervical dysplasia.

71. It is inappropriate to treat cervical dysplasia

based on visual colposcopic findings or on Pap smear without benefit of tissue confirmation. (T. 479, 732, 766)

72. Respondent admitted that on occasion he relied on colposcopic findings without laboratory confirmation. (T. 944, 994)

Paragraph C(2) of the Statement of Charges

73. With regard to Patients C through S, excluding G, N, and R, Respondent performed cervical laser vaporizations which were unnecessary and not indicated by the patients' clinical conditions and/or prior diagnostic testing. (T. 251-257, 259-265, 267-271, 273-276, 278-280) Patient G's cervical laser vaporization was appropriate and indicated because of histologic changes suggestive of flat condyloma. (Ex. 13)

74. With respect to Patients C through S excluding G, Respondent erroneously stated in the admission record for the laser vaporization or conization that the patient was suffering from dysplasia when he knew that the pathologist had not found dysplasia in the biopsy. (T. 265, 280, 534, 951)

Paragraph C(3) of the Statement of Charges

75. Diagnostic conization is indicated if the entire transformation zone is not visible through the colposcope. (T. 248, 536, 584, 595; Ex. D)

76. With respect to Patients N and R, the entire transformation zones were not visible through the colposcope (Exs. 27, 35).

77. Respondent's performance of laser conization of the

cervix, excisional cone, on Patients N and R was indicated for each by findings on colposcopy. (T. 588, 595)

Paragraph C(4) of the Statement of Charges

78. Respondent subjected Patients C through S, with the exceptions of Patients G, N, and R, to an unnecessary surgical procedure done under general anesthesia with its attendant risks. (T. 280-282)

79. If Respondent did not agree with the pathologist's diagnoses, he should have done additional diagnostic procedures such as another biopsy, or he should have reviewed the slides with the pathologist. Another possibility would have been to send the slides to another pathologist. In the presence of continued uncertainty, additional testing should have been performed to establish a definitive diagnosis. (T. 265, 282, 477-478, 756, 952, 977)

CONCLUSIONS

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

FIRST SPECIFICATION: ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE THE PROFESSION

The Committee concludes that the factual allegations in paragraphs A, A.1(a), A.1(b) and A.1(c) should be sustained (Findings of Fact 2-9, 12-19), except it is concluded that Student

A was not Respondent's student. (Findings of Fact 10-11)

The conclusion that Respondent engaged in sexual conduct, including sodomy, against Student A's clearly expressed will was determined as a matter of credibility. The testimony of Respondent and Student A is diametrically opposed regarding whether Student A consented or appeared to consent to Respondent's conduct. The Committee believes that Student A clearly objected to the sexual contact and that Respondent knew that consent did not exist. (Findings of Fact 16-17)

Credibility was determined in this matter by using the statutorily mandated standard of "preponderance of the evidence," rather than stricter non-applicable standards such as "clear and convincing evidence" or "beyond a reasonable doubt." Respondent's credibility regarding the central issues in this charge suffered, because the committee concluded that he had not been truthful on other issues in the following aspects of his testimony:

1. It is not credible, as asserted by Respondent, that when he called Student A a couple of days after the May 20th incident she told him to call her later in the week in order to get together. (T. 1036) This testimony does not ring true whether the May 20th incident had been a forced sexual encounter, or a situation where she consented and later changed her story. Student A's testimony that she told him not to call (T. 156-157) is more believable in either circumstance.

2. The committee finds credible the testimony of John Remillard, President of A.O. Fox Memorial Hospital, that,

following the May 20th incident, Respondent told him that he only knew Student A in relation to when she had observed him in surgery. (T. 1082, 1090, 1095-1096). That statement by Respondent was, of course, untrue as both Respondent and Student A acknowledged during this proceeding.

3. Respondent was evasive and less than truthful while testifying regarding his relationship and living arrangements with a women during May of 1993. (T. 1072-1073)

Although the material factual allegations regarding the events of May 20, 1993 have been sustained by the committee, it is concluded that the **FIRST SPECIFICATION** should not be sustained. New York Education Law Section 6530(20) requires that in order to sustain this charge, the conduct which evidences moral unfitness must have been conducted "in the practice of medicine." The administrative officer has advised the committee that it is legally bound by Section 6521 of the New York State Education Law regarding the definition of the practice of medicine pursuant to a Court of Appeals determination using that definition in a medical misconduct proceeding in 1988. (Gross v. Ambach, 71NY2d859)

Section 6521 defines the practice of medicine as follows:

> The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.

The committee notes that it concluded herein that

Student A was not Respondent's student as alleged by Petitioner. It is further concluded that Respondent's actions as alleged in the Statement of Charges in paragraphs A, A.1(a), A.1(b) and A.1(c) and found as fact by the committee herein do not constitute the practice of medicine as defined by Section 6521 of the Education Law.

SECOND SPECIFICATION: PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE REGARDING PATIENT B

The definition of gross negligence applied by the committee as instructed by the administrative officer accepts the view as expressed in the Health Department's memorandum dated February 5, 1992 which was distributed to the parties and the committee by the Department. That definition is as follows:

> Gross negligence is a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. The act or omission must be of an aggravated nature manifesting a disregard of the consequences which may ensue from the act and indifference to the rights of others. There must, therefore, be evidence of a consciousness on the part of the physician of impending dangerous consequences if he persists in his conduct. Proof of actual injury is not an element of gross negligence.

Respondent's actions (Findings of Fact 36-39) constituted a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances (negligence), but it was not shown by a preponderance of the evidence that there was a conscious disregard by Respondent of the

possible consequences and indifference to the patient's rights. The **SECOND SPECIFICATION** should not be sustained.

THIRD SPECIFICATION: PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE REGARDING PATIENTS C THROUGH S

Respondent's actions (Findings of Fact 66-79) constituted a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances (negligence), but it was not shown by a preponderance of the evidence that the failures were egregious or conspicuously bad, or that there was consciousness on Respondent's part of impending dangerous consequences. The **THIRD SPECIFICATION** should not be sustained.

FOURTH SPECIFICATION: PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION REGARDING PATIENTS B AND C THROUGH S

Respondent's actions (Findings of Fact 34-39, 66-79) constituted negligence on more than one occasion. The **FOURTH SPECIFICATION** should be sustained.

FIFTH SPECIFICATION: PRACTICING THE PROFESSION FRAUDULENTLY REGARDING PATIENTS C THROUGH S

As instructed by the administrative officer, the fraudulent practice of medicine involves an intentional

misrepresentation or concealment of a known fact. Respondent's actions (Findings of Fact 66-79) did not constitute fraudulent practice because it was not shown by a preponderance of the evidence that Respondent intended to misrepresent or conceal a known fact. The committee notes that its finding that Respondent erroneously stated in the records of Patients C through S, excluding G, that the patient was suffering from dysplasia when he knew that the pathologist had not found dysplasia in the biopsy (Finding of Fact 76) does not constitute fraud, because Respondent's errors, though examples of inaccurate records and judgement, were not shown to be intentional deceptions. The **FIFTH SPECIFICATION** should not be sustained.

SIXTH SPECIFICATION: ORDERING EXCESSIVE TESTS, TREATMENT OR USE OF TREATMENT FACILITIES NOT WARRANTED BY THE CONDITION OF THE PATIENT REGARDING PATIENTS C THROUGH S

Respondent actions (Findings of Fact 66, 73, 78) constituted ordering excessive tests, treatment and use of treatment facilities not warranted by the condition of the patient. The **SIXTH SPECIFICATION** should be sustained.

SEVENTH SPECIFICATION: FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE EVALUATION AND TREATMENT OF THE PATIENT REGARDING PATIENTS C THROUGH S

Respondent's actions (Finding of Fact 76) constituted the maintaining of inaccurate patient records. The **SEVENTH SPECIFICATION** should be sustained.

RECOMMENDATION ON SUMMARY ORDER

Pursuant to Public Health Law Section 230(12), the hearing committee unanimously recommends that the commissioner modify the summary order to be consistent with the committee's Order which follows herein. That is, Respondent's license to practice medicine should be restored, except as it pertains to treating cervical disease. Respondent is not found to be engaging in conduct constituting an imminent danger to the health of the people regarding other areas of medical practice.

DETERMINATION AND ORDER

Pursuant to the hearing committee's findings of fact and conclusions herein, **IT IS DETERMINED THAT THE FOLLOWING SPECIFICATIONS ARE SUSTAINED:**

FOURTH SPECIFICATION (Negligence On More Than One Occasion)

SIXTH SPECIFICATION (Ordering Excessive Tests, Treatment and Use Of Treatment Facilities)

SEVENTH SPECIFICATION (Maintaining Inaccurate Patient Records)

AND

THE FOLLOWING SPECIFICATIONS ARE NOT SUSTAINED:

FIRST SPECIFICATION (Conduct In The Practice Of Medicine Which Evidences Moral Unfitness To Practice Medicine)

SECOND SPECIFICATION (Gross Negligence)

THIRD SPECIFICATION (Gross Negligence)

FIFTH SPECIFICATION (Practicing The Profession Fraudulently)

AND

IT IS HEREBY ORDERED THAT:

Pursuant to Section 230-a(2) of the Public Health Law, Respondent's license to practice medicine is partially suspended in that he is not permitted to treat cervical disease until he successfully completes retraining in that area of medical practice. The necessary retraining should be a Personalized Education Program offered as a post-graduate course by the American College of Obstetricians and Gynecologists or, a retraining program sponsored by the Department of Family Practice at SUNY Syracuse, or another program acceptable to the New York State Department of Health. The program undertaken by Respondent must have a goal toward proficiency in investigating, diagnosing and treating cervical disease.

Upon entering the training program, Respondent will be placed on probation for one year during which time he will not be allowed to practice medicine in the area of cervical disease except as related to his retraining, and until he completes said

retraining. A condition of Respondent's probation is that he successfully completes the retraining program within the one year probation period.

DATED: Halesite, New York
December 27, 1993

STEPHEN A. GETTINGER, M.D.
Chairperson

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

MUDGE ROSE GUTHRIE ALEXANDER & FERDON

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WALTER P. LOUGHLIN
PARTNER
DIRECT DIAL NUMBER
(212) 510-7451

July 16, 1993

VIA TELECOPY

Hon. Gerald Liepshutz,
Administrative Law Judge
New York State
Department of Health
Empire State Plaza
Corning Tower Building, 25th Floor
Albany, NY 12237-0026

Re: In re Ziyad A. Mansur, M.D.

Dear Judge Liepshutz:

This letter responds to the request of Ms. Finkelstein, made during our telephone conversation this afternoon, to the effect that I clarify that the respondent's waiver of the 90-day time limit for summary action, N.Y. Pub. Heath Law §230-12, as set forth in the letter to you, dated July 15, 1993, from Mark D. Beckett of my firm, also includes an agreement that the summary order will remain in full force and effect until a final decision has been rendered by the committee or, if review is sought, by the administrative review board, even if more than 90 days elapses between the date of the order and the date of any such final decision.

I regret that our earlier letter did not make this clear.

Sincerely,

Walter P. Loughlin

Walter P. Loughlin

WPL:ps

cc: Sylvia Pastor Finkelstein, Esq.

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July 15, 1993

VIA FEDERAL EXPRESS

Hon. Gerald Liepshutz,
Administrative Law Judge
Empire State Plaza
Corning Tower Building, 25th Floor
Albany, NY 12237-0026

Re: In re Ziyad A. Mansur, M.D.

Dear Judge Liepshutz:

During the proceedings in this matter on July 9, your Honor indicated that two dates that were convenient days for the members of the hearing committee (the Committee) to continue the proceedings, August 19 and August 20, posed a conflict for your Honor because of another previously scheduled summary suspension proceeding. Your Honor indicated that another hearing officer might be assigned to preside over the proceedings in this matter on the days which your Honor was unavailable. Respondent stated his strong preference that the proceedings not be continued on the dates in question, or on any other dates that your Honor was unavailable, and noted the prejudice that might attend a substitution of hearing officers in the midst of a proceeding.

In light of this, the respondent made a formal application to the committee that the proceedings not be held on August 19 and 20, or on any other day on which your Honor was unavailable. Respondent also agreed, as set forth in greater detail below, to waive the 90-day time limitation for summary suspensions imposed by the Public Health Law, should it become necessary to accommodate your Honor's schedule. Ultimately, counsel for the Office of Professional Medical Conduct (the Office) took no position on this request and the Committee agreed to consider this application in a conference call with your Honor scheduled for Friday, July 16.

This letter will confirm the respondent's position as stated on the record during the proceedings in this matter on July 9. In order to permit your Honor to continue as the hearing officer in this matter and to avoid the need to substitute another hearing officer if you are unavailable, the respondent agrees to continue to abide by the terms of the summary suspension, should the 90-day limitation established by Public Health Law section 230-12 elapse before the proceedings are concluded, until such time that the Committee makes a final finding regarding whether or not the respondent's continued practice of medicine poses an "imminent danger" to the health of the people of the state. The respondent understands that this finding may not be made until there is a final determination of all of the charges proffered by the Office because its summary suspension case is based on all of the charges and allegations in the aggregate and since it is in the Committee's discretion whether or not to make an independent finding regarding imminent danger.

Respondent also agrees that he will not challenge any adverse decision reached by the Committee before the administrative review board or in an action brought pursuant to Article 78 of the Civil Practice Law and Rules on the ground that the Committee did not complete the hearing within 90 days of the original Notice and Order.

Sincerely yours,

Mark D. Beckett

cc: Silvia Pastor Finkelstein, Esq.

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

IN THE MATTER

OF

ZIYAD A. MANSUR, M.D.

: COMMISSIONER'S
: ORDER AND
: NOTICE OF HEARING

TO: ZIYAD A. MANSUR, M.D.
400 Main Street
Oneonta, NY 13820

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by ZIYAD A. MANSUR, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately ZIYAD A. MANSUR, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless

modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 8th and 9th day of July, 1993 at 10:00 at Corning Tower Building, Room 2509, Empire State Plaza, Albany, N.Y. 12237 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the

State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
June 28, 1993

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
SILVIA P. FINKELSTEIN
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza, Room 601
New York, NY 10001

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

IN THE MATTER

OF

ZIYAD A. MANSUR, M.D.

STATEMENT

OF

CHARGES

ZIYAD A. MANSUR, M.D., the Respondent was authorized to practice medicine in New York State on April 16, 1982, by the issuance of license number ~~153488~~ 149509 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 400 Main Street, Oneonta, New York 13820.

FACTUAL ALLEGATIONS

A. At all times herein mentioned, Respondent was an obstetrician-gynecologist affiliated with A.O. Fox Memorial Hospital, Oneonta, New York. At all times herein mentioned, Student A (Student A and all patients are identified in Appendix A) was a 21 year-old student nurse enrolled in the Otsego Area School of Practical Nursing, BOCES, program conducted at A.O. Fox Memorial Hospital,

Oneonta, New York. On or about May 16, 1993, as part of her training program, Student A was Respondent's student.

1. On or about May 20, 1993, at approximately 10:30 P.M., Respondent appeared at Student A's home and engaged in conduct as follows:

   a) Respondent made verbal sexual advances toward Student A which she refused.

   b) Respondent put his arms around Student A and kissed her against her will.

   c) Respondent then sodomized Student A.

B. Respondent treated Patient B, a 20 year-old female, at A.O. Fox Memorial Hospital, between on or about January 1992 and August 1992. In or about January 1992, Patient B was seen by Respondent complaining of infertility for two years with a history of previous pelvic inflammatory disease. On or about January 17, 1992 Respondent performed a laparoscopy on Patient B at which time it was noted that the right adnexa and uterus were normal but there were adhesions around the bimbriated end of the fallopian tube. The adhesions were lysed and a D&C was performed. On or about May 14, 1992 Patient B was admitted to the hospital at approximately 4-5 weeks gestation with a history of abdominal

cramping and vaginal bleeding. She had a positive pregnancy test. Ultrasound had been performed which showed a four week pregnancy with a gestational sac but no fetus. On or about May 15, 1992, Respondent performed a D&C which yielded a scant amount of tissue which was submitted to pathology. Patient B was discharged on that date. The corresponding pathology report dated May 18, 1993 shows no fetal tissue or chorionic villi which, if present, would confirm the presence of an intrauterine gestation. On or about May 24, 1992, Patient B reported to another hospital with complaints of severe abdominal pain. She was transferred to A.O. Fox Memorial Hospital where on May 25, 1992 she was re-operated on by another physician for a ruptured left ectopic pregnancy.

1. Respondent failed to do an evaluation of Patient B for the possibility of ectopic pregnancy prior to her discharge on May 15, 1992. In light of the inadequate amount of tissue obtained in the D&C, Respondent's failure included, but was limited to, his failure to order a quantitative BETA HCG blood test and/or his failure to follow-up on the results of the pathology lab analysis which indicated that there were no fetal tissue or villi obtained in the D&C.

2. Respondent failed to warn Patient B of the possibility of ectopic pregnancy prior to her discharge on May 15, 1992.

C. Respondent rendered medical care to Patients C through S at his office, located at 400 Main Street, Oneonta and at A.O. Fox Memorial Hospital, Oneonta. The nature and dates of care rendered to Patients D through T are as follows:

PATIENT	PAP	COLPOSCOPIC BIOPSY	SURGICAL PROCEDURE	DATE OF PROCEDURE
C	Koilocytosis	Chr. cervicitis	laser vaporization	3/ 2/92
D	Benign atypia	Sq. metaplasia	laser vaporization	5/ 8/92
E	Neg.	Sq. metaplasia	laser vaporization	5/15/92
F	Neg.	Sq. metaplasia	laser vaporization	6/ 1/92
G	Reactive	Chr. cervicitis	laser vaporization	7/10/92
H	?CIN	Chr. cervicitis	laser vaporization	7/22/92
I	Neg.	Sq. metaplasia	laser vaporization	8/28/92
J	Benign atypia	Sq. metaplasia	laser vaporization	8/31/92
K	Neg.	Chr. cervicitis	laser vaporization	9/ 2/92
L	Neg.	Koilocytosis	laser vaporization	9/11/93
M	Benign atypia	Chr. cervicitis	laser vaporization	10/ 9/92
N	Neg.	Atropic cervicitis	laser conization	10/15/92
O	Neg.	Neg/endocervicitis	laser vaporization	10/23/92
P	?CIN I	Mild atypia	laser vaporization	10/30/92
Q	Neg.	Normal	laser vaporization	10/30/92
R	Neg.	Telangiectasia	laser conization	11/ 4/92
S	Neg.	Chr. cervicitis	laser vaporization	11/20/92

1. With regard to each of Patient's C through S, Respondent performed colposcopic examinations, including biopsies, which were unnecessary and not indicated by the patients' clinical conditions and/or Pap smear results, except Patients H+P.

amended by petitioner 7-8-93, no objection. GAL

2. With regard to each of Patient's C through S, excluding N and R, Respondent performed cervical laser vaporizations which were unnecessary and not indicated by the Patients' clinical conditions and/or prior diagnostic testing.

   a) With respect to Patient C through S Respondent knowingly and falsely stated in the admission record for the laser vaporization that the colposcopy findings demonstrated dysplasia when he knew that only normal or physiologic changes had been found.

3. With respect to Patient N and R, Respondent performed a laser conization of the cervix (excisional cone) each of which was unnecessary and not indicated by the Pap smear findings or the colposcopic biopsy findings.

4. Respondent subjected each of Patients C through S to unnecessary surgical procedures done under general anesthesia with its attendant risks.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE THE PROFESSION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law -6530(2) (McKinney Supp. 1993) by engaging in conduct in the practice of medicine which evidences moral unfitness to practice the profession, in that Petitioner charges:

1. The facts in paragraphs A, A.1(a), A.1(b) and A.1(c).

SECOND AND THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law -6530(4) (McKinney Supp. 1993) by practicing the profession with gross negligence, in that Petitioner charges:

2. The facts in paragraphs B, B.1 and/or B.2.

3. The facts in paragraphs C, C.1, C.2, C.2(2), C.3 and/or C.4, with respect to Respondent's care and treatment of Patients C through S.

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law -6530(3) (McKinney Supp. 1993) in that he practiced the profession with negligence on more than one occasion, specifically Petitioner charges two or more of the following:

4. The facts in Paragraphs B, B.1, and/or B.2 with respect to Respondent's care and treatment of Patient B, and C, C.1, C.2, C.2(a), C.3 and/or C.4, with respect to Respondent's care and treatment of Patients C through S.

FIFTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law -6530(2) (McKinney Supp. 1993) by practicing the professional fraudulently, in that Petitioner charges:

5. The facts in Paragraphs C, C.1, C.2, and/or C.3 with respect to Patients C through S.

SIXTH SPECIFICATION

ORDERING TREATMENT OR USE OF TREATMENT FACILITIES

NOT WARRANTED BY THE CONDITION OF THE PATIENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law -6530(35) (McKinney Supp. 1993) by ordering excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient, in that Petitioner charges:

6. The facts in paragraphs C, C.1, C.2, C.3, and/or C.4, with respect to Patients C through S.

SEVENTH SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law section 6530(32), (McKinney Supp. 1993), by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

7. The facts in Paragraphs C.2(a) with respect to Patients C through S.

DATED: NEW YORK, NEW YORK
June 28, 1993

Chris Stern Hyman

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct