STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

May 21, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
Associate Counsel
NYS Dept. of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Michael Kelton, Esq.
Lippman, Krasnow & Kelton, LLP
711 Third Avenue
New York, New York 10017-4059

Constant Mamouris, M.D.
936 Fifth Avenue
New York, New York 10021

Effective Date: 05/28/96

RE: In the Matter of Constant Mamouris, M.D.

Dear Mr. Smith, Mr. Kelton and Dr. Mamouris:

Enclosed please find the Determination and Order (No. 96-123) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 then 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), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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
Empire State Plaza
Corning Tower, Room 2503
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.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

COPY

IN THE MATTER

OF

CONSTANT MAMOURIS, M.D.

DETERMINATION

AND

ORDER

BPMC-96-123

PATRICK F. CARONE, M.D., Chairman, **RICHARD N. ASHLEY, M.D.** and **MS. TRENA DeFRANCO**, 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 Sections 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 submits this **DETERMINATION AND ORDER.**

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	November 21, 1995
Pre-Hearing Conference:	January 12, 1996
Hearing Dates:	January 19, 1996 February 2, 1996 February 9, 1996 March 22, 1996
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York 10001

Date of Deliberations:	April 19, 1996
Petitioner Appeared By:	Henry M. Greenberg, Esq., General Counsel NYS Department of Health
BY:	David W. Smith, Esq. Associate Counsel, of Counsel
Respondent Appeared By:	Lippman, Krasnow & Kelton, LLP 711 Third Avenue New York, New York 10017-4059
BY:	Michael Kelton, Esq.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with Negligence on More Than One Occasion; Incompetence on More Than One Occasion; Gross Negligence; Gross Incompetence; Failure to Maintain Records; Guaranteeing a Cure; and Excessive treatment.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

WITNESSES

For the Petitioner:	Cavin P. Leeman, M.D. Patient A
For the Respondent:	Constant N. Mamouris, M.D., the Respondent Sidney M. Cohen, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages 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 evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

FINDINGS AS TO THE RESPONDENT

1 The Respondent was authorized to practice medicine in New York State in 1959, by the issuance of license number 083071 by the New York State Education Department (Pet's. Exs. 1 and 3; Resp's. Ex. A).

2. The Respondent has practiced medicine as a psychiatrist since November, 1959. He is not board certified in psychiatry (Pet's. Ex. 1; Resp's. Ex. A; Tr. 207-209).

3 At the times specified in the Statement of Charges (1989-1993), the Respondent practiced psychiatry at his offices at 133 East 73rd Street, New York, New York.

FINDINGS AS TO PATIENT A

4 Patient A presented at the Respondent's office on January 19, 1989, complaining of a long history of premature ejaculation and inability to maintain an erection (Pet's. Ex. 4; Tr. 347, 354, 355, 593, 594).

5 The Respondent's notes on Patient A's medical history indicate that Patient A had a stroke in 1985 with right hemiplegia and also had had a kidney stone (Pet's. Ex. 4; Tr. 360-363, 594).

6 The Respondent's initial history for this patient is inadequate in that:

* There is no notation dealing with the state of the patient's general health.
* There is nothing to either suggest or contribute to ruling out that the patient might have some medical illness which could be responsible for his physical symptom.
* There is no discussion of any signs and symptoms that the patient might have to support the conclusion that Patient A had depression and anxiety.
* There is no indication of the patient's daily functioning.
* In spite of the fact that the Respondent noted that the patient was depressed, there is nothing to indicate whether or not there are any psychotic features to his depression, whether or not he might be suicidal (Pet's. Ex. 4; Tr. 14).

7 The Respondent conducted some mental status examinations of Patient A, observing, among other things, that Patient A was emotional and excitable, had a reactive depression, and was suffering from psychogenic factor with reactive depression (Pet's. Ex. 4; Tr. 434, 601-603, 651).

8 The Respondent did not record any mental status examinations for Patient A. Such record should include among other things, a description of the patient's behavior, of his speech, of his affect or mood of his thought processes (Pet's. Ex. 4; Tr. 15, 604-605).

9 The Respondent performed an adequate physical and neurological examination of Patient A which resulted in no positive findings (Pet's. Ex. 4).

10. The Respondent diagnosed Patient A with a psychogenic factor with reactive depression (Pet's. Ex. 4; Tr. 596).

11. The evidence in the record does not justify a diagnosis of premature ejaculation, anxiety and depression (Pet's. Ex. 4; Tr. 14, 16-17).

12. There is no convincing evidence in the record that the Respondent ever promised Patient A a "cure" for his sexual dysfunction.

13. The Respondent prescribed Halotestin for Patient A on January 29, 1989 and March 16, 1989. Patient A stopped taking the Halotestin within one week after the first prescription, and failed to advise Respondent that he had stopped taking the medication (Pet's. Ex. 4; Tr. 381-383, 386, 392, 596, 614-615).

14. Based on Patient A's medical records, the use of Halotestin was not justified (Pet's. Ex. 4; Tr. 48).

15. The Respondent gave Patient A intramuscular injections of Elavil 25 mg. on March 16, 1989, March 27, 1989, April 8, 1989, April 13, 1989 and April 20, 1989 (Pet's. Ex. 4).

16. Elavil would be an appropriate medication to prescribe for a patient suffering from the symptoms of depression. However, the Respondent's impression of depression is not justified in this case, and furthermore the dosage of Elavil administered by the Respondent was not adequate to treat a patient suffering from depression (Pet's. Ex. 4; Tr. 48-51).

17 The Respondent gave Patient A prostatic massages on January 19, 1989, March 16, 1989, March 21, 1989, April 6, 1989, April 11, 1989 and April 18, 1989 (Pet's. Ex. 4; Tr. 615-617)

18 Prostatic massage is not a proper treatment for premature ejaculation, anxiety or depression. The Respondent himself acknowledged that the prostatic massage was not useful and did not conform with usual psychiatric practice. Prostatic massage constituted an excessive treatment in this case (Tr. 17, 637-639, 648-649).

19 The Respondent did not massage Patient A's scalp with a vibrator. The Respondent used a tuning fork as part of his neurological examination of the patient. The use of a tuning fork was appropriate in those circumstances (Tr. 33, 445, 639-641).

20 The Respondent failed to maintain adequate progress notes regarding issues discussed in psychotherapy. Such notes should include Patient A's participation in psychotherapy and the responses of Patient A to psychotherapy. There was no requirement that the Respondent indicate the length of psychotherapy sessions in his progress notes (Tr. 449, 643-644).

21 The Respondent gave Patient A injections in the penis which turned the penis black and blue. He told Patient A that he would feel better soon (Tr. 349-352.
(Vote 2-1)

22 On April 6, 1989, the Respondent recommended that Patient A use a topical anesthetic cream 15 minutes before performing coitus (Pet's. Ex. 4; Tr. 626, 647).

FINDINGS AS TO PATIENT B

23 On April 17, 1989, Patient B presented at the Respondent's office with a chief complaint of phobias, insomnia, depression and panic attacks. The Respondent elicited a past history, physical history and family history. The Respondent had seen Patient B once some 25 years earlier, and Patient B's symptoms were the same at that time (Pet's. Ex. 5; Tr. 212-214).

24 The Respondent's initial history and mental status examination notes for Patient B are minimally acceptable. However, the Respondent saw the patient for about 150 sessions and he failed to document that he elicited any further history from the patient throughout that entire time (Pet's. Ex. 5; Tr. 60).

25. The Respondent's diagnosis of chronic depression was supported by the record (Tr. 75, 489, 510).

26 The Respondent evaluated, followed up and treated Patient B's depression continuously from April 17, 1989 until the patient was discharged from the Respondent's care on July 8, 1992. During that time, the Respondent evaluated, followed up and treated Patient B's depression on each and every visit. Such treatments included prescriptions for chlordiazepoxide, Xanax, Tofranil, Parnate, Prozac, Tagamet, Triavil, Elavil and Mellaril (Pet's. Ex. 5).

27 The Respondent's diagnosis, evaluation, follow-up, and treatment of Patient B's chronic depression were adequate (Pet's. Ex. 5 and 6A; Tr. 75, 78-82, 102-103, 215, 489).

28. The Tricyclic injections administered by the Respondent made Patient B feel better, the Xanax controlled her anxiety and the Respondent continuously encouraged the patient (Pet's. Ex. 6A; Tr. 102-103).

29 Tofranil was an appropriate medication for the treatment of Patient B's complaints and conditions. The Respondent initially prescribed a minimally effective dosage of Tofranil 25 milligrams three times per day. However, Patient B expressed an inability to take oral Tofranil due to gastritis and continuing complaints of stomach distress. The Respondent suspected that Patient B was not taking the oral Tofranil and so gave Patient B intermittent injections of the drug. The determination by Respondent to supplant the oral Tofranil with Tofranil injections during Patient B's visits with the Respondent was a matter of clinical judgment (Pet's. Ex. 5 and 6A; Tr. 68-69, 96, 102, 220, 227, 230, 235, 285).

30 The Respondent gave Patient B intermittent injections of Elavil. He initially prescribed oral Elavil 25 milligrams three times per day. However, when Patient B continued to complain that she could not tolerate the oral medication, the Respondent gave the patient intramuscular injections of Elavil 1 cc in addition to the oral Elavil (Pet's. Ex. 5).

31 Elavil was an appropriate medication for treating Patient B's complaints and condition (Tr. 100)

32 The Respondent would, on occasion, use an otoscopic light to examine Patient B's pupils to determine whether they were dilating appropriately (Tr. 237).

33 The Respondent did not deviate from accepted practice in examining the dilation of Patient B's pupils with an otoscopic light (Tr. 500-502).

34 Patient B did show periodic periods of improvement during the course of Respondent's treatment, but overall her condition was deteriorating. There is nothing in the record to suggest that the Respondent refused to suggest or arrange consultations with other physicians at any time (Pet's. Ex. 5; Tr. 58, 79, 81-82, 87-88).

35. The Respondent had an affirmative obligation to arrange for an outside consultation because of Patient B's overall course of deterioration. She improved dramatically subsequent to changing treatment with another physician (Tr. 87-90, 94).

36 The Respondent failed to maintain full and adequate progress notes regarding psychotherapy sessions with Patient B. Such notes should include issues discussed in psychotherapy, Patient B's participation in psychotherapy and the responses of Patient B to psychotherapy sessions. Although the Respondent utilized key words and phrases to indicate the details of these items, he has acknowledged that the progress notes did not contain a full and adequate description of these issues. There was no obligation to indicate the length of psychotherapy sessions in the progress notes (Pet's. Ex. 5; Tr. 283-505).

37 The Respondent's notes for Patient B were also inadequate in that they lacked a sufficient patient history and they did not contain a sufficient explanation or description of Patient B's psychosis (Pet's. Ex. 5; Tr. 63-66, 110-113, 120-122).

FINDINGS AS TO PATIENT C

38 On June 5, 1992, Patient C presented at the Respondent's office with the complaint that a white homosexual had sucked his penis, that he smelled a continuous odor from his body, and that people think that he is a homosexual (Pet's. Ex. 7; Tr. 666).

39. The Respondent took a history and elicited, among other things, that Patient C had arrived in the United States six years earlier from the Ivory Coast to study accounting; that he worked nights as a forklift operator; that he was going to Queens College during the day; that he was married in Africa and had a seven year old son; and that he had a brother in Africa. The Respondent called Patient C's brother in Africa to discuss Patient C's history (Pet's Ex. 7, Tr. 665-670).

40. The Respondent's record for Patient C does not contain any family history. Also, there is nothing about the patient's life, how he has functioned in the past or how he is functioning recently and currently.

The mental status notes by the Respondent for this patient were partial since they refer only to ideas or reference, auditory hallucinations and olfactory hallucinations.

For a patient with psychotic symptoms, the metal status notes should include, among other things:

* observations about anything bizarre or unkempt about the patient's behavior, including his dress or his speech;
* was the patient hyperactive;
* The notes should contain a more elaborate description of his affect, his form of thought and whether he has looseness of association.

These items were not noted by the Respondent in Patient C's chart (Pet's. Ex. 7; Tr. 126-127, 675).

41. At the time of the June 5, 1992 visit, the Respondent diagnosed Patient C's condition as paranoid schizophrenia but failed to record his diagnosis in the Patient's chart (Tr. 527, 530, 675-676)

42. The Respondent prescribed Taractan 25 milligrams three times per day for Patient C on the first visit on June 5, 1992. He continued the Taractan at the same dosage on June 10, 1992. On September 25, 1992, the Respondent increased the daily dose of Taractan to 25 milligrams four times per day. On January 12, 1993, he continued the Taractan at 25 milligrams four times per day.

On January 21, 1993, the Respondent increased the dosage of Taractan again to 50 milligrams three times per day. On February 3, 1993, he continued the Taractan at the level of 50 milligrams three times per day (Pet's. ex. 7; Tr. 677).

43 Taractan was an appropriate choice of medication for Patient C, considering his presenting conditions and complaints. However, the patient remained symptomatic throughout, indicating that the dosages of Taractan prescribed by the Respondent were not adequate (Pet's. Ex. 7, Tr. 128-129, 132, 138-141).

44. The Respondent failed to maintain an adequate record which accurately reflected his evaluation and treatment of Patient C (Tr. 126, 127, 673, 675).

FINDINGS AS TO PATIENT D

45 On June 10, 1992, Patient D presented at the Respondent's office with complaints of auditory hallucinations, visual hallucinations and paranoia. She had come to Respondent's office with several family members. The Respondent recommended hospitalization but Patient D refused (Pet's. Ex. 8; Tr. 704-705, 709).

46 The Respondent failed to note the complete medical history of Patient D in the patient's chart (Pet's. Ex. 8, Tr. 152, 539, 551).

47. The Respondent failed to note the full mental status examination of Patient D in the patient's chart (Pet's. Ex. 8; Tr. 154-155, 540).

48. The Respondent failed to adequately document the substantiation for his diagnosis of paranoid schizophrenia (Pet's. Ex. 8; Tr. 718-720, 721-722).

49. The Respondent prescribed Thorazine for Patient D, but failed to note the dosage and route of administration (Pet's. Ex. 8; Tr. 155-156).

50. On July 2, 1992, the Respondent prescribed Tofranil 25 milligrams twice a day for Patient D. There is no evidence in the record that Tofranil was indicated in this case (Pet's. Ex. 8; Tr. 161).

51. The Respondent prescribed Taractan 25 milligrams, three times a day on June 10, 1992, July 2, 1992 and July 5, 1992, but failed to explain in the patient's record his reasons for switching from Thorazine to Taractan. Also, the patient remained symptomatic, indicating that the dosage of Taractan was inadequate (Pet's. Ex. 8; Tr. 158-162).

52. On June 25, 1992, June 30, 1992, July 3, 1992 and July 5, 1992, the Respondent noted in the patient's chart that Patient D was depressed. The Respondent's evaluation was based upon his direct observations of the patient. However, the Respondent failed to note in the patient's chart the basis for his evaluation of Patient D as depressed (Pet's. Ex. 8; Tr. 161, 548, 738).

53. The care rendered to Patient D by the Respondent does not meet minimum acceptable standards of medical practice (Pet's. Ex. 8, Tr. 162-170).

FINDINGS AS TO PATIENT E

54 On April 17, 1992, Patient E presented at the Respondent's office with a complaint of sexual dysfunction, specifically, that his "penis couldn't go up and he could not go with women". Patient E, who had recently arrived from Haiti, could only speak Creole. The Respondent did not speak Creole, but he is fluent in French. He attempted to converse with Patient E in French and or/Creole, but could not get a history, nor could he understand most of what Patient E was saying.

The Respondent was able to understand that Patient E had sexual difficulties of an erection and the patient looked unhappy to the Respondent (Tr. 324) (Pet's. Ex. 9; Tr. 320-321).

55 Despite the lack of communication, the Respondent inappropriately prescribed Triavil for Patient E because he looked unhappy (Pet's. Ex. 9; Tr. 194-197, 324-325, 331, 337-338).

56 The Respondent did not know what was wrong with Patient E, but nonetheless inappropriately prescribed Yokon (Pet's. Ex. 9; Tr. 194-199, 328-330).

57 The Respondent's record for Patient E is incomplete and inadequate. There is no medical history or mental status exam, no diagnosis and no justification noted for the drugs prescribed (Pet's. Ex. 9; Tr. 194-197).

58 The care rendered by Respondent to Patient E did not meet minimum acceptable standards of medical practice (Pet's. Ex. 9; Tr. 197).

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise indicated)

FIRST SPECIFICATION: (Negligence On More Than One Occasion)

SUSTAINED As to the charges specified in Paragraphs A1, A2, A4, A5, A6, A8, B2, B6, C1, C2, C4, D1, D2, D3, D4, D5, D6, E1, E2 and E3 of the Statement of Charges.

Note D3 Thorazine was an appropriate medication in this case, but the Respondent failed to note the dosage and route of administration.

NOT SUSTAINED As to the charges specified in Paragraphs A3, A7, A9, B1, B3, B4, B5 and C3 of the Statement of Charges.

SECOND SPECIFICATION: (Incompetence on More Than One Occasion)

SUSTAINED as to those charges specified in Paragraphs A1, A2, A4, A5, A6, B1, B2, B6, C1, C2, C4, D1, D2, D3, D4, D5, D6, E1, E2 and E3 of the Statement of Charges.

Note D3 Thorazine was an appropriate medication in this case, but the Respondent failed to note the dosage and route of administration.

NOT SUSTAINED as to those charges specified in Paragraphs A3, B3, B4, B5 and C3 of the Statement of Charges.

THIRD AND FOURTH SPECIFICATIONS: (Gross Negligence)

NOT SUSTAINED as to any of the charges.

FIFTH AND SIXTH SPECIFICATIONS: (Gross Incompetence)

NOT SUSTAINED as to any of the charges.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS: (Failure To Maintain a Record)

SUSTAINED as to those charges specified in Paragraphs A1, A2, A8, B1, B2, B6, C1, C2, C3, D1, D2, D3, D4, D6, E1, E2 and E3 of the Statement of Charges.

NOT SUSTAINED as to those charges specified in Paragraph B5 of the Statement of Charges.

TWELFTH SPECIFICATION: (Guaranteeing a Cure)

NOT SUSTAINED as to the charges specified in Paragraph A3 of the Statement of Charges.

THIRTEENTH AND FOURTEENTH SPECIFICATIONS: (Excessive Treatment)

SUSTAINED as to the charges specified in Paragraph A6 of the Statement of Charges.

NOT SUSTAINED as to the charges specified in Paragraphs A7, A9 and B4 of the Statement of Charges.

HEARING COMMITTEE DETERMINATION

The Hearing Committee has voted to sustain 19 charges of Negligence, 20 charges of Incompetence, 17 charges of Failing To Maintain Records and 1 charge of Excessive Treatment against the Respondent.

The Hearing Committee did not sustain any of the charges of Gross Negligence, Gross Incompetence or Guarenteeing a Cure.

The Hearing Committee notes with dismay the Respondent's lack of insight regarding his wrongdoing and his lack of remorse. He also seems to have little concept of the limitations of the scope of his psychiatric practice.

The Respondent is in definite need of an attitude correction, since his attitude toward his patients suggests carelessness and contempt.

Despite his current lack of insight and his current need for attitude correction, the Hearing Committee believes that a significant period of suspension and a requirement for reeducation will focus the Respondent to correct these problems.

The Hearing Committee determines: (1) that the Respondent's license to practice medicine should be suspended, that the suspension be partially stayed; and (2) that the Respondent be put on probation; the terms of probation to include reeducation and supervision. The terms of suspension and probation are set forth hereinafter in the Hearing Committee's ORDER.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for a period of two (2) years, the last eighteen (18) months of said suspension is **STAYED**, six (6) month actual suspension, with terms of probation as follows:

2. The Respondent shall successfully complete the Psychiatry Board Review Course offered on October 4-6, 1996 by the NYU Post-Graduate Medical School, and shall submit to the Office of Professional Medical Conduct a certificate indicating his successful completion of said course. If for some reason the Respondent is unable to attend the course offered by the NYU Post-Graduate Medical School, he may attend an equivalent Psychiatry Board Review Course offered by another institution, but he must obtain prior approval from the Office of Professional Medical Conduct.

3. During the eighteen (18) month period of **STAYED SUSPENSION** the Respondent's psychiatric practice shall be supervised by a board certified psychiatrist who is on the teaching facility of a Department of Psychiatry in a medical school; who is familiar with the terms of this **DETERMINATION AND ORDER;** who did not participate in this hearing; and who is approved by the Office of Professional Medical Conduct.

4. The supervising psychiatrist shall supervise the Respondent's psychiatric practice, including recordkeeping, and shall meet weekly with the Respondent for traditional case supervision. The supervising psychiatrist shall submit quarterly reports to the Office of Professional Medical Conduct regarding the quality of the Respondent's practice and the Respondent's compliance or failure to comply with the terms of this **ORDER.**

5. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: **New York**
May 29, **1996**

Patrick F. Carone, M.D.

PATRICK F. CARONE, M.D.
Chairman

RICHARD N. ASHLEY, M.D.
MS. TRENA DeFRANCO

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

IN THE MATTER

OF

CONSTANT MAMOURIS, M.D.

NOTICE

OF

HEARING

TO: Constant Mamouris, M.D.
936 Fifth Avenue
New York, New York 10021

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on January 19, 1996, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (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. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §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.

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 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 OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO

REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
[illegible], 1995

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: DAVID W. SMITH
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2617

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

IN THE MATTER

OF

CONSTANT MAMOURIS, M.D.

STATEMENT

OF

CHARGES

CONSTANT MAMOURIS, M.D., the Respondent, was authorized to practice medicine in New York State in 1959, by the issuance of license number 083071 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From in or about January, 1989 through in or about April, 1989, Respondent treated Patient A for premature ejaculation and other medical conditions at his office at 133 East 73rd Street, New York City. (All patients are identified in the Appendix attached hereto)

1. Respondent failed to obtain an adequate history or note such history, if any.

2. Respondent failed to conduct an adequate mental status examination or note such examination, if any.

3. At the beginning of the treatment, Respondent inappropriately told Patient A that he could "cure" him of his sexual dysfunction.

4. Respondent inappropriately diagnosed Patient A with premature ejaculations, anxiety and depression.

5. Throughout the period, Respondent inappropriately prescribed Elavil and Halotestin for Patient A.

6. Throughout the period, Respondent inappropriately gave prostatic massages to Patient A.

7. Respondent inappropriately massaged the scalp of Patient A with a vibrator.

8. Respondent failed to maintain adequate progress notes including, among other things, length of sessions, issues discussed in psychotherapy, Patient's A participation in psychotherapy and the responses of Patient A to treatment.

9. Respondent inappropriately treated Patient A with anesthetic of the penis head.

B. From in or about April, 1989 to in or about October, 1992, Respondent treated Patient B for depression and other medical conditions at his office at 133 East 73rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate history or note such history, if any.

2. Respondent failed to adequately evaluate, follow-up or treat Patient B's depression or note such follow-up, evaluation or treatment, if any.

3. Respondent inappropriately gave Patient B injections of Tofranil and Elavil.

4. Respondent inappropriately gave Patient B ophthalmoscopic examinations and deliberately misled Patient B as to their purpose and findings.

5. Throughout the period, the condition of Patient B grew worse but Respondent inappropriately refused to suggest or arrange any consultations or note such suggestions, arrangements or consultations, if any.

6. Respondent failed to maintain adequate progress noted including among other things, length of sessions, issues discussed in psychotherapy, Patient B's participation in psychotherapy and the responses of Patient B to treatment.

C. Between in or about June, 1992, and in or about February, 1993, Respondent treated Patient C for paranoia and other medical conditions at his office at 133 East 73rd Street, New York.

1. Throughout the period, Respondent failed to obtain an adequate history or note such history, if any.

2. Respondent failed to conduct an adequate mental status examination or note such examination, if any

3. Throughout the period, Respondent failed to make a diagnosis or note such diagnosis, if any.

4. Respondent inappropriately prescribed Taractan for Patient C.

D. Between in or about June 1992, and in or about July, 1992, Respondent treated Patient D for schizophrenia at his office at 133 East 73rd Street, New York City.

1. Respondent failed to obtain an adequate history or note such history, if any.

2. Respondent failed to conduct an adequate mental status examination or note such examination, if any.

3. Respondent inappropriately injected Patient D twice with Thorazine, failing to note the strength thereof or route of administration.

4. Respondent failed to record an adequate differential diagnosis and failed to adequately substantiate his diagnosis of paranoid schizophrenia.

5. Respondent inappropriately prescribed Tofranil and Taractan for Patient D.

6. Respondent failed to adequately evaluate or follow-up his finding of depression or note such evaluation or follow-up, if any.

E. Between in or about April, 1992, and in or about May, 1992, Respondent treated Patient E for sexual dysfunction at his office at 133 East 73rd Street, New York City.

1. Respondent failed to obtain an adequate history or note such history, if any.

2. Respondent failed to conduct an adequate mental status examination or note such examination, if any.

3. Respondent inappropriately diagnosed Patient E with sexual dysfunction and failed adequately to follow-up, evaluate or treat such condition or note such evaluation or follow-up or treatment, if any.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law §6530(3) (McKinney Supp. 1995) as alleged in the facts of two or more of the following:

1. Paragraphs A and A1-9; B and B1-6; C and C1-4; D and D1-6; and/or E and E1-3.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A1-9; B and B1-6; C and C1-4; D and D1-6; and/or E and E1-3.

THIRD AND FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraphs A and A1-9.

4. Paragraphs B and B1-6.

FIFTH AND SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1995) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

5. Paragraphs A and A1-9.

6. Paragraphs B and B1-6.

SEVENTH THROUGH ELEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN A RECORD

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of each patient within the meaning of N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) as alleged in the facts of the following:

7. Paragraphs A and A1, 2, and 8.

8. Paragraphs B and B1, 2, 5, and 6.

9. Paragraphs C and C1-3.

10. Paragraphs D and D1, 2, 3, 4 and 6.

11. Paragraphs E and E1, 2, 3.

TWELFTH SPECIFICATION

GUARANTEEING A CURE

Respondent is charged with guaranteeing a cure within the meaning of N.Y. Educ. Law §6530(34) (McKinney Supp. 1995) as alleged in the facts of the following:

12. Paragraphs A and A3.

THIRTEENTH AND FOURTEENTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with the ordering of excessive tests or treatment not warranted by the condition of the patient within the meaning of N.Y. Educ. Law §6530(35)(McKinney Supp. 1995) as alleged in the facts of the following:

13. Paragraphs A and A6, ~~7~~ 9.

14. Paragraphs B and B4.

DATED: November 2 , 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct