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

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

Andre Nehorayoff, Physician
Manhattan Women's Medical Center
115 East 23rd Street
New York, New York 10010

December 23, 1991

Re: License No. 115290

Dear Dr. Nehorayoff:

Enclosed please find Commissioner's Order No. 12342. This Order goes into effect five (5) days after the date of this letter.

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

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DHJ/GM/er

CERTIFIED MAIL - RRR
cc: Lifshutz & Polland
One Madison Avenue
7A Tower
New York, New York 10010

REPORT OF THE
REGENTS REVIEW COMMITTEE

ANDRE NEHORAYOFF

CALENDAR NO. 12342

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ANDRE NEHORAYOFF **No. 12342**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

This matter, heard initially before a hearing committee, concerns conclusions recommended by the hearing committee and designee of the Commissioner of Health that respondent is guilty of the thirteenth specification (negligence on more than one occasion) regarding his care and treatment of Patients A through E and of the fifteenth through seventeenth specifications (unprofessional conduct for record-keeping violations) regarding his records for Patients A through D. The allegations of negligence on more than one occasion sustained by the hearing committee and designee involve respondent failing to record the findings of an adequate medical history and physical examination (A1 and B1); failing to employ pre-operative laminaria (A3, B2, D2, and E3); giving a patient oral fluids which were not indicated (A5); failing to transfer a patient to a hospital expeditiously (A6) and at all

(E6), and inappropriately deciding to transfer a patient to a distant hospital (A7); during a procedure, delivering a loop of bowel through the cervix (B4) and continuing that procedure in spite of presence of bowel (B6); performing a first trimester abortion (C1); failing to order certain tests and pathology report (C3) and waiting to order a sonogram and diagnose an ectopic pregnancy (C4); failing to record the findings of an adequate medical history and physical examination (D1) and not reporting a pre-operative or post-operative diagnosis in an operative report (D7); performing a procedure which was not indicated on an outpatient basis (D3); dilating the cervix inadequately (D4); performing a second procedure (D5); and failing to forward tissue for examination (D8) and failing to remove and identify fetal parts (E5). The allegations of unprofessional conduct of record-keeping violations sustained by the hearing committee and designee involve respondent failing to record the findings of an adequate medical history and physical examination (A1 and B1); failing to record the findings of an adequate medical history and physical examination (D1) and not reporting a pre-operative or post-operative diagnosis in an operative report (D7).

On February 21, 1991 Commissioner of Health, David Axelrod, determined that the continued practice of medicine in the State of New York by respondent constituted an imminent danger to the health of the people of this State and, pursuant to Public Health Law §230(12), that respondent shall not practice medicine in the State

of New York. On the same date, he signed the Notice of Hearing and Health Commissioner's Order summarily suspending respondent's license to practice medicine in New York. A copy of such Order and Notice of Hearing, each referring to Public Health Law §230, is annexed hereto, made a part hereof, and marked as Exhibit "A". On February 25, 1991, said Order and Notice of Hearing together with the statement of charges were served upon respondent. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "B". Allegations C2 and D6 were withdrawn at the hearing.

Between March 6, 1991 and April 25, 1991 a hearing was held in nine sessions before a hearing committee of the State Board for Professional Medical Conduct. At the conclusion of the eighth session, the hearing committee deliberated on the issue of respondent's summary suspension and voted unanimously to recommend that the Order be modified. The modification recommended by the hearing committee allowed respondent to resume all aspects of his practice, except that he be prohibited from performing or being associated with any termination of pregnancy procedures pending the final determination of the matter. The Administrative Officer then stated that this interim recommendation will be reviewed by the "Commissioner or his representative" and that "we are still bound by the provisions of Section 230".

On April 23, 1991, Linda Randolph, M.D., Director of the Office of Public Health issued an Order: indicating that she was

acting for and on behalf of David Axelrod, M.D., Commissioner of Health; deciding that she would not limit the scope of the "summary order"; and ordering that the "summary order" shall continue in full force and effect. A copy of that Order is annexed hereto, made a part hereof, and marked as Exhibit "C". This April 23, 1991 Order was transmitted to the parties by the Director of Adjudication (who was also the Administrative Officer).

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "D". On June 10, 1991, the hearing committee found and concluded that respondent was guilty of the fifteenth through seventeenth specifications, was guilty to the extent indicated in its report of the thirteenth specification of negligence on more than one occasion, and was not guilty of the remaining specifications and charges, and recommended that respondent's license to practice medicine be suspended for a period of three years, with two years stayed, providing respondent enters a qualified residency program.

On June 20, 1991, in an unrelated disciplinary matter, the Supreme Court, Appellate Division, held in Edelman v. Sobol, 571 N.Y.S.2d 592 (3rd Dept. 1991), that a claim that the hearing committee was appointed improperly was not preserved for judicial review where the party raising the issue failed to advance it at the administrative level.

On July 8, 1991, respondent submitted to the Department of Health the following: (1) respondent's exceptions to the hearing committee report and (2) respondent's motion with supporting papers to vacate the report and recommendations of the hearing committee and to dismiss the charges or, in the alternative, to remand the matter to an Administrative Law Judge for a hearing. The motion was based upon respondent's claim that he was denied a proper statutory hearing in that both the hearing committee and the Chairperson of the hearing committee "were not appointed as required by Public Health Law Section 230(10)(e)."

On August 2, 1991, Linda Randolph, M.D., recommended to the Board of Regents, in her Commissioner's Recommendation and Disposition of Requests and Motions, that the findings of fact and conclusions of the hearing committee be accepted, the recommendation of the hearing committee as to the measure of discipline be rejected and, in lieu thereof, respondent's license to practice medicine be revoked, the request by respondent's attorney to vacate her Order to continue the "summary order" be rejected, and respondent's motion to vacate the hearing committee report and recommendations or to remand the case be denied because, among other things, the Chairperson may delegate his powers as appropriate and no prejudice or unfairness has been shown. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "E".

On September 27, 1991, respondent appeared before us and was

represented by his attorney, Joseph K. Gormley and his "special" Counsel, Wilfred T. Friedman, Esq. Terrance Sheehan, Esq., presented oral argument on behalf of the Department of Health. At oral argument, we ruled that respondent's seven proposed submissions (see his attorney's September 13, 1991 letter and letter from Dr. Peterson) were received into the record.

Respondent submitted to us a written application dated September 13, 1991 asking that this Committee and the Board of Regents: (1) take official notice of certain facts regarding many members of the public holding views that termination of pregnancy should not be permitted; and (2) any member who has or shares in such views not participate in any deliberation or decision in this matter. We orally ruled, in regard to the application by respondent, that the Regents Review Committee was unanimous in its belief that: (1) this matter should be determined solely on the basis of the record and not on the basis of any views as to whether termination of pregnancy should be permitted; (2) this Regents Review Committee could be fair and impartial and could participate in this review and the deliberation without any prejudice to respondent; and (3) this Committee could not rule on the participation by members of the Board of Regents in their endeavors to finally determine this matter.

The materials originally forwarded to us by the Health Department did not include the pre-hearing conference transcripts. Therefore, a special request was made on our behalf for the

pre-hearing conference transcripts to be sent to us. Subsequently, we received the requested pre-hearing transcripts sent by the Administrative Officer who was serving as the Director of the Bureau of Adjudication.

The pre-hearing conference transcripts, which are part of the record in this matter, were, according to the Director of the Bureau of Adjudication, not received by the "Commissioner of Health" prior to the issuance of his recommendation. We interpret this explanation to mean that the pre-hearing transcripts were not received or reviewed by the Health Commissioner's designee. However, the record available for review at the time of the issuance of the recommendation of the Health Commissioner's designee reflected the holding of four pre-hearing conferences. The designee could have chosen, as we did, to request a copy of the transcripts kept within the Department of Health.

In our unanimous opinion, the designee's lack of receipt and review of the pre-hearing conference transcripts did not violate any required statutory procedure with regard to this disciplinary matter and did not deny respondent due process. See, Matter of Smith, Cal. No. 11657; Matter of Briggs, Cal. No. 11695; and Matter of Hah, Cal. No. 11953. Cf., DiMarsico v. Ambach, 48 N.Y.2d 576 (1979).

We have considered the record in this matter as transferred by the Executive Secretary for the Board for Professional Medical Conduct and the Director of the Bureau of Adjudication before our

meeting; respondent's August 29, 1991, August 31, 1991, and September 3, 1991 letters along with petitioner's September 3, 1991 letter and our Ruling as shown in a letter dated September 20, 1991 as to respondent's application for an adjournment; each of the six submissions by respondent referred to in respondent's September 13, 1991 letter, the one submission by respondent referred to in respondent's other September 13, 1991 letter, and petitioner's September 16, 1991 objections to those submissions, including the attached exhibit of the March 12, 1991 delegation of authority from Ms. McBarnette to Dr. Randolph; respondent's September 30, 1991 objection to said delegation of authority; an October 4, 1991 letter sent on behalf of this Committee as to the issue of said delegation of authority; and petitioner's October 9, 1991 response to our letter and respondent's October 18, 1991 reply to petitioner's October 9, 1991 letter.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was revocation.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was maximum leniency. Respondent also recommended in writing that we approve the arrangement with four physicians, "in place and working" as referred to in respondent's September 13, 1991 affidavit.

Various arguments have been asserted by respondent regarding

both the propriety of the procedures followed during the Health Department proceedings and the merits of the charges. We initially consider threshold procedural issues which warrant discussion.

First, respondent contends, to us, that the hearing was void and a nullity because the hearing committee was not appointed as required by Public Health Law §230. Although he was represented by counsel, respondent did not, either at the commencement or during the course of the hearing, inquire into or challenge the validity of the appointment of the hearing committee. It was only after both the completion of the hearing and the rendering by the hearing committee of a verdict unfavorable to him when respondent, almost a month after the hearing committee report was issued, first raised, in his motion to the Department of Health, the issue of the hearing committee and its Chairperson not being appointed by the Chairman of the Board of Professional Medical Conduct.

Respondent's attorney could have inquired some time during the hearing as to the procedures followed in the appointment process. In fact, in a pre-hearing conference, respondent's counsel inquired and was informed as to the names of each of the hearing committee members. At the commencement of the hearing, the Chairperson of the hearing committee informed the parties that this hearing by the State Board for Professional Medical Conduct is conducted pursuant to Public Health Law §230 and such section created the Board and empowered it to conduct the hearing. Also, the Chairperson stated that the members of the hearing committee were members of the State

Board for Professional Medical Conduct. When one member stated that he was a past neighbor of respondent, respondent's attorney declared that he has "no objection" to said member sitting on the committee. Significantly, when petitioner's attorney asked respondent's counsel whether there was an objection on "any basis" to any member, respondent's counsel did not raise any objection to the hearing committee as a whole or to any of its individual members.

Had respondent timely raised an objection, another hearing committee and its Chairperson might possibly have been appointed by the Chairperson of the Board. Respondent's attorney only objected belatedly after the Court in Edelman, supra, determined that, in order for the issue to be preserved it must be raised administratively. In our unanimous opinion, as contended by petitioner, respondent's failure to object before the hearing committee issued its report either constitutes a waiver of this issue or results in respondent being estopped from being permitted to raise it at this time. Accordingly, respondent's motion to vacate the report and recommendations of the hearing committee and to dismiss the charges, or in the alternative, remand the matter to an Administrative Law Judge for a hearing is denied. The Health Commissioner's designee was not required to grant any relief to respondent in this regard.

Second, respondent contends that this Committee has no

jurisdiction in this matter because there has been no recommendation by the "Commissioner of Health". It is undisputed that the recommendation referred to in Public Health Law §230(10)(i) was not rendered by the Commissioner of Health who signed the Notice of Hearing and Health Commissioner's order (summary suspension) nor by the Executive Deputy Commissioner, Ms. Lorna McBarnette, but by Dr. Randolph, the Director of the Office of Public Health. At the hearing, respondent's attorney challenged the authority of Dr. Randolph to act on behalf of the Commissioner of Health.

The presumption of regularity attaches to the recommendation advanced by Dr. Randolph and supported by petitioner. The recommendation of Dr. Randolph is clearly labelled "COMMISSIONER'S RECOMMENDATION AND DISPOSITION OF REQUESTS AND MOTIONS". In our unanimous opinion, respondent has not overcome the presumption in this matter.

Respondent's contentions, both that, under Public Health Law §230(10)(i), the recommendation of the Commissioner of Health may not be delegated to anyone, and that, if such authority may be delegated, Ms. McBarnette is not an appropriate person to delegate it, are not persuasive. Respondent has not convinced us that the authority to issue the recommendation of the Commissioner of Health is not delegable by an appropriate person. Public Health Law §206(8) provides that the Commissioner of Health may deputize in writing any officer or employee in the Department of Health to do

or perform the act in his place and stead. The Board of Regents has previously held that the recommendation pursuant to Public Health Law §230(10)(i) is delegable under Public Health Law §206(8). Cf., Matter of Perlroth, Cal. No. 4266.

The second portion of respondent's contention relates to whether the Executive Deputy Commissioner had the authority to designate Dr. Randloph to act in the place and stead of the Commissioner of Health. Respondent has not submitted any evidence to show that there were two or more deputies at the time of the delegation or that, if there were two or more deputies of the same principal officer, requisite filings have not been made. The record adduced by petitioner shows there is "but one" Executive Deputy Commissioner. It is our unanimous opinion that, based upon this record, the powers of the Commissioner of Health devolved upon Ms. McBarnette in accordance with Public Officers Law §9. With respect to said Public Officers Law §9 and Public Health Law §208, respondent has not shown who is the "first deputy commissioner" and has not shown that, at the time in question, there were "other deputy commissioners".

There is an absence of proof by respondent that the delegation of authority signed by both Ms. McBarnette and Dr. Randolph on March 12, 1991 is invalid, improper, or ultra vires. Under these circumstances, Ms. McBarnette possessed the powers and performed the duties of the Commissioner of Health during the absence or

inability to act of her principal or during a vacancy in her principal's office. Thus, based on the record herein, the delegation of authority was lawfully made by the person acting in the place and stead of the Commissioner of Health.

In any event, the designee's recommendation, as well as the other recommendations we have received, are not binding on us or on the Board of Regents. If any error was committed in rendering the designee's recommendation, we find such would be no more than harmless error. Respondent has been accorded due process by this Committee and we have independently fulfilled our duties. Accordingly, there is no merit to respondent's position as to there being no jurisdiction for this Committee to render its decision and for the Board of Regents to be the ultimate fact finder, and there is no reason to delay this matter because of the interpretation of law by the Health Commissioner's designee. See, Morfesis v. Sobol, 567 N.Y.S.2d 954 (3rd Dept. 1991); and D'Amico v. Commissioner of Education of State of New York 563 N.Y.S.2d 326 (3rd Dept. 1990).

We do not agree with respondent's other argument that it was unfair or improper for petitioner to charge respondent with each of the allegations brought against him and for this proceeding to be conducted in accordance with the summary suspension procedures. As to the earlier investigation resulting in respondent being notified on November 17, 1988 that the investigation as to patient E had been closed, petitioner was not collaterally estopped or otherwise precluded, by that investigative course taken without a hearing,

from pursuing the charges as to patient E. Those charges, along with other charges and evidence obtained regarding negligence on more than one occasion, were subject, under Public Health Law §230, to investigative screening and full review.

NEGLIGENCE AND RECORD-KEEPING

We accept the hearing committee's and designee's conclusions as to Patient A that respondent is guilty of negligence as to allegations A3 and A5 and is not guilty of negligence as to allegations A2, A4, and A8. We also accept their conclusions as to allegation A6[1] that respondent is guilty of negligence to the extent of the conclusion on page 8 of the hearing committee report that respondent did not expeditiously transfer patient A to a hospital, but said allegation is not proven to the extent it alleges, in the last sentence, that respondent waited until 5:25 p.m. (see findings 13 and 14). We also accept their conclusions as to allegation A1 insofar as they recommend that respondent is guilty of negligence and unprofessional conduct due to respondent's failure to record an accurate pre-operative physical examination. However, there are no findings sufficient to support allegation A1 as to an adequate medical history and the conclusion that respondent failed to record Patient A's medical history is contradicted by petitioner's own expert witness. Transcript

[1]We believe that, although not made clear on page 9 of the hearing committee report, the hearing committee sustained both allegations A6 and A7.

(hereafter T.__) page 22.

We do not accept their conclusions as to patient A that respondent is guilty of negligence as to allegation A7[2]. There is no evidence to establish that, as alleged in allegation A7, respondent decided to make that transfer to a distant hospital at 5:25 p.m. when respondent had consented to such transfer prior thereto at least by 5:00 p.m. Further, finding 15 which indicated that respondent did not have a formal, which was not alleged, back-up relationship and the conclusions which indicated that he did not have an affiliation agreement, which was also not alleged, with a nearby hospital do not establish the allegation that respondent did not have "a backup relationship with any hospital".

We accept the hearing committee's and designee's conclusions as to patient B that respondent is guilty of negligence as to allegations B2, B4, and B6 and is not guilty of negligence as to allegations B3, B7, and B8. We also accept their conclusions that respondent is guilty of negligence as to allegation B1 insofar as they recommend that respondent failed to record an adequate physical. Like allegation A1, we cannot accept that portion of their conclusions as to allegation B1, which are not supported by sufficient findings of any failure to record an adequate medical history and are contradicted by petitioner's own expert witness

[2]See footnote 1.

T. 71-72. With respect to allegation B5, inasmuch as there is no conclusion whether to sustain the charge and respondent did not admit to negligence, we do not sustain this allegation.

We accept the hearing committee's and designee's conclusions as to Patient C that respondent is guilty of negligence as to allegation C4 due to respondent's failure, before October 18, 1988, to timely order a sonogram and diagnose an ectopic pregnancy. However, we cannot accept their conclusions as to allegations C1 and C3. There is neither any charge in allegation C1 nor finding as to such allegation regarding a departure from acceptable medical practice. Further, respondent asserted correctly that there is no evidence of negligence on September 20, 1988. With respect to allegation C3, there is no conclusion that respondent is negligent for failing to order a sonogram and repeat a pregnancy test. The charge regarding respondent failing to "review" the pathology report on September 28, 1988 is not proven by a preponderance of the evidence and is not supported adequately by the hearing committee's conclusion on page 13 of its report that the September 29, 1988 report was "readily available" by telephone on September 28, 1988. In any event, such conclusion is not adequately supported by testimony from anyone who has knowledge of such fact. See T. 107.

It was improper for the hearing committee and designee to conclude that respondent was guilty of unprofessional conduct for record-keeping violations as to patient C. We cannot accept a

conclusion involving misconduct which respondent was never charged with committing.

We accept the hearing committee's and designee's conclusions as to patient D that respondent is guilty of negligence as to allegations D1, D2, D3, and D8 and is not guilty of negligence as to allegation D9. We also accept their conclusions as to allegation D1 insofar as they recommend that respondent is guilty of unprofessional conduct due to respondent's failure to record an adequate physical examination.

We do not accept their conclusions as to patient D that respondent is guilty of negligence as to allegations D4 and D5. There is no finding as to allegation D4 that the degree of dilation achieved was, as charged, inadequate (see finding 33). With respect to allegation D5, there is no charge as to respondent deviating from acceptable medical standards. Further, the conclusions rendered are different from and go beyond allegation D5. We also do not accept their conclusions as to patient D that respondent is guilty of negligence and unprofessional conduct as to allegation D7. There is no finding or specific conclusion as to this charge, as compared with the different specific conclusion on page 16 of the hearing committee report regarding something that was not charged.

We accept the hearing committee's and designee's conclusions as to patients E and F that respondent is guilty of negligence as

to allegations E3, E5, and E6, and is not guilty of negligence as to allegations E1, E2, E4, E7, E8, E9, F1, F2, and F3.

OTHER CHARGES

We accept the hearing committee's and designee's conclusions as to patients A through F that respondent is not guilty of gross negligence, gross incompetence, and incompetence on more than one occasion.

In this matter involving conflicting expert testimony, we have assessed the relative qualifications of the expert witness for each party. As the hearing committee found, petitioner's expert is experienced in practicing in New York City in the special area of medicine in issue. She is well qualified to testify in this matter. Although respondent's expert is clearly qualified, we assign greater weight to the testimony of petitioner's expert over conflicting testimony of respondent's expert. See, Hodge v. New York State Department of Education, 568 N.Y.S.2d 188 (3rd Dept. 1991). We were persuaded that petitioner's expert knew about relevant standards and practices and was genuinely concerned for the patients' need to receive acceptable medical care. We find her testimony, as a whole, was more objective, convincing, and consistent than respondent's expert.

We reject respondent's contention that the "vast superiority" of the expert testimony on behalf of respondent was "especially evident on the question of the use of laminaria". In our unanimous opinion, respondent's expert was not as credible as petitioner's

expert. See, Stein v. Board of Regents, 564 N.Y.S.2d 585 (3rd Dept. 1991). The conflicting expert opinions on this issue were: petitioner's expert took the position that the issue of laminaria is standard practice as part of the D & E procedure; and respondent's expert took the position that alternative methods of dilation are equally acceptable. Hearing committee report page 8.

Respondent's expert believed that he was "possibly" in the minority position regarding using laminaria and that he was at variance with popular opinion on this issue, T. 376. In spite of his position, he is the only physician in his clinic who uses laminaria in a substantial percentage of mid-trimester abortions, T. 414, 448, and 449, and the use of laminaria enables him to avoid cervical laceration, T. 450. At the same time, respondent's expert could not find it appropriate for other physicians to use laminaria. T. 451. The majority of the hearing committee, which observed the demeanor of the witnesses, concluded correctly, on the basis of a preponderance of evidence, that the position of petitioner's expert better represented acceptable standard practice.

In arriving at the measure of discipline to be imposed, we have considered the entire record, including the summary suspension respondent has already served, respondent being not guilty of any gross negligence, gross incompetence, or incompetence on more than one occasion, some of the allegations sustained by the hearing committee and Health Commissioner's designee were not sustained by

us, the conclusions of guilt of the hearing committee and Health Commissioner's designee which were not based upon the charges, respondent's claim, which was not rebutted by petitioner, that he has changed his practices and now uses laminaria, respondent's licensure since 1973, the letters of support from respondent's patients, and the probation terms we are recommending.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner's designee as to those findings of fact be accepted, except findings of fact 22 and 26 and the portion of the last sentence of finding of fact 9 which states "three and one-half hours" not be accepted;

2. The following additional findings of fact, referable to all the patients, be accepted:

   3(a) Petitioner's expert was board certified in obstetrics and gynecology in 1976 and was so certified at the time of respondent's conduct. T. 13.

   3(b) Petitioner's expert performs about two to 300 abortions a year and is knowledgeable about and familiar with the standards and practice in New York City. T. 53.

3(c) Petitioner's expert's experiences have also included working in a high volume recovery room, T. 45, being on staff at New York Medical College, Assistant Professor with a private practice, and being in solo clinical practice. T. 13.

3(d) In the past, petitioner's expert performed terminations of 18 to 20 week pregnancies. T. 59.

3(e) Respondent's expert is licensed only in the District of Columbia and has practiced at the Washington Hospital Center in Washington D.C. from 1970 through the present. Respondent's Exhibit B; T. 313-315.

3(f) Respondent's and petitioner's respective experts differed over their own notion of appropriate practices. T. 363.

3(g) In his practice, respondent's expert uses laminaria, in patients 18 to 19 weeks pregnant, on the average of 23 percent of the time and, in patients 20 or more weeks pregnant, 52 percent of the time. T. 451.

3. The conclusions of the hearing committee and Health Commissioner's designee be modified;

4. By a preponderance of the evidence, respondent is guilty of the thirteenth specification to the extent of allegations A3, A5, B2, B4, B6, C4, D1, D2, D3, D8, E3, E5, and E6, in full, and, partially, to the extent indicated by the hearing committee, of allegations A1, A6, and B1 for negligence on more than one occasion involving respondent failing to record the findings of an adequate physical examination, failing to employ pre-operative laminaria, giving a patient oral fluids which were not indicated, failing to transfer a patient to a hospital expeditiously and at all, during a procedure, delivering a loop of bowel through the cervix and continuing that procedure in spite of presence of bowel, waiting to order a sonogram and diagnose an ectopic pregnancy, failing to record the findings of an adequate physical examination and failing to perform an adequate medical history, performing a procedure which was not indicated on an outpatient basis, failing to forward tissue for examination, and failing to remove and identify fetal parts; respondent is guilty of the fifteenth and sixteenth specifications, partially, to the extent indicated by the hearing committee, of allegations A1 and B1 for unprofessional conduct regarding record-keeping violations involving respondent's failing to record the findings of an adequate physical examination, and of the

seventeenth specification, partially, to the extent indicated by the Regents Review Committee, of allegation D1 for failing to record the findings of an adequate physical examination; and is not guilty of the remaining specifications and allegations; and

5. The measure of discipline recommended by the hearing committee and by the Health Commissioner's designee be modified, and respondent be suspended for three years upon each specification of the charges of which respondent has been found guilty, as aforesaid, said suspensions to run concurrently, execution of said concurrent suspensions be stayed and respondent be placed on probation for three years in accordance with the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "F", which include provision for supervision of respondent's abortion, OB/GYN, and record-keeping practices.

Respectfully submitted,

LAURA BRADLEY CHODOS

JOHN T. McKENNAN

GEORGE POSTEL

Chairperson

Dated: December 11, 1991

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

IN THE MATTER

OF

ANDRE NEHORAYOFF, M.D.

: COMMISSIONER'S
: ORDER AND
: NOTICE OF HEARING

TO: ANDRE NEHORAYOFF, M.D.
115 East 23rd Street
New York, New York 10010

The undersigned, Commissioner of Health of the State of New York, after an investigation and upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, has determined that the continued practice of medicine in the State of New York by ANDRE NEHORAYOFF, 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 1990), that effective immediately ANDRE NEHORAYOFF, 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 1990).

EXHIBIT "A"

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1991). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 6th day of March, 1991 at 10:00 A.M. at 5 Penn Plaza, Sixth Floor, New York, New York 10001-1803 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 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.

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. Moreover, a request for an adjournment in this matter may be regarded as a "delay caused by the physician" within the meaning of N.Y. Pub. Health Law -230(12) (McKinney 1990) causing the Order of the Commissioner to be continued until the committee makes its recommendation to the Commissioner. 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 a determination concerning what action should be taken with respect to Respondent's license to practice medicine in the State of New York.

BECAUSE THESE PROCEEDINGS MAY RESULT IN A RECOMMENDATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 21, 1991

DAVID AXELROD, M.D.
Commissioner of Health

Inquiries should be directed to:

Terrence Sheehan
Associate Counsel
N.Y.S. Department of Health
Bureau of Professional
Medical Conduct
5 Penn Plaza - 6th floor
New York, New York 10001-1803
(212) 613-2601

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

IN THE MATTER	:	STATEMENT
OF	:	OF
ANDRE NEHORAYOFF, M.D.	:	CHARGES

ANDRE NEHORAYOFF, M.D., the Respondent, was authorized to practice medicine in New York State on January 22, 1973 by the issuance of license number 115290 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, 1990 through December 31, 1992 from 115 East 23rd Street, New York, N. Y.

FACTUAL ALLEGATIONS

A. On or about June 23, 1990, Patient A (whose name along with other Patient names is contained in the attached Appendix), a 36 year-old woman, visited Respondent's office, known as Manhattan Women's Medical Offices, at 115 East 23rd Street, New York, N.Y., for a dilation and evacuation for fetal demise.

EXHIBIT "B"

1. Prior to performing the abortion, Respondent failed to perform and/or record the findings of an adequate medical history and physical examination.

2. Respondent also failed to order for Patient A the following pre-operative tests: pt; ptt; platelets; fibrinogen and a hematocrit.

3. Respondent failed to employ pre-operative laminaria for Patient A.

4. On or about June 23, 1990, Respondent performed a dilation and evacuation of a fetal demise. Respondent dilated Patient A's cervix to only 35 mm., which is an inadequate degree of dilation.

5. While in the recovery room Patient A was given Anaprox and oral fluids which were not indicated.

6. Patient A was observed in the recovery room from 12 noon to 5:25 p.m. During this period the Patient was weak, unresponsive and had a falling blood pressure. Respondent should have transferred the Patient to a hospital by 2 p.m. Instead, he waited until 5:25 p.m. when the patient was cyanotic with a blood pressure of 80/0.

7. At 5:25 p.m., Respondent inappropriately decided to transfer Patient A to Central Suffolk Hospital, a transfer which would have taken two hours. The husband of Patient A insisted that an ambulance be called and that Patient A be transferred to a nearby hospital. Respondent did not have a back-up relationship with any hospital, so a nurse called 911 and Patient A was transferred to Beth Israel Medical Center, New York, N.Y. (Beth Israel).

8. Upon arrival at Beth Israel, Patient A had a hemoglobin of 7.8 and a hematocrit of 23.4. She was in shock with BP of 80/0 and a pulse of 126. During surgery two lacerations were noted in the uterus, however, the Patient's bleeding could not be controlled and an emergency hysterectomy had to be performed. In the procedure performed on June 23, 1990, Respondent had improperly perforated Patient A's uterus.

B. On or about November 22, 1989, Patient B, an 18-year old woman, visited Respondent's office for a mid-trimester abortion.

1. Prior to performing the abortion on Patient B, Respondent failed to perform and/or record the findings

of an adequate medical history and physical examination.

2. Respondent failed to employ pre-operative laminaria for Patient B.

3. On or about November 22, 1989, Respondent performed a dilation and evacuation. Respondent dilated Patient B's cervix to only 29 mm., which is inadequate dilation in a mid-trimester abortion.

4. During the course of the procedure Respondent delivered a loop of Patient B's bowel through the Patient's cervix.

5. During the procedure Respondent caused a 2.5 cm. tear in the anteolateral aspect of the uterus of Patient B.

6. Once Respondent noted a portion of the small bowel in the cervix, Respondent should have stopped the dilation and evacuation of Patient B. Instead he continued the procedure.

7. After the procedure, Patient B was transferred to the New York Hospital, New York, N.Y. where exploratory surgery revealed a 6.5 foot segment of devascularized

bowel which was resected and the ends joined. Fetal parts were also found in the uterus.

C. On or about September 20, 1988, Patient C, a 22 year-old woman visited Respondent's office for an abortion.

1. On or about September 20, 1988, Respondent performed a first-trimester abortion on Patient C.

2. On or about September 22, 1988, Patient C called Respondent and complained of shoulder pain and cramps. Respondent failed to examine Patient C and failed to order a sonogram in response to these complaints in order to rule out an ectopic pregnancy or a perforation of the uterus. 3/6/91

3. On or about September 28, 1988, Patient C went to Respondent's office with a complaint of lower abdominal pain. Respondent failed to order a sonogram, repeat a pregnancy test and review the Patient's pathology report.

4. It was not until on or about October 18, 1988, that Respondent ordered a sonogram and diagnosed an ectopic pregnancy.

D. On or about October 18, 1988, Patient D, a 27 year-old woman, visited Respondent's office for a mid-trimester abortion.

1. Prior to performing the abortion, Respondent failed to perform and/or record the findings of an adequate medical history and physical examination.

2. Respondent failed to employ pre-operative laminaria.

3. On or about October 18, 1988, Respondent performed a dilation and evacuation. This procedure was not indicated on an outpatient basis due to Patient D's low hematocrit of 26%.

4. Respondent dilated Patient D's cervix to only 35 mm., which is inadequate dilation in a mid-trimester abortion.

5. On or about October 22, 1988, Respondent performed a second dilation and evacuation on Patient D.

6. Respondent failed to order the following test prior to the second operation: a repeat hematocrit.

7. The operative report for the second procedure does not contain a pre-operative or post-operative diagnosis.

8. Respondent failed to forward for pathological examination the tissue purportedly removed in the procedure performed on or about October 22, 1988.

9. Given the lack of supporting pre-operative and post-operative documentation of the need for the dilation and evacuation performed on October 22, 1988, the procedure was not indicated.

E. On or about November 29, 1983, Patient E, an 18 year-old woman, visited Respondent's office for a mid-trimester abortion.

1. Prior to performing the abortion, Respondent failed to perform and/or record the findings of an adequate medical history and physical examination.

2. Respondent also failed to order the following pre-operative test: a sonogram.

3. Respondent failed to employ pre-operative laminaria.

4. On or about November 29, 1983, Respondent performed a dilation and evacuation. Respondent dilated Patient E's cervix to only 35 mm., which is inadequate dilation in a mid-trimester abortion.

5. Respondent failed to remove and identify all fetal parts.

6. Respondent knew or should have known that he had performed an incomplete abortion. Respondent failed to have Patient E transferred to a hospital for observation and completion of the procedure.

7. On or about December 1, 1983, Respondent received a pathology report indicating that Respondent had removed only placental tissue in the procedure performed on November 29, 1983. Respondent failed to make any notations in Patient E's chart indicating that he had reviewed this report, was aware of the serious consequences it posed for Patient E and that he had taken all possible steps to contact Patient E.

8. On or about December 3, 1983, at 5:10 a.m., Patient E was admitted to the emergency room at West Hudson Hospital, Kearney, New Jersey, in a coma with shallow

respirations. Patient E died at 6:20 a.m., the same day.

9. On or about December 3, 1983, at 4:30 p.m., the Hudson County Medical Examiner performed an autopsy on Patient E. The Medical Examiner found a portion of the fetal left leg protruding from the uterus and concluded that Patient E had died of hemmorrhage due to an incomplete abortion.

F. On or about December 15, 1979, Patient F, a 19 year-old woman, visited Respondent's office for an abortion.

1. Prior to performing the abortion, Respondent failed to perform and/or record the findings of an adequate medical history and physical examination.

2. On or about December 15, 1979, Respondent performed a suction curettage. After the procedure, at 2:25 p.m., Patient F was transferred to the recovery room. While in the recovery room, Respondent failed to provide adequate monitoring of Patient F's condition. Specifically, continuous visual observation and EKG monitoring were lacking.

3. At or about 3:25 p.m. Patient F became cyanotic and without pulse. The Patient was transferred to Roosevelt Hospital, New York, N.Y. where she was pronounced dead.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law section 6509(2) (McKinney 1985) in that Petitioner charges:

1. The facts in paragraphs A and A.1 through A.8.

2. The facts in paragraphs B and B.1 through B.7.

3. The facts in paragraphs C and C.1 through C.4.

4. The facts in paragraphs D and D.1 through D.9.

5. The facts in paragraphs E and E.1 through E.9.

6. The facts in paragraphs F and F.1 through F.3.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law section 6509(2) (McKinney 1985), in that the Petitioner charges:

7. The facts in paragraphs A and A.1 through A.8.

8. The facts in paragraphs B and B.1 through B.7.

9. The facts in paragraphs C and C.1 through C.4.

10. The facts in paragraphs D and D.1 through D.9.

11. The facts in paragraphs E and E.1 through E.9.

12. The facts in paragraphs F and F.1 through F.3.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

13. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, C and C.1, C.2, C.3, C.4, D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9 and/or F and F.1, F.2., F.3.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

14. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, B and B.1, B.2, B.3, B.4, B.5, B.6, B.7, C and C.1, C.2, C.3, C.4, D and D.1, D.2, D.3, D.4, D.5, D.6, D.7, D.8, D.9, E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, E.8, E.9 and/or F and F.1, F.2., F.3.

FIFTEENTH THROUGH NINETEENTH SPECIFICATIONS

COMMITTING UNPROFESSIONAL CONDUCT AS DEFINED BY THE BOARD OF REGENTS

INADEQUATE MEDICAL RECORDS

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law 6509(9) (McKinney 1985) by failing to

maintain an accurate record for each patient in violation of 8 NYCRR 29.2(a)(3) (1987) in that Petitioner charges:

15. The facts in paragraphs A and A.1.

16. The facts in paragraphs B and B.1.

17. The facts in paragraphs D and D.1 and D.7.

18. The facts in paragraphs E and E.1, E.5 and E.7.

19. The facts in paragraphs F and F.1.

DATED: New York, New York
February 19, 1991

Chris Stern Hyman
Counsel
Bureau of Professional Medical Conduct

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

IN THE MATTER :

OF : ORDER

ANDRE NEHORAYOFF, M.D. :

----------X

The undersigned, Linda Randolph, M.D., Director of the Office of Public Health, acting for and on behalf of David Axelrod, M.D., Commissioner of Health of the State of New York, has reviewed the Interim Report of the Hearing Committee (transcript pages 3-5, attached) on the issue of Imminent Danger in the above captioned matter, the Committee's finding that Andre Nehorayoff, M.D., Respondent, does present an imminent danger to the health of the people of the State of New York, and the Hearing Committee's recommended action that the Summary Order prohibiting Andre Nehorayoff, M.D., Respondent, from practicing medicine in the State of New York be modified. I am not convinced at this time that Respondent's skills and judgment as evidenced by his surgical practices are not indicative of his skills and judgment in other areas of his practice and I, therefore, would not limit the scope of the Summary Order at this time. Therefore, it is

EXHIBIT [illegible]

ORDERED, that pursuant to Public Health Law §230(12), the Summary Order prohibiting Andre Nehorayoff, M.D., Respondent, from practicing medicine in the State of New York shall continue in full force and effect.

DATED: Albany, New York
April 23, 1991

Linda A. Randolph

LINDA RANDOLPH, M.D.
Director
Office of Public Health

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

IN THE MATTER	:	REPORT OF THE
OF	:	HEARING
ANDRE NEHORAYOFF, M.D.	:	COMMITTEE

TO: LORNA MCBARNETTE, EXECUTIVE DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

Albert M. Ellman, M.D., Chairperson, Ms. Ann Shamberger and Stephen A. Gettinger, M.D., 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, are serving as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Tyrone T. Butler, Administrative Law Judge, served as the Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

SUMMARY OF PROCEEDINGS

Service of Commissioner's Order and Notice of Hearing and Statement of Charges:	February 25, 1991
Prehearing and Intra-hearing conference(s):	March 5, 1991 March 6, 1991 April 15, 1991 April 25, 1991

EXHIBIT "D"

Date of Interim Report on Imminent Danger:	April 15, 1991 (T. 1281-1283
Hearing Dates:	March 6, 1991 March 7, 1991 March 21, 1991 March 22, 1991 April 1, 1991 April 11, 1991 April 12, 1991 April 15, 1991 April 25, 1991
Deliberations were held on:	May 24, 1991 June 10, 1991
Place of Hearings:	Five Penn Plaza New York, New York
Department of Health appeared by:	Peter J. Millock, Esq. General Counsel by Terrence Sheehan, ESq. Associate Counsel Bureau of Professional Medical Conduct Five Penn Plaza New York, New York
Respondent appeared by:	Lifshutz & Polland, P.C. Joseph K. Gormley, Esq. of Counsel One Madison Avenue New York, New York

Witnesses for the Department of Health:

CAROL LIVOTI, M.D.	OB/GYN - Expert Witness
ZEINAB FATHELBAB, M.D.	OB/GYN - Fact Witness
HUSBAND OF PATIENT A	Fact Witness

Witnesses for Respondent:

WILLIAM F. PETERSON, M.D. OB/GYN - Expert Witness

RESPONDENT

Petitioner (Department) filed Proposed Findings of Fact, Conclusions of Law: May 17, 1991

Respondent filed Proposed Findings of Fact, Conclusions of Law: May 17, 1991

On February 25, 1990, the Respondent was served with the Commissioner's Order, Notice of Hearing and Statement of Charges. On April 15, 1991, the Committee deliberated on the issue of "Imminent Danger" and issued an Interim Report, on the Record (Panel Ex. 5). The Department of Health and the Respondent presented their entire cases and the record was closed on April 25, 1991. On May 24, 1991 and June 10, 1991, the Committee held deliberations.

SUMMARY OF CHARGES

In the Statement of Charges (Dept.'s Ex. 1 - copy attached), the Respondent, Andre Nehorayoff, M.D. was charged with professional misconduct pursuant to Education Law §6509. The specific charges were: practicing the profession with gross

negligence [Education Law §6509(2)] (First through Sixth Specification), practicing the profession with gross incompetence [Education Law §6509(2)] (Seventh through Twelfth Specification), practicing the profession with negligence on more than one occasion [Education Law §6509(2)] (Thirteenth Specification), practicing the profession with incompetence on more than one occasion [Education Law §6509(2)] (Fourteenth Specification) and committing unprofessional conduct [Education Law §6509(9)] by failing to maintain an accurate record for each patient [NYCRR 29.2(a)(3)].

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Pre-hearing transcript was not made available to the Hearing Committee at the time of deliberations.

PATIENT A

1. Andre Nehorayoff, M.D., the Respondent, was authorized to practice medicine in New York State on January 22, 1973, by the issuance of license number 115290 by the New York State Education Department. (Ex. 1)

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1990 through December 31, 1992, from 115 East 23rd Street, New York, New York. (Ex. 1)

3. Carol A. Livoti, M.D., testified as an expert witness for the Department. Dr. Livoti is a board certified obstetrician/gynecologist. She has a full time private practice in New York City and is a Senior Adjunct at Lenox Hill Hospital. (T. 12-13)

4. Patient A visited the Respondent's Office on June 23, 1991 for a dilation and evacuation for fetal demise. She was referred by Dr. Zeinab Fathelbab, her private obstetrician. Patient A was in the second trimester of her pregnancy. (Ex. 14, T. 12-13, 1293-1294)

5. The Respondent failed to record a pre-operative physical examination including a cardiovascular examination and a pulmonary examination for Patient A. (Ex. 2, T. 20-22, 1158, 1257)

6. The Respondent did not use Laminaria pre-operatively to dilate the uterine cervix before performing a dilation and evacuation ("D & E") on Patient A. (Ex. 2, T. 22-24, 831, 1160)

7. The pre-operative use of Laminaria decreases the risk of cervical laceration and of long term complications. (Ex. 13, 15; T. 22-23)

8. During the course of the D & E, the Respondent dilated Patient A's cervix to "35 French" (Charriere scale = 11.67 mm). (Ex. 2, T. 24-25)

9. Patient A was transferred to the recovery room at 12 noon. The patient's condition began to deteriorate. She complained of pain and was weak. Upon admission to the recovery room, her blood pressure was 130/90. At 2 p.m. it was 80/50 while she was on IV fluids. The Respondent did not transfer Patient A to a hospital for observation until three and one-half hours later during which time her condition had continued to deteriorate. (Ex. 2, T. 26-30, 62-63, 1260)

10. While in the Recovery Room, in Trendelenberg position, Patient A was given oral medication and oral fluids. (Ex. 2, T. 27)

11. The hospital admission records indicate that Patient A had received 5 liters of fluid replacement. The Respondent was unaware of the volumes that he administered while

Patient A was in the recovery room with deteriorating vital signs. (Ex. 8, T. 1261)

12. The Respondent's expert witness, Dr. William Peterson, testified that he had some concerns about the wisdom of giving oral fluids to a patient such as Patient A. (T. 462-463)

13. The Respondent communicated with Patient A's personal gynecologist, Dr. Fathelbab, and arrangements were made for the patient to be admitted to Central Suffolk Hospital, a hospital at least two hours distant, by ambulance. (Ex. 2, T. 31, 1296)

14. On or about 5:00 p.m. in response to a call to 911, Patient A was transferred to Beth-Israel Medical Center. (Ex. 2, T.31-33, 1319-1324)

15. The Respondent had no formal back-up relationship with any hospital nor did he have hospital privileges at any hospital. (T. 412, 815-817)

16. On or about 9:30 p.m. an exploratory laparotomy was performed at Beth-Israel on Patient A. The procedure revealed a hemoperitoneum secondary to a lacerated lower portion of the uterus. The surgeons were unable to correct the defect necessitating a total abdominal hysterectomy. (Ex. 8, T. 36-38)

CONCLUSIONS - PATIENT A

The Committee finds that in the Respondent's care and treatment of Patient A, he failed to recognize that there was an intraperitoneal bleed with impending shock secondary to his having lacerated her uterus. He did not expeditiously transfer this patient to a nearby hospital. He compromised the patient's well-being by administering oral medicine and fluids. He demonstrated his failure to appreciate the severity of her condition by consenting to her transfer to a hospital at least two hours distant. We conclude from the Respondent's records in evidence, that he did fail to properly record an adequate medical history and physical findings. However, there is nothing in the record to substantiate that he did not perform these examinations. The Committee is divided by a 2 to 1 majority in favor of the use of laminaria in a late mid-trimester abortion (16 to 20 weeks gestation). The majority holds with Dr. Livoti's position that the use of laminaria is standard practice as part of the D & E procedure. In contrast, the minority accepts the testimony of Dr. Peterson that alternative methods of dilation are equally acceptable.

The Committee is not convinced that the dilation of Patient A's cervix to a 35 French (11.67 mm) was inadequate for this procedure.

The Committee finds that the administration of oral fluids to Patient A in the recovery room was contraindicated. The patient was being observed for complications following an abortion and the administration of liquids at this time could lead to aspiration and compromise the patient's airway. We do not mean to state that the administration of oral fluids to patients in a recovery room is always improper. However, in this instance the Respondent placed Patient A in a Trendelenberg position because of hypotension, thereby indicating that he was aware of the risk of complications.

We do not find that factual allegation A-8 describes a recognized breach of the duty of care. A uterine perforation is not an indication of negligence or incompetence per se. Perforation of the uterus is a well recognized complication in the performance of an abortion. However, we find that the failure to recognize and treat the perforation constitutes negligence.

The Committee concludes that the Respondent's care and treatment of Patient A falls below the standards of acceptable medical practice as regards to the maintenance of records (A1), the employment of laminaria (A3), the administration of oral fluids and oral medications in the recovery room (A5), the time of transfer to a hospital and the lack of affiliation or agreement for backup with a nearby hospital.

We find that the Respondent's conduct in this instance is negligent. We do not find gross negligence, gross incompetence or incompetence.

PATIENT B

17. On or about November 22, 1989, Patient B went to Respondent's office for a mid-trimester abortion. (Ex. 3)

18. Aside from a pulse, blood pressure and weight, there is no record of any pre-operative physical examination having been performed on Patient B. (Ex. 3)

19. During this D and E, Respondent achieved 29 French (9.6 mm) of dilation of Patient B's cervix. (Ex. 3, T. 72-73)

20. In the course of the procedure, Respondent caused a loop of small bowel to be delivered through the patient's cervix. Respondent then proceeded to replace the portion of the bowel back into the peritoneal cavity.

21. The patient was transferred to the New York Hospital. Upon exploratory surgery, a 2.5 centimeter tear in the anterolateral aspect of the uterus was located. During the procedure, Respondent caused a 2.5 cm tear in the anterolateral aspect of the uterus of Patient B. (Ex. 9, T. 74)

22. Upon exploratory surgery at the New York Hospital, fetal parts were found in the patient's abdomen and were removed.

The diagnosis of fetal parts was confirmed by pathological examination. (Ex. 9, T. 76)

CONCLUSIONS - PATIENT B

The Committee concludes that the Respondent was negligent in his care and treatment of Patient B. We do not base this finding on the fact that the Respondent perforated the patient's uterus but the fact that he delivered a loop of bowel through the patient's cervix and did not terminate the procedure at this point and transfer the patient to a hospital. We do not agree that continuation of the curettage was necessitated by the presence of excessive bleeding by the patient as stated by the Respondent's expert witness. The evidence in the record does not support a finding that the patient was in fact bleeding excessively at the time that the bowel was replaced into the peritoneal cavity.

As in Patient A (supra), the Respondent did not record an adequate history and physical nor did he utilize laminaria. The Committee is again divided as whether the failure to utilize laminaria is a violation of the standard of care or not.

The Committee does not find the cervical dilation of 29 French in this instance to be contrary to an accepted standard of care. The Respondent has stipulated to causing a 2.5 cm tear in

the anterolateral aspect of the patient's uterus. We find this to be an accepted complication to the D and E procedure.

We do not find that allegation B7 spells out a course of conduct attributable to the Respondent.

We conclude that Allegations B1, B2, B4 and B6 are sustained. B3 and B8 are not sustained. B5 has been stipulated to by the parties.

We find that in the care and treatment of Patient B, the Respondent was negligent and failed to maintain adequate records. We do not find his conduct grossly negligent, grossly incompetent or incompetent.

PATIENT C

23. On or about September 20, 1988, Respondent performed a first trimester abortion on Patient C, age 22. (EX. 4)

24. The Respondent's office records for Patient C indicated that on September 22, 1988 she called and complained of shoulder pain and cramps. (Ex. 4)

25. On September 28, 1988, Patient C was seen by the Respondent and complained of abdominal pain. The Respondent failed to order any tests to determine the presence of an ectopic pregnancy. (Ex. 4, T. 104-105, 1061-1062)

26. From September 20 through September 28, the Respondent did not pursue the results of the pathology report. (Ex. 4, T. 104-105, 547-548)

27. The Respondent received a pathology report that was not compatible with an intrauterine pregnancy on September 29, 1988. He did not see Patient C until October 18, 1988. (Ex. 4, T. 105-106, 1066, 1070)

28. On October 18, 1988, the Respondent diagnosed an ectopic pregnancy for Patient C after ordering a sonogram. (Ex. 4, T. 105-106.

CONCLUSIONS - PATIENT C

The Committee concludes that the Respondent was negligent in his care and treatment of Patient C in that he failed to make a timely diagnosis of ectopic pregnancy. On September 28, 1988, at which time Patient C had a history and findings strongly suggestive of ectopic pregnancy, a pathology report, if obtained, would have further suggested the presence of an ectopic pregnancy. The Respondent failed to make the effort to obtain the report even though it was readily available by telephone. The patient's record does not reflect efforts by the Respondent to notify her upon his receipt of the pathology report with further indication of an ectopic pregnancy.

We find that Respondent's care and treatment of Patient C was negligent. We sustain allegations C1, C3 and C4. We do not find that the Respondent was grossly negligent, grossly incompetent or incompetent.

PATIENT D

29. On October 18, 1988, Patient D, age 27, visited Respondent's office for a mid-trimester abortion. (Ex. 5)

30. The Respondent failed to record a pre-operative physical examination including a cardiovascular examination and a pulmonary examination for Patient D.

31. The Respondent did not explore Patient D's past cardiovascular history. (Ex. 5, T. 128)

32. Respondent failed to employ pre-operative laminaria which were indicated in this mid-trimester abortion. (T. 129)

33. Respondent achieved 35 French (11.67 mm) of cervical dilation in this procedure. (Ex. 5, T. 130)

34. Patient D had a hematocrit of 26 percent. (Ex. 5, T. 129-130, 142, 151)

35. On October 22, 1988, after the completion of a D and E, a second surgical procedure a D & C was performed, because the Respondent considered the D and E to be incomplete. He then recommended that Patient D return two days later for follow-up

after getting a sonogram. The Patient did not return until four days later. At that time, the Respondent performed a second D & C. (Ex. 5, T. 139-142)

36. It is routine to forward the tissue for a D & C for pathological examination. Respondent failed to do so with respect to the October 22, 1988 procedure. (Ex. 5, T. 140)

CONCLUSIONS - PATIENT D

The panel found that the Respondent was negligent in his care and treatment of Patient D in four instances as follows:

- he performed a D & C on a patient who had significant anemia, on an out-patient basis;
- he discharged her from his clinic when there was significant question, on his part, as to whether or not he had successfully completed the procedure;
- he failed to submit the specimen from the third procedure for pathological examination; and
- he failed to maintain adequate medical records of his care and treatment of this patient.

Had this patient experienced excessive blood loss during or after the procedure, her life would have been jeopardized. Because of her anemia, excessive blood loss could have led to shock and death. Patients with this degree of anemia should properly undergo this procedure in a hospital setting.

The Committee concludes that when there is a question of retained tissue, the patient should be monitored on an in-hospital patient basis.

We conclude that the medical records were inadequate in that there was no specific notation in Patient D's record that a second procedure was done on October 18, 1988.

We find that Respondent's care and treatment of Patient D was negligent. Allegations D1 through D5 and D7, D8 are sustained; D9 is not sustained. Allegation D6 has been withdrawn by consent of the parties. We do not find the Respondent to have been grossly negligent, grossly incompetent or incompetent with respect to Patient D.

PATIENT E

37. On November 29, 1983, Patient E, an 18 year old, visited Respondent's office for a mid-trimester abortion. (Ex. 6)

38. The past medical history portion of this Patient's chart does not contain any entries. (Ex. 6; T. 171

39. Respondent failed to employ pre-operative laminaria. (Ex. 6; T. 172)

40. The degree of dilation achieved by Respondent was 35 french 11.67 mm. (Ex. 6; T. 173)

41. On or about December 1, 1983 a pathology report was issued reporting only placental tissue in the specimen submitted by Respondent. No action was taken to contact Patient E and follow-up. (Ex. 6; T. 213-214, 670-671)

42. Patient E died on December 3, 1982 at West Hudson Hospital in Kearny, New Jersey. According to the New Jersey Medical Examiner the cause of death was "Hemorrhage due to incomplete abortion". Upon autopsy, a portion of the fetal left leg wrapped in placental tissue was found protruding from the cervical os. (Ex. 6)

43. Respondent placed the following entry in the patient's chart. "Pt. is advised that she might pass some tissue, contact me at any time or if she bleeds heavily". (Ex. 6; T. 216-217)

44. Respondent allowed the patient to go home after the procedure. (Ex. 6; T. 184)

CONCLUSIONS - PATIENT E

The Committee finds that the Respondent was negligent in his care and treatment of Patient E.

Although we do not find the Respondent's medical records for Patient E to be of satisfactory quality in that they contain

a paucity of information, there is enough notation to convey minimal information.

The Committee agrees with the Department's witness that the standards of eight years ago, 1983, did not require a sonogram in every instance.

The Committee reiterates its prior conclusion with dissent on the question of the employment of laminaria (supra).

The Committee is not convinced that the dilation of Patient E's cervix to a 35 French (11.67 mm) was inadequate for this procedure.

The Committee concludes that it is a fact that the Respondent failed to remove and identify all fetal parts. In addition, the Respondent either knew or should have known that he failed to completely evacuate the contents of Patient E's uterus. The Respondent negligently discharged Patient E from his clinic to home when she should have been transferred to a hospital for observation and completion of the procedure. He, thereby, jeopardized her life.

The Committee finds that the Respondent's failure to follow-up on the incomplete pathological report does not constitute negligence. The Respondent testified that he had removed some fetal parts and we conclude that he knew the pathologist's report was incomplete.

The Committee concedes that allegations E8 and E9 are the by-products of the Respondent's negligence. However, we do not see these as issues of negligence by the Respondent, merely statements of fact.

We found that Respondent's care and treatment of Patient E was negligent. Allegations E3 (2-1), E5 and E6 are sustained. Allegations E1, E2, E4, E7 through E9 are not sustained. We conclude, therefore, that the Respondent was not grossly negligent, grossly incompetent or incompetent in his care and treatment of Patient E or that he failed to maintain adequate medical records in this instance.

PATIENT F

45. On or about December 15, 1979, Patient F visited Respondent's office for a first-trimester abortion. (Ex. 7)

46. A D & C was performed at approximately 2:10 p.m. on December 15, 1979. At 3:00 p.m. the patient was stable. At 3:25 p.m. the patient was without pulse and unarousable, and died. (Ex. 7; T. 247-249, 284, 290-292, 733-734, 741-743)

CONCLUSIONS - PATIENT F

The Committee concludes that the patient records for Patient F are not of a satisfactory quality in that they contain

a paucity of information. However, there is enough notation to convey minimal information.

The Committee agrees that patients in a recovery room should not just die. However, based upon the medical records or the testimony, we cannot conclude that Respondent's negligence was responsible for or contributed to Patient F's death in the recovery room.

Therefore, we do not sustain allegations F1 through F3 and we do not find the Respondent grossly negligent, grossly incompetent, negligent, incompetent or that he failed to maintain adequate medical records in this instance.

RECOMMENDATIONS

The Committee has concluded that in his care and treatment of Patients A through E the Respondent acted negligently on more than one occasion. In addition, we find that his records for Patients A through D were not adequate. We did not find that his treatment of these patients was grossly negligent, grossly incompetent, or incompetent. Therefore, we recommend, by a vote of 2 to 1 against revocation, that the Respondent's license to practice medicine in the State of New York be suspended for a period of three (3) years with two (2) years stayed providing the

Respondent enters a qualified residency program monitored by the Office of Professional Medical Conduct, New York State Department of Health.

DATED: Albany, New York
June 10, 1991

ALBERT M. ELLMAN, M.D., Chairperson

Ann Shamberger
Stephen A. Gettinger

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

IN THE MATTER : COMMISSIONER'S RECOMMENDATION AND DISPOSITION OF REQUESTS AND MOTIONS

OF :

ANDRE NEHORAYOFF, M.D. :

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on March 6, 1991, March 7, 1991, March 21, 1991, March 22, 1991, April 1, 1991, April 11, 1991, April 12, 1991, April 15, 1991 and April 25, 1991. Respondent, Andre Nehorayoff, M.D., appeared by Joseph K. Gormley, Esq. The evidence in support of the charges against the Respondent was presented by Terrence Sheehan, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be rejected and, in lieu thereof, Respondent's license to practice medicine should be revoked. With respect to Patient A, the Committee concluded (and I concur), among other things, that Respondent's practice was substandard in the

maintenance of records, the employment of laminaria, the administration of oral fluids and medications, the time of transfer and the absence of an affiliation agreement. With respect to Patient B, the Committee concluded (and I concur), among other things, that Respondent's practice was substandard in the maintenance of records, employment of laminaria, delivery of a loop of the patient's bowel, and his continuation of the procedure. With respect to Patient C, the Committee concluded (and I concur), among other things, that Respondent's practice was substandard, in his failure to make a timely diagnosis of an ectopic pregnancy. With respect to Patient D, the Committee concluded (and I concur), among other things, that Respondent's practice was substandard in the maintenance of records, failure to employ laminaria, performance of a D&C on an outpatient basis, discharge of the patient, and his failure to submit a specimen for pathological examination. With respect to Patient E, the Committee concluded (and I concur), among other things, that Respondent's practice was substandard, in that he failed to employ pre-operative laminaria, failed to remove and identify all fetal parts, knew or should have known that he performed an incomplete abortion, and discharged the patient instead of transferring her to a hospital.

This pattern of poor care justifies revocation of Respondent's license. The residency recommended by the panel would address a failure in knowledge or training (i.e., incompetence) which the Committee did not find. To say that a physician who has been in practice for almost 20 years should enter a residency program reveals a severe lack of confidence in Respondent's abilities. The increased risk to his patients from continued practice is not warranted.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

D. I reject Respondent's attorney's request by letter, dated April 26, 1991, that I reconsider and vacate my continuation of the Summary Order prohibiting Respondent from practicing medicine. That order was and is amply justified by the scope Respondent's demonstrated poor practice;

E. I deny Respondent's motion to vacate the Report and Recommendations or to remand the case based on the purported failure of the Chairperson of the Board for Professional Medical Conduct to appoint the Hearing Committee because, among other things, the Chairperson may delegate his powers as appropriate and no prejudice or unfairness to the Respondent by the Hearing Committee as constituted has been shown.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
August 2, 1991

Linda A. Randolph

LINDA RANDOLPH, M.D.
Director, Office of Public Health
New York State Department of Health

EXHIBIT "F"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

ANDRE NEHORAYOFF

CALENDAR NO. 12342

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall be in compliance with the standards of conduct prescribed by the law governing respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has

advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That, with respect to Obstetrics and Gynecology and the performance of abortions, respondent shall only practice as a physician in a supervised setting under the supervision of a physician board certified in Obstetrics and Gynecology, said supervising physician to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said supervision to also include respondent's record-keeping practices;

3. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

ORDER OF THE DEPUTY COMMISSIONER FOR THE PROFESSIONS OF THE STATE OF NEW YORK

ANDRE NEHORAYOFF

CALENDAR NO. 12342

The University of the State of New York

IN THE MATTER

OF

ANDRE NEHORAYOFF
(Physician)

DUPLICATE ORIGINAL
VOTE AND ORDER
NO. 12342

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12342, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (December 20, 1991): That, in the matter of ANDRE NEHORAYOFF, respondent, this determination is solely on the basis of the record and not on the basis of any views as to whether termination of pregnancy should be permitted, and the Board of Regents present on December 20, 1991 could be fair and impartial and could participate in this determination without any prejudice to respondent; that the record herein be accepted; that the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner's designee as to those findings of fact be accepted, except findings of fact 22 and 26 and the portion of the last sentence of finding of fact 9 which states "three and one-half hours" not be accepted;
2. The following additional findings of fact, referable to all the patients, be accepted:

3(a) Petitioner's expert was board certified in obstetrics and gynecology in 1976 and was so

certified at the time of respondent's conduct. T. 13.

3(b) Petitioner's expert performs about two to 300 abortions a year and is knowledgeable about and familiar with the standards and practice in New York City. T. 53.

3(c) Petitioner's expert's experiences have also included working in a high volume recovery room, T. 45, being on staff at New York Medical College, Assistant Professor with a private practice, and being in solo clinical practice. T. 13.

3(d) In the past, petitioner's expert performed terminations of 18 to 20 week pregnancies. T. 59.

3(e) Respondent's expert is licensed only in the District of Columbia and has practiced at the Washington Hospital Center in Washington D.C. from 1970 through the present. Respondent's Exhibit B; T. 313-315.

3(f) Respondent's and petitioner's respective experts differed over their own notion of appropriate practices. T. 363.

3(g) In his practice, respondent's expert uses laminaria, in patients 18 to 19 weeks pregnant, on the average of 23 percent of the time and, in patients 20 or more weeks pregnant, 52 percent of the time. T. 451.

3. The conclusions of the hearing committee and Health Commissioner's designee be modified;

4. By a preponderance of the evidence, respondent is guilty of the thirteenth specification to the extent of allegations A3, A5, B2, B4, B6, C4, D1, D2, D3, D8, E3,

E5, and E6, in full, and, partially, to the extent indicated by the hearing committee, of allegations A1, A6, and B1 for negligence on more than one occasion involving respondent failing to record the findings of an adequate physical examination, failing to employ pre-operative laminaria, giving a patient oral fluids which were not indicated, failing to transfer a patient to a hospital expeditiously and at all, during a procedure, delivering a loop of bowel through the cervix and continuing that procedure in spite of presence of bowel, waiting to order a sonogram and diagnose an ectopic pregnancy, failing to record the findings of an adequate physical examination and failing to perform an adequate medical history, performing a procedure which was not indicated on an outpatient basis, failing to forward tissue for examination, and failing to remove and identify fetal parts; respondent is guilty of the fifteenth and sixteenth specifications, partially, to the extent indicated by the hearing committee, of allegations A1 and B1 for unprofessional conduct regarding record-keeping violations involving respondent's failing to record the findings of an adequate physical examination, and of the seventeenth specification, partially, to the extent indicated by the Regents Review Committee, of allegation D1 for failing to record the findings of an adequate physical examination; and is not guilty of the remaining specifications and allegations;

that the recommendation of the Regents Review Committee be modified as to the measure of discipline, that the recommendation of the hearing committee be modified as to the measure of discipline, and that, based on a more serious view of the misconduct committed and in agreement with the Commissioner of Health's designee, respondent's license to practice as a physician in the State of New

York be revoked upon each specification of the charges of which respondent was found guilty;
and that the Deputy Commissioner for the Professions be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and SO ORDERED, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Henry A. Fernandez, Deputy Commissioner for the Professions of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand, at the City of Albany, this 20th day of December, 1991.

HENRY A. FERNANDEZ
DEPUTY COMMISSIONER FOR THE PROFESSIONS