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

IN THE MATTER

OF

MOHAMMAD OLOUMI-YAZDY, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: MOHAMMAD OLOUMI-YAZDY, M.D.

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Amended and Supplemental Statements of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by MOHAMMAD OLOUMI-YAZDY, 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 §230(12), that effective immediately MOHAMMAD OLOUMI-YAZDY, 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 §230(12).

PLEASE TAKE NOTICE that a hearing will be continued pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct which commenced hearing on the allegations set forth in said Amended Statement of Charges on November 14, 2000, at the offices of the New York State Health Department, 5 Penn

Plaza - 6th Floor, New York, NY 10001, and which shall continue at such other adjourned dates, times and places as the committee may direct, as set forth in §230(12) of the Public Health Law. The Respondent may file an answer to the Supplemental Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, further evidence will be received concerning the allegations set forth in the Amended Statement of Charges, and evidence will be received concerning the allegations set forth in the Supplemental Statement of Charges. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical

documentation.

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

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

DATED: Albany, New York
May 3 ,2001

ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Claudia M. Bloch
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
145 Huguenot Street - Room 601
New Rochelle, New York 10801
914-654-7043

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

IN THE MATTER

OF

MOHAMMAD OLOUMI-YAZDY, M.D.

SUPPLEMENTAL STATEMENT

OF

CHARGES

MOHAMMAD OLOUMI-YAZDY, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 24, 1976, by the issuance of license number 128705 by the New York State Education Department.

FACTUAL ALLEGATIONS

I. Eighty-nine year old (89 y.o.) Patient I came under the care and treatment of Respondent during an admission to NYMH from on or about September 1, 2000 through on or about September 18, 2000. Patient I was first seen in the emergency room with complaints of increased difficulty breathing over the past two weeks and, from there admitted to the Medical Service on telemetry and treated for congestive heart failure. On the day following admission, Patient I was diagnosed with pneumonia. Despite multiple antibiotics, Patient I 's temperature continued elevated and multiple episodes of cardiac arrhythmia were noted. On hospital day seven, Patient I aspirated vomitus and spiked a temperature to 104 F. The patient again began to drop her oxygen saturation, requiring oxygen under increased pressure and frequent suctioning of oropharyngeal secretions. Due to concerns over her inability to eat, on or about September 15, 2000, an attempt was made by a gastroenterologist to place a gastrostomy tube by means of a "PEG." Shortly after commencing the procedure, it was aborted, inasmuch as the patient became cyanotic with a drop in oxygen saturation. On or about September 18, 2000, Respondent

performed an open surgical procedure on Patient I, under a high epidural anesthetic, constructing a Janeway feeding gastrostomy. In his care and treatment of Patient I, Respondent:

1. Failed to perform and/or note an appropriate physical examination and/or surgical evaluation and assessment of the patient prior to performing an open gastrostomy.
2. Failed to appropriately advise the medical team caring for Patient I against an open gastrostomy and to appropriately advise of alternative measures for feeding access.
3. Inappropriately, and without appropriate indication and/or justification, elected to perform an open surgical procedure under anesthesia.
4. Inappropriately and without indication, elected to perform a Janeway gastrostomy.
5. Failed to follow and/or note his follow-up of the patient postoperatively.
6. Failed to order the appropriate postoperative care and monitoring for the patient.
7. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient I both preoperatively and postoperatively.
8. In performing a non-emergent open gastrostomy, inappropriately subjected the patient to unjustified risk given her unstable clinical condition at the time.
9. Failed to maintain an office record for Patient I in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

J. Forty-nine year old (49 y.o.) Patient J came under the care and treatment of Respondent on or about . Patient J was admitted to NYMH by Respondent on or about February 22, 2001 through on or about February 24, 2001, for the purpose of performing elective bariatric surgery for weight reduction, Pre-operative work-up ordered by Respondent included a gallbladder sonogram, performed on or about February 8, 2001, which reported a 8.7 x 5.7 x 4.9 cm. cystic mass in the mid to left of the midline in the epigastric region just below the abdominal wall. Notwithstanding this finding, Respondent proceeded with the planned elective procedure on or about February 22, 2001, the day of admission to NYMH. Intra-operatively, Respondent identified a "5 x 10 cm cystic mass in the omentum" which he removed and sent for routine pathological evaluation. Respondent then proceeded to perform the vertical banded gastroplasty without knowledge of the pathologic diagnosis of the mass. On or about February 23, 2001 the pathologist reported a diagnosis of the mass as papillary adenocarcinoma with poorly differentiated areas. A follow-up pathology report of on or about February 28, 2001 determined that the findings were most consistent with an ovarian etiology. In his care and treatment of Patient J, Respondent:

1. Failed to properly evaluate and follow-up on and/or note his evaluation and follow-up of the results of the sonogram as set forth in paragraph J, supra.
2. Failed to appropriately order further diagnostic testing and/or consultation after obtaining the results of the sonogram and prior to proceeding with elective bariatric surgery.
3. Failed to advise the patient preoperatively of the findings from the sonogram.

4. Inappropriately and without appropriate medical evaluation and clearance, proceeded with the planned elective bariatric surgery without having first properly evaluating the patient as set forth in paragraph J(1), supra.

5. Failed to properly obtain an intra-operative consultation with a pathologist by frozen section of the identified mass.

6. In failing to obtain an intra-operative diagnosis of the mass, denied the patient prompt management and treatment of ovarian cancer, in that he inappropriately failed to explore the abdomen and stage and debulk the cancer.

7. Inappropriately proceeded to perform a vertical banded gastroplasty without having properly obtained a pathology consultation, as set forth in paragraph J(1), supra.

8. Demonstrated a lack of the requisite knowledge in that, upon information and belief, he stated that:

   a. he believed that the mass found on the sonogram was either an omental cyst or a pancreatic cyst, which he would take care of at surgery.

   b. had he known intraoperatively the diagnosis of the mass, he still would have performed the gastroplasty.

9. Failed to maintain a hospital record for Patient J in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

SPECIFICATION OF CHARGES

FORTIETH AND FORTY-FIRST SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2001) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

40. The facts in paragraphs I and I(1) - I(9).

41. The facts in paragraphs J, J(1) - J(7), J(8)(a), J(8)(b) and J(9).

FORTY-SECOND AND FORTY-THIRD SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2001) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

42. The facts in paragraphs I and I(1) - I(9).

43. The facts in paragraphs J, J(1) - J(7), J(8)(a), J(8)(b) and J(9).

FORTY-FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2001) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

44. The facts in paragraphs I, I(1) - I(9), J, J(1) - J(7), J(8)(a), J(8)(b) and J(9).

FORTY-FIFTH 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. 2001) 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:

45. The facts in paragraphs I, I(1) - I(9), J, J(1) - J(7), J(8)(a), J(8)(b) and J(9).

FORTY-SIXTH AND FORTY-SEVENTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 2001) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

46. The facts in paragraphs I, I(3) and I(4).

47. The facts in paragraphs J, J(4) and J(7)

FORTY-EIGHTH AND FORTY-NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2001) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

48. The facts in paragraphs I, I(1), I(5), I(7) and I(9).

49. The facts in paragraphs J, J(1) and J(9)

DATED: May 1, 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

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

IN THE MATTER

OF

MOHAMMAD OLOUMI-YAZDY, M.D.

AMENDED STATEMENT OF CHARGES

MOHAMMAD OLOUMI-YAZDY, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 24, 1976, by the issuance of license number 128705 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Eighty-seven year old (87 y.o.) Patient A (all patients are identified in Appendix A) came under the care and treatment of Respondent during an admission to New York Methodist Hospital (hereinafter referred to as NYMH) from on or about January 30, 1995 through on or about February 13, 1995. On or about February 2, 1995, Respondent performed an open cholecystectomy on Patient A. Intraoperatively, Respondent packed the liver bed in an attempt to stop hemorrhaging which occurred. On or about February 6, 1995, in the ICU, Respondent removed the packing. Bleeding from the site occurred immediately. Patient A was taken then to the operating room where, after observation, Respondent placed a Penrose drain through the wound down to the liver. In his care and treatment of Patient A, Respondent:

DEFENDANT'S
DEPTS 1-A
EXHIBIT NO.
FOR IDENTIFICATION
12/4/00 M
DATE RPTR.

1. Failed, preoperatively, to:

   a. perform and/or note a physical examination and ~~[illegible]~~ SURGICAL EVALUATION OF THE PATIENT.

12/4/00 M.C.

b. properly assess the clinical data and the patient's condition and/or note his assessment thereof.

c. properly consider and/or note his consideration of the opinion of the gastroenterology consultation.

2. Performed an open cholecystectomy without appropriate medical indication and/or justification.

3. Failed to examine and/or assess the patient postoperatively, and/or failed to note his examination and/or assessment of the patient postoperative.

4. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient A both preoperatively and postoperatively.

5. Inappropriately chose the setting of the ICU to remove the wound packing.

6. Failed to maintain a hospital record for Patient A in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Sixty-nine year old (69 y.o.) Patient B came under the care and treatment of Respondent during an admission to NYMH from on or about February 24, 1994 through on or about May 2, 1994. On or about February 25, 1994, Respondent performed a transverse colostomy to relieve an intestinal obstruction caused by a mass in the descending colon. Postoperatively, the patient remained febrile and on a ventilator. On or about March 31, 1994, Respondent performed a ~~second~~ THIRD surgical procedure to resect the colon tumor.

Respondent: 12/4/00 MFE

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.

2. Prior to the ~~second~~ THIRD surgery, failed to:

   a. properly assess and/or note his assessment of the patient's condition,

   b. properly follow up on the radiologist's finding and report of an abdominal CAT scan performed on March 23, 1994.

3. Performed the ~~second~~ THIRD surgical procedure on March 31, 1994 without appropriate medical and/or surgical indication and/or justification.

4. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient B both preoperatively and postoperatively.

5. Failed to maintain a hospital record for Patient B in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

C. Seventy four year old (74 y.o.) Patient C came under the care and treatment of Respondent during an admission to NYMH from on or about November 17, 1998 through on or about December 3, 1998. On examination, the patient was found to have a rectal tumor with evidence of metastatic disease to the liver and ascites. On or about November 21, 1998, during an attempt to place a nasogastric tube, Patient C arrested. The patient was resuscitated, however, suffered ischemic encephalopathy and remained comatose and on ventilatory support. At the family's request, the patient was made DNR. Due to severe abdominal distention, a surgical consultation was requested and, on

or about November 22, 1998, a resident, on behalf of Respondent, was able to effectively decompress the abdomen by inserting a rectal tube past the tumor. On or about November 23, 1998, Respondent performed a transverse colostomy on Patient C. Respondent:

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.
2. Performed surgery on Patient C, on or about November 23, 1998, without appropriate medical and/or surgical indication and/or justification.
3. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient C both preoperatively and postoperatively.
4. Inappropriately dictated an operative report approximately nine months after surgery and, in it, Respondent knowingly falsely reported that a "rectal tube was tried without success."
5. Failed to maintain a hospital record for Patient C in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Eighty year old (80 y.o.) Patient D came under the care and treatment of Respondent during an admission to NYMH from on or about October 21, 1998 through on or about October 27, 1998. Patient D was admitted with a history of a previous sigmoid resection in October, 1997 for a Duke's B carcinoma. A colonoscopic examination, performed on the day of admission, found an irregular mass at the anastomotic site with no evidence of obstruction. Results of a biopsy taken during colonoscopy were pending when, on or about October 22, 1998, Respondent performed a resection of the anastomosis.

Both the biopsy done on admission and the pathology report from the frozen section at surgery were negative for carcinoma. Respondent:

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.
2. Failed to wait for and review the results of the biopsy, taken on the day of admission, prior to performing surgery on Patient D.
3. Performed surgery on Patient D, on or about October 22, 1998, without appropriate medical and/or surgical indication and/or justification.
4. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient D both preoperatively and postoperatively.
5. Inappropriately dictated an operative report approximately five months after surgery and, in it, Respondent knowingly falsely reported a pre-operative diagnosis to include "distal bowel obstruction."
6. Failed to maintain a hospital record for Patient D in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

E. Eighty-one year old (81 y.o.) Patient E came under the care and treatment of Respondent during an admission to NYMH from on or about December 30, 1995 through on or about February 19, 1996. Patient E was admitted with lower extremity edema and cellulitis of one leg; a history of congestive heart failure, gallstones and liver disease; a mass on one breast suspicious for carcinoma; a ventral hernia containing omentum; and electrolyte and liver function abnormalities. Respondent performed a left modified radical

mastectomy on or about January 4, 1996, a cholecystectomy and cholangiography on or about January 11, 1996, and repair of the ventral hernia and placement of a port-a-cath for chemotherapy on or about January 18, 1996. There was significant drainage from the cholecystectomy wound and on or about February 5, 1996, Respondent performed a closure of a wound dehiscence and also drained a large amount of fluid from the mastectomy site. Respondent:

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.
2. Performed all three surgeries, the modified radical mastectomy, cholecystectomy and ventral hernia repair, without appropriate medical and/or surgical indication and/or justification.
3. Failed to order and/or note his order for consult with a gastroenterologist and/or hepatologist prior to performing any surgery on Patient E.
4. Failed to appropriately review and/or act upon the laboratory findings on Patient E before performing surgery.
5. Inappropriately and without medical and/or surgical justification, cleared Patient E for chemotherapy in the presence of an existing problem with wound healing.
6. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient E both preoperatively and postoperatively.
7. Failed to maintain a hospital record for Patient E in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

F. Ninety year old (90 y.o.) Patient F came under the care and treatment of Respondent during an admission to NYMH from on or about June 1, 1995 through on or about June 3, 1995. Urinalysis on admission showed numerous red blood cells, packed white blood cells and large amounts of bacteria. On or about the day of admission, June 1, 1995, Respondent performed surgery on Patient F based upon his preoperative diagnosis of acute appendicitis. Respondent removed a normal appendix and a calcified free body found in the pelvis. Respondent:

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.
2. Failed to review and/or note his review of the urinalysis results prior to performing surgery on Patient F.
3. Failed to perform and/or order any diagnostic testing to rule out other medical/surgical causes for the patient's presenting condition.
4. Inappropriately performed surgery on Patient F when there existed evidence of a significant urinary tract infection.
5. Performed surgery on Patient F without appropriate medical and/or surgical indication and/or justification.
6. Inappropriately ordered the removal of a urinary catheter from Patient F on the day after surgery.
7. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient F both preoperatively and postoperatively.
8. Failed to maintain a hospital record for Patient F in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.

9. Respondent created an operative report and discharge summary for Patient F which is false and inaccurate and does not legitimately reflect the condition of Patient F, nor the care and treatment rendered by Respondent to the patient.

G. Seventy-four year old (74 y.o.) Patient G came under the care and treatment of Respondent during an admission to NYMH from on or about January 14, 1999 through on or about February 9, 1999. Patient G was admitted to the surgical service of the hospital from the Rehabilitation Service of NYMH where she had been since on or about December 28, 1998 for rehabilitation following radiotherapy and chemotherapy for rectal cancer with metastatic disease to the liver. While on the Rehabilitation Service, she was noted to have bright red bleeding from the rectum. On or about January 14, 1999, Respondent performed a diverting end colostomy. The operative report notes a finding of an unresectable rectosigmoid cancer, frozen pelvis, ascites and liver metastases. In both the his operative report and discharge summary, Respondent states that, prior to surgery, Patient G was experiencing continuous soilage due to serosanguinious drainage from the rectum and maceration of the perineal area and was a nursing problem. Respondent:

1. Failed to perform and/or note any physical examination and/or surgical evaluation and assessment of the patient.
2. Performed an end colostomy on Patient G without appropriate medical and/or surgical indication and/or justification.
3. Inappropriately dictated an operative report approximately seven months after surgery and, in it, Respondent knowingly falsely reported a pre-operative diagnosis of "extensive serosanguinious drainage and maceration of the perineal area," when, in fact,

Patient G had intermittent rectal bleeding, and was noted to have prominent hemorrhoids.

4. Failed to appropriately perform and/or order the performance of a proctoscopic exam to determine the cause of bleeding.
5. Failed to supervise and/or note his supervision of the surgical resident(s) caring for Patient G both preoperatively and postoperatively.
6. Failed to maintain a hospital record for Patient G in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.
7. Respondent created an operative report and discharge summary for Patient G which is false and inaccurate and does not legitimately reflect the condition of Patient G, nor the care and treatment rendered by Respondent to the patient.

H. Nine year old (9 y.o.) Patient H came under the care and treatment of Respondent at his office, located at 258 85th Street, Brooklyn, N.Y. 11209, from on or about June 23, 1999 through on or about April 12, 2000. Patient H presented with a complaint of a tender left breast mass, described by Respondent in his note of June 23, 1999 as "3 x 2 1/2 cm" in size. Respondent's note for that date also indicates that he advised the patient's mother to "wait and see the progress of the mass," and to return to his office for re-evaluation in two weeks. However, on or about June 28, 1999, Patient H was admitted to the ambulatory surgery unit of NYMH under the care of Respondent, at which time, Respondent performed an "incisional" biopsy of the left breast, removing a substantial portion of the mass. The pathology report of the tissue specimen submitted from this surgery was, "Juvenile

(Virginal) Hyperplasia (Benign)." In his care and treatment of Patient H, Respondent:

1. Failed, preoperatively, to:
   a. perform and/or note an appropriate physical examination and surgical evaluation of the patient.
   b. appropriately evaluate the breast by means of ultrasound examination before recommending and/or performing surgery on the breast tissue.
   c. properly advise Patient H's mother with regard to her concerns over the presence of the breast mass.
   d. properly obtain a second surgical consultation and/or advise Patient H's mother to seek a second surgical consultation.
2. Inappropriately and without appropriate medical and/or surgical indication and/or justification, performed a biopsy of the patient's left breast.
3. Inappropriately and without appropriate medical and/or surgical indication and/or justification, removed more than 50% of the mass.
4. Failed to maintain an office record for Patient H in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.
5. Failed to maintain a hospital record for Patient H in accordance with accepted medical/surgical standards and in a manner which accurately reflects his care and treatment of the patient.
6. Respondent created an office record and an operative report and/or hospital record for Patient H which is false and inaccurate

and does not legitimately reflect the size of the mass, nor the care and treatment rendered by Respondent to the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A, A(1)(a) - A(1)(c), A(2) - A(6), B, B(1), B(2)(a), B(2)(b), B(3) - B(5), C, C(1) - C(5), D, D(1) - D(6), E, E(1) - E(7), F, F(1) - F(9), G, G(1) - G(7), H, H(1)(a) - H(1)(d) and H(2) - H(6).

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. 2000) 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. The facts in paragraphs A, A(1)(a) - A(1)(c), A(2) - A(6), B, B(1), B(2)(a), B(2)(b), B(3) - B(5), C, C(1) - C(5), D, D(1) - D(6), E,

29. The facts in paragraphs F and F(5).

30. The facts in paragraphs G and G(2).

31. The facts in paragraphs H, H(2) and H(3).

THIRTY-SECOND THROUGH THIRTY-NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

32. The facts in paragraphs A, A(1)(a) - A(1)(c), A(3), A(4) and A(6).

33. The facts in paragraphs B, B(1), B(2)(a), B(4) and B(5).

34. The facts in paragraphs C, C(1) and C(3) - C(5).

35. The facts in paragraphs D, D(1) and D(4) - D(6).

36. The facts in paragraphs E, E(1), E(3), E(6) and E(7).

37. The facts in paragraphs F, F(1), F(2) and F(7) - F(9).

38. The facts in paragraphs G, G(1), G(3) and G(5) - G(7).

39. The facts in paragraphs H, H(1)(a) and H(4) - H(6).

DATED: November 3, 2000
New York, New York

Roy Nemerson
by: Claudia M. Flores

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct