STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 30, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Roy Nemerson, Esq.
NYS Department of Health
Bureau of Professional Med. Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

Claudia Morales Bloch, Esq.
NYS Department of Health
Office of Professional Med. Conduct
145 Huguenot Street – 6th Floor
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Financial Plaza
Post Office Box 4878
Syracuse, New York 13221-4878

Mohammad Oloumi-Yazdy, M.D.
230 Ocean Terrace
Staten Island, New York 10301

RE: In the Matter of Mohammad Oloumi-Yazdy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-190) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

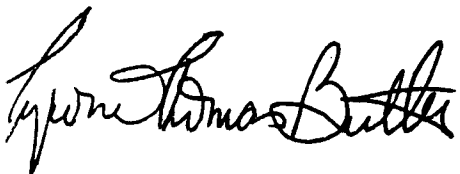
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

MOHAMMAD OLOUMI-YAZDY, M.D.

DETERMINATION

AND

ORDER

BPMC 01 - 190

STEPHEN W. HORNYAK, M.D. (Chair), **JOEL H. PAULL, DDS, M.D.** and **REVEREND EDWARD J. HAYES**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) and §230(12) of the Public Health Law ("**P.H.L.**").

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health ("**Department**") appeared by **CLAUDIA MORALES BLOCH, ESQ.**, Associate Counsel.

MOHAMMAD OLOUMI-YAZDY, M.D., ("**Respondent**") appeared personally and was represented by **HISCOCK & BARCLAY, LLP**, by **ROBERT A. BARRER, ESQ.** and **DAVID P. GLASEL, ESQ.**, of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order in accordance with the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	August 25, 2000
Date of Statement of Charges:	September 25, 2000
Date of Answer to Charges:	October 10, 2000
Pre-Hearing Conference Held:	October 23, 2000
Stipulation regarding Service of Notice of Hearing and Statement of Charges:	October 23, 2000 [P.H.T-25-26] [1].
Date of Amended Statement of Charges:	November 3, 2000
Date of Answer to Amended Statement of Charges:	November 10, 2000
Hearings Held: - (First Hearing day):	November 14, 2000

December 04, 2000; December 05, 2000; December 18, 2000 and December 19, 2000; January 22, 2001; January 23, 2001; February 26, 2001; February 27, 2001; March 12, 2001; April 2, 2001; April 3, 2001; April 30, 2001; May 1, 2001; May 11, 2001; June 1, 2001; June 25, 2001; and June 26, 2001

Intra-Hearing Conferences Held: November 14, 2000

December 04, 2000; December 05, 2000; December 18 2000; January 22, 2001; January 23, 2001; February 27, 2001; March 12, 2001; April 2, 2001; April 30, 2001; May 1, 2001; May 10, 2001; May 11, 2001; June 1, 2001; June 25, 2001; and June 26, 2001

While the Hearing was progressing, the Commissioner of the New York State Department of Health ("**Commissioner**") caused a Summary Order, Notice of Hearing and Supplemental Statement of Charges to be served on Respondent.

Date of Commissioner's Order and Notice of Hearing: May 3, 2001

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[1] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing transcripts, the Intra-Hearing transcripts or the ALJ Exhibits.

Date of Supplemental Statement of Charges: May 1, 2001

Date of Answer to Supplemental Statement of Charges: May 7, 2001

The effective date of the service of the summary order was set at May 4, 2001. The first day of the Summary Hearing was held on May 11, 2001.

Department's Proposed Findings of Fact, Proposed Conclusions of Law and Proposed Sanction: Received July 18, 2001

Respondent's Proposed Findings of Fact, and Conclusions of Law Received July 18, 2001

Respondent's Requests to Charge to the Panel Received July 18, 2001 [2]

Witnesses called by the Department of Health:
Ronald Forlenza, M.D.; Aaron Hoffman, M.D.; Tano Carbonaro, M.D.; Mohammad Oloumi-Yazdy, M.D.; I. Michael Leitman; M.D.

Witnesses called by the Respondent, Mohammad Oloumi-Yazdy, M.D.:
Stanley Sherbell, M.D.; Richard Schwartz, M.D.; Bruce Sosler, M.D.; Anthony Saleh, M.D.; Gamil Kostandy, M.D.; P. Daniel Penha, M.D.; Antonio Mascatello, M.D.; Asrael Bamberger, M.D.; Ferdinand Garafalo, M.D.; Paul Gaudio, Jr.; Mohammad Oloumi-Yazdy, M.D.; Manouchehr Amini, M.D.; Timothy Canterbury, M.D.; Joseph SchianodiCola, M.D.; C.V.R. Reddy, M.D.; Musthuswami Krishnamurthy, M.D.; Hossein Hedayati, M.D.

The record remained open (request of Respondent) for the receipt of copies of Respondent's Exhibits # III and JJJ (copies received by the ALJ on June 28, 2001).

Respondent's Exhibits # III and JJJ were admitted in evidence, by the ALJ, on July 6, 2001.

Deliberations Held: July 23 and 24, 2001

On July 24, 2001, the Hearing Committee issued a Determination on the Continuation of the Summary Order Pursuant to Public Health Law §230(12)(a) [a copy is attached as Appendix 1]. The

[2] The Hearing Committee did not review this document. The ALJ's instructions (or charge) to the Hearing Committee is contained in this Determination and Order.

Hearing Committee unanimously determined that the Commissioner's Summary Order should remain in full force and effect until we issue our final Determination and Order.

STATEMENT OF CASE

This case was brought by the Department pursuant to §230 of the P.H.L.

MOHAMMAD OLOUMI-YAZDY, M.D., ("**Respondent**" or "**Dr. Oloumi**") is charged with a total of forty-nine (49) specifications of professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (32) and (35) of the Education Law of the State of New York ("**Education Law**") [3]

Respondent is charged with professional misconduct by reason of: (1) practicing the profession with negligence on more than one occasion [4]; (2) practicing the profession with incompetence on more than one occasion [5]; (3) practicing the profession with gross negligence [6]; (4) practicing the profession with gross incompetence [7]; (5) practicing the profession of medicine

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[3] A copy of the Commissioner's Order and Notice of Hearing, the Supplemental Statement of Charges and the Amended Statement of Charges is contained within Appendix 1.

[4] Education Law §6530(3) - (see also the First Specification of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Forty-Fourth Specification of the Supplemental Statement of Charges [Department's Exhibit # 15]).

[5] Education Law §6530(5) - (see also the Second Specification of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Forty-Fifth Specification of the Supplemental Statement of Charges [Department's Exhibit # 15]).

[6] Education Law §6530(4) - (see also the Third through Tenth Specifications of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Fortieth and Forty-First Specifications of the Supplemental Statement of Charges [Department's Exhibit # 15]).

[7] Education Law §6530(6) - (see also the Eleventh through Eighteenth Specifications of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Forty-Second and Forty-Third Specifications of the Supplemental Statement of Charges [Department's Exhibit # 15]).

fraudulently [8]; (6) ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient [9] ; and (7) failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient [10].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct in the care and treatment of ten (10) patients [11].

Respondent generally admits to treating each patient and admits that he didn't express his thoughts and opinions in the medical records of the patients as well as he should have but denies that his actions deviated from accepted medical standards and denies all specifications of misconduct (Respondent's Exhibits # I, II, and U) [12].

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable

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[8] Education Law §6530(2) - (see also the Nineteenth through Twenty-Third Specifications of the Amended Statement of Charges [Department's Exhibit # 1-A].

[9] Education Law §6530(35) - (see also the Twenty-Fourth through Thirty-First Specifications of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Forty-Sixth and Forty-Seventh Specifications of the Supplemental Statement of Charges [Department's Exhibit # 15]).

[10] Education Law §6530(32) - (see also the Thirty-Second through Thirty-Ninth Specifications of the Amended Statement of Charges [Department's Exhibit # 1-A] and the Forty-Eighth and Forty-Ninth Specifications of the Supplemental Statement of Charges [Department's Exhibit # 15]).

[11] All patients are identified in the Appendix annexed to the Amended Statement of Charges (Department's Exhibit # 1-A) or the Appendix annexed to the Supplemental Statement of Charges (Department's Exhibit # 15).

[12] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Mohammad Oloumi-Yazdy (Respondent's Exhibit #).

or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on September 24, 1976 by the issuance of license number 128705 by the New York State Education Department (Department's Exhibits # 1-A & # 2); (Respondent's Exhibit # M).

2. Respondent is currently not authorized to practice medicine, in the State of New York, due to the Commissioner's issuance and service of a Summary Order of Suspension on May 4, 2001 (Department's Exhibit # 15) [13].

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent stipulated to service).

Patient A

4. Patient A, an 87 year old female came under the care and treatment of Respondent during an admission to New York Methodist Hospital ("**NYMH**") from January 30, 1995 through February 13, 1995. On February 2, 1995, Respondent performed an open cholecystectomy on Patient A. Intra-operatively, Respondent packed the patient's liver bed in an attempt to stop the hemorrhaging which occurred (Department's Exhibit # 3B); (Respondent's Exhibit # II).

5. The hospital chart ("**medical records**") for Patient A does not contain any notes or any record that Respondent performed a physical examination or surgical evaluation of the patient prior

[13] As previously discussed, the Commissioner's Summary Order has been continued by the Hearing Committee (see Appendix 1).

to performing the cholecystectomy. Respondent also did not make any record of his rationale for performing the surgery at that time (Department's Exhibit # 3B).

6. The medical records for Patient A do not contain any notes that Respondent assessed the clinical data of the patient's condition (Department's Exhibit # 3B).

7. The medical records for Patient A do not contain any notes regarding Respondent's consideration of the opinion of the gastroenterology consultation (Department's Exhibit # 3B); [T-62-66].

8. The substantial risk of performing an open cholecystectomy on a patient with portal hypertension should be known to a reasonably prudent physician, to wit: excessive intra-operative bleeding. Respondent should have known that performing the surgery on a patient with such compromised liver function as Patient A, exposed the patient to the risk of liver failure (Department's Exhibit # 3B); [T-61-63, 77, 163, 2537].

9. In a patient with portal hypertension, a reasonably prudent physician must assess and determine the least risky approach to caring for the patient. In this case, a reasonably prudent physician would have elected to do an endoscopic retrograde cholangiopancreatography ("**ERCP**") and not an open cholecystectomy (Department's Exhibit # 3B); [T-164].

10. A ERCP was successfully performed on Patient A by a gastroenterologist on February 9, 1995. A ERCP was recommended by both the hematologist and gastroenterologist who saw the patient prior to the open cholecystectomy performed by Respondent on February 2, 1995. A ERCP was available at NYMH on February 2, 1995 (Department's Exhibit # 3B); [T-61-63, 66, 69-70, 72-73].

11. A ERCP is a less invasive procedure than an open cholecystectomy. A ERCP does not require a general anesthetic, would have more directly addressed Patient A's problem and carries a much lesser risk of bleeding, especially given the evidence of portal hypertension exhibited in this patient (Department's Exhibit # 3B); [T-72-73].

12. An appropriate surgical consultation done prior to February 2, 1995, when Respondent performed the open cholecystectomy, would have reported that Patient A had an obstructive jaundice probably secondary to common duct stones. As such, an appropriate surgical recommendation would have advised against surgical intervention and for the performance of an ERCP (Department's Exhibit # 3B); [T-91-92, 93-96].

13. Respondent performed an open cholecystectomy without appropriate medical indication or justification (Department's Exhibit # 3B); [T-89-96].

14. The medical records of Patient A do not contain any postoperative notes by the Respondent. Respondent failed to note any examination or postoperative assessment of the patient (Department's Exhibit # 3B); [T-80-83].

15. Respondent failed to note his supervision of the surgical resident(s) caring for Patient A both preoperatively and postoperatively (Department's Exhibit # 3B).

16. On February 6, 1995, Respondent removed the packing (placed in the patient during the February 2nd surgery) at the patient's bedside in the intensive care unit ("**ICU**") of NYMH . This resulted in an immediate outpouring of copious amounts of dark red blood from the wound (greater than 500 cc). The patient was rushed to the operating room and, when stable, a Penrose drain was placed through the wound down to the liver. Over the next several days, smaller quantities of bloody-bilious fluid drained thru the Penrose drain (Department's Exhibit # 3B); [T-83-84].

17. At the time Respondent removed the packing, the patient had a prothombin time of 15 and an INR of 1.7 which indicate an abnormal coagulation pattern (Department's Exhibit # 3B); [T-2572].

18. Appropriate surgical practice is to remove hepatic packing in the setting of the operating room because bleeding can occur which would require immediate control. This is especially true in the face of a patient with portal hypertension (Department's Exhibit # 3B); [T-84-86, 162, 2572-2573].

19. Notes are made by a physician in a patient's medical records to document the physician's presence in caring for the patient, as a teaching modality in a teaching institution such as NYMH, as a means of communication between the various health care providers caring and treating for the patient and as a means of chronicling the patient's progress and condition [T-1143-1146, 1172-1175].

20. There is no note in Patient A's medical records by Respondent of his care and treatment of the patient nor any additional reference of his attendance to the patient (except for one note by a nurse indicating Respondent's presence at the patient's bedside in the ICU to remove the packing on February 6, 1995) (Department's Exhibit # 3B); [T-80, 82, 148].

21. Respondent failed to maintain a hospital record for Patient A in accordance with accepted medical or surgical standards and in a manner which accurately reflected the care and treatment of the patient (Department's Exhibit # 3B); [T-59-61].

Patient B

22. Patient B, a 69 year old female came under the care and treatment of Respondent during an admission to NYMH from February 24, 1994 through May 2, 1994. On 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 March 16, 1994, the patient had a tracheostomy and on March 31, 1994, Respondent performed a (third surgical) procedure to resect the colon tumor (a segmental colectomy) (Department's Exhibit # 4B); (Respondent's Exhibit # II).

23. A surgical consultation was done by a resident. There are no progress notes nor consultation report in the medical records of Patient B by Respondent. There is no note in the medical records that, prior to performing a transverse colostomy on Patient B on February 25, 1994, Respondent ever saw the patient, conducted an examination of the patient, assessed the patient's condition, nor conducted a surgical evaluation (Department's Exhibit # 4B); [T-189-194, 319].

24. The decision of whether or not to follow a radiologist's recommendations is a clinical judgment which, under the circumstances present here, was not a departure from accepted standards of practice. The patient had a source of sepsis and a barium enema may have been contraindicated [T-241-243, 2288-2289].

25. The third surgical procedure (March 31, 1994) had some indication or justification, although not explained by Respondent in the medical records of Patient B. Patient B was septic with unknown source of sepsis. The patient continued to have very high fevers in spite of very strong and rigorous antibiotic therapy (Department's Exhibit # 4B); [T-1108-1109, 2247-2248, 2580].

26. Between the period of the performance by Respondent of the tracheostomy and the resection of the colon tumor on March 31, 1994, Respondent did not note his examination or assessment of the patient (Department's Exhibit # 4B); [T-212-214].

27. Respondent failed to note his supervision of the surgical residents caring for Patient B, both preoperatively and postoperatively (Department's Exhibit # 4B); [T-321-322].

28. Respondent failed to maintain a hospital record for Patient B in accordance with accepted medical or surgical standards and in a manner which accurately reflected the care and treatment of the patient (Department's Exhibit # 4B); [T-322].

Patient C

29. Patient C, a 74 year old male, came under the care and treatment of Respondent during an admission to NYMH from November 17, 1998 through 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 November 21, 1998, during an attempt to place a nasogastric tube, Patient C arrested. The patient was resuscitated. However, Patient C suffered ischemic encephalopathy and remained comatose and on ventilatory support. At the family's request, the patient was made DNR (do not resuscitate) (Department's Exhibit # 5B); (Respondent's Exhibit # II).

30. Respondent failed to note in the medical records for Patient C any physical examination, surgical evaluation, an assessment or medical rationale for performing surgery. There is a complete lack of charting by Respondent in the hospital chart (Department's Exhibit # 5B); [T-265-266,1252-1255].

31. The patient continued to have abdominal distension and a surgical consultation with Respondent was ordered and carried out by a surgical resident on November 22, 1998. On examination, the resident found the rectal mass to be three centimeters from the anal verge extending high up. A rectal tube catheter was inserted, releasing greater than 1,000 ccs' of air into a Foley bag. Following the release of air, the abdomen was softer and less distended. The Foley was put

to gravity and left in situ. The resident noted a recommendation to follow-up with abdominal x-rays and to request that a gastroenterologist ("**GI**") consultant further decompress the bowel. There is also a note by the resident indicating he discussed his consultation with Respondent. Nurses' notes in the patient's medical records document that there continued to be drainage from the rectal tube and that the patient's abdomen remained less distended, with bowel sounds heard (Department's Exhibit # 5B); [T- 260-263, 289, 2324-2325].

32. A resident's surgical consultation note and a nurse's note indicate that the rectal tube was working to some extent, to decrease the distension (Department's Exhibit # 5B); [T-2613].

33. Based on the effectiveness of the rectal tube to this point, there was no urgency to proceed to surgery (Department's Exhibit # 5B); [T-1266-1268, 2613-2614]. 34. On November 23, 1998, Respondent performed a transverse colostomy on Patient C (Department's Exhibit # 5B); (Respondent's Exhibit # II).

35. At the time Respondent performed surgery, the patient was ventilator dependent and responsive to only deep pain stimuli (Department's Exhibit # 5B); [T-1249-1252, 2308-2310, 2607-2608].

36. Respondent performed a transverse colostomy on Patient C without appropriate medical and surgical indication or justification. The surgical resident had successfully decompressed the bowel and released a great deal of air and fluid, resulting in less abdominal distension. A GI consultation and not surgery would have been the appropriate next step, as recommended by Respondent's resident (Department's Exhibit # 5B); [T-266-268, 278-279].

37. Given the patient's clinical picture and the findings after use of the rectal tube, Ogilvie's syndrome (a pseudo obstruction) should have been considered by Respondent, as was considered

by his resident. A reasonably prudent surgeon would have recommended a colonoscopy prior to performing surgery on this patient [T-1259-1266].

38. There is nothing in the patient's medical records to indicate that his condition had changed in the 24 hour period after the resident successfully decompressed the bowel to warrant undertaking the surgical procedure (Department's Exhibit # 5B); [T-280-282].

39. Respondent failed to assess the patient's condition. Patient C had a very grave prognosis, having suffered a severe neurologic event, ventilator dependent, with abdominal ascites and probable liver metastasis. A reasonably prudent surgeon would seek to provide palliative care to the patient and seek to avoid, if at all possible, major surgical intervention. Given that the abdominal distention had been successfully temporized with the rectal tube, Respondent had no reasonably acceptable justification for subjecting the patient to a major surgical procedure (Department's Exhibit # 5B); [T-271-273, 279-280, 808-309].

40. Respondent failed to supervise the resident caring for Patient C both preoperatively and postoperatively (Department's Exhibit # 5B); [T-1255-1259, 1263-1264, 2332-2337, 2608-2610].

41. Respondent failed to note any indication of his supervision of the resident caring for the patient (Department's Exhibit # 5B) [T-309, 1263-1264, 2608-2611, 2623-2624].

42. Respondent dictated an operative report approximately nine months after surgery which contained statements ("rectal tube tried without success") not corroborated by the medical records of Patient C (Department's Exhibit # 5B).

43. There is insufficient evidence to conclude, by a preponderance of the evidence, that the erroneous statements dictated by Respondent were made knowingly and deliberately with intention to mislead (Department's Exhibit # 5B); [T-2292-2348].

44. Respondent failed to note in the medical records for Patient C any evaluation, assessment and/or medical rationale for performing surgery. There is a complete lack of charting by Respondent. Respondent failed to maintain a hospital record for Patient C in accordance with accepted medical or surgical standards and in a manner which accurately reflected the care and treatment of the patient (Department's Exhibit # 5B); [T-265-266,1252-1255].

Patient D

45. Patient D, an 80 year old female, came under the care and treatment of Respondent during an admission to NYMH from October 21, 1998 through 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 a colonoscopy were pending when, on 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 (Department's Exhibit # 6B); (Respondent's Exhibit # II).

46. There is a preoperative note in the medical records of Patient D from Respondent indicating his surgical assessment and plan for the surgery (Department's Exhibit # 6B); [T-348].

47. Dr. Geders performed the colonoscopy on October 21, 1998 starting at 3:25 p.m. and was completed by 4:15 p.m. A complete colonoscopy was performed with the scope advanced to the cecum. Dr. Geders reported a finding of an irregularity at the ileocecal valve and an irregular mass at the suture line of the prior colon resection. Both sites were biopsied by Dr. Geders. She noted that her impression was a recurrent colon cancer and recommended follow-up pathology and a surgical consult, in that order (Department's Exhibit # 6B); [T-343-347, 2649-2650].

48. Following the colonoscopy and prior to the results of the biopsy, Respondent performed surgery on Patient D. A preoperative note indicates that Respondent intended to perform an anterior lower resection based on his preoperative diagnosis of a recurrent rectal sigmoid cancer (Department's Exhibit # 6B; [T-347].

49. There is a distinct difference between an impression and a final diagnosis. Since there was no urgency, a reasonably prudent physician would have waited for the results of the biopsies before subjecting the patient to an invasive surgical procedure (Department's Exhibit # 6B); [T-346-349, 353, 2662-2664].

50. There was no urgency in performing the surgery without awaiting the results of the biopsies. The colonoscopy was scheduled as an elective procedure, almost two weeks prior to the time it was performed. Nothing in the medical records points to any change in the patient's overall condition that would require taking the patient urgently to the operating room (Department's Exhibit # 6B); [T-350-251, 2650-2653].

51. There was no mechanical obstruction of the bowel, nor any clinical indications of an obstruction of the bowel that would indicate the possible need for immediate surgery to relieve an obstruction. Dr. Geders' report of colonoscopy on the day before surgery indicates her finding on examination of positive bowel sounds and a soft, non-tender abdomen. Other examinations of Patient D's abdomen by residents on admission indicate the same findings. As with her previous consultation report, there is no record that Dr. Geders had any concern that there was an obstruction nor that there was any urgent situation (Department's Exhibit # 6B); [T-356-357, 1340-1341, 2389-2391, 2630, 2650-2651].

52. On October 22, 1998, Respondent performed a rectosigmoid resection, removing the area of the anastomosis. However, Dr. Geders, during the colonoscopy (on October 21, 1998) also biopsied the area of the ileocecal valve. Respondent did not address this area during his procedure on Patient D. It was a departure from minimum accepted standards of care to have failed to await the results of biopsy and proceed to surgery without first ascertaining if there was a cancer at the location biopsied. If in fact there was a cancer at that location, and at the anastomosis site, (which there was not in this case) a competent surgeon would not perform just a resection of one area, but rather perform a subtotal colectomy (Department's Exhibit # 6B); [T-351-353, 1368-1379, 2405-2411, 2663-2665].

53. On October 21, 1998, Dr. Geders biopsied two sites. On October 22, 1998, Respondent performed surgery without appropriate medical justification because he did not have the results of the biopsies (Department's Exhibit # 6B); [T-351-353, 1368-1379, 2405-2411, 2663-2665].

54. The medical records for Patient D contain a few countersignatures of residents' notes by Respondent. Although these notes fail to document adequate medical record keeping of Respondent's supervision of the residents, the notes do suggest that Respondent was aware of resident activities. There is insufficient evidence to conclude that Respondent failed to actually supervise the residents (Department's Exhibit # 6B); [T-2349-2412].

55. Respondent dictated an operative report approximately five months after surgery which contained statements (a preoperative diagnosis of "distal bowel obstruction") not corroborated by the medical records of Patient D (Department's Exhibit # 6B).

56. There is insufficient evidence to conclude, by a preponderance of the evidence, that the erroneous statements dictated by Respondent were made knowingly and deliberately with intention to mislead (Department's Exhibit # 6B); [T-2349-2412]

57. The medical records for Patient D do contain some countersignatures by Respondent but lack any meaningful note by Respondent which documents the care and treatment that he provided to Patient D. Respondent failed to maintain medical records for Patient D in accordance with accepted medical/surgical standards and in a manner which accurately reflected his care and treatment of the patient. (Department's Exhibit # 6B); [T-2657-2658].

Patient E

58. Patient E, an 81 year old female, came under the care and treatment of Respondent during an admission to NYMH from December 30, 1995 through 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 January 4, 1996, a cholecystectomy and cholangiography on January 11, 1996, and repair of the ventral hernia and placement of a Portacath for chemotherapy on January 18, 1996. There was significant drainage from the cholecystectomy wound and on February 5, 1996, Respondent performed a closure of a wound dehiscence and also drained a large amount of fluid from the mastectomy site (Department's Exhibit # 7); (Respondent's Exhibit # II).

59. The medical records of Patient E contain insufficient notes or documentation from Respondent to indicate that Respondent examined and evaluated the patient prior to scheduling her for a mastectomy and cholecystectomy. The medical records of Patient E contain no consultation report nor any progress notes by Respondent prior to performing the first surgery (Department's Exhibit # 7); [T-465-466, 520, 559-567].

60. Prior to this admission, Patient E had been scheduled by Respondent for a left breast biopsy and cholecystectomy to be performed the following week. Patient E was noted to have a 4 x 4 centimeter moveable mass of the left breast with no enlarged axillary lymph nodes palpable. The patient also had a history of colitis, rectal bleeding, questionable liver disease and an easily reducible umbilical hernia (Department's Exhibit # 7); [T-443-447. 2427-2428].

61. The scheduling of the mastectomy and cholecystectomy, both elective procedures, had been canceled at least twice because the patient was not feeling well. Patient E came to the hospital on December 30, 1995 because she was feeling quite ill, and not to have the elective procedures performed. On admission, Patient E's symptoms and the presenting laboratory and clinical data were such as to be associated with cirrhosis of the liver (Department's Exhibit # 7); [T-2684-2685].

62. The left modified radical mastectomy (first surgery) performed by Respondent on Patient E was indicated. The timing of the first surgery is questionable considering the patient's clinical condition (Department's Exhibit # 7); [T-257-258, 447-454, 2444-2447, 2685-2686].

63. The cholecystectomy (second surgery) performed by Respondent on Patient E was indicated. However, the second surgery should not have been performed, at this hospital admission, considering the patient's clinical condition (Department's Exhibit # 7); [T-257-258, 447-454, 2444-2447, 2685-2686].

64. The repair of the ventral hernia (third surgery) performed by Respondent on Patient E was not indicated or justified by the medical records or by the patient's clinical condition (Department's Exhibit # 7); [T-257-258, 447-454, 486-488, 503, 2444-2447, 2685-2686].

65. The CT scan was an appropriate initial diagnostic evaluation, however, it is not sensitive enough for the detection of the presence of a biliary obstruction and did not establish the cause of

the patient's jaundice and liver abnormalities. Obtaining additional studies, prior to proceeding with any surgeries, by means of an ultrasound of the abdomen and gallbladder, which is more sensitive for detection of an obstruction, was indicated along with a gastroenterology consultation and possible ERCP (as recommended by the house physician on initial evaluation of the patient) (Department's Exhibit # 7); [T-455-456].

66. In proceeding with the mastectomy prior to a complete assessment of the patient's liver abnormalities, Respondent failed to recognize and consider the risk to the patient as a result of her uncorrected and unresolved liver abnormalities and poor nutritional status. The patient was at risk for bleeding from the wound, poor wound healing and liver damage from the anesthetic agents and other medication possibly used post operatively (Department's Exhibit # 7); [T-463-464].

67. A reasonable, prudent surgeon would have sought the least invasive diagnostic and treatment modality for this patient by consultation with a gastroenterologist for consideration of an ERCP [T-471, 504-506, 2450-2451].

68. Respondent did not (preoperatively) order appropriate diagnostic tests for Patient E to determine whether the etiology of her liver function abnormalities was medical or surgical (such as a titer scan, a ERCP, an intravenous cholangiography). A prudent physician would have continued to work up the patient before proceeding to surgery [T-2488-2494].

69. On admission, laboratory data of Patient E revealed, a WBC of 11200, a low Hemoglobin of 12, low Hematocrit of 37, and a low platelet count of 56,000. The patient's PT was prolonged at 19 seconds, she had an abnormal INR of 3, and an abnormal PTT of 52 seconds. Patient E's electrolytes were grossly abnormal. The patient's liver function tests were abnormally high, with an albumen of 3, bilirubin of 4.8, alkaline phosphatase of 179, and a SGOT of 135 (Department's Exhibit # 7); [T-447-450].

70. Respondent failed to review or act on the laboratory findings on Patient E before performing the surgery [T-506].

71. It was not reasonable or prudent for Respondent to have proceeded, on January 4, 1996, to perform a radical mastectomy on Patient E. It was premature for Respondent to have proceeded to a major surgery on this patient in view of the patient's unresolved liver abnormalities and jaundice. The patient had gallstones and a low grade fever. It was still unclear whether the patient was suffering from a low grade septic process, or a cholangiolitis in the bile system. These unresolved issues posed a greater immediate risk to the patient than the presence of the breast mass and should have been addressed by Respondent first (Department's Exhibit # 7); [T-458-464, 498, 506, 808-809, 2449-2451, 2686-2687].

72. The placement of a Portacath in Patient E during the third surgery (January 18, 1996) is not the equivalent of clearing the patient for chemotherapy. There was no contraindication to the placement of the Portacath [T-486, 2678-2680, 2821-2822].

73. There is no documentation in the medical records of Patient E or sufficient evidence that Respondent cleared the patient for chemotherapy (Department's Exhibit # 7); [T-3003-3005].

74. Respondent failed to note his supervision of the residents caring for Patient E, both preoperatively and postoperatively (Department's Exhibit # 7); [T-513-517].

75. There are no notes in the medical records of Patient E by Respondent regarding his management of the patient, nor for his rationale or assessment of the patient prior to performing the open cholecystectomy, prior to the insertion of the Portacath and prior to the repair of the ventral hernia (Department's Exhibit # 7); [T-483-484, 488-489].

76. Respondent failed to maintain a hospital record for Patient E in accordance with accepted medical and surgical standards and in a manner which accurately reflects the care and treatment provided by Respondent to the patient (Department's Exhibit # 7); [T-496-497, 517-518].

77. Respondent operated on Patient E in rapid succession of consecutive Thursdays with a disregard for the patient's presenting condition and without allowing for any recuperation, especially given evidence of infection, wound healing problems and unresolved hepatic abnormalities (Department's Exhibit # 7); [T-500-505, 2463-2468, 2469-2471, 2707-2708].

Patient F

78. Patient F, a 90 year old female, came under the care and treatment of Respondent during an admission to NYMH from June 1, 1995 through June 3, 1995. Urinalysis on admission showed numerous red blood cells, packed white blood cells and large amounts of bacteria. On the day of admission, June 1, 1995, Respondent performed surgery on Patient F based on his preoperative diagnosis of acute appendicitis. Respondent removed a normal appendix and a calcified free body found in the pelvis (Department's Exhibit # 8); (Respondent's Exhibit # II); [T-585-586, 588-590, 2710-2711].

79. There is no note in the medical records of Patient F by Respondent which would indicate that he performed a physical examination or surgical evaluation and assessment of the patient prior to surgery (Department's Exhibit # 8); [T-602].

80. Emergency Room nurses' notes indicate that the patient voided in the bathroom and urine was sent to the lab for analysis on June 1, 1995 at about 10:10 am. The results of the urinalysis was never reviewed or obtained by Respondent prior to performing surgery on Patient F. Had Respondent obtained the urinalysis results, he would have found that the patient suffered from a significant urinary tract infection on admission which would account for her symptoms on June 1, 1995 (Department's Exhibit # 8); [T-593-596].

81. The incidence of appendicitis in a 90 year old are distinctly unusual. The operative note and the pathology report note indicate that the appendix of this patient was normal (Department's Exhibit # 8); [T-599, 604, 2719-2720].

82. A urinary tract infection would account for some of the symptoms that the patient had, and urinary tract infections in elderly women occur much more frequently than appendicitis [T-2721, 2731].

83. An acute abdomen would refer to an abdominal process that poses an immediate threat to life or limb. Patient F did not manifest signs of an acute abdomen. Even with an acute abdomen, there is no irreparable harm in waiting an hour or two until all the appropriate diagnostic tests are completed [T-615-618, 2721].

84. Respondent's failure to await the results of the urinalysis prior to performing surgery was a significant and egregious departure from accepted standards of practice. A urinalysis is an important part of the preoperative evaluation of this patient. It is a departure for the surgeon to not make himself aware, and note his awareness in the chart, of important laboratory data which might influence the decision to perform surgery [T-595, 615, 2730, 2734-2735].

85. An appropriate work-up of a 90 year old woman with a suspected appendicitis would include a full and complete history and physical examination; obtaining and reviewing appropriate laboratory tests, and an abdominal x-ray. In this case the laboratory tests were obtained, but Respondent failed to review them prior to performing surgery. A review of the tests performed on Patient F prior to surgery would have indicated that more tests were necessary prior to performing non-urgent surgery on Patient F. No preoperative abdominal x-ray was obtained. Respondent failed to perform an appropriate preoperative evaluation and assessment of Patient F (Department's Exhibit # 8); [T-597-599].

86. There are many conditions other than appendicitis that can account for abdominal pain and for which surgery is not indicated. Postoperative abdominal x-ray showed a focal dilation of

the small bowel, and the entire colon filled with feces. Simple constipation can be a cause of abdominal pain and distention. The patient's past medical history was positive for GI bleeding with angiodysplasia and ischemic diverticulitis, also signs of abdominal pain and distention. The patient was not in acute distress and there were many possible causes for abdominal pain which were not evaluated by Respondent (Department's Exhibit # 8); [T-598-600, 2720-2721, 2731-2732].

87. In 1995, there were other appropriate, available diagnostic tests to help delineate the clinical findings, including, plane films of the abdomen to look for free air or an obstructive pattern, or an abdominal CT scan. Neither test was performed nor ordered by Respondent (Department's Exhibit # 8); [T-618-619, 1785, 2712-2714, 2833-2834].

88. Respondent failed to perform any diagnostic testing to rule out other medical/surgical causes for the patient's presenting condition (Department's Exhibit # 8).

89. Respondent failed to order any diagnostic testing to rule out other medical/surgical causes for the patient's presenting condition (Department's Exhibit # 8).

90. Respondent inappropriately performed surgery on Patient F when evidence of a significant urinary tract infection existed (Department's Exhibit # 8).

91. Respondent performed surgery on Patient F without appropriate medical and/or surgical indication and/or justification (Department's Exhibit # 8).

92. The removal of the catheter from Patient F on the day after surgery was not unwarranted [T-2717-2719].

93. Respondent failed to note his supervision of the residents caring for Patient F, both preoperatively and postoperatively (Department's Exhibit # 8); [T-2866-2872].

94. Respondent failed to maintain a hospital record for Patient F in accordance with accepted medical and surgical standards and in a manner which accurately reflects the care and treatment provided by Respondent to the patient (Department's Exhibit # 8); [T-2728-2730, 2840-2842, 2858-2861].

95. Postoperatively the patient began to complain of recurrent pain; spiked a temperature to 102 degrees, remained febrile; and had marked urinary retention, which along with the significant urinary tract infection on admission, showed signs of a developing urosepsis (Department's Exhibit # 8); [T-602-604].

96. Respondent dictated a discharge summary for the patient's admission, approximately one and one half years after the admission, wherein he falsely noted that the patient's postoperative course was uneventful. There is insufficient evidence to conclude, by a preponderance of the evidence, that the erroneous discharge summary dictated by Respondent was made knowingly and deliberately with intention to mislead (Department's Exhibit # 8); [T-2823-2874].

Patient G

97. Patient G, a 74 year female, came under the care and treatment of Respondent during an admission to NYMH from January 14, 1999 through 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 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 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 metastasis. In both the 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 (Department's Exhibit # 9B); (Respondent's Exhibit # II); [T-633-635].

98. There is no note in the medical records of Patient G by Respondent which would indicate that he performed a physical examination or surgical evaluation and assessment of the patient prior to surgery (Department's Exhibit # 9B); [T-651-652, 668-672].

99. The Department did not prove that the diverting end colostomy performed on Patient G, by Respondent on January 14, 1999, was not medically justified. Performing a colostomy to divert the fecal strain should stop some of the drainage and may help with some of the bleeding. The procedure may also improve the patient's quality of life (Department's Exhibit # 9B); [T- 649, 1633-1635, 1666-1669, 2743-2745, 2885-2886].

100. Respondent dictated an operative report for Patient G, approximately seven months after the surgery, wherein Respondent reported a preoperative diagnosis of "extensive serosanguinious drainage and maceration of the perineal area". There is insufficient evidence to conclude, by a preponderance of the evidence, that the operative report dictated by Respondent was significantly false or inaccurate or made with the intention to mislead (Department's Exhibit # 9B); [T-2875-2935].

101. Dr. Bamberger performed a colonoscopy on Patient G on January 2, 1999 (Department's Exhibit # 9B); [T-1631, 1684].

102. Respondent did not fail to order a proctoscopic exam for Patient G (Department's Exhibit # 9B); [T-1631, 1684].

103. The medical records of Patient G supports a finding that Respondent failed to note his supervision of the surgical resident staff caring for the patient both preoperatively and postoperatively. Mere undated countersignatures on the record are insufficient to constitute evidence of supervision (Department's Exhibit # 9B); [T-653, 666-668, 1712-1715, 2930-2934].

104. The medical records of Patient G contain insufficient documentation or notations by Respondent regarding the care and treatment he provided to the patient. Respondent 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 (Department's Exhibit # 9B); [T-651-652].

105. There is insufficient evidence to conclude, by a preponderance of the evidence, that Respondent created an operative report and discharge summary for Patient G which is significantly false or inaccurate or made with intention to mislead (Department's Exhibit # 9B); [T-2875-2935].

Patient H

106. Patient H, a 9 year old female came under the care and treatment of Respondent at his office, located at 258 85th Street, Brooklyn, N.Y. 11209, from June 23, 1999 through 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 "two and a half centimeter firm, moveable, tender mass left breast. No sign of any hormonal activity. Rest of PE (physical exam) normal". Respondent notes an initial impression of questionable fibroadenoma or virginal hyperplasia. 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. On 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)" (Department's Exhibit # 10A); (Respondent's Exhibit # II); [T-684-688, 701-702, 2937-2938].

107. Respondent performed and noted an acceptable physical examination and evaluation of Patient H at the June 23, 1999 visit (Department's Exhibit # 10A); [T-687-688].

108. Without any further explanation in the medical records of Patient H, and notwithstanding Respondent's recommendation to wait and reevaluate the mass in two weeks time, Respondent, just two days later, on June 25, 1999, scheduled the patient for surgery to excise the lesion of the left breast. Both Respondent's office record, and the preoperative note and anesthesia record in the hospital chart for June 28, 1999, the date the surgery was performed, note that the operation to be performed was an excisional biopsy of left breast (Department's Exhibits # 10A, 10B); [T- 689-690, 695-696, 702, 2200-2202].

109. The operative report is the only document in the medical records of Patient H which notes any indication for performing the procedure, stating: "nine year old white female presented with a left subareolar breast mass. Physical examination was unremarkable except for a palpable pebble size firm nodule approximately one by point five centimeters (1 x 0.5 cm) under the areola of the left breast." (Department's Exhibit # 10B); [T-732, 2949, 2982-2983].

110. There is insufficient evidence regarding Respondent's advice to Patient H's mother regarding her concerns over the presence of a breast mass except that Respondent failed to advise Patient H's mother to seek a second surgical consultation (Department's Exhibits # 10A, 10B); [T-2936-2992].

111. Respondent failed, preoperatively, to obtain a second surgical consultation (Department's Exhibits # 10A, 10B); [699-700].

112. The operative report, dictated immediately after the operation, was completed by Aaron Hoffman, M.D., the resident who assisted Respondent at the time. The size of the mass (1 x 0.5cm) as originally stated by Dr. Hoffman accurately correlated with the pathological measurement of the specimen excised (Department's Exhibit # 10B); [T-727-735, 745-746,1475-1479].

113. Dr. Hoffman was called in to assist Respondent and arrived in the operating room after the patient was asleep and draped, but prior to the initial incision. The operative field was exposed, revealing "a very small chest of a young person." Respondent allowed Dr. Hoffman to examine the patient before incision, pointing out the mass. The mass felt like a firm nodule under the areola of the left breast, described as "the size of a pebble or small cat's eye marble" [T-727-728, 730,746-479].

114. Respondent's office record and the hospital chart do not note findings nor rationale to support taking this patient to the operating room and removing any portion of this mass. The appropriate and acceptable standard of care, after having discovered this mass, would have been to wait and watch its development. Respondent's office record documents an appropriate original plan but does not document the reason why Respondent diverted from this original plan. If Respondent felt constrained to take more aggressive action, an ultrasound of the breast, which is noninvasive, should have been done (Department's Exhibits # 10A, 10B); [T- 695-697].

115. If indeed Respondent felt a need to proceed past the wait and watch phase then the next step would have been an ultrasound and/or a consultation. Although there is no explanation in the record for proceeding to biopsy, Respondent did not even get an ultrasound exam preoperatively. Respondent failed, preoperatively, to appropriately evaluate the breast before performing surgery on the breast tissue of a nine (9) year old girl (Department's Exhibits # 10A, 10B); [699-700].

116. A primary breast carcinoma in a 9 year old, prepubertal female is extraordinarily rare, at best. There is effectively almost no potential for breast cancer in a nine year old premenstrual female, as Patient H. The diagnosis of virginal hyperplasia is non-malignant and, in fact, represents normal breast tissue developing chronologically early. The diagnosis is primarily a temporal one, in that virginal hyperplasia is a development occurring prior to puberty and is a form of premature thelarche [T- 697, 704, 711-712, 874-875, 1457, 1461-1465, 2968-2969].

117. Respondent inappropriately and without any medical or surgical indication or justification performed a biopsy of Patient H's left breast, removing a substantial portion, if not all, of the breast mass (Department's Exhibit # 10B) [T- 698].

118. Respondent's claim that he brought Patient H to the operating room and performed a biopsy to allay the fears of the patient's mother is without merit and irresponsible to the well-being of this child. The appropriate response to a mother's fears in this situation is reassurance and appropriate information [T- 699, 712-713, 2940-2942].

119. If Respondent was acting on the fears of the patient's mother, as Respondent claimed, he could not explain why he did not perform a less invasive needle biopsy [T- 2973-2977].

120. The medical records of Patient H do not contain any information that the patient's mother was anxious about the mass, nor is there any note in Respondent's differential diagnosis indicating a concern that the mass may represent a primary cancer (Department's Exhibit # 10A); [T-2202].

121. Respondent's justification for the procedure, that having a diagnosis of virginal hyperplasia allowed him to warn the mother that Patient H may have enlargement of the breast as an adult is not credible and is not a valid reason for performing a potentially deforming operation on a patient, especially a child [T-2950, 2953-2954, 2978-2980, 2987-2988].

122. "When the mother of a little girl discovers a tumor beneath the child's nipple, she is apt to overlook the possibility of the precocious or early puberty and rush off to her local surgeons. I cannot condemn too strongly any kind of surgical procedure upon the breasts of a child. The hazardous damage to an early-developing breast is great." Haagensen's, Diseases of the Breast, (as agreed to by Dr. Manouchehr Amini) [T-2221-2222].

123. If Respondent, as he claimed, felt obliged to biopsy this patient in response to parental panic, as opposed to the exercise of good medical judgement and standards, he is practicing bad medicine [T-2233].

124. Respondent had never performed a breast biopsy on a child this age before. Given that Respondent did not have experience with breast biopsies in this age group, and was presented with the fears of the patient's mother, the prudent course would have been to refer the patient to a pediatric surgeon [T-699-700, 1442-1443, 2953, 2956-2957, 2971-2972, 2981].

125. Respondent inappropriately and without appropriate medical or surgical indication or justification biopsied the mass in Patient H's left breast and may have removed more than 50% of the patient's budding left breast (Department's Exhibits # 10A, 10B); [T-723-756, 743].

126. Respondent changed the dimensions of the mass recorded in the operative report to read, "3 x 3 ". Respondent created a medical 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 (Department's Exhibit # 10B page 26); [T-723-756, 2948-2949, 2982-2983].

127. The medical records of Patient H contain insufficient and inaccurate documentation or notations by Respondent regarding the care and treatment he provided to the patient. Respondent failed to maintain a hospital record and 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 (Department's Exhibits # 10 and 10B).

Patient I

128. Patient I, an 89 year old female, came under the care and treatment of Respondent during an admission to NYMH from September 1, 2000 through 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 September 15, 2000, an attempt was made by a gastroenterologist to place a percutaneous endoscopic gastrostomy ("**PEG**") tube. Shortly after commencing the procedure, it was aborted, inasmuch as the patient became cyanotic with a drop in oxygen saturation. On September 18, 2000, Respondent performed an open surgical procedure on Patient I, under a high epidural anesthetic, constructing a Janeway feeding gastrostomy (Department's Exhibit # 16); (Respondent's Exhibit # U); [T-3053-3057, 3261-3262, 3264-3265].

129. Respondent does not have any entry in the medical records for Patient I with regard to his initial encounter with the patient. The hospital record does not contain any consultation report by Respondent nor any progress note by him. Respondent does not have an office copy of a consultation report. In addition to a consultation report, standard medical or surgical practice is for a consultant to write a note in the progress section of the chart as a chronological reference to the patient's care (Department's Exhibit # 16); [T-3034-3040, 3260, 3277-3278].

130. Respondent failed to note an appropriate physical examination or surgical evaluation and assessment of the patient and rationale for proceeding to surgery prior to performing an open gastrostomy on Patient I on September 18, 2000 (Department's Exhibit # 16); [T-3129-3131, 3269-3270, 3274-3277, 3280-3281].

131. Respondent first saw Patient I on September 13, 2000 at the request of Dr. Sosler, the patient's primary physician, to consult with regard to the advisability of providing nutritional access to the patient (Department's Exhibit # 16); [T-3031-3033, 3260, 3265].

132. Respondent recommended a PEG be attempted, a less invasive procedure and an alternative measure, for feeding access [T-3043, 3057].

133. The treatment team for Patient I discussed other alternatives to the placement of a gastrostomy tube but these alternatives were discounted [T-3046-3047, 3460-3461, 3465, 3614-3615].

134. Following the exhaustion of less invasive alternatives to provide nutrition and medication for Patient I, it was agreed that something had to be done, as Patient I's condition was deteriorating. Respondent was consulted and concurred that a feeding (and medication) tube placement was the only viable alternative [T-3065-3067, 3469-3479, 3618].

135. The Department did not prove that the open surgical procedure (gastrostomy) performed by Respondent was without appropriate indication (Department's Exhibit # 16); [T-3070-3071, 3347, 3471-3472].

136. On September 18, 2000, Dr. Oloumi performed a Janeway feeding gastrostomy on Patient I (Department's Exhibit # 16);

137. If an open procedure had to be done on Patient I, it was not inappropriate for Respondent to perform a Janeway gastrostomy on Patient I [T-3100-3102, 3355-3358, 3555-3556, 3619-3620].

138. The medical records of Patient I do not contain any notes by Respondent regarding the follow-up of the patient postoperatively (Department's Exhibit # 16).

139. The Department did not prove that Respondent failed to order appropriate postoperative care and monitoring for Patient I [T-3354-3355, 3428,3623-3624].

140. Respondent did not note his supervision of the surgical resident(s) caring for Patient I both preoperatively and postoperatively (Department's Exhibit # 16).

141. Following the aborted PEG procedure, Patient I's condition continued to deteriorate. The night before Respondent performed the open gastrostomy, at 6 p.m. on September 17th, Patient I sustained a sixteen beat run of ventricular tachycardia and another group of episodes of asystole, at about 1 a.m. on the morning of September 18th, one lasting as long as four seconds where her heart stopped and her condition deteriorated. On September 18, 2001 at 11:07 a.m. Patient I had a critically elevated PCO_2 of 82, indicative of severe carbon dioxide retention. Patient I's presentment was consistent with respiratory acidosis. None of these events and findings were evaluated by Respondent prior to operating on Patient I (Department's Exhibit # 16); [T-3279-3282, 3285-3286, 3435, 3563-3568].

142. If a surgeon is not going to see a patient until just prior to operating, as Respondent did in this case, then he has an absolute obligation to review the patient's medical records, including all the progress notes and laboratory studies, prior to subjecting the patient to an operative procedure [T-3282-3283].

143. The patient's episodes of ventricular tachycardia, asystole and her critically elevated PCO_2 presented a clear contraindication to proceeding with the open gastrostomy [T-3283, 3565-3568].

144. The carbon dioxide level of 82, reported on the morning of the surgery, was the highest measured during the patient's 18 day hospitalization. Respondent was responsible to be informed of the patient's PCO_2 level prior to surgery. There was no urgency to the gastrostomy. Respondent subjected Patient I to an open procedure without proper evaluation and assessment of her significant derangements in her respiratory status as manifested by her elevated PCO_2. Respondent's failure to make himself aware of the patient's precarious condition prior to operating is a gross deviation from the standard of care (Department's Exhibit # 16); [T-3095-3100, 3285-3287, 3563-3569].

145. In performing a non-emergent open gastrostomy, Respondent inappropriately subjected the patient to unjustified risk given her unstable clinical condition at the time (Department's Exhibit # 16); [T-3095-3100, 3285-3287, 3563-3569].

146. Respondent failed to maintain a hospital 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 (Department's Exhibit # 16); [T-3031-3132, 3547-3573].

Patient J

147. Patient J, a 49 year old female, came under the care and treatment of Respondent starting on January 9, 2001. Patient J was admitted to NYMH by Respondent on February 22, 2001 for the purpose of performing elective bariatric surgery for weight reduction. Patient J remained at NYMH through February 24, 2001. Preoperative work-up ordered by Respondent included a gallbladder sonogram, performed on 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 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 ("**VBG**") without knowledge of the pathologic diagnosis of the mass. On February 23, 2001 the pathologist reported a diagnosis of the mass as papillary adenocarcinoma with poorly differentiated areas. A follow-up pathology report of February 28, 2001 determined that the findings were most consistent with an ovarian etiology (Department's Exhibits # 17A, 17B); (Respondent's Exhibit # U); [T-3133-3137].

148. The radiologist who performed the ultrasound, on February 8, 2001, recommended further evaluation via CT scan of the abdomen. The radiologist reported that "the exact origin of this mass is not clear in the given images as the pancreas could not be well seen due to the overlying bowel gas. Various probabilities to consider are mesenteric cysts, a pseudocyst or cystic neoplasm of the pancreas cannot be excluded." (Department's Exhibit # 17B); [T-3366].

149. The sonogram report does not indicate that the mass is a simple cyst, but rather expresses some concern about a possible cystic neoplasm. A cystic mass in the upper abdomen is a highly unusual and atypical finding. This finding absolutely requires further assessment [T-3369-3369].

150. On or about February 9, 2001 Respondent became aware of the ultrasound findings of a cystic mass [T-3137-3138].

151. Notwithstanding the finding on the February 8, 2001 sonogram, and without informing Patient J or conducting any further work-up or assessment of the cystic mass, Respondent proceeded with the planned elective VBG on February 22, 2001 (Department's Exhibit # 17B).

152. Preoperatively, Respondent failed to properly evaluate and follow-up on the results of the sonogram (Department's Exhibits # 17A, 17B); [T-3366-3367].

153. Preoperatively, Respondent failed to note his evaluation and follow-up on the results of the sonogram (Department's Exhibits # 17A, 17B).

154. Respondent failed to appropriately order a consultation after obtaining the results of the sonogram and prior to proceeding with the VBG (Department's Exhibit # 17A).

155. A proper evaluation and follow up (further diagnostic testing) would include: preoperative tests such as a CT scan and/or an MRI; a laparoscopic procedure; a biopsy; a frozen section. While Respondent's claim that a CT scan was impossible on this patient at NYMH because her weight exceeded the capacity of the machine is plausible (although not noted in the patient's medical records), Respondent did not explore the option of having a CT scan performed elsewhere (Department's Exhibit # 17A); [T-3140-3143, 3150-3152, 3220, 3384, 3390-3391].

156. While Respondent's claim that Patient J could not tolerate an MRI, due to a negative prior experience with an MRI and, because of her weight, she could not lie down long enough to complete the study is plausible (although not noted in the patient's medical records), Respondent did not explore the option of having an MRI performed elsewhere (Department's Exhibit # 17A); [T-3152].

157. Respondent failed to order further diagnostic testing (such as a frozen section - intra-operatively) after obtaining the results of the sonogram and prior to proceeding with the VBG (Department's Exhibit # 17A); [T-3367-3368, 3372].

158. Respondent failed to inform the patient preoperatively of the findings on the sonogram. Respondent admitted that he did not discuss the findings with the patient nor get her consent to remove the mass, despite his assertions that he had intended, on seeing the sonogram report, to remove the mass at the time of surgery [T-3158-3159].

159. Respondent had an affirmative duty to make a recommendation for further work-up and to advise the patient of the finding of the mass prior to proceeding with the VBG [T-3366-3368].

160. Respondent began the planned VBG on Patient J on February 22, 2001. Respondent found a 5 x 10 centimeter cyst in the Patient's omentum and removed the cyst. Respondent had "never seen a cyst like this" (Department's Exhibit # 17B); [T-3221-3224].

161. Once having visualized a mass in the omentum, a reasonably prudent surgeon would palpate the internal organs including the ovaries, fallopian tubes and uterus. It is the accepted custom and practice during bariatric surgery to routinely perform this type of complete abdominal exploration [T-3372-3373, 3395].

162. Intra-operatively, the appropriate course is to either biopsy or excise the mass, depending on what is found; to fully explore the abdomen, and to obtain a frozen section for pathological evaluation and diagnosis before proceeding to the VBG [T-3370-3372].

163. The exploration of the patient's abdomen and obtaining a frozen section of the cyst are appropriate diagnostic tools in evaluating the patient before proceeding with the VBG. Respondent did not explore the patient's abdomen nor obtain a frozen section of the cyst. Respondent failed to properly evaluate Patient J before proceeding with the VBG (Department's Exhibit # 17B); [T-3370-3372].

164. Respondent failed to properly obtain an intra-operative consultation with a pathologist by frozen section of the identified mass (Department's Exhibit # 17B); [T-3222-3224].

165. The likelihood of a cyst in the omentum being a primary malignancy is extraordinarily rare. A frozen section would indicate whether the cyst was benign or malignant. If the cyst is malignant, as was true in this case, then a reasonable conclusion would be drawn that the patient has a metastatic lesion from an unknown primary source [T-3232-3234, 3394-3395].

166. In failing to obtain an intra-operative diagnosis of the cyst, Respondent denied Patient J prompt management and treatment of ovarian cancer, in that he inappropriately failed to explore the abdomen (Department's Exhibit # 17B); [T-3375, 3395-3397].

167. Respondent inappropriately proceeded to perform the VBG without first having obtained a pathology consultation (Department's Exhibit # 17B); [T-3374-3375, 3391-3394].

168. In response to the following question "Would you have done a vertical banded gastroplasty if the frozen section was malignant?", Respondent answered "I would say most probably I would still go ahead and do the vertical banded gastroplasty." [T-3229-3230].

169. The facts that Respondent encountered a cyst that he had never seen before, did not obtain a frozen section, continued without further exploration, and continued without a consultation demonstrate that Respondent lacks the requisite knowledge to practice this type of surgery and calls into question Respondent's medical judgment [T-3143-3144, 3164-3168, 3221-3229, 3234-3236, 3369-3374, 3391-3397].

170. In Patient J's office record, as maintained by Respondent, there is no note regarding the abnormality found on the February 8, 2001 sonogram nor a note regarding Respondent's plans relative to that abnormality. Respondent failed to maintain an office record for Patient J in accordance with accepted practice and in a manner which accurately reflects his care and treatment of the patient (Department's Exhibit # 17A); [T-3378-3379].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Amended Statement of Charges and the Supplemental Statement of Charges were by a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, in the November 3, 2000 Amended Statement of Charges are **SUSTAINED**:

Paragraphs A, A2, A5, A6;
Paragraphs B, B5;
Paragraphs C, C2, C3, C5;
Paragraphs D, D2, D3, D6;
Paragraphs E, E4, E7;
Paragraphs F, F2, F3, F4, F5, F8;
Paragraphs G, G6;
Paragraphs H, H1b, H1d, H2, H3, H4, H5.

The Hearing Committee concludes that the following Factual Allegations, in the May 1, 2001 Supplemental Statement of Charges are **SUSTAINED**:

Paragraphs I, I8, I9;
Paragraphs J, J1, J2, J3, J4, J5, J6, J7, J8b, J9.

The Hearing Committee concludes that the following Factual Allegations, in the November 3, 2000 Amended Statement of Charges are **PARTIALLY SUSTAINED**:

Paragraphs A1a, A1b, A1c, A3, A4 (all as to failures to note);
Paragraphs B1, B2a, B4, (all as to failures to note);
Paragraphs C1 (as to failures to note), C4 (the report contained statements not corroborated by other parts of the medical records);
Paragraphs D4 (as to failures to note), D5 (the report contained statements not corroborated by other parts of the medical records);
Paragraphs E1 (as to failures to note), E2 (as to the ventral hernia repair), E3 (as to the gastroenterologist), E6 (as to failures to note);
Paragraphs F1 (as to failures to note), F7 (as to failures to note), F9 (the reports contained statements not corroborated by other parts of the medical records);
Paragraphs G1 (as to failures to note), G3 (the report contained statements not corroborated by other parts of the medical records), G5 (as to failures to note).
Paragraph H6 (the report contained false and inaccurate statements not corroborated by other parts of the medical records).

The Hearing Committee concludes that the following Factual Allegations, in the May 1, 2001 Supplemental Statement of Charges are **PARTIALLY SUSTAINED**:

Paragraphs I1, I5, I7 (all as to failures to note).

The Hearing Committee concludes that the following Factual Allegations, in the November 3, 2000, Amended Statement of Charges, are **NOT SUSTAINED**:

Paragraphs B2b, B3,
Paragraph C4 (knowingly falsely reported is not sustained);
Paragraphs D1, D5 (knowingly falsely reported is not sustained);
Paragraphs E2 (as to the modified radical mastectomy and the cholecystectomy), E3 (as to the hepatologist), E5;
Paragraphs F6, F9 (knowingly falsely reports is not sustained);
Paragraphs G2, G3 (knowingly falsely reported is not sustained), G4, G7;
Paragraphs H1a, H1c.

The Hearing Committee concludes that the following Factual Allegations, in the May 1, 2001 Supplemental Statement of Charges are **NOT SUSTAINED**:

Paragraphs I2, I3, I4, I6;
Paragraph J8a.

Based on the entire record, the Findings of Fact, and the Discussion that follows, the Hearing Committee unanimously concludes that the following twenty-six (26) Specifications of Charges of misconduct contained in the Amended Statement of Charges and the Supplemental Statement of Charges are **SUSTAINED** [14]:

[14] The paragraph citations refer to the paragraphs in the Factual Allegations contained in the Amended Statement of Charges and the Supplemental Statement of Charges which support each Specification.

FIRST and FORTY-FOURTH SPECIFICATIONS (**NEGLIGENCE ON MORE THAN ONE OCCASION**): Paragraphs: A, A2, A5; C, C2, C3; D, D2, D3; E, E2, E3, E4; F, F2, F3, F4, F5; H, H1b, H1d, H2, H3, H6; I, I8; J, J1, J2, J3, J4, J5, J6, J7, J8b.

SECOND and FORTY-FIFTH SPECIFICATION: (**INCOMPETENCE ON MORE THAN ONE OCCASION**): H, H2; J2, J5, J6, J8b.

THIRD, SIXTH, SEVENTH, EIGHTH, TENTH, FORTIETH and FORTY-FIRST SPECIFICATIONS (**GROSS NEGLIGENCE**): A, A5; D, D2, D3; E, E2, E3, E4, F, F2, F3, F4, F5; H, H2; I, I8; J, J1, J4, J5, J6.

TWENTY-FOURTH, TWENTY-SIXTH through TWENTY-NINTH, THIRTY-FIRST and FORTY-SEVENTH SPECIFICATIONS (**UNWARRANTED TREATMENT**): A, A2; C, C2; D, D2, D3; E, E2, F, F5, H, H2, H3; J, J4, J7.

THIRTY-SECOND through THIRTY-NINTH, FORTY EIGHTH and FORTY-NINTH SPECIFICATIONS (**FAILURE TO MAINTAIN RECORDS**): A, A1a, A1b, A1c, A3, A4, A6; B, B1, B2a, B4, B5; C, C1, C5; D, D4, D6; E, E1, E6, E7; F, F1, F7, F8; G, G1, G5, G6; H, H4, H5, H6, I, I1, I5, I7, I9; J, J1, J9.

Based on the entire record, the Findings of Fact, and the Discussion that follows, the Hearing Committee unanimously concludes that the following twenty-three (23) Specifications of Charges of misconduct contained in the Amended Statement of Charges and the Supplemental Statement of Charges are **NOT SUSTAINED**:

FOURTH, FIFTH, and NINTH SPECIFICATIONS (**GROSS NEGLIGENCE**).

ELEVENTH through EIGHTEENTH, FORTY-SECOND and FORTY-THIRD SPECIFICATIONS (**GROSS INCOMPETENCE**).

NINETEENTH through TWENTY-THIRD SPECIFICATIONS (**FRAUDULENT PRACTICE**).

TWENTY-FIFTH, THIRTIETH and FORTY-SIXTH SPECIFICATIONS (**UNWARRANTED TREATMENT**).

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with a total of forty-nine (49) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of many of the types of misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from two memoranda, one submitted by the Department, entitled: Definitions of Professional Misconduct under the New York Education Law and the second, submitted by Respondent, entitled Respondent's Requests to Charge to the Panel. During the course of its deliberations on these charges, the Hearing Committee consulted the following instructions prepared by the ALJ from the above two documents:

References to M & M Conferences

You are to disregard any questions, answers, or references to Morbidity and Mortality Conferences that may have been elicited during these Hearings.

Summary Suspension

You must first address the question of the Commissioner's summary suspension of Dr. Oloumi from the practice of medicine. In accordance with §230(12)(a) of the Public Health Law, this Hearing Committee is charged with the duty of determining:

> If, at the conclusion of the hearing, (i) the hearing committee of the board finds the licensee guilty of one or more of the charges which are the basis for the summary order, (ii) the hearing committee determines that the summary order continue, and (iii) the ninety day term of the order has not expired, the summary order shall remain in full force and effect until a final decision has been rendered by the committee or, if review is sought, by the administrative review board.

The effective date of the service of the summary order for the 90 day statutory time purposes was set at May 4, 2001. The first day of the Summary Hearing was held on May 11, 2001. The term of the Commissioner's Order is in effect until August 1, 2001. Your first duty is to review the evidence offered by the parties and determine whether to continue the Summary Order until such time as the full decision on all of the charges can be rendered. In making that determination, you must consider the language of the Public Health Law and whether the Department has proved by a preponderance of the evidence that Dr. Oloumi is guilty of one or more of the charges which are the basis for the Summary Order.

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits you find to be worthy to be believed.

Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to you as more nearly representing what took place than the evidence opposed to its claim. In order to sustain a specification of misconduct the Hearing Committee can only use the sustained or believed factual allegations.

Negligence on More Than One Occasion

Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by Dr. Oloumi caused actual harm to a patient. If you should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that you may consider on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that you may consider on the question of what penalty, if any, should be imposed.

The failure to maintain records which accurately reflect the evaluation and treatment of the patient and which does not affect patient treatment will not constitute negligence. Where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may constitute negligence.

Gross Negligence on a Particular Occasion

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

Incompetence on More Than One Occasion

Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning. These factors may include your impression of Dr. Oloumi's technical knowledge and competence on the various issues and the charges under consideration.

Gross Incompetence

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

Practicing the Profession Fraudulently

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. In order to support the charge that medicine has been practiced fraudulently, the Department must prove by a preponderance of the evidence that (1) Dr. Oloumi made a false representation, whether by words, conduct, or concealment of that which should have been disclosed; (2) Dr. Oloumi knew that the representation was false; and (3) Dr. Oloumi intended to mislead through the false representation. The opinion of the medical experts of the occurrence of or non occurrence of fraud should be disregarded in total. The Hearing Committee is the sole arbiter of whether fraud occurred and must base its determination on the credible facts (including Respondent's testimony) and not on whether others believe that fraud occurred or did not occur.

Failure to Maintain Records

A physician must record meaningful and accurate information in a patient's medical records, which accurately reflects the care and treatment of the patient, for a number of reasons. These reasons include: (1) the physician's own use; (2) the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient. In making your determination of the adequacy of the records in question, you may be guided by the testimony of the witnesses presented by both parties.

Performance of Unwarranted Treatment

In making your determination on whether the Department has sustained its burden of proof on this issue, you should be guided by the evidence adduced with respect to the condition of the patients and the indications for tests and/or treatment at the time of the events.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards. The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility. The Hearing Committee understood that as the trier of fact they may accept so much of a witnesses' testimony as is deemed true and disregard what is found to be false.

Witnesses

Dr. Ronald Forlenza, the Department's expert witness for Patients A through H was found to be credible, knowledgeable, and persuasive. His reasoning was consistent and his

testimony fair. Dr. I. Michael Leitman, the Department's expert witness for Patients I and J, was very persuasive, straightforward, non-evasive, extremely knowledgeable, balanced and unbiased. Neither expert knew Respondent personally, or as referring physicians prior to the Hearing. Neither witnesses had any reason to fabricate testimony nor was any bias shown. Their testimony was credited by the Hearing Committee when it was based on the medical records and the expert witnesses' medical opinions and experiences.

Dr. Aaron Hoffman, the physician involved in the surgery on Patient H, was a credible and persuasive witness. The Hearing Committee realized the tremendous pressure that Dr. Hoffman was facing in his position as a resident. Dr. Hoffman's testimony was candid and honest.

Dr. Timothy Canterbury, Respondent's expert as to Patients A through G, was credible and straightforward even when his testimony was not helpful to Respondent. Dr. Canterbury was not always in support of Respondent's positions and answered the questions posed succinctly and without evasion. Dr. Hossein Hedayati, Respondent's expert as to Patients I and J, was well spoken and forthright. On occasions, he also did not support Respondent's positions.

Dr. P. Daniel Penha, Respondent's witness as to Patient H, was eminently qualified, credible and perspicacious, but his testimony was not relevant to the Charges. Dr. Bruce Sosler, Dr. Anthony Saleh, Dr. Asrael Bamberger, Dr. Ferdinand Garafalo, Dr. C.V.R. Reddy, and Dr. Musthuswami Krishnamurthy were all admitting or attending physicians at NYMH who testified on behalf of Respondent. All were extremely supportive in their testimony of Respondent. The Hearing Committee comprehended that they all had significant professional referral relationships with Respondent. The testimony of Mr. Paul Gaudio, Jr. was mostly irrelevant and his bias was evident.

Obviously Respondent had the greatest amount of interest in the results of this proceeding. The Hearing Committee accepted many of Respondent's explanations about performing physical examinations. The Hearing Committee did not accept Respondent's perfect memory [for example, see T-1961, T-2085-2086 BUT see T-2029, T-2062, T-2103, T-2140, T-2254]. Respondent was, at times, a credible witness who claimed to have a very good memory but on numerous occasions that claim did not prove to be the case. Although the Hearing Committee took Respondent's testimony at face value, we did find Respondent to be evasive and non-responsive at times. The Hearing Committee observed an intelligent physician who knew that his record keeping was at best, less than optimal.

With regard to a finding of medical misconduct, the Hearing Committee assessed Respondent's medical treatment and care of the patients, without regard to outcome, in a step-by-step assessment of patient situation, followed by medical responses provided by Respondent to each situation. In all of the cases presented, the medical care provided by Respondent was difficult to evaluate with certainty due to Respondent's extremely poor documentation and medical record keeping. Therefore the Hearing Committee listened to Respondent's undocumented explanations.

Using the above definitions and understanding, including the instructions and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted significant professional misconduct under the laws of New York State.

The Department of Health has met its burden of proof as to: Gross Negligence in the care and treatment of seven (7) patients; numerous acts of negligence in the care and treatment of eight (8) patients; two (2) acts of Incompetence in the care and treatment of two (2) patients; numerous acts of failing to maintain accurate records in the care and treatment of ten (10) patients; and seven

(7) separate acts of unwarranted treatment (unjustified or not medically indicated surgeries) in the care and treatment of seven (7) patients.

Failure to maintain a record for each patient which accurately reflects the care and treatment of the patient.

Respondent's record keeping practices are the worst medical records practices seen by this Hearing Committee. In fact, as to most patients there is an almost complete lack of notes by Respondent in the patients' medical records. The failure to write an order is equal to the failure to maintain a record. The failure to write in the medical records presents a potential harm because the communication is not there for others. The inadequacy of medical records has a potential for direct patient outcome. Even though Respondent took a medical record keeping course, the medical records of Patient J (subsequent treatment to the course) is tremendously lacking.

Respondent's failure to note in the medical records for each patient, either, a physical examination, a surgical assessment, an assessment of the patient's condition, a reason for not following the recommendations of a consultation, a report of his findings or a justification for performing surgery is a departure from accepted standard of practice.

Given the above, the Hearing Committee sustained all of the "failures to note" charges [15]. We did not sustain the failure to maintain records as negligence.

Patient A.

Respondent was grossly negligent when he chose the setting of the ICU to remove the wound packing from Patient A especially in light of the patient's abnormal coagulation pattern at the time. There was no physical evidence present of an acute cholecystitis. An ERCP is both a

[15] Failure to note a physical examination; failure to note a surgical evaluation; failure to note assessment, failure to note his examination, failure to note his supervision.

diagnostic and treatment tool and in 1995 was the preferred course of treatment for this patient. The patient should not have been subjected to an open cholecystectomy. The procedure was not indicated for this patient with a high mortality rate (due to her cirrhosis and portal hypertension) and there is no plausible justification in the record to prove Respondent's position regarding this patient. Nor was there any credible testimony to prove Respondent's position. Respondent was moderately to grossly negligent in his unjustified decision to perform an open cholecystectomy on Patient A.

Respondent's poor judgment in the care and treatment he provided to Patient A was serious. The Hearing Committee concludes that it was egregious and sustains the gross negligence charge. Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient A is also sustained.

Patient A was subjected to a surgery which was not justified by Respondent or indicated by her medical condition. Respondent is guilty, as to Patient A, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient A's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient A indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedures. No issue was raised with the manner in which the surgery was performed.

Patient B.

The Hearing Committee found that there was some justification for the colectomy on March 31, 1994. Patient B was febrile with an unknown source of sepsis and some suggestion that there may be an inflammatory process in the abdomen. We also agree with Respondent that it was not necessary to follow the radiologist's recommendation (although a note to that effect should have been present in the medical records).

The Hearing Committee does not sustain the charge of gross negligence or negligence in the care and treatment Respondent provided to Patient B.

The Hearing Committee does not find that Respondent's actions as to Patient B indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence.

The Hearing Committee does not sustain the charge of unwarranted treatment. Respondent is not guilty, as to Patient B, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient B's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

Patient C

Respondent subjected Patient C to unnecessary surgery. Respondent performed a transverse loop colostomy, under general anesthesia on this comatose, post cardiopulmonary arrest, very poor risk patient, with anoxic encephalopathy, despite no clinical evidence of mechanical obstruction. Respondent performed surgery on this patient without an attempt at viable, less

invasive measures and under clinical circumstances which had no urgency.

Respondent's poor judgment in the care and treatment he provided to Patient C was severe negligence but did not rise to the level of egregious or conspicuously bad conduct. We do not sustain the charge of gross negligence charge. Respondent also failed to supervise the surgical resident caring for Patient C both preoperatively and postoperatively. We do sustain the charge of practicing the profession with negligence as to Patient C.

Patient C was subjected to a surgery which was not justified by Respondent or indicated by her medical condition. Respondent is guilty of committing professional misconduct within the meaning of Education Law §6530(35).

Patient C's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient C indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedure. No issue was raised with the manner in which the surgery was performed.

Although we found that the operative note dictated by Respondent contained statements not corroborated by other parts of the patient's medical records, we do not sustain the charge of fraudulent practice because we conclude that the Department did not prove by a preponderance of the evidence that Respondent intentionally misrepresented the inaccurate information. We are not convinced that Respondent intended to mislead but rather that he is a very poor medical record scrivener.

Patient D

Respondent's conduct in this case evidences a wanton disregard of the minimum standards of care. Respondent subjected Patient D to an unnecessary, major surgical procedure, without appropriately waiting for confirmation of the presence of cancer by pathological review of the two biopsies taken. There is nothing in the patient's clinical record which provides any reasonable basis not to have waited for the results. The happenstance that Respondent was correct is hindsight and does not justify his actions. The rationale for taking a biopsy is that the physician believes there may be something abnormal. For Respondent to not wait for the results of the biopsies, in a non urgent situation, is a gross deviation from the minimally acceptable standard of care.

Unlike most of the other medical records, this patient's medical records contain some countersignatures of the residents' notes. However Respondent was still grossly deficient in his notes. To the extent that the countersignatures are in the medical records, it tends to suggest that Respondent was aware of resident activity.

Respondent exhibited very poor judgment in the care and treatment he provided to Patient D. The Hearing Committee concludes that it was egregious and sustains the gross negligence charge. Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient D is sustained as well.

Patient D was subjected to a surgery at a particular point and time which was premature and not justified by Respondent. Respondent is guilty, as to Patient D, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient D's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which

accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient D indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedures. No issue was raised with the manner in which the surgery was performed.

Although we found that the operative note dictated by Respondent contained statements not corroborated by other parts of the patient's medical records, we do not sustain the charge of fraudulent practice because the Department did not prove by a preponderance of the evidence that Respondent intentionally misrepresented the inaccurate information. We are not convinced that Respondent intended to mislead but rather that he is a very poor medical record scrivener.

Patient E

Respondent subjected this elderly, frail patient to three large operations, with the risks of anesthesia (with a potential for further damages to her liver) within the span of just three weeks. Respondent did not give this ill, 81 year old cancer patient with severely deranged liver function, any chance to heal and continued to operate despite severely compromised wound healing, leakage and infection.

The mastectomy was indicated but was not urgent. The cholecystectomy was indicated but not necessarily at this particular hospital admission and definitely not one week after the mastectomy. Considering the patient's clinical condition on admission, the delay of all the elective surgeries would have been a more prudent course of action.

Respondent exhibited repetitively poor judgment in the care and treatment he provided to Patient E. The Hearing Committee concludes that the multiple acts of negligence committed by

Respondent in the care and treatment of Patient E cumulatively amount to egregious conduct. Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient E is sustained as well.

Patient E was subjected to a surgery (ventral hernia repair) which was not justified by Respondent or indicated by her medical condition. Respondent is guilty, as to Patient E, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient E's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient E indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedures. No issue was raised with the manner in which the surgery was performed.

Patient F

Respondent rushed this patient to surgery without adequate indication or justification. Respondent failed to consider other causes for the patient's symptoms and complaints. Respondent failed to recognize that Patient F had chronic urinary tract infection ("**UTI**") which was a contraindication to surgical intervention for appendicitis. Although there is validity to clinical acumen or clinical diagnosis, a physician who decides not to perform additional tests and to rush the patient to surgery must explain in the medical records his justification or reasoning. There is no reliable evidence that Patient F had an acute abdomen. Respondent's failure to review the urinalysis

results and failure to order other diagnostic tests prior to performing surgery was a gross deviation and egregious conduct. Proceeding to do an appendicitis in a 90 year old woman with evidence of significant UTI and performing the procedure without adequate indication or medical justification also constitutes gross negligence by Respondent in the care and treatment he provided to Patient F.

Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient F is sustained as well.

Patient F was subjected to a surgery (removal of her appendix) which was not justified by Respondent or indicated by her medical condition. Respondent is guilty, as to Patient F, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient F's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient F indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedures. No issue was raised with the manner in which the surgery was performed.

Although we found that the operative note and the discharge summary dictated by Respondent contained statements not corroborated by other parts of the patient's medical records, we do not sustain the charge of fraudulent practice because the Department did not prove by a preponderance of the evidence that Respondent intentionally misrepresented the inaccurate information. We are not convinced that Respondent intended to mislead but rather that he is a very poor medical record scrivener.

Patient G

On January 2, 1999 Patient G had a colonoscopy. The patient was found to have ulcers in the rectal sigmoid area, hemorrhoids and diverticulosis pouches in her large intestine. Respondent had some justification for the performance of an end colostomy on this patient on January 14, 1999.

The Hearing Committee does not sustain the charge of gross negligence or negligence in the care and treatment Respondent provided to Patient G.

The Hearing Committee does not find that Respondent's actions as to Patient G indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence.

The Hearing Committee does not sustain the charge of unwarranted treatment. Respondent is not guilty, as to Patient G, of committing professional misconduct within the meaning of Education Law §6530(35).

Although we found that the operative note dictated by Respondent contained statements not corroborated by other parts of the patient's medical records, we do not sustain the charge of fraudulent practice because the Department did not prove by a preponderance of the evidence that Respondent intentionally misrepresented the inaccurate information. We are not convinced that Respondent intended to mislead but rather that he is a very poor medical record scrivener.

Patient G's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

Patient H

Respondent biopsied the breast bud of a 9 year old. Respondent completely failed to exercise appropriate medical or surgical judgement and, without rationale, justification or indication, brought this patient to the operating room. By performing such a grossly unnecessary procedure on this child, Respondent risked future development of the patient's breast and deformity. We found Dr. Hoffman completely credible in his testimony. Respondent falsified the record in an attempt to justify his actions and to lie about the events surrounding his treatment of Patient H.

Respondent's conduct in the care and treatment he provided to Patient H was perfidious. Respondent's attempts to justify the removal, without further evaluations, of a breast mass on a 9 year old female because of the mother's insistence and pressure is incomprehensible. The Hearing Committee concludes that the care and treatment that Respondent provided to Patient H and the biopsy of Patient H's left breast by Respondent was egregious and we sustain the charge of gross negligence. Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient H is sustained as well.

Patient H was subjected to a surgery at a particular point and time which was completely unnecessary and not justified by Respondent. Respondent is guilty, as to Patient H, of committing professional misconduct within the meaning of Education Law §6530(35).

Regarding Patient H, we do find that Respondent's actions indicated that Respondent lacked the skill or knowledge necessary to practice the profession. Respondent did not even evaluate the patient's breast by means of an ultrasound examination before rocketing her to surgery. Respondent also did not exhibit independent medical judgment which is a necessary skill to practice the profession. We find Respondent guilty of incompetence with regard to Patient H. No issue was raised with the manner in which the surgery was performed and we do not find Respondent guilty of gross incompetence.

Although we found that Respondent changed the operative note and the note therefore contained false statements not corroborated by other parts of the patient's medical records, we do not sustain the charge of fraudulent practice because the Department did not prove by a preponderance of the evidence that Respondent intended to mislead others. Respondent is not guilty of committing professional misconduct by practicing the profession of medicine fraudulently within the meaning of Education Law §6530(2).

Patient H's medical records are incomplete, inaccurate and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

Patient I

The Hearing Committee concludes that there was some indication to do a gastrostomy under some kind of anesthesia. Although we did not sustain the charge that Respondent inappropriately and without justification performed an open surgical procedure under anesthesia, we do believe that Respondent should have tried lesser invasive treatment before proceeding. The open gastrostomy was a non-emergent procedure. On the day of the scheduled gastrostomy, the patient's PCO_2 and other clinical signs were so critical that the procedure should have been cancelled by Respondent. The failure of Respondent to cancel the surgery and/or to fully evaluate the patient before proceeding to surgery subjected this patient to an unjustified and unacceptable risk. Respondent should have been aware of impending dangerous consequences of performing the open gastrostomy given the patient's unstable clinical condition immediately prior to the surgery. Respondent is guilty of egregiously not exercising the care that would be exercised by a reasonably prudent physician under the circumstances.

Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient I is sustained as well.

Patient I's medical records are incomplete and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

The Hearing Committee does not find that Respondent's actions as to Patient I indicated that Respondent lacked the skill or knowledge necessary to practice the profession and does not sustain the charges of gross incompetence or of incompetence. There was insufficient evidence that Respondent lacked the skills necessary to perform the procedures. No issue was raised with the manner in which the surgery was performed.

The Hearing Committee does not sustain the charge of unwarranted treatment because there was some indication for the surgery, but not at the time that Respondent performed it. Respondent is not guilty, as to Patient I, of committing professional misconduct within the meaning of Education Law §6530(35).

Patient J

Respondent became aware that the patient had a cystic mass prior to surgery and proceeded with his plans for a VBG without discussing the cystic mass findings from the sonogram with Patient J. Respondent, intra-operatively, found a "simple cyst" in the patient's epigastric region. Respondent had never seen this type of "simple cyst" before in thirty years of surgery. Respondent did not obtain a frozen section but, instead, did the planned VBG. A reasonably prudent surgeon, following the most minimal standards of practice, would not proceed to or continue to perform an elective procedure without first attempting to diagnose an unexpected findings.

Respondent ignored a glaring abnormal finding on a preoperative sonogram. Respondent failed to advise the patient and obtain consent. Respondent correctly removed the mass intra-operatively but then failed to obtain a frozen section analysis of a cystic mass in the omentum of a 49 year old woman. Respondent failed to obtain an intra-operative consultation in the face of a finding which he had never seen before. Respondent failed to completely explore the patient's abdomen, especially her ovaries.

Respondent's conduct in this case was blatantly and egregiously negligent. Respondent is guilty of violating Education Law §6530(4). The charge of practicing the profession with negligence as to Patient J is sustained as well.

Patient J was subjected to a surgery at a particular point and time which was completely unnecessary and not justified by Respondent. Respondent is guilty, as to Patient J, of committing professional misconduct within the meaning of Education Law §6530(35).

With regard to Patient J, we do find that Respondent's actions indicated that Respondent lacked the skill or knowledge necessary to practice the profession. Respondent did not properly evaluate the patient's cystic mass by means of a frozen section analysis before blindly persisting towards his planned VBG. Respondent failed to exhibit the medical judgment which is a necessary skill to practice the profession. We find Respondent guilty of incompetence with regard to Patient J. No issue was raised with the manner in which the VBG surgery was performed and we do not find Respondent guilty of gross incompetence.

Patient J's medical records are incomplete, inaccurate and lack important details of patient care. Respondent did not maintain an accurate record which reflected the actual care and treatment the patient received. Respondent is guilty of failing to maintain a record for this patient which accurately reflected the evaluation and treatment of the patient, within the meaning of Education Law §6530(32).

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented during 18 days of Hearing and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

Once the Hearing Committee arrived at the findings of numerous acts of practicing the profession with gross negligence, of practicing the profession with negligence on numerous occasions, of practicing the profession with incompetence on more than one occasion, of practicing the profession by treating the patients with surgery without indication or justification, given the patients' conditions, and of practicing the profession with a total lack of medical record keeping, we voted unanimously for the Revocation of Respondent's license as the only appropriate penalty.

Given the serious nature of the professional misconduct committed by Respondent, censure and reprimand and performing community service is inadequate. Respondent was not found guilty of fraud and there was no evidence presented that the acts committed by Respondent were for mere pecuniary benefits and therefore we determined that a monetary fine was not appropriate. The nature and the severity of the misconduct were of such magnitude and occurrences that a suspension of Respondent's license would not serve to protect the public. The potential to return Respondent to active practice of medicine by retraining or rehabilitation of Respondent is unrealistic. Respondent

took a medical records keeping course and has shown a total failure to learn from that training. Even though Respondent was under investigation, the medical records of Patients I and J (years 2000 and 2001) did not significantly change from the medical records of the other 8 patients (years 1994 through 1999). The Hearing Committee perceived a long history and pattern of misconduct by Respondent. Respondent still does not understand that part of treating a patient involves maintaining an accurate medical record for that patient.

In arriving at an appropriate penalty determination, the Hearing Committee also weighed the testimony provided by Respondent and Respondent's witnesses. For example, it was extremely discerning to hear Respondent's own witnesses indicate that he was not a good listener and that Respondent "... made a joke that from now on I have to document everything because I'm being investigated ...". As to Patient D, Respondent testified that it did not matter what the results of the biopsies were. To not wait for the results of a diagnostic test, ordered by another physician, before proceeding to surgery in a non urgent situation is bad medical practice. If one of the biopsy sites had been malignant, the patient would have been subjected to a second operative procedure.

Respondent failed to demonstrate any sagaciousness of his deficiencies. Respondent's insight is devoid of any admission of misconduct or wrongdoing or even errors with the exception of his acknowledgment of inadequate medical record keeping. The last three cases (Patients H, I and J) indicate a severe, recent and continuing lack of medical judgment by Respondent. Respondent has no insight on even why he lacks the judgment necessary to practice medicine. Respondent's belief that the only problem with his practice of medicine is a matter of documentation, evidences a glaring deficiency in his skill and knowledge to practice medicine. Respondent's lack of insight and understanding of his acts and omissions rules out rehabilitation. We perceived no possibility of rehabilitation or successful retraining.

We found that on one occasion Respondent failed to supervise the surgical resident under his charge and on ten occasions Respondent failed to note his supervision of the residents. The lack of correction of contradictory orders made for the patient by the resident versus Respondent's action is another example of bad practice of medicine by Respondent.

The Hearing Committee entertained the voluminous mitigating circumstances and evidence presented by Respondent, but the offenses themselves were of such magnitude that anything short of revocation was unrealistic. The issue before us was not a question of the surgical skills of the Respondent which were amply expounded on by his colleagues. The issue before us was not a question of Respondent's contribution to NYMH or to the advancement of medicine at NYMH. The issue before us was not a question of Respondent's integrity in dealing with his colleagues or most of his patients. The issue before us was not a question of Respondent being a caring physician. Rather, the issue before us was Respondent's severe lack of judgment in critical aspects of surgery.

Although the above factors were considered as possible mitigation in arriving at an appropriate penalty determination, the aggravating circumstances present in the sustained charges greatly surpass the mitigation presented.

Perhaps one of the most troubling evidence adduced was Respondent's significant disregard for completely assessing a patient prior to operative interventions. Respondent exhibited unsatisfactory fundamental knowledge in the necessary minimum standard of practice. Respondent demonstrated a pattern of practice of proceeding too quickly to surgery without first assuring that the patient had been optimally and adequately stabilized and without adequate and appropriate preoperative evaluation and staging. Respondent also failed to utilize available and proper diagnostic tools. Respondent exhibited a pattern of operating without any documentation of the indications and rationale for the surgery. Respondent repeatedly under-utilized non-operative

modalities, often in elderly, frail, high risk patients, and subjected his patients to unjustified medical procedures.

The Hearing Committee concludes and determines that Respondent's acts of gross negligence as to Patients A, D and E standing alone provide sufficient grounds to revoke Respondent's license. We also conclude and determine that Respondent's acts of gross negligence as to Patients F and H standing alone provide sufficient grounds to revoke Respondent's license. We further conclude and determine that Respondent's acts of gross negligence as to Patients I and J standing alone provide sufficient grounds to revoke Respondent's license.

The Hearing Committee concludes and determines that Respondent's numerous acts of negligence standing alone provide sufficient grounds to revoke Respondent's license.

To practice medicine, a physician must possess integrity as much as he must possess knowledge or skill. A physician must deal honestly with his patients, their families, with other physicians, with the facilities at which he practices, and with regulators Respondent's intentional misrepresentations, in the operative report and to the Hearing Committee, as to the size of the patient's mass is a character flaw which cannot be corrected by a course of education or training or probation.

The Hearing Committee was also very concerned about the total lack of appropriate or even minimal documentation by Respondent in the patients' medical records. Respondent made repeated statements that he realizes his lack of documentation has been an error, however it is clear to the Hearing Committee that Respondent totally disregards the importance of documentation in relationship to quality patient care.

Respondent's records deviated significantly from accepted medical standards both because of their deficiencies and their lack of accurate information. Respondent's incomplete records and incompetence taken together would also result in a finding by the Hearing Committee that the only appropriate sanction is revocation.

A physician will be given wide berth within the area of what is considered exercise of judgment. However, there are minimal standards of care that must be applied in exercising that judgment. Of great consideration to a physician exercising reasonable medical/surgical judgment is whether a given surgical procedure poses such a significant risk of morbidity or mortality to the patient as to make it improper to perform. A physician's decision or act which is without proper medical foundation nor the product of careful examination, or which deviates from acceptable medical standards or knowledge, is more than a mere error in medical judgment. Respondent failed, in each of the cases sustained, to exercise reasonable, prudent medical and surgical judgment based on principles of minimally accepted standards of care.

Respondent is a unacceptable danger to the People of the State of New York.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction imposed strikes the appropriate balance between the need to punish Respondent, deter future misconduct, and protect the public.

The Hearing Committee considers Respondent's misconduct to be very serious. No other available sanction is deemed sufficient to address Respondent's gross negligence, negligence on numerous occasions, incompetence on more than one occasion, providing unnecessary treatment, and lack of medical record keeping.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, by the Chair, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding and are unanimous in their Determination.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The FIRST and FORTY-FOURTH Specifications (NEGLIGENCE ON MORE THAN ONE OCCASION) of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **SUSTAINED,** and;

2. The SECOND and FORTY-FIFTH Specifications (INCOMPETENCE ON MORE THAN ONE OCCASION) of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **SUSTAINED,** and;

3. The THIRD, SIXTH, SEVENTH, EIGHTH, TENTH, FORTIETH and FORTY-FIRST Specifications (GROSS NEGLIGENCE) of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **SUSTAINED,** and;

4. The TWENTY-FOURTH, TWENTY-SIXTH through TWENTY-NINTH, THIRTY-FIRST and FORTY-SEVENTH Specifications (UNWARRANTED TREATMENT) of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **SUSTAINED,** and;

5. The THIRTY-SECOND through THIRTY-NINTH, FORTY-EIGHTH and FORTY-NINTH Specifications (FAILURE TO MAINTAIN RECORDS) of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **SUSTAINED,** and;

6. The NINETEENTH through TWENTY-THIRD Specifications (FRAUDULENT PRACTICE) of professional misconduct from the Amended Statement of Charges (Department's Exhibits # 1-A) are **NOT SUSTAINED,** and;

7. All other Specifications of professional misconduct from the Amended Statement of Charges and the Supplemental Statement of Charges (Department's Exhibits # 1-A and 15) are **NOT SUSTAINED,** and;

8. Respondent's license to practice medicine in the State of New York is hereby **REVOKED**; and

9. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: New York, New York
August 27, 2001

STEPHEN W. HORNYAK, M.D. (Chair)
JOEL H. PAULL, DDS, M.D.
REVEREND EDWARD J. HAYES

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APPENDIX 1

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

IN THE MATTER

OF

MOHAMMAD OLOUMI-YAZDY, M.D.

HEARING COMMITTEE'S DETERMINATION ON THE CONTINUATION OF THE SUMMARY ORDER PURSUANT TO PUBLIC HEALTH LAW §230(12)(a)

STEPHEN W. HORNYAK, M.D. (Chair), **JOEL H. PAULL, DDS, M.D.** and **REVEREND EDWARD J. HAYES**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) and §230(12) of the Public Health Law ("**P.H.L.**").

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health ("**Department**") appeared by **CLAUDIA MORALES BLOCH, ESQ.**, Assistant Counsel.

MOHAMMAD OLOUMI-YAZDY, M.D., ("**Respondent**") appeared personally and was represented by **HISCOCK & BARCLAY, LLP**, by **ROBERT A. BARRER, ESQ.** and **DAVID P. GLASEL, ESQ.**, of Counsel.

Respondent was served with a Notice of Hearing; Statement of Charges, dated September 25, 2000; and Amended Statement of Charges, dated November 3, 2000. The first day of the Hearing was held on November 14, 2000.

While the Hearing was progressing, the Commissioner of the New York State Department of Health ("**Commissioner**") caused a Summary Order, Notice of Hearing and Supplemental Statement of Charges to be served on Respondent. The effective date of the service of the summary order for the 90 day statutory (P.H.L. §230[12]) time purposes was set at May 4, 2001. The first day of the Summary Hearing was held on May 11, 2000. In total, Hearings were held on November 14, December 04, December 05, December 18 and December 19, 2000; January 22, January 23, February 26, February 27, March 12, April 2, April 3, April 30, May 1, May 11, June 1, June 25, and June 26, 2001. Evidence was received and examined. Transcripts of the proceeding were made. The Hearing Committee, after hearing the testimony to date and reviewing the evidence submitted including the transcripts of the Hearings held previously, issues this Hearing Committee's Determination on the Continuation of the Summary Order Pursuant to Public Health Law §230(12)(a).

MOHAMMAD OLOUMI-YAZDY, M.D., ("**Respondent**") is presently charged with a total of 49 specifications of professional misconduct within the meaning of §§6530 (2), (3), (4), (5), (6), (32) and (35) of the Education Law of the State of New York ("**Education Law**"). A copy of the Commissioner's Order and the Supplemental Statement of Charges is attached to this Hearing Committee's Determination as Appendix I.

In accordance with P.H.L. §230(12)(a), this Hearing Committee is charged with the duty of determining:

> ... [I]f, at the conclusion of the hearing, (i) the hearing committee of the board finds the licensee guilty of one or more of the charges which are the basis for the summary order, (ii) the hearing committee determines that the summary order continue, and (iii) the ninety day term of the order has not expired, the summary order shall remain in full force and effect until a final decision has been rendered by the committee or, if review is sought, by the administrative review board.

The ninety day term of the Commissioner's Order is in effect until August 1, 2001 and therefore has not expired.

Based on the evidence presented in this proceeding, it is the opinion of this Hearing Committee that Respondent is guilty of at least one of the factual allegations and at least one of the specification of misconduct.

At this time, the Hearing Committee determines that the Department has proven, by a preponderance of the evidence, that factual allegations: A(5); I(8); J(1); J(4); J(5) and J(6) are true. The Hearing Committee determines that the care and treatment provided to Patients A, I and J by Respondent constituted Gross Negligence. Respondent is guilty of committing professional misconduct as defined in Education Law §6530[4]). The Hearing Committee will articulate its reasoning and fully address all of the allegations and specifications of professional misconduct when we issue our full Determination and Order within 60 days of the date of this preliminary Determination.

Based on all of the evidence presented to us we unanimously determine that the Summary Order shall remain in full force and effect until a final decision has been rendered by this Hearing Committee.

By execution of this document by the Chair, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding and are unanimous in their Determination.

DATED: New York, New York
Tuesday, July 24, 2001

STEPHEN W. HORNYAK, M.D. (Chair)
JOEL H. PAULL, DDS, M.D.
REVEREND EDWARD J. HAYES

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APPENDIX I

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.

Department 15 In Evid
5-10-01

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~~ A HOSPITAL 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.

6/1/01
MPZ

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.

6/01/01

9. Failed to maintain AN OFFICE ~~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 ' , 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:

~~DEFENDANTS~~ DEPTS 1-A
EXHIBIT NO.
FOR IDENTIFICATION
12/4/00 RPTR. M
DATE:

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 MFZ

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: 2/4/00 MPD

   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. 12/4/00 MPD

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,

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).

THIRD THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

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

ELEVENTH THROUGH EIGHTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

11. The facts in paragraphs A, A(1)(a) - A(1)(c) and A(2) - A(6).
12. The facts in paragraphs B, B(1), B(2)(a), B(2)(b) and B(3) - B(5).
13. The facts in paragraphs C and C(1) - C(5).
14. The facts in paragraphs D and D(1) - D(6).

15. The facts in paragraphs E and E(1) - E(7).

16. The facts in paragraphs F and F(1) - F(9).

17. The facts in paragraphs G and G(1) - G(7).

18. The facts in paragraphs H, H(1)(a) - H(1)(d) and H(2) - H(6).

NINETEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

19. The facts in paragraphs C and C(4).

20. The facts in paragraphs D and D(5).

21. The facts in paragraphs F and F(9).

22. The facts in paragraphs G, G(3) and G(7).

23. The facts in paragraphs H and H(6).

TWENTY-FOURTH THROUGH THIRTY-FIRST SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) 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:

24. The facts in paragraphs A and A(2).

25. The facts in paragraphs B and B(3).

26. The facts in paragraphs C and C(2).

27. The facts in paragraphs D, D(2) and D(3).

28. The facts in paragraphs E and E(2).

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. Klar

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct