STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

March 24, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Samir Mostafa, M.D.
REDACTED

Raymond W. Belair, Esq.
Belair & Evans
61 Broadway
New York, New York 10006

Kevin C. Roe, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237-0026

RE: In the Matter of Samir Mostafa, M.D.

Dear Dr. Mostafa, Mr. Belair and Mr. Roe:

Enclosed please find the Determination and Order (No. 93-45) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0030

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

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

Very truly yours,

REDACTED
Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
SAMIR MOSTAFA, M.D.	:	ORDER

ORDER NO. BPMC-93-45

AARON B. STEVENS, M.D., Chairman, **ALBERT L. BARTOLETTI, M.D.**, and **MR. SUMNER SHAPIRO**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.**, Administrative Law Judge, served as Administrative Officer for all hearings except that **JONATHAN M. BRANDES, ESQ.**, Administrative Law Judge, served as the Administrative Officer at the December 14, 1992 hearing.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing and Statement of Charges:	May 27, 1992
Amended Statement of Charges:	August 10, 1992
Second Amended Statement of Charges:	September 17, 1992
Pre-Hearing Conference:	August 3, 1992
Hearing Dates:	August 17, 1992 August 18, 1992

	September 16, 1992 September 17, 1992 October 2, 1992 October 26, 1992 December 14, 1992
Place of Hearing:	NYS Department of Health Albany, New York
Date of Deliberations:	February 5, 1993 March 12, 1993
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Kevin C. Roe, Esq. Associate Counsel
Respondent appeared by:	Belair & Evans, Esqs. 61 Broadway New York, NY 10006 Raymond W. Belair, Esq. of Counsel

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with practicing the profession with gross incompetence; gross negligence; incompetence on more than one occasion, and negligence on more than one occasion.

The Charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

WITNESSES

For the Petitioner

Corazon Carr, M.D.

Lauren Anderson, R.N.

Delf King, M.D.

Ronald Andree, M.D.

Victoria Goedel, R.N.

Pamela J. Zeltner, R.N.

For the Respondent

Patrick Germain, M.D.

Samir Mostafa, M.D., the Respondent

Philip Lumb, M.D.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDING

The Respondent is a physician duly licensed to practice medicine in the State of New York under license number 160951 issued by the State Education Department.

The Respondent is not currently registered to practice medicine in New York State. He was last registered to practice medicine in New York State for the period January 1, 1989 through December 31, 1991, from 28 Suncrest Terrace, Oneonta, New York 13820 (Pet's. Ex. 1B).

The Respondent currently practices family medicine at 113 14th Street, Hoboken, New Jersey (Tr. 995-996).

FINDINGS AS TO PATIENT A

1. On October 20, 1988, Patient A was admitted to the A.O. Fox Memorial Hospital, One Norton Avenue, Oneonta, New York (Fox Hospital) for a left total knee replacement (Pet's. Ex. 2, pg 1).

2. The operation was scheduled to begin at 7:40 am on October 21, 1988 and the Respondent was the anesthesiologist (Pet's. Ex. 2, pg. 20).

3. At approximately 8:15 am, Patient A developed bradycardia with pulse rate dropping from 75 beats per minute to 30 to 37 beats per minute (Pet's. Ex 2, pg. 20).

4. Bradycardia of 30 to 37 beats per minute was a significant event during anesthesia requiring treatment (Tr. 433).

5. The Respondent did not make a contemporaneous notation of the bradycardia at or about 8:15 am. At approximately 2:55 pm on October 21, 1988, the Respondent made an addendum to the anesthesia record which indicated that Patient A's pulse decreased to 30 to 37 beats per minute at around 8:15 am (Pet's. Ex. 2, pg. 20).

6. A contemporaneous notation of the patient's bradycardia should have been made (Tr. 433).

7. The Respondent administered 1.2. mg of atropine in

three discreet doses of 0.4 mg each at 40 to 50 seconds to correct the bradycardia (Tr. 751, 1166).

8. The total dosage of atropine, 1.2 mg, used by the Respondent to correct Patient A's bradycardia was an appropriate dose given the fact that the patient weighed 100 kilograms (Pet's. Ex. 2, pg. 20; Tr. 457-458, 480, 779-780).

9. In the Post Anesthesia Care Unit (PACU), the Respondent ordered the administration of physostigmine. One milligram doses of physostigmine were administered at approximately 9:30 am, 10:25 am and 11:20 am (Pet's. Ex. 2, pgs. 16-19).

10. While the need for the use of physostigmine in this case is questionable, the dosages used conform with accepted medical practice (Tr. 459-465, 782).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to make a contemporaneous notation of bradycardia at approximately 8:15 am on October 21, 1988.

The Hearing Committee rejects the Respondent's argument that the presence of bradycardia could be easily inferred from the contemporaneous recording of other events in the anesthesiology record.

2. The amounts of atropine used by the Respondent to treat Patient A's bradycardia were not excessive.

3. The amounts of physostigmine used by the Respondent

in this case were not excessive.

FINDINGS AS TO PATIENT B

1. On November 8, 1988, Patient B, an 86 year old female, was admitted to Fox Hospital for bilateral total knee replacements (Pet's. Ex. 3, pg. 1).

2. A medical evaluation done prior to the contemplated surgery by Dr. Xanthaky yielded diagnoses of (1) arteriosclerotic heart disease with early concentric left ventricular hypertrophy, subcritical aortic stenosis and decreased ejection fraction; (2) chronic anemia and leukopenia, etiology undetermined; (3) noninsulin dependent diabetes mellitus; (4) peripheral neuropathy; (5) azotemia probably secondary to diabetic nephrosclerosis; (6) peripheral vascular disease; (7) gout; (8) probable chronic obstructive and restricted pulmonary disease with old healed TB; (9) chronic bronchitis; (10) end stage osteoarthritis of the knee; (11) arterial oxygen desaturation (Pet's. Ex. 3, pg. 43).

3. The Respondent provided anesthesia to Patient B at Fox Hospital on November 9, 1988 beginning at 8:50 am for a right knee replacement (Pet's. Ex. 3, pg. 47).

4. At 10:15 am, Patient B was transferred from the operating room to the PACU. Patient B's vital signs were first recorded in the PACU at 10:20 am (Pet's. Ex. 2, pg. 49).

5. Blood pressure and pulse were recorded in the PACU as follows:

TIME	BLOOD PRESSURE	PULSE
10:20 a.m.	258/135	135
10:25 a.m.	269/120	120
10:30 a.m.	262/110	125
10:35 a.m.	266/110	135
10:40 a.m.	238/90	120
10:45 a.m.	200/85	135
10:50 a.m.	245/95	135
10:55 a.m.	230/75	135
11:00 a.m.	220/95	120
11:05 a.m.	210/75	130
11:10 a.m.	210/90	135
11:15 a.m.	200/70	115
11:20 a.m.	195/65	105
11:25 a.m.	195/65	105
11:30 a.m.	180/60	105
11:40 a.m.	190/80	110
11:50 a.m.	160/60	100
12:00	165/60	100

(Pet's. Ex. 3, pg. 49).

6. Patient B was medicated in the PACU for the treatment of hypertension and tachycardia as follows:

TIME	MEDICATION	DOSE	ROUTE
10:24	Morphine	5 mg.	IVP
10:27	Morphine	5 mg.	IVP
10:30	Procardia	10 mg.	sublingual
10:32	Morphine	5 mg.	IVP
10:40	Apressoline	5 mg.	IVP
10:40	Morphine	5 mg.	IVP
11:05	Cephadyl	500 mg.	IVPB

(Pet's. Ex. 3, pg. 49).

7. It was not necessary for the Respondent to monitor Patient B's arterial blood gases during this procedure (Tr. 821-824).

CONCLUSIONS AS TO PATIENT B

1. It was not necessary for the Respondent to monitor Patient B's arterial blood gases during the procedure.

2. The Respondent's treatment of Patient B's hypertension and tachycardia in the recovery room was adequate and appropriate.

FINDINGS AS TO PATIENT C

1. On December 1, 1988, the Respondent provided anesthesia to Patient C at the Fox Hospital in anticipation of a diagnostic laparoscopy (Pet's. Ex. 4).

2. At approximately 2:25 p.m. the Respondent initiated anesthesia by administering sublimase 50 mcg., sodium pentothal 300 mg., and succinylcholine 100 mg. Patient C developed a rash on her face and upper chest (Pet's. Ex. 4, pgs. 2, 4; Tr. 563).

3. Patient C became cyanotic. Attempts to provide positive pressure ventilation with the mask and bag were markedly difficult (Pet's. Ex. 4, pgs. 2, 4; Tr. 565).

4. The Respondent unsuccessfully attempted intubation under direct laryngoscope with a #7.5 endotracheal tube. A stylet was placed and the endotracheal tube inserted in the trachea. Patient C remained cyanotic (Pet's. Ex. 4, pg. 4, Tr. 564).

5. After intubation and prior to summoning assistance,

the Respondent's attempts at positive pressure ventilation were met with great resistance. Breath sounds could not be heard in the chest or stomach. Patient C remained cyanotic (Pet's. Ex. 4, pg. 2; Tr. 565).

6. Approximately two to three minutes after Patient C was intubated, Corazon Carr, M.D., was summoned to provide assistance (Tr. 566).

7. When Dr. Carr arrived, she observed a rash on the patient's abdomen and lower chest, and cyanosis of the upper chest, neck, lips and face. The pulse oximeter showed oxygen saturation of 20, indicating hypoxia. She observed no chest movements (Tr. 19-21).

8. Dr. Carr auscultated Patient C and did not hear any sounds indicating movement of air in either the chest or abdomen (Tr. 20-21, 66).

9. When Dr. Carr arrived, the vaporizer was set to provide an anesthetic gas in addition to oxygen. Dr. Carr turned off the vaporizer so that the anesthesia machine would provide 100% oxygen (Tr. 20, 31-32).

10. Dr. Carr informed the Respondent that she heard no breath sounds and suggested that the patient be extubated and reintubated with a fresh tube. The Respondent indicated that the patient was correctly intubated and that he would demonstrate such with a direct laryngoscopy. The Respondent conducted a direct laryngoscopy and then attempted to ventilate Patient C by squeezing the anesthesia

bag, meeting with great resistance. Dr. Carr informed the Respondent that she still did not see any chest movement and again suggested extubation and reintubation with a fresh tube. The Respondent extubated Patient C. Dr. Carr attempted reintubation without success. An oral airway was placed (Tr. 20-22, 53, 75).

11. Sometime during the above-described activity, the circulating nurse attempted to provide positive pressure ventilation by mask and bag. The bag was hard and totally resistant (Tr. 567, 599).

12. Dr. Carr attempted positive pressure ventilation with the mask and bag, meeting with a great degree of resistance. The degree of resistance found by Dr. Carr indicated that there was something wrong with the machine. She immediately checked the anesthesia machine, and found that the valve on the anesthesia machine was turned towards the ventilator and not towards the bag. Dr. Carr informed the Respondent of the problem and moved the switch to the bag position. Pressure in the bag was released, Dr. Carr squeezed the bag a few times, oxygen was delivered to the patient and the pulse oximeter readings went from the twenties to the seventies (Tr. 22-23, 63, 568).

13. After Dr. Carr arrived and prior to the change in the position of the ventilator switch, there were no respirations or chest movements (Tr. 23, 569).

14. Approximately two to three minutes went by from

the time Dr. Carr arrived until the position of the anesthesia machine switch was changed and the patient was ventilated (Tr. 569).

15. The anesthesia record made by the Respondent indicated that respirations were decreased for a period of time somewhat over five minutes (Pet's. Ex. 4, pg. 4).

16. No residual signs or symptoms of an alleged bronchospasm were observed or documented (Pet's. Ex. pgs. 4-6, 8; Tr. 77, 599).

CONCLUSIONS AS TO PATIENT C

1. There is insufficient evidence in the record to determine whether the anesthesia machine was turned toward the anesthesia bag and not toward the ventilator prior to intubating and ventilating the patient.

2. The Respondent failed to recognize that the ventilator switch was in the wrong position in a timely manner.

3. The Respondent failed to turn off all gases other than oxygen when the patient became cyanotic.

FINDINGS AS TO PATIENT D

1. On September 25, 1989, Patient D was admitted to Fox Hospital for repair of a ruptured right achilles tendon. The Respondent provided anesthesia to Patient D on this date (Pet's. Ex. 5, pgs 1, 2, 8).

2. After surgery, Patient D was transferred from the

operating table to a stretcher. After approximately five minutes of monitoring, the Respondent extubated Patient D (Pet's. Ex. 5, pg. 12; Tr. 91-92).

3. When extubated, Patient D developed laryngospasm and did not breath spontaneously. Attempts at stimulation were unsuccessful and Patient D did not respond to verbal commands. An oral airway was placed (Pet's. Ex. 5, pg 12; Tr. 92-93).

4. Patient D became cyanotic. The pulse oximeter was reapplied and yielded readings in the forties. The Respondent unsuccessfully attempted to provide positive pressure ventilation. No respirations were noted. Patient D began thrashing his upper extremities in non-purposeful movement. His teeth were clenched (Pet's. Ex. 5, pg. 12; 93-94, 159).

5. The Respondent attempted to reintubate with a #8 endotracheal tube and a stylet. Patient D's teeth were clenched around the oral airway. After the tube was inserted gurgling sounds were heard from the abdomen and the tube was removed. The heart rate, which had been in the hundreds, (102-110), was now down to the fifties, (54-60). The pulse oximeter read in the teens, (15 or so) (Pet's. Ex. 5, pg. 12; Tr. 94, 96, 159).

6. After the laryngospasm began and prior to the attempted reintubation, no medication was administered to Patient D (Pet's. Ex. 5, pgs. 8, 12; Tr. 103, 160-161).

7. Positive pressure ventilation was again attempted unsuccessfully. Patient D's heart rate remained in the fifties or lower and oxygen saturation was in the teens (Pet's. Ex. 5, pg. 12; Tr. 159-160).

8. The circulating nurse, Lauren Anderson, R.N., informed the Respondent that assistance was needed and he agreed. She exited the room, leaving the Respondent alone with the patient. At the time, the pulse oximeter was on and showed an oxygen saturation of approximately 15. Patient D was not thrashing (Tr. 94, 149, 163-164).

9. Approximately three to four minutes had lapsed from the time Patient D was extubated until Nurse Anderson left the room to summon assistance (Tr. 105, 145).

10. Victoria Goedell, R.N., was preparing another operating room for surgery. She heard Nurse Anderson in the hallway requesting assistance. When Nurse Goedell entered the room, Patient D was dusky, he was not breathing, and there were no chest movements. The Respondent was suctioning the patient. The pulse oximeter was not attached to the patient. Nurse Goedell did not observe whether the pulse oximeter machine itself was on or off. There was no alarm sounding from the pulse oximeter machine. (An alarm will sound if the probe is not attached and the machine is on.) Nurse Goedell asked the Respondent if he wanted the pulse oximeter back on the patient and he replied in the negative. Nurse Anderson and Dr. King entered the room

shortly thereafter (Tr. 138, 497-499, 543).

11. Delf O. King, M.D., was in the anesthesia office and heard Nurse Anderson's request for assistance. Dr. King and Nurse Anderson entered the room simultaneously approximately 30 seconds after Nurse Anderson had left. The Respondent was attempting to provide positive pressure ventilation. Patient D was very cyanotic, he was not breathing and was flaccid. There were no chest movements. Nurse Anderson observed the patient to be slightly less cyanotic than when she left. Patient D's heart rate was in the fifties (Pet's. Ex. 5, pgs. 12-13; Tr. 96-98, 129, 167, 184).

12. When Nurse Anderson and Dr. King entered the room, the pulse oximeter probe was not attached to the patient and the machine was off. The probe was by the machine. Dr. King applied the probe and turned the machine on (Pet's. Ex. 5, pg. 13; Tr. 98-99, 123, 137, 139, 161, 163-164, 186, 499).

13. The Respondent and Dr. King discussed the situation. The Respondent was alternatively suctioning and attempting to ventilate the patient with the mask (Pet's. Ex. 5, pgs, 12-13; Tr. 99, 101, 499).

14. Dr. King prepared a syringe with 0.4 mg. of Robinol and informed the Respondent that he was going to administer it. He showed Respondent the vial and syringe and then administered the medication to the patient (Pet's.

Ex. 5, pgs. 12-13; Tr. 99, 186, 499).

15. Dr. King then prepared a syringe with 40 mg. of Anectine, showed Respondent the vial and syringe and informed him of the need to administer the drug. The Respondent discontinued his attempts to provide positive pressure ventilation to the patient, took the syringe from Dr. King and expelled the medication from the syringe into the air. The Respondent then redrew 40 mg. of Anectine from the same vial that Dr. King had used and administered the medication to the patient (Pet's. Ex. 5, pg. 13; Tr. 99, 101, 186-187, 500, 541-543).

16. Prior to the administration of Anectine, Patient D remained cyanotic without chest movements. His condition had not improved from the time Nurse Goedell, Nurse Anderson, and Dr. King entered the room. When the Anectine was administered, the patient relaxed, the laryngospasm was broken and with positive pressure ventilation his heart rate improved serially from the fifties to the 110's, oxygen saturation improved from the fifties to 96 and carbon dioxide decreased from 70.1 to 64 over a two minute period. Patient D's color improved from deep cyanosis to pink. (Pet's. Ex. 5, pgs. 12-13; Tr. 101, 187, 501, 543, 552-54).

17. A pulse oximeter measures oxygen saturation in a patient's blood. This information is critical to the proper care and treatment of a patient during anesthesia and especially during a laryngospasm and hypoxic episode such

as that suffered by Patient D (Tr. 192-193, 272-273).

18. The proper course of treatment of laryngospasm is to attempt positive pressure ventilation. If this is not successful, medication should be administered to relax the patient, and intubation or reintubation should be considered (Tr. 191, 262-263, 952, 968).

19. The Respondent's anesthesia record does not adequately describe the length and severity of the hypoxic episode. He made no progress note regarding the incident. The attending surgeon was not informed of the events until 1:00 p.m. on September 26, 1989, when he was made aware of the post-operative problems by his surgical technician (Pet's. Ex. 5, pgs. 4, 8).

CONCLUSIONS AS TO PATIENT D

1. The Respondent failed to administer appropriate medications prior to attempting reintubation.

2. The Respondent refused to accept a syringe prepared with the appropriate dose of Anectine from a colleague.

3. The Respondent inappropriately discontinued use of the pulse oximeter.

4. The Respondent failed to notify the attending surgeon of the hypoxic episode and sequelae.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

FIRST TO FOURTH SPECIFICATIONS
(Gross Incompetence)

NOT SUSTAINED as to any of the charges specified in the Statement of Charges

FIFTH THROUGH EIGHTH SPECIFICATION
(Gross Negligence)

SUSTAINED as to the charges specified in paragraphs C and C2, D and D1

NOT SUSTAINED as to the charges specified in paragraphs A and A1, A2, A3, B and B1, B2, C and C1, C3, D and D2, D3, D4

NINTH SPECIFICATION
(Incompetence on more than one occasion)

NOT SUSTAINED as to any of the Charges specified in the Statement of Charges

TENTH SPECIFICATION
(Negligence on more than one occasion)

SUSTAINED as to the Charges specified in paragraphs A and A1, C and C2, D and D1, D3, D4 of the Statement of Charges

NOT SUSTAINED as to the charges specified in paragraphs A and A2, A3, A4, B and B1, B2, C and C1, D and D2.

DETERMINATION

The Hearing Committee has voted unanimously (3-0) that five of the charges against the Respondent alleging **NEGLIGENCE** are **SUSTAINED**, to wit: the Charges specified in paragraphs A and A1, C and C2, D and D1, D2, D3, of the Statement of Charges.

The Hearing Committee has determined that the violations by the Respondent, as specified in paragraphs C

and C2 and D and D1, are so egregious that they constitute **GROSS NEGLIGENCE** and the Hearing Committee has voted unanimously (3-0) to **SUSTAIN** the Charges of **GROSS NEGLIGENCE** in these two instances.

The Hearing Committee has voted unanimously (3-0) that all of the charges against the Respondent alleging **GROSS INCOMPETENCE** and **INCOMPETENCE ON MORE THAN ONE OCCASION ARE NOT SUSTAINED**.

Throughout the testimony there were repeated references to the severe emotional stress experienced by the Respondent during the time period of the cases involving Patients A, B, C and D, October 21, 1988 - September 25, 1989.

The Respondent's emotional stress continued to show during the hearing process. On several occasions this required short recesses to allow the Respondent to compose himself for further testimony (Tr. 704, 741, 743, 745, 997, 1044, 1046, 1071, 1075, 1105, 1314-1316, 1371 and 1407).

The Committee feels that the degree of emotional distress elicited and exhibited by the Respondent throughout the hearing constitutes a potential hazard both for the patients and the Respondent.

The Respondent stated, "I never practiced anesthesia since I left the hospital...Now I am in a state of mind that I cannot go back to anesthesia, you know. I don't feel that I'll be able to handle it... And now that I am not

practicing anesthesia for almost three years, you know, just reviewing this case is giving me a lot of trouble psychologically, at least." (Tr. 1315-1316).

The Hearing Committee wholeheartedly agrees with the Respondent's decision and fully endorses this statement.

The Hearing Committee has considered the full spectrum of available penalties, including revocation, suspension, probation, censure and reprimand or the imposition of civil penalties not to exceed $10,000 per violation.

The Hearing Committee determines that the Respondent's license to practice medicine in the State of New York should be **SUSPENDED INDEFINITELY** subject to the provisions specified in the **ORDER.**

ORDER

IT IS HEREBY ORDERED THAT:

The Respondent's license to practice medicine in the State of New York is SUSPENDED INDEFINITELY, subject to the following conditions:

1. The Respondent must make a showing of his fitness and competency in medical practice by participating in the Physician Prescribed Educational Program sponsored by the Department of Medical Education, St. Joseph's Hospital Health Center, Syracuse, New York and the Department of Family Medicine, State University of New York, Health Service Center at Syracuse.

2. Upon certification by the Physicians Prescribed Educational Program that the Respondent is fit and competent to practice medicine, the indefinite suspension of the Respondent's license shall be lifted.

3. In addition, should the Respondent reconsider his decision and in the future contemplate a return to the practice of anesthesia in New York State, he shall first enroll in a years fellowship training in a formally recognized anesthesia teaching program. At the conclusion of this refresher year training and before resuming unsupervised practice, the anesthesia teaching program's chief shall certify in writing, his/her specific approval and recommendation of the Respondent's clinical and emotional readiness to resume anesthesia practice.

DATED: Cambridge, New York
March 12, 1993

REDACTED

AARON B. STEVENS, M.D.

ALBERT L. BARTOLETTI, M.D.
MR. SUMNER SHAPIRO

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
SAMIR MOSTAFA, M.D.	:	CHARGES

----------X

SAMIR MOSTAFA, M.D., the Respondent, was authorized to practice medicine in New York State on December 10, 1984, by the issuance of license number 160951 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine. He was last registered to practice medicine for the period January 1, 1989 through December 31, 1991, from 28 Suncrest Terrace, Oneonta, New York 13820.

FACTUAL ALLEGATIONS

A. Respondent provided anesthesia to Patient A (all patients are identified in the attached appendix) on October 21, 1988, at the A.O. Fox Memorial Hospital, One Norton Avenue, Oneonta, New York 13820 (Fox Hospital). During the course of a left total knee replacement, Patient A developed bradycardia approximately 30 minutes after spinal anesthesia was

established. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to use epinephrine together with the tretracaine to establish spinal anesthesia.
2. Respondent failed to make a contemporaneous notation of nausea, vomiting and bradycardia at approximately 8:15 a.m.
3. Respondent failed to inform Post Anesthesia Care Unit personnel of Patient A's bradycardia during anesthesia.
4. Respondent administered excessive amounts of atropine to treat bradycardia.
5. Respondent administered excessive amounts of physostigmine.

B. Respondent provided anesthesia to Patient B at Fox Hospital on November 9, 1988. During the course of a right total knee replacement, Patient B suffered abrupt increases in pulse and blood pressure when inhalation of the anesthetic agent was discontinued at approximately 10:30 a.m. Patient B remained hypertensive for more than an hour in the recovery room. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to monitor oxygen saturation and arterial blood gases during the procedure.
2. Respondent failed to administer adequate doses of intravenous morphine, apresoline and sublingual nifedipine in the operating room or other drugs to contol blood pressure and pulse.
3. Respondent failed to adequately treat Patient B's hypertension and tachycardia in the recovery room.

episode and surgery was cancelled. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to insure that the valve on the anesthesia machine was turned toward the anesthesia bag and not towards the ventilator prior to intubating and ventilating the patient.
2. Respondent failed to recognize that the ventilator switch was in the wrong position in a timely manner.
3. Respondent failed to turn off all gases other than oxygen when the patient became cyanotic.

D. Respondent provided anesthesia to Patient D at the Fox Hospital on September 25, 1989. After surgery for repair of a ruptured Achilles tendon, Patient D developed laryngospasms and ceased breathing when he was extubated. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to administer appropriate medications prior to attempting reintubation.
2. Respondent failed to reintubate Patient D in a timely manner.
3. Respondent refused to accept a syringe of Anecitine from a colleague, prepared with the appropriate dose.
4. Respondent inappropriately discontinued use of the pulse oximeter.
5. Respondent failed to notify the attending surgeon of the hypoxic episode and sequelae.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of N.Y. Educ. Law §6530(6) (McKinney Supp. 1992) in that, Petitioner charges:

1. The facts in paragraphs A and A.1, A.2, A.3, and/or A.4.
2. The facts in paragraphs B and B.1, and/or B.2.
3. The facts in paragraphs C and C.1, C.2, and/or C.3.
4. The facts in paragraphs D and D.1, D.2, D.3, D.4 and/or D.5.

FIFTH THROUGH EIGHTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of N.Y. Educ. Law §6530(4) (McKinney Supp. 1992) in that, Petitioner charges:

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

NINTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law §6530(5) (McKinney Supp. 1992) in that, Petitioner charges that the Respondent committed two or more of the following:

9. The facts in paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2; C and C.1, C.2, C.3; and/or D and D.1, D.2, D.3, D.4, D.5.

TENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) in that, Petitioner charges that the Respondent committed two or more of the following:

10. The facts in paragraphs A and A.1, A.2, A.3, A.4; B and B.1, B.2; C and C.1, C.2, and/or C.3; and/or D and D.1, D.2, D.3, D.4, D.5.

DATED: Albany, New York
August 10, 1992

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

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

Pet EXHIBIT 1A EVD.
DATE 8-17-92
BETSY HELM, CSR., RPR

IN THE MATTER	:	AMENDED
OF	:	STATEMENT
SAMIR MOSTAFA, M.D.	:	OF CHARGES

SAMIR MOSTAFA, M.D., the Respondent, was authorized to practice medicine in New York State on December 10, 1984, by the issuance of license number 160951 by the New York State Education Department. The Respondent is not currently registered with the New York State Education Department to practice medicine. He was last registered to practice medicine for the period January 1, 1989 through December 31, 1991, from 28 Suncrest Terrace, Oneonta, New York 13820.

FACTUAL ALLEGATIONS

A. Respondent provided anesthesia to Patient A (all patients are identified in the attached appendix) on October 21, 1988, at the A.O. Fox Memorial Hospital, One Norton Avenue, Oneonta, New York 13820 (Fox Hospital). During the course of a left total knee replacement, Patient A developed bradycardia approximately 30 minutes after spinal anesthesia was

established. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

X 1. Respondent failed to use epinephrine together with the tretracaine to establish spinal anesthesia.

X 2. Respondent failed to make a contemporaneous notation of ~~nausea, vomiting and~~ bradycardia at approximately 8:15 a.m.

3. Respondent administered excessive amounts of atropine to treat bradycardia.

4. Respondent administered excessive amounts of physostigmine.

B. Respondent provided anesthesia to Patient B at Fox Hospital on November 9, 1988. During the course of a right total knee replacement, Patient B suffered abrupt increases in pulse and blood pressure when inhalation of the anesthetic agent was discontinued at approximately 10:30 a.m. Patient B remained hypertensive for more than an hour in the recovery room. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

X 1. Respondent failed to monitor ~~oxygen saturation and~~ arterial blood gases during the procedure.

2. Respondent failed to adequately treat Patient B's hypertension and tachycardia in the recovery room.

C. Respondent provided anesthesia to Patient C at the Fox Hospital on December 1, 1988. During preparation for a diagnostic laparoscopy, Patient C suffered a prolonged hypoxic

C. Respondent provided anesthesia to Patient C at the Fox Hospital on December 1, 1988. During preparation for a diagnostic laparoscopy, Patient C suffered a prolonged hypoxic episode and surgery was cancelled. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to insure that the valve on the anesthesia machine was turned toward the ventilator and not towards the anesthesia bag prior to intubating and ventilating the patient.
2. Respondent failed to recognize that the ventilator switch was in the wrong position in a timely manner.
3. Respondent failed to turn off all gases other than oxygen when the patient became cyanotic.

D. Respondent provided anesthesia to Patient D at the Fox Hospital on September 25, 1989. After surgery for repair of a ruptured Achilles tendon, Patient D developed laryngospasms and ceased breathing when he was extubated. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care, in that:

1. Respondent failed to administer appropriate medications prior to attempting reintubation.
2. Respondent failed to reintubate Patient D in a timely manner.
3. Respondent refused to accept a syringe of Anecitine from a colleague, prepared with the appropriate dose.

4. Respondent inappropriately discontinued use of the pulse oximeter.

5. Respondent failed to notify the attending surgeon of the hypoxic episode and sequelae.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of N.Y. Educ. Law §6530(6) (McKinney Supp. 1992) in that, Petitioner charges:

1. The facts in paragraphs A and A.1, A.2, A.3, A.4, and/or A.5.
2. The facts in paragraphs B and B.1, B.2 and/or B.3.
3. The facts in paragraphs C and C.1, C.2, and/or C.3.
4. The facts in paragraphs D and D.1, D.2, D.3, D.4 and/or D.5.

FIFTH THROUGH EIGHTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of N.Y. Educ. Law §6530(4) (McKinney Supp. 1992) in that, Petitioner charges:

5. The facts in paragraphs A and A.1, A.2, A.3, A.4, and/or A.5.

6. The facts in paragraphs B and B.1, B.2 and/or B.3.

7. The facts in paragraphs C and C.1, C.2, and/or C.3.

8. The facts in paragraphs D and D.1, D.2, D.3, D.4 and/or D.5.

NINTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law §6530(5) (McKinney Supp. 1992) in that, Petitioner charges that the Respondent committed two or more of the following:

9. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5; B and B.1, B.2, B.3; C and C.1, C.2, C.3; and/or D and D.1, D.2, D.3, D.4, D.5.

TENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) in that, Petitioner charges that the Respondent committed two or more of the following:

10. The facts in paragraphs A and A.1, A.2, A.3, A.4, A.5; B and B.1, B.2, B.3; C and C.1, C.2, and/or C.3; and/or D and D.1, D.2, D.3, D.4, D.5.

DATED: Albany, New York
May 27, 1992

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

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

2nd AMENDED STATEMENT OF CHARGES

IN THE MATTER

OF

SAMIR MOSTAFA, M.D.

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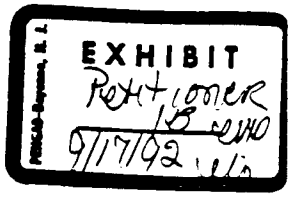

established. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent failed to make a contemporaneous notation of bradycardia at approximately 8:15 a.m.
2. Respondent administered excessive amounts of atropine to treat bradycardia.
3. Respondent administered excessive amounts of physostigmine.

B. Respondent provided anesthesia to Patient B at Fox Hospital on November 9, 1988. During the course of a right total knee replacement, Patient B suffered abrupt increases in pulse and blood pressure when inhalation of the anesthetic agent was discontinued at approximately 10:30 a.m. Patient B remained hypertensive for more than an hour in the recovery room. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent failed to monitor arterial blood gases during the procedure.
2. Respondent failed to adequately treat Patient B's hypertension and tachycardia in the recovery room.

C. Respondent provided anesthesia to Patient C at the Fox Hospital on December 1, 1988. During preparation for a diagnostic laparoscopy, Patient C suffered a prolonged hypoxic episode and surgery was cancelled. Respondent's care and

treatment of Patient C failed to meet acceptable standards of medical care, in that:

1. Respondent failed to insure that the valve on the anesthesia machine was turned toward the anesthesia bag and not towards the ventilator prior to intubating and ventilating the patient.
2. Respondent failed to recognize that the ventilator switch was in the wrong position in a timely manner.
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1. Respondent failed to administer appropriate medications prior to attempting reintubation.
2. Respondent refused to accept a syringe of Anecitine from a colleague, prepared with the appropriate dose.
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TENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Educ. Law §6530(3) (McKinney Supp. 1992) in that, Petitioner charges that the Respondent committed two or more of the following:

10. The facts in paragraphs A and A.1, A.2, A.3; B and B.1, B.2; C and C.1, C.2, and/or C.3; and/or D and D.1, D.2, D.3, D.4.

DATED: Albany, New York
September 17, 1992

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct