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

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

October 31, 1990

Swamisaran Bommakanti, Physician
1225 Summit Avenue - Apt. 208
Oshkosh, Wisconsin 54901

Re: License No. 164833

Dear Dr. Bommakanti:

Enclosed please find Commissioner's Order No. 11005. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc:

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

SWAMISARAN BOMMAKANTI **No. 11005**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

SWAMISARAN BOMMAKANTI, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

Between September 29, 1988 and October 4, 1989 a hearing was held in 13 sessions before a hearing committee of the State Board for Professional Medical Conduct. The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without the attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B". On March 12, 1990, the hearing committee found and concluded that respondent was guilty of the second through seventh specifications, guilty to the extent

indicated in its report of the first specification, and not guilty of the eighth specification, and recommended that (1) respondent's license to practice as a physician in the State of New York be suspended partially in the area of surgery until he successfully completes a course of retraining approved by the American Board of Ophthalmology, (2) respondent be required to pass the certifying examination of the American Board of Ophthalmology, and (3) after the suspension has ended, respondent be placed on probation for a period of two years with the terms of probation to include monitoring by another physician of respondent's surgical cases and review of his medical records. The suspension would allow respondent to continue his office practice.

The Commissioner of Health recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted in full, the recommendation of the hearing committee be rejected, and respondent's license to practice be revoked. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On July 10, 1990, respondent appeared before us and stated that he wished to proceed on his own behalf without an attorney. Paul White, Esq. presented oral argument on behalf of the Department of Health.

We have considered the record in this matter as transferred by the Commissioner of Health, including the June 22, 1990 letter

from respondent's former attorney; the June 26, 1990 letter from respondent with attachments, and petitioner's July 3, 1990 letter. At out meeting, respondent offered two last minute documents for our consideration. We ruled that these two documents were submitted too late and in violation of our procedure, and were therefore not accepted into the record. After our meeting concluded, respondent, on July 26, 1990 attempted to submit a letter dated July 18, 1990 and various documents. It is our ruling that this latest submission is not accepted into the record in this matter. Respondent has failed to meet our deadlines for making timely submissions.

Petitioner's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, which is the same as the recommendation of the Commissioner of Health, was that respondent's license to practice as a physician in the State of Ne York be revoked.

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was that no penalty is needed or warranted.

The hearing committee and Commissioner of Health concluded that respondent's guilt relates to negligence on more than one occasion and unprofessional misconduct involving record-keeping. They also concluded that respondent was not guilty of incompetence on more than one occasion. The charges concern six patient cases.

SWAMISARAN BOMMAKANTI (11005)

The hearing committee report shows that respondent was found to have committed negligence: as to all paragraphs charged regarding Patient E; and as to the paragraphs charged to the extent indicated by the hearing committee regarding Patients A; B, C, and D. No negligence or other professional misconduct was found as to the paragraphs charged regarding Patient F. The hearing committee report also shows that respondent was found to have committed unprofessional conduct regarding patients A, B, C, D, and E, and that respondent was not guilty as to paragraph G of the charges.

In our unanimous opinion, in agreement with the hearing committee and Commissioner of Health, respondent committed negligence on more than one occasion by failing to determine pre-operatively the best corrected vision for four patients, preparing a false operative report in one case, and having one patient require corrective treatment and surgical intervention to preserve the patient's vision subsequent to respondent's treatment in one case. Also, in our unanimous opinion, in agreement with the hearing committee and Commissioner of Health, respondent committed unprofessional conduct by preparing post-operative treatment and office notes which were inadequate and inaccurate in five cases insofar as they relate to respondent's observations of the patients and noting of patient's complaints and/or abnormalities, and by preparing a false operative report in one case.

However, we do not agree with the hearing committee's and Health Commissioner's finding of guilt as to paragraph C.1. The record shows that when petitioner's expert witness testified that she did not see any indication for respondent's performance of the surgery, she had been asked to assume that the patient's uncorrected vision in her right eye was 20/30. Transcript (hereafter T.) 369 and 370. However, that uncorrected vision was really 20/300. Respondent inadvertently wrote 20/30 in the patient's medical record. See hearing committee finding 53. Petitioner's expert rendered her opinion in reliance on her reading of the chart, see T. 371 and 372, which showed the patient had good vision in her right eye, T. 421, or was within acceptable limits, T. 612. Significantly, when that witness was thereafter asked on cross-examination to assume that the patient's vision without glasses in the right eye was not 20/30 but rather 20/300, she retracted her opinion. T. 612. Accordingly, in our unanimous opinion, petitioner has not proven, by a preponderance of the evidence, that respondent is guilty of paragraph C.1 of the first specification of the charges.

The parties widely divergent penalty recommendations reflect their different views as to the extent of respondent's misconduct. Respondent asserted that (1) this matter is primarily based on inadequate record-keeping charges. On the other hand, petitioner asserted that this matter is distinguished from one which involves

mere record-keeping irregularities by the hearing committee's finding that respondent failed to treat a variety of post-operative complaints and abnormalities and (2) respondent's office practice was "significantly deficient" in part due to respondent's repeated failure to treat a variety of ophthalmic abnormalities and complaints. We cannot fully agree with either of these characterizations of respondent's misconduct.

An appropriate penalty should be based on the negligent medical care respondent provided to five patients as well as on the inadequate and inaccurate records respondent maintained for each of those patients. However, respondent may not be found guilty of committing negligence by failing to treat these patients post- operatively.

Paragraphs A.2, B.3, C.2, and D.2 of the charges, plainly relate to respondent's notes being "inadequate and inaccurate in that" they do not note respondent's observations, patient's complaints and abnormalities, and treatment of such complaints and abnormalities. These paragraphs serve as the entire factual allegations for the separate specifications regarding record-keeping and negligence on more than one occasion as to these acts. Although these paragraphs refer to respondent's treatment in the context of his notations of the treatment, they do not, as drafted, give respondent fair notice that he is charged with negligence based on his failure to treat these patient complaints and

abnormalities. Furthermore, a literal reading of the reference in the charges to treatment as meaning that respondent was charged with failing to treat is inconsistent with other allegations being framed in terms of respondent's records being inaccurate or inadequate. If respondent failed to treat, then the absence of notes in his records as to the treatment would not be inaccurate and inadequate. On the other hand, if respondent did treat, but did not note his treatment, respondent may not be guilty of failing to treat. Accordingly, the manner in which these paragraphs of the charges were drafted is insufficient to support petitioner's contention that respondent was negligent for failing to treat a variety of post-operative complaints and abnormalities in four cases. Therefore, the penalty which we recommend, in regard to the guilt which is properly established in this record, will not be based on any consideration of petitioner's contentions or the hearing committee's findings that respondent was guilty of these four paragraphs of the charges for such failures to treat post-operatively in four cases.

We note that petitioner conceded that respondent was not charged with any gross negligence and is not guilty of any incompetence or gross incompetence.

Respondent opposes the penalty recommendation of the hearing committee and Commissioner of Health, and stresses that the "extremity" of the Health Commissioner's position is "simply not

borne by the weight of the evidence adduced during this proceeding." Respondent questions the brevity of the Health Commissioner's recommendation which did not refer to the transcripts or exhibits for support.

In our unanimous opinion, a revocation of licensure is not the appropriate measure of discipline. While respondent's guilt relates to his office practices, each case upon which respondent is found guilty arises form respondent's surgical practice. However, respondent is not guilty for failing to treat a variety of post-operative complaints and abnormalities. Respondent should be partially suspended for an indefinite period until he receives the retraining in the area of surgery recommended by the hearing committee. We agree with the hearing committee that respondent should be placed on probation for two years following the termination of this suspension. These terms of probation should include requirements for monitoring respondent's pre-operative work-up and post-operative follow-up and for reviewing respondent's medical records. The requirement for reviewing respondent's medical records should be imposed immediately as well as after any possible termination of the suspension. Therefore, we would also place respondent on probation for three years running from the commencement of the partial suspension. We are aware that there may be a full or partial overlap of time when the terms of probation shown in both Exhibits "D" and "E", which exhibits are

annexed hereto and made a part hereof, are both in effect or there may be a time when no terms of probation are in effect after the three year period of probation in Exhibit "D" has been served at which time the partial suspension would continue to remain in effect prior to its termination and the subsequent commencement of the two year period of probation in Exhibit "E". Nevertheless, respondent should be on probation for three years whether or not he is successfully retrained in the area of surgery and should be on probation for two full years upon the termination of the indefinite suspension after respondent has been successfully retrained in the area of surgery. In this manner, respondent would be on probation for at least the first three years.

Respondent should not be mandated to be, as the hearing committee recommends, "board certified in order to practice medicine."

Based on the guilt we find respondent committed, the penalty we unanimously recommend will protect the public, prohibit respondent from performing further surgery until he is retrained, and provide respondent the opportunity recommended by the hearing committee of obtaining the retraining he needs before he is allowed to perform surgery.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the

recommendation of the Commissioner of Health as to those findings of fact be accepted, except the first sentence of finding of fact 56 as well as those portions of findings of fact 26, 44, and 90 relating solely to respondent failing to treat the patients should not be accepted;

2. The conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those conclusions be modified;

3. Respondent is, by a preponderance of the evidence, guilty of the first specification based on negligence on more than one occasion as to paragraphs A.1, B.2, C.3, D.1, E.1, and E.2; guilty to the extent indicated by the hearing committee as to paragraph B.1; guilty to the extent indicated by the hearing committee, except regarding failing to treat, as to paragraphs A.2, B.3, C.2, and D.2; and not guilty as to the remaining paragraphs in the first specification. Additionally, respondent is, by a preponderance of the evidence, guilty of the third and seventh specifications, guilty of the second, fourth, fifth, and sixth specifications, except regarding failing to treat; and is not guilty of the eighth specification and the charges regarding failing to treat.

4. The measure of discipline recommended by the hearing committee be modified and the measure of discipline recommended by the Commissioner of Health not be accepted; and

5. Respondent's license to practice as a physician in the State of New York be partially suspended in the area of surgery upon each specification of the charges of which we recommend respondent be found guilty until respondent submits written proof to the satisfaction of the Executive Director of the Office of Professional Discipline, New York State Education Department, that respondent has successfully completed a course of retraining, at respondent's expense, to consist of a course in surgery taken in the United States or Canada and previously approved by the American Board of Ophthalmology; and respondent be placed on probation for three years as set forth under the terms of probation which are annexed hereto, made a part hereof, and marked as Exhibit "D". Upon the termination of the aforesaid indefinite suspension of respondent's license to practice as a physician in the State of New York, respondent then be placed on probation for a period of two years as set forth under the terms of probation which are annexed hereto, made a part hereof, and marked as Exhibit "E".

SWAMISARAN BOMMAKANTI (11005)

Respectfully submitted,

J. EDWARD MEYER

MELINDA AIKINS BASS

SIMON J. LIEBOWITZ

Chairperson

Dated: August 31, 1995

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
SWAMISARAN BOMMAKANTI, M.D.	:	CHARGES

----------X

SWAMISARAN BOMMAKANTI, M.D. hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on December 4, 1985 by the issuance of License Number 164833 by the State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from the Medical Dental Building, 307 Meadow Street, Johnstown, New York 12095.

FACTUAL ALLEGATIONS

A. The Respondent performed a right intracapsular cataract extraction with an intraocular lens implant on Patient A (Patient A as well as all other patients are identified in Appendix A) on June 3, 1986 at the Little Falls Hospital, Little Falls, New York. Patient A terminated treatment with the Respondent on August 20, 1986 and was thereafter treated by another ophthalmologist.

EXHIBIT "A"

1. The Respondent's pre-operative evaluation was inadequate in that there was no evidence of an attempt to improve Patient A's vision by non-surgical means nor any follow-up to the initial intraocular pressure testing.

2. The Respondent's post-operative treatment and office notes were inadequate and inaccurate in that visual acuity was recorded on only one date, no intraocular pressure was noted, the condition of the right cornea was not consistently and accurately noted and post surgical complaints and abnormalities were not noted and treated.

3. Subsequent to termination of treatment with the Respondent, Patient A required laser surgery for iris incarceration, hospitalization for a vitrectomy and an intraocular lens exchange.

B. The Respondent performed a right extracapsular cataract extraction with an intraocular lens implant on Patient B on September 2, 1986 at the Little Falls Hospital. Patient B terminated treatment with the Respondent on October 15, 1986 and was thereafter treated by another ophthalmologist.

1. The Respondent's pre-operative evaluation was inadequate in that there was no evidence of an attempt to improve Patient B's vision by non-surgical means nor evidence of a comprehensive work-up for Patient B's headache.

2. The operative report was false in that it described intracapsular cataract surgery when, in fact, extracapsular cataract surgery was performed. In addition, the operative report falsely stated that the cataract extraction was performed using a cryoextractor.

3. The Respondent's post-operative treatment and office notes were inadequate and inaccurate in that visual acuity and intraocular pressure were not noted, and post-surgical complaints and abnormalities were not noted and treated.

4. Subsequent to termination of treatment with the Respondent, Patient B required lysis of the anterior synechia, a peripheral iridectomy, a partial anterior vitrectomy, removal of retained residual cortex and exchange of the intraocular lens.

C. The Respondent performed a right intracapsular cataract extraction with an intraocular lens implant on Patient C on October 14, 1986 at the Little Falls Hospital. Patient C terminated treatment with the Respondent on November 4, 1986 and was thereafter treated by another ophthalmologist.

1. On October 1, 1986, the Respondent determined that Patient C's uncorrected vision in the right eye was 20/30. In addition, there was no pre-operative complaint by

Patient C related to visual acuity. As such, Patient C's cataract surgery was not medically indicated.

2. The Respondent's post-operative treatment and office notes were inadequate and inaccurate in that visual acuity and intraocular pressure were not noted and post surgical complaints and abnormalities were not noted and treated.

3. Subsequent to termination of treatment with the Respondent, Patient C's required removal of the intraocular lens, lysis of the peripheral anterior synechia, a partial anterior vitrectomy and a peripheral iridectomy.

D. The Respondent performed a right intracapsular cataract extraction with an intraocular lens implant on Patient D on October 28, 1986 at the Little Falls Hospital. Patient D terminated treatment with the Respondent on March 13, 1987 and was thereafter treated by another ophthalmologist.

1. The Respondent's pre-operative evaluation was inadequate in that there was no evidence of an attempt to improve Patient D's vision by non-surgical means.

2. The Respondent's post-operative treatment and office notes were inadequate and inaccurate in that visual acuity was recorded on only two dates, intraocular pressure was not noted and post-surgical abnormalities were not noted and treated.

3. Subsequent to termination of treatment with the Respondent, Patient D required an intraocular lens exchange, a partial anterior vitrectomy and a peripheral iridectomy.

E. The Respondent performed a left intracapsular cataract extraction with an intraocular lens implant on Patient E on July 8, 1986 at the Little Falls Hospital. On September 2, 1986, the Respondent surgically repositioned the intraocular lens. Thereafter, on December 30, 1986, the Respondent removed the intraocular lens. Patient E terminated treatment with the Respondent on May 8, 1987 and was thereafter treated at an ophthalmology clinic.

1. The Respondent's pre-operative evaluation was inadequate in that there was no evidence of an attempt to improve Patient E's vision by non-surgical means.

2. The Respondent's post-operative treatment and office notes were inadequate and inaccurate in that visual acuity was not recorded until nearly six months following the original cataract surgery, intraocular pressure was not noted until ten months after the original surgery and cystoid macular edema was not noted.

F. The Respondent performed a right extracapsular cataract extraction with an intraocular lens implant on Patient F on

October 23, 1986 at the Johnstown Hospital in Johnstown, New York. The Respondent planned to perform cataract surgery with a lens implant on Patient F's left eye.

1. Patient F did not benefit from her right eye cataract surgery as she suffered from Leber's optic atrophy. In addition, the right eye cataract surgery resulted in a peripheral iridectomy and entrapment of the superior haptic of the intraocular lens producing an elongation of the pupil.

2. The proposed left eye surgery was not medically indicated because the patient's cataract was clinically insignificant and the patient suffered from Leber's optic atrophy.

G. The operative report concerning the cataract surgery performed on Patients A, B, C, D and E were essentially identical and failed to identify any surgical complications.

SPECIFICATION OF CHARGES

PRACTICING WITH NEGLIGENCE AND/OR INCOMPETENCE ON MORE THAN ONE OCCASION

First Specification

The Respondent is charged with practicing the profession of medicine with negligence and/or incompetence on more than one

occasion under N.Y. Educ. Law §6509(2) (McKinney 1985), in that the Petitioner charges:

1. The facts of paragraphs A and A.1 and/or A.2 and/or A.3; B and B.1 and/or B.2 and/or B.3 and/or B.4; C and C.1 and/or C.2 and/or C.3; D and D.1 and/or D.2 and/or D.3; E and E.1 and/or E.2; F and F.1 and/or F.2.

FAILURE TO MAINTAIN AN
ACCURATE MEDICAL RECORD

Second Through Eighth Specifications

The Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509(9) (McKinney 1985) as he failed to maintain a medical record which accurately reflected the evaluation and treatment of his patients within the meaning of 8 NYCRR 29.2(a)(3) (1987) in that, the Petitioner charges:

2. The facts of paragraph A and A.2.

3. The facts of paragraph B and B.2.

4. The facts of paragraph B and B.3.

5. The facts of paragraph C and C.2.

6. The facts of paragraph D and D.2.

7. The facts of paragraph E and E.2.

8. The facts of paragraph G.

DATED: Albany, New York
August 29, 1995

DAVID A. DIETRICH
Associate Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER	:	REPORT OF THE HEARING COMMITTEE
OF	:	
SWAMISARAN BOMMAKANTI, M.D.	:	

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Gerald Evans, M.D., Chairperson, Msgr. Peter J. Owens and Paul M. DeLuca, M.D., 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. Debra L. Smith, Esq. served as the Administrative Officer for the Hearing Committee except for the June 20 and 21, 1989 hearing dates at which Larry G. Storch, Esq. served as the Administrative Officer.

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

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges on Respondent:	September 7, 1988
Prehearing conference (by telephone):	September 20, 1988

EXHIBIT "6"

Hearing dates:	1988: September 29, November 7, December 1; 1989: January 5, February 23, February 24, May 2, May 3, June 20, June 21, June 28, August 9, October 4
Post-hearing conference:	November 13, 1989
Deliberations:	November 14 and 15, 1989; January 3, 4, 19 and 22, 1990
Adjournments:	
Respondent's request for adjournment of December 16, 1988 hearing date (illness in attorney's family) granted	October 31, 1988
Respondent's request for adjournment of December 1 and 2, 1988 hearing dates (Respondent's attorney actually engaged in proceeding commencing after these hearing dates set) made and denied	November 29, 1988 December 1, 1988 (T:341-353)
December 2, 1988 hearing date adjourned (unnecessary due to scheduling circumstances)	December 1, 1988 (T:501-505)
May 24, 1989 hearing date adjourned (Hearing Committee member unavailable)	April 4, 1989
Respondent's request for adjournment of July 12, 1989 hearing date (witness unavailable) made and granted	June 29, 1989

Place of hearing:	Offices of the New York State Department of Health and other New York State government offices, Albany, New York
Department of Health appeared by:	Paul R. White, Esq. Corning Tower - 25th Floor Empire State Plaza Albany, New York 12237
Respondent appeared by:	Scott T. Johnson, Esq. Maynard, O'Connor & Smith 80 State Street Albany, New York 12207
Witnesses for Department of Health:	Sharon Kuritzky, M.D. Dr. Robert G. Tamsett Patient F's sister
Witnesses for Respondent:	Swamisaran Bommakanti, M.D (Respondent) Richard S. Smith, M.D.
Key ruling: Respondent's proposed corrections to transcript, made by letter dated November 2, 1989 and unopposed by Department, accepted	November 13, 1989

SUMMARY OF CHARGES

In the Statement of Charges (Ex. 1 - copy attached), the Respondent, Swamisaran Bommakanti, M.D., was charged with professional misconduct pursuant to Education Law §6509. The specific charges were practicing the profession with negligence and/or incompetence on more than one occasion (Education Law

§6509(2)) (First Specification) and failing to maintain patient records which accurately reflect evaluation and treatment (Education Law §6509(9), paragraph 29.2(a)(3) of Title 8 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR)) (Second through Eighth Specifications).

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. The Hearing Committee unanimously reached each of the following findings of fact unless otherwise noted.

1. Swamisaran Bommakanti, M.D., the Respondent, was authorized to practice medicine in the State of New York on December 4, 1985 by the issuance of license number 164833 by the New York State Education Department. The Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1986 through December 31, 1988 from the Medical Dental Building, 307 Meadow Street, Johnstown, New York 12095. (Uncontested; T: 975; Ex. B)

2. The Respondent first obtained hospital privileges at Little Falls Hospital in May 1986. The Respondent's operating

privileges at Little Falls Hospital were restricted in June 1987. (T: 993-994)

3. The Respondent also had hospital privileges at the Johnstown Hospital from February 1986 until it closed in February 1988, which was the last time he performed cataract surgery. (T: 995-996)

4. The Respondent twice failed the certifying examination of the American Board of Ophthalmology. The Respondent is not board certified by the relevant speciality board in the United States. (T: 1002-1003)

5. The Respondent is not a member of the New York State Ophthalmologic Society, the American Academy of Ophthalmology, the New York State Medical Society or any county medical society. (T: 1003-1004).

6. A patient's visual acuity is what the patient is capable of seeing. (T: 40)

7. A refraction is the use of lenses to obtain the best possible visual acuity for that patient. (T: 39)

8. It is customary medical practice for an ophthalmologist to record a refraction each time he/she does one. (T: 1840-1841)

9. Richard S. Smith, M.D., the Respondent's expert witness, testified that he was trained that there was no evidence that a

procedure was done if it was not recorded in the patient's medical record. (T: 2021)

10. The standard of care for a presurgical evaluation prior to contemplated cataract surgery requires that the treating ophthalmologist determine the best corrected visual acuity in each eye. (T: 42-46; Ex. C)

11. A patient's visual acuity should be noted for each post-operative visit following cataract extraction surgery so that the post-operative course can be properly evaluated and late complications from surgery can be identified. (T: 69-76, 1842)

Patient A

12. Patient A, a fifty-nine year old female, was first seen in the Respondent's office on May 13, 1986. Patient A complained of decreased visual acuity in the right eye for one year. Patient A also stated that she was not happy with the glasses which she received one month earlier from an optometrist in Little Falls. (T: 36-37; Ex. 2 - p. 1)

13. The Respondent's records contain no indication as to the prescription of Patient A's present glasses. (T: 39; Ex. 2 - p. 1)

14. Patient A saw better out of her right eye with her glasses off than with them on. (T: 38-39; Ex. 2 - p. 1)

15. The Respondent did not ascertain Patient A's best corrected vision prior to cataract surgery. The Respondent did not use refraction or any other method to determine Patient A's best corrected vision. (T: 38-40, 42-45, 1782-1783, 1794-1795; Ex. 2 - p. 1)

16. Patient A had a family history of glaucoma. The Respondent's clinical impression was that Patient A was a glaucoma suspect. In light of this clinical impression, gonioscopy, visual field testing and a repeat intraocular pressure reading were all indicated pre-operatively to rule out glaucoma and other ocular pathology. (T: 37, 52-54; Ex. 2 - p. 1)

17. The Respondent did not perform gonioscopy or visual field testing prior to Patient A's surgery. These diagnostic procedures were scheduled for May 20, 1986, but were not performed on that date. A repeat intraocular pressure reading was not taken. (T: 52-54, 296; Ex. 2) (2-1 vote of Hearing Committee)

18. The Respondent performed a right intracapsular cataract extraction with an anterior chamber lens implant on Patient A on June 3, 1986 at Little Falls Hospital, Little Falls, New York. (T: 60-61; Ex. 2 - p. 1, Ex. 3 - p. 17)

19. The Respondent saw Patient A post-operatively in his office on June 4, June 10, June 14, June 19, June 23, July 23 and August 20, 1986. (Ex. 2 - pp. 1-2)

20. Patient A's visual acuity was noted on only one occasion post-operatively (June 14, 1986). (Ex. 2)

21. Patient A's intraocular pressure was not recorded post-operatively. Intraocular pressure should be recorded post-operatively when an anterior chamber lens implant is used as this type of lens implant can cause an elevation of intraocular pressure. It was especially important to ascertain Patient A's intraocular pressure post-operatively because this patient was a glaucoma suspect. (T: 76-77; Ex. 2)

22. The Respondent recorded that the patient's right cornea was clear with some keratitis on June 14, 1986. Keratitis is an inflammation of the cornea and is commonly seen post-operatively. Patient A's medical record for June 14, 1986 is inconsistent in that the cornea is not clear if keratitis is present. (T: 64-65; Ex. 2)

23. On June 19, 1986, the Respondent noted that the cornea was superiorly hazy and that there was inflammation of the cornea at the suture site. These sutures were subsequently removed because of the irritation which they were causing. FML was prescribed for keratitis. The Respondent properly treated Patient A's keratitis. (T: 65-67, 1784; Ex. 2 - pp. 1-2)

24. Patient A last saw the Respondent on August 20, 1986. Eighteen days later this patient sought treatment with a different ophthalmologist, John Kearney, M.D. (T: 78; Exs. 2, 4)

25. At Patient A's first visit to him, Dr. Kearney found that Patient A's iris and vitreous were caught in the wound. These post-surgical abnormalities existed at the time that Patient A was under the Respondent's care. These post-surgical abnormalities were not noted or treated by the Respondent. (T: 83, 150; Ex. 2, Ex. 4, Ex. 5 - p. 9)

26. Patient A had a painful, tearing right eye since the cataract surgery in June 1986. However, the Respondent did not note or treat these complaints. (T: 97; Ex. 2, Ex. 4 - p. 1R, Ex. 5 - p. 9)

27. The record does not establish, by a preponderance of the evidence, that any other post-surgical complaint of Patient A which was noted by Dr. Kearney existed during the time that the Respondent was providing care to Patient A. (Record as whole concerning Patient A)

28. Dr. Kearney performed laser surgery for iris incarceration, a vitrectomy and an intraocular lens exchange on Patient A. (Ex. 5)

29. The record does not establish, by a preponderance of the evidence, that these procedures performed by Dr. Kearney (Finding

of Fact 28) were necessary. (Record as whole concerning Patient A)

Patient B

30. Patient B, a sixty-three year old female, was first seen in the Respondent's office on June 4, 1986. Patient B complained of blurry vision in the right eye for a few months and headaches. (Ex. 10 - p. 1)

31. The Respondent found that Patient B's visual acuity in the right eye without glasses was 20/70. (Ex. 10 - p. 1)

32. One month earlier, on May 20, 1986, Dr. Kearney found that Patient B's visual acuity in the right eye was 20/40 with glasses. (Ex. 12 - p. 2R)

33. The Respondent failed to perform a refraction or use any other method to determine Patient B's best corrected vision prior to cataract surgery. (T: 311-314, 1872; Ex. 10 - pp. 1-2)

34. Patient B came to the Respondent's office with only reading glasses and did not have glasses for distance. The Respondent did not note the prescription of the patient's reading glasses and made no attempt pre-operatively to ascertain what other glasses would improve her vision for distance. (T: 311-314, 607-608, 1575-1576; Ex. 10 - p. 1)

35. In addition to blurry vision, Patient B complained of headaches. However, the record does not establish, by a

preponderance of the evidence, that the lack of a comprehensive work-up for Patient B's headache was an inadequate pre-operative evaluation. (Record as whole concerning Patient B) (2-1 vote of Hearing Committee for second sentence of this finding)

36. The Respondent performed a right extracapsular cataract extraction with an intraocular lens implant on Patient B on September 2, 1986 at the Little Falls Hospital. (Exs. 10, 11)

37. Although the title on the operative report of that operation was an extracapsular cataract extraction, the description in the predictated operative report was of an intracapsular cataract extraction. (Exs. 11, 14)

38. According to the operative report, a cryoextractor was used in the procedure. The use of a cryoextractor is part of an intracapsular cataract extraction, which was not the surgery performed on Patient B. (T: 325; Ex. 11 - p. 11)

39. These errors in the written operative report (Findings of Fact 37 and 38) were discovered and corrected by the Respondent 10 months after the surgery was performed. (Ex. 14 - p. 13)

40. The Respondent saw Patient B post-operatively in his office on September 3, September 24 and October 15, 1986. (Ex. 10)

41. The Respondent did not note Patient B's visual acuity with or without correction at any time post-operatively. (T: 313-314, 328; Ex. 10 - p. 2)

42. The Respondent did not note Patient B's intraocular pressure post-operatively. (T: 326-328; Ex. 10 - pp. 1-2)

43. There was no indication that intraocular pressure readings needed to be taken during the 6 week post-operative period during which the Respondent was providing care to Patient B. (Record as whole concerning Patient B; T: 1844-1845)

44. On September 24, 1986 the Respondent found flare and cells in Patient B's right eye. However, he made no further notation about this condition and he did not issue a prescription. The Respondent did not treat the flare and cells and should have. (T: 327; Ex. 10)

45. Patient B terminated treatment with the Respondent on October 15, 1986. (Ex. 10)

46. Beginning on November 19, 1986, ophthalmologist John Kearney, M.D. saw Patient B. Dr. Kearney found large cortical remnants, vitreous entrapment by the intraocular lens, very slight flare and cells and anterior synechia in Patient B's right eye. The record does not establish, by a preponderance of the evidence, that Dr. Kearney found a malposition of the intraocular lens. Dr. Kearney made a diagnosis of retained cortex with secondary iritis,

vitreous entrapment by the intraocular lens and possible cystoid macular edema (CME). (Ex. 12 - p. 2, Ex. 13; record as whole concerning Patient B)

47. The Respondent did not note large cortical remnants in Patient B's right eye during the time that the Respondent was providing post-operative care to the patient. (Ex. 10)

48. The record does not establish, by a preponderance of the evidence, that the Respondent should have observed large cortical remnants during the time that the Respondent was providing post-operative care to Patient B. (Record as whole concerning Patient B; T: 332) (2-1 vote of Hearing Committee)

49. The record does not establish, by a preponderance of the evidence, that vitreous entrapment by the intraocular lens, anterior synechia and iritis in Patient B's right eye existed during the time that the Respondent was providing post-operative care to Patient B. (Record as whole concerning Patient B) (2-1 vote of Hearing Committee)

50. On November 20, 1986 Dr. Kearney performed lysis of the anterior synechia, a peripheral iridectomy, a partial anterior vitrectomy, removal of retained residual cortex and exchange of the intraocular lens on Patient B. (Ex. 13 - pp. 21-22)

51. The record does not establish, by a preponderance of the evidence, that these procedures performed by Dr. Kearney (Finding

of Fact 50) were necessary. (Record as whole concerning Patient B; T: 332-333, 1884-1886)

Patient C

52. Patient C, an almost eighty-nine year old female, was first seen in the Respondent's office on October 1, 1986. Patient C's complaint was pain in the right eye which had started three days earlier. Patient C's medical record does not indicate any complaint related to visual acuity. (T: 366; Ex. 6)

53. On October 1, 1986 the Respondent determined that Patient C's uncorrected vision in her right eye was 20/300. The Respondent inadvertently wrote in Patient C's medical record that the uncorrected vision in her right eye was 20/30. (T: 1380; Exs. 6, F)

54. The Respondent noted that Patient C's vision in her right eye with glasses was 20/50 and in her left eye without glasses was 20/25. (T: 367; Ex. 6 - p. 1)

55. The Respondent did not refract Patient C or use any other method to ascertain the best corrected vision in her right eye. (T: 367-368; Ex. 6 - p. 1)

56. Cataract surgery on Patient C was not indicated because Patient C had good uncorrected visual activity in her left eye, the corrected vision in her right eye was within acceptable

limits, and she had no visual complaints. (T: 369-372, 407, 420-421, 611-614; Ex. 6 - p. 1)

57. The Respondent performed a right intracapsular cataract extraction with an intraocular lens implant on Patient C on October 14, 1986 at the Little Falls Hospital. (Ex. 7)

58. The Respondent did not note Patient C's visual acuity at any time post-operatively. (T: 382-383; Ex. 6 - pp. 1-2)

59. The Respondent did not note Patient C's intraocular pressure post-operatively. There was a notation dated October 21, 1986 which indicated that the pressure was up, but no quantitative value was recorded. (T: 376-377, 631-632; Ex. 6 - pp. 1-2)

60. In case of elevated intraocular pressure, it is crucial to note the degree of elevation. (T: 376-378)

61. The medical record for Patient C during the time that the Respondent was providing post-operative care to her does not contain an adequate explanation of the condition of Patient C's eye when the intraocular pressure increased. (T: 377-378; Ex. 6)

62. The Respondent prescribed Timoptic 0.5% twice daily for the right eye and Diamox t.i.d. for Patient C's elevated intraocular pressure. The Respondent did not note Patient C's intraocular pressure on the two office visits following the elevated pressure reading. Therefore it can not be determined

whether the Respondent's prescription regimen for the elevated intraocular pressure was sufficient or effective. The treatment was not adequate because the Respondent did not properly monitor the effectiveness of these prescriptions. (T: 381; Ex. 6 - p. 2)

63. Patient C last saw the Respondent on November 14, 1986. On November 24, 1986 Patient C first saw ophthalmologist John Kearney, M.D. (Exs. 6, 8)

64. On his first office examination, Dr. Kearney found that Patient C had pupillary block glaucoma with an intraocular pressure of 77. (T: 392; Ex. 8 - p. 1R)

65. Patient C complained of pain in her right eye since the Respondent performed her cataract surgery. The Respondent did not note that complaint in Patient C's medical record or treat it, and should have. (T: 388-389, 408; Ex. 6, Ex. 8)

66. Dr. Kearney also found a hazy cornea, marked corneal edema, folds in the cornea, stripping of Descemet's membrane, a partial separation of the wound, blood in the inferior foot of the intraocular lens and internal iris prolapse with pupillary block by the lens and vitreous. (Ex. 8 - p. 1)

67. On November 24, 1986 Dr. Kearney found that Patient C's vision was limited to only an ability to perceive light.

Furthermore, the patient's vision could not be improved by refraction. (T: 385-387; Ex. 8 - p. 1R)

68. On the first day Dr. Kearney saw Patient C, he immediately hospitalized her and performed emergency laser surgery to stabilize the pupillary block glaucoma. (T: 403-404, 408; Ex. 9 - p. 16)

69. The following day, after Patient C's glaucoma had stabilized, Dr. Kearney performed further remedial surgery. On November 25, 1986, Dr. Kearney removed the intraocular lens. He also performed a partial anterior vitrectomy, a peripheral iridectomy and lysis of the peripheral anterior synechia. (T: 404-405; Ex. 9 - p. 23)

70. The immediate laser treatment and surgical intervention by Dr. Kearney were required to preserve Patient C's vision. (T: 671)

71. During the time that the Respondent was providing post-operative care to Patient C, pupillary block glaucoma, a hazy cornea, marked corneal edema and folds in the cornea existed and were observed by the Respondent as evidenced by a number of factors. These factors were the elevated intraocular pressure, an irregular pupil, pain, the proposed lens exchange, the irregular cornea and the medication prescribed by the Respondent.

However, the Respondent did not adequately note these conditions and did not treat them. (T: 408, 416-417, 670; Ex. 6)

72. Stripping of the Descemet's membrane is a complication which is noted at the time of surgery or in the very early post-operative course. The Respondent never noted this complication in Patient C and should have. (T: 408, 417-418, 634-635)

73. The record does not establish, by a preponderance of the evidence, that a partial separation of the wound and internal iris prolapse existed during the time that the Respondent was providing post-operative care to Patient C. (Record as whole concerning Patient C; T: 621, Ex. 6) (2-1 vote of Hearing Committee)

74. During the time that the Respondent was providing post-operative care to Patient C, he noted hyphema, which is blood in the inferior foot of the intraocular lens. (Ex. 6)

75. Patient C developed pupillary block glaucoma as a result of having had the cataract extraction. Subsequent treatment by Dr. Kearney (Findings of Fact 68 - 69) was required to correct this pupillary block glaucoma and was proper. (T: 408; Ex. 9 - p. 23)

Patient D

76. Patient D, a seventy-seven year old female, was first seen by the Respondent on October 15, 1986 with a complaint that

the vision in her right eye had decreased. (T: 429, 1255-1256; Ex. 15 - p. 1)

77. Patient D's vision in her right eye was better without glasses than with her existing glasses. The Respondent did not attempt to improve Patient D's vision by prescribing new glasses. (T: 429-432, 1256, 2016; Ex. 15 - p. 1)

78. The Respondent did not note the prescription of the patient's present eyeglasses. (T: 430; Ex. 15 - p. 1)

79. Although the patient's record noted that a visual acuity was obtained, the Respondent failed to perform a refraction or use any other method to determine Patient D's best corrected vision prior to cataract surgery. (T: 1256, 2016, 2025-2027; Ex. 15)

80. The Respondent performed a right intracapsular cataract extraction with an intraocular lens implant on Patient D on October 28, 1986 at Little Falls Hospital. (T: 432; Ex. 16 - p. 12)

81. The Respondent saw Patient D seven times post-operatively. The Respondent recorded Patient D's visual acuity post-operatively as follows: 20/20 on December 30, 1986, 20/30 on January 8, 1987 and 20/20 on February 25, 1987. (Ex. 15)

82. The Respondent noted Patient D's intraocular pressure in the right eye on one occasion post-operatively, that is, as 16 on January 8, 1987. (T: 435; Ex. 15 - p. 3)

83. The record does not establish, by a preponderance of the evidence, that there was any indication that intraocular pressure readings for Patient D needed to be recorded more than on that one occasion. (Record as whole concerning Patient D; T: 2030-2031)

84. The Respondent noted flare on February 11, 1987 and treated it with FML. This condition was the only post-surgical abnormality in Patient D which was noted and treated by the Respondent. (T: 2016-2017; Ex. 15)

85. Patient D's last visit to the Respondent was on March 13, 1987. At that time no post-surgical abnormalities were noted. (Ex. 15)

86. Thirteen days later, on March 26, 1987, Patient D first saw ophthalmologist John Kearney, M.D.. (Ex. 17 - p. 2)

87. In Dr. Kearney's office record for Patient D, numerous post-surgical complications found on examination were noted. Vitreous entrapment was found with vitreous going through the pupil between the haptic and adhering to the wound at the eleven o'clock position. A smoldering infection was found. In addition, it was noted that there was an elongation of the pupil along the long axis of the intraocular lens, subluxation of the lens supratemporally, and precipitates on the lens, capsule and anterior vitreous face. (T: 439-449, 2017-2018, 2022; Ex. 17 - pp. 2-2R)

88. The record does not establish, by a preponderance of the evidence, that precipitates on the capsule existed during the time that the Respondent was providing post-operative care to Patient D, particularly in light of the fact that Patient D had an intracapsular cataract extraction. (Record as whole concerning Patient D; T: 707-708) (2-1 vote of Hearing Committee)

89. During the time that the Respondent was providing post-operative care to Patient D, these other post-surgical abnormalities (vitreous entrapment, smoldering infection, elongation of the pupil, subluxation of the lens and precipitates on the lens and anterior vitreous face) existed and were observable as evidenced by a number of factors. These factors were the length of time (thirteen days) between the patient's last visit with the Respondent and first visit in Dr. Kearney's office, the length of time (four months) since the cataract extraction, the patient's flare as noted by the Respondent, and the patient's complaints of intermittent blurring of vision and eye irritation while under the Respondent's care. In using a slit lamp to examine Patient D, these post-surgical abnormalities were observable to the Respondent. (T: 456-457, 762-764, 1264; Ex. 15, Ex. 17)

90. The Respondent did not note these post-surgical abnormalities (vitreous entrapment, smoldering infection, elongation of the pupil, subluxation of the lens and precipitates

on the lens and anterior vitreous face) while he was providing care to Patient D and should have. The Respondent did not adequately medically treat Patient D's post-operative smoldering infection and flare and should have. The Respondent did not treat the other post-surgical abnormalities (vitreous entrapment, elongation of the pupil, subluxation of the lens and precipitates on the lens and anterior vitreous face) while he was providing care to Patient D. The record does not establish, by a preponderance of the evidence, that the Respondent needed to treat these additional post-surgical abnormalities (vitreous entrapment, elongation of the pupil, subluxation of the lens and precipitates on the lens and anterior vitreous face). (T: 764, 1275-1276, 1279-1280, 2007-2008; Ex. 15; record as whole - concerning Patient D)

91. On March 30, 1987, Dr. Kearney performed an intraocular lens exchange, a partial anterior vitrectomy and a peripheral iridectomy on Patient D. (T: 445; Ex. 18 - p. 15)

92. The record does not establish, by a preponderance of the evidence, that these procedures performed by Dr. Kearney (Finding of Fact 91) were medically necessary and appropriate. (Record as whole concerning Patient D; T: 764, 2005, 2011-2012)

Patient E

93. Patient E, an eighty-six year old female, first saw the Respondent on June 4, 1986 for a complaint of decreased vision, inability to read and blurry vision. (T: 467; Ex. 19 - p. 1)

94. The Respondent did not perform a refraction or use any other method to ascertain this patient's best corrected vision. Although one of Patient E's presenting complaints was her inability to read, no reading vision was recorded by the Respondent. (T: 467-470, 791, 1224-1228, 2046, 2067; Ex. 19)

95. At that June 4, 1986 visit, Patient E's present eyeglass prescription was two years old. The Respondent did not note the prescription of those present eyeglasses. (T: 467-471, 791; Ex. 19 - p. 1)

96. On July 8, 1986 the Respondent performed a left intracapsular cataract extraction with an intraocular lens implant on Patient E at Little Falls Hospital. (T: 468; Ex. 20 - p. 14)

97. On September 2, 1986 the Respondent surgically repositioned Patient E's intraocular lens. (Ex. 21 - p. 9)

98. On December 30, 1986 the Respondent removed Patient E's intraocular lens. (Ex. 22 - p. 11)

99. Patient E's visual acuity was not noted post-operatively until December 31, 1986, which was nearly six months following the cataract surgery. (T: 472-474, 478-479, 2048; Ex. 20 - pp. 1-4)

100. Hospitals require that an admission note is to include a statement concerning visual acuity before eye surgery. (T: 479)

101. The Respondent failed to note Patient E's intraocular tension post-operatively until May 1, 1987, which was nearly ten months following the cataract surgery. This one-time notation for this patient was not adequate. (T: 472-474, 481-483, 486-489, 2049; Ex. 19 - pp. 1-5)

102. Although the Respondent noted macular changes in Patient E in January and February 1987, the Respondent did not specifically note in his record for Patient E that this patient had cystoid macular edema. (T: 477-478, 815-816, 2052-2053; Ex. 19 - pp. 1-5)

103. Patient E's last visit with the Respondent was on May 8, 1987. (Ex. 19 - p. 5)

104. Following termination of treatment with the Respondent, Patient E was treated two months later at the Ophthalmology Clinic at Mary Imogene Bassett Hospital. (T: 475; Ex. 23 - p. 18)

105. The treating ophthalmologist at Bassett Hospital found chronic cystoid macular edema in Patient E's left eye. (T: 477; Ex. 23 - p. 18)

106. Cystoid macular edema is known to occur in totally uncomplicated, perfect cataract operations. (T: 495)

107. The chronic nature of Patient E's cystoid macular edema indicated that it existed during the period of time that the Respondent was providing post-operative care to Patient E. (T: 477)

Patient F

108. Patient F, a fifty-eight year old mentally retarded woman, was first seen by the Respondent on June 16, 1986. At that time she had glasses that she had obtained seven months earlier. (T: 844; Ex. 24 - p. 1)

109. The Respondent found evidence of an optic nerve abnormality as the patient's optic discs were slightly pale. He also found central lens opacities. (T: 845-846; Ex. 24 - p. 1, Ex. 25 - p. 2)

110. As evidenced by her pale optic discs, Patient E had optic atrophy. There are many types of optic atrophy, which are due to many causes. The record does not establish, by a preponderance of the evidence, which type of optic atrophy that Patient F had. The record does not establish, by a preponderance of the evidence, that Patient F's optic atrophy was the Leber's type. (T: 845-847, 857, 859, 867, 2089-2091; Ex. 24; record as whole concerning Patient F)

111. On October 23, 1986 the Respondent performed a right extracapsular cataract extraction with an intraocular lens implant

on Patient F at Johnstown Hospital, Johnstown, New York. (Exs. 24, 25)

112. Patient F's optic atrophy did not preclude the performance of cataract surgery on her right eye. The visual potential of a retarded patient is difficult to assess. This October 23, 1986 cataract surgery was not contraindicated. (T: 851, 2092-2094, 2112-2115)

113. The record does not establish, by a preponderance of the evidence, that a peripheral iridectomy was performed on Patient F. (Record as whole concerning Patient F)

114. On February 3, 1988 ophthalmologist John Kearney, M.D. and Dr. Robert G. Tamsett, an optometrist working for Dr. Kearney, found entrapment of the superior haptic of the intraocular lens producing an elongation of the pupil in Patient F. (T: 878-879, 933; Ex. 27)

115. This entrapment was the result of the cataract surgery because that surgery included the lens implant. However, the record does not establish, by a preponderance of the evidence, when this entrapment occurred. The record also does not establish, by a preponderance of the evidence, that this entrapment was the result of any improper action or inaction by the Respondent. (T: 2105; record as whole concerning Patient F)

116. Before Patient F's right eye cataract surgery, her sister wanted the cataracts on both of Patient F's eyes to be removed at the same time. However, the Respondent decided to operate only on Patient F's right eye at that time. (T: 953, 956-957)

117. After Patient F's right eye cataract surgery, the Respondent did not plan to perform cataract surgery on Patient F's left eye. (T: 953, 956-957, 959, 971)

Additional Findings

118. The operative reports for the cataract surgeries performed on Patients A, B (report before corrected by the Respondent), C, D and E (July 8, 1986 operation) were essentially identical with the following three exceptions. First, the operative report for Patient A included a notation of general anesthesia. Second, the operative report for Patient B had a title of extracapsular cataract extraction. Third, the operative report for Patient D had a heading which indicated general anesthesia and the body of the report described local anesthesia. (Exs. 3, 7, 11, 16, 20)

119. None of these operative reports indicated that there were surgical complications. (Exs. 3, 7, 11, 16, 20)

120. The record does not establish, by a preponderance of the evidence, that complications existed and/or should have been

observed by the Respondent at the time of these operations on Patients A, B, C, D and E. (Record as whole concerning Patients A, B, C, D and E)

CONCLUSIONS

The Hearing Committee first determined whether the factual allegations set forth in the Statement of Charges were sustained and then determined whether any sustained factual allegation constituted professional misconduct as charged. The Hearing Committee unanimously reached each of the the following conclusions unless otherwise noted.

I. Practicing with negligence and/or incompetence on more than one occasion (First Specification)

Negligence was defined as a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Incompetence was defined as a lack of the skill or knowledge necessary to practice medicine.

Patient A

The factual allegation set forth in paragraph A of the Statement of Charges (the charges) should be sustained (Findings of Fact 18 and 24).

The factual allegation set forth in paragraph A. 1 of the charges should be sustained and constitutes negligence (Findings of Fact 6-10, 12-17). The Hearing Committee voted 2-1 in reaching

these conclusions concerning the second portion of the charge (follow-up to the initial intraocular pressure testing) and unanimously concerning the remainder of the charge. This failure by the Respondent to evaluate Patient A adequately pre-operatively does not constitute incompetence, as defined.

The factual allegation set forth in paragraph A. 2 of the charges should be sustained in part and not sustained in part. The portion of the factual allegation concerning visual acuity should be sustained (Findings of Fact 11, 19-20). The portion of the factual allegation concerning intraocular pressure should be sustained (Findings of Fact 19, 21). The portion of the factual allegation concerning the right cornea should be sustained (Finding of Fact 22). The portion of the factual allegation concerning post-surgical complaints and abnormalities should be sustained only as to the patient's iris and vitreous being caught in the wound and as to the tearing eye (Findings of Fact 24-26), and otherwise should not be sustained (Findings of Fact 23-24, 27). To the extent that this factual allegation (paragraph A. 2 of the charges) should be sustained, the Respondent's action and inaction constitute negligence with the following exception. The Respondent's failure to note consistently and accurately the condition of the patient's right cornea does not constitute negligence, as defined. To the extent that this factual

allegation should be sustained, the Respondent's action and inaction do not constitute incompetence, as defined.

The factual allegation set forth in paragraph A. 3 of the charges should not be sustained (Findings of Fact 28-29).

Patient B

The factual allegation set forth in paragraph B of the charges should be sustained (Findings of Fact 36, 45-46).

The first portion of the factual allegation set forth in paragraph B. 1 of the charges (attempt to improve the patient's vision by non-surgical means) should be sustained (Findings of Fact 6-10, 30-34). This failure by the Respondent to evaluate Patient B adequately pre-operatively constitutes negligence but does not constitute incompetence, as defined. By a 2-1 vote, the second portion of the factual allegation set forth in paragraph B. 1 of the charges (comprehensive work-up for the patient's headache) should not be sustained (Findings of Fact 30, 35).

The factual allegation set forth in paragraph B. 2 of the charges should be sustained and constitutes negligence (Findings of Fact 36-39). It does not constitute incompetence, as defined.

The factual allegation set forth in paragraph B. 3 of the charges should be sustained in part and not sustained in part. The portion of the factual allegation concerning visual acuity should be sustained and constitutes negligence (Findings of Fact

11, 40-41). The portion of the factual allegation concerning intraocular pressure should be sustained in that no notation was made but does not constitute negligence (Findings of Fact 40, 42-43). The portion of the factual allegation concerning post-surgical complaints and abnormalities should be sustained as to flare and cells and to that extent constitutes negligence (Findings of Fact 44-45). By a 2-1 vote of the Hearing Committee, the remainder of the factual allegation concerning post-surgical complaints and abnormalities should be not be sustained (Findings of Fact 45-49). The Hearing Committee member who concluded that the remainder of the factual allegation concerning post-surgical complaints and abnormalities should be sustained also concluded that the Respondent's inactions constitute negligence. To the extent that this factual allegation should be sustained, the Respondent's inactions do not constitute incompetence, as defined.

The factual allegation set forth in paragraph B. 4 of the charges should not be sustained (Findings of Fact 50-51).

Patient C

The factual allegation set forth in paragraph C of the charges should be sustained except that Patient C terminated treatment with the Respondent on November 14, 1986 rather than November 4, 1986 as charged (Findings of Fact 57, 63)..

The first sentence of the factual allegation of paragraph C. 1 of the charges should not be sustained (Finding of Fact 53). The remainder of that factual allegation should be sustained and constitutes negligence (Findings of Fact 52, 54-57). It does not constitute incompetence, as defined.

The factual allegation set forth in paragraph C. 2 of the charges should be sustained in part and not sustained in part. The portion of the factual allegation concerning visual acuity should be sustained and constitutes negligence (Findings of Fact 11, 58). The portion of the factual allegation concerning the lack of notation of intraocular pressure should be sustained and constitutes negligence (Findings of Fact 59-60). The portion of the factual allegation concerning post-surgical complaints and abnormalities should be sustained and constitutes negligence as to the following: the notation and treatment of the patient's elevated intraocular pressure, pain, pupillary block glaucoma, hazy cornea, marked corneal edema and folds in the cornea, and the notation of the stripping of the Descemet's membrane (Findings of Fact 61-66,68, 71-72). The Hearing Committee voted 2-1 in reaching the conclusion that the Respondent's failure to note the stripping of the Descemet's membrane constitutes negligence. As to the other post-surgical complaints and abnormalities, this portion of the factual allegation should not be sustained

(Findings of Fact 73-74). The Hearing Committee voted 2-1 in reaching the conclusion concerning partial separation of the wound and internal iris prolapse (Finding of Fact 73). The Hearing Committee member who voted to sustain that portion of the factual allegation also concluded that it constitutes negligence. To the extent that this factual allegation should be sustained, the Respondent's inactions do not constitute incompetence, as defined.

The factual allegation set forth in paragraph C. 3 of the charges should be sustained and constitutes negligence (Findings of Fact 63, 68-70, 75). It does not constitute incompetence, as defined. As noted in Finding of Fact 75, the factual allegation of paragraph C. 3 which should be sustained is the result of the cataract surgery which was not medically indicated (factual allegation of paragraph C. 1 of the charges).

Patient D

The factual allegation set forth in paragraph D of the charges should be sustained (Findings of Fact 80, 85-86).

The factual allegation set forth in paragraph D. 1 of the charges should be sustained and constitutes negligence (Findings of Fact 6-10, 76-79). It does not constitute incompetence, as defined.

The factual allegation set forth in paragraph D. 2 of the charges should be sustained in part and not sustained in part.

The portion of the factual allegation concerning visual acuity should be sustained except that the Respondent recorded visual acuity on three dates rather than two dates as charged (Findings of Fact 11,81). By a 2-1 vote, the Hearing Committee concluded that this inaction by the Respondent constitutes negligence. The portion of the factual allegation concerning intraocular pressure should not be sustained (Findings of Fact 82-83). The portion of the factual allegation concerning post-surgical abnormalities should be sustained and constitutes negligence as to the following: the notation and treatment of smoldering infection, the treatment of flare, and the notation of vitreous entrapment, elongation of the pupil, subluxation of the lens and precipitates on the lens and anterior vitreous face (Findings of Fact 80, 84-87, 89-90). As to the other post-surgical abnormalities, this portion of the factual allegation should not be sustained (Findings of Fact 87-88,90). To the extent that this factual allegation should be sustained, the Respondent's actions and inactions do not constitute incompetence, as defined.

The factual allegation set forth in paragraph D. 3 of the charges should not be sustained (Findings of Fact 91-92).

Patient E

The factual allegation set forth in paragraph E of the charges should be sustained (Findings of Fact 96-98, 103-104).

The factual allegation set forth in paragraph E. 1 of the charges should be sustained and constitutes negligence (Findings of Fact 6-10, 93-95). It does not constitute incompetence, as defined.

The factual allegation set forth in paragraph E. 2 of the charges should be sustained and constitutes negligence (Findings of Fact 11, 96-107). It does not constitute incompetence, as defined.

Patient F

The first sentence of the factual allegation set forth in paragraph F of the charges should be sustained (Finding of Fact 111). The second sentence of the factual allegation of paragraph F of the charges should not be sustained (Findings of Fact 116-117).

The first sentence of the factual allegation set forth in paragraph F. 1 of the charges should not be sustained, except as to Patient F's having a type of optic atrophy (Findings of Fact 108-112). The portion of the second sentence of that factual allegation concerning peripheral iridectomy should not be sustained (Finding of Fact 113). The portion of that second sentence concerning entrapment of the superior haptic should be sustained, but does not constitute negligence or incompetence, as defined (Findings of Fact 114-115).

The factual allegation set forth in paragraph F. 2 of the charges should not be sustained (Findings of Fact 116-117).

Summary

As set forth above and to the extent set forth above, charges of practicing the profession with negligence should be sustained concerning Patients A, B, C, D and E. Because the sustained charges constitute practicing the profession with negligence on more than one occasion, the First Specification should be sustained as to negligence to the extent set forth above. As set forth above, the First Specification should not be sustained as to Patient F and should not be sustained as to incompetence.

II. Failing to maintain accurate records (Second through Eighth Specifications)

The Second through Seventh Specifications should be sustained based on the following Findings of Fact.

Specification -	Second	Findings of Fact -	11, 19-22, 24-26
	Third		36-39
	Fourth		11, 40-41, 44-45
	Fifth		11, 58-66, 71-72
	Sixth		11, 80-81, 85-87, 89-90
	Seventh		11, 96-107

The Hearing Committee voted 2-1 in reaching the conclusion that the Sixth Specification should be sustained as to the recording of visual acuity and was unanimous in reaching its conclusions concerning the remainder of that specification.

The factual allegation set forth in paragraph G of the charges should not be sustained (Findings of Fact 118-120). Therefore, the Eighth Specification should not be sustained.

RECOMMENDATIONS

As set forth above and to the extent set forth above, the Hearing Committee recommends that the following specifications be sustained: First (practicing the profession with negligence on more than one occasion - Patients A, B, C, D and E), and Second through Seventh (failing to maintain accurate records). The Hearing Committee further recommends that the other specifications (First as to Patient F and as to incompetence; Eighth as to failing to maintain accurate records) not be sustained.

In light of the nature and seriousness of the sustained charges and after consideration of the possible sanctions, the Hearing Committee unanimously recommends that the following penalty be imposed. The Respondent's license to practice medicine should be suspended partially until he successfully completes a course of retraining. This suspension should be partial in that the Respondent should be allowed to continue his office practice but should not be allowed to perform surgery. This retraining should be in the United States or Canada, and should be in a program approved by the American Board of Ophthalmology. The Hearing Committee recognizes that a physician does not have to be

board certified in order to practice medicine. However, the Respondent should be required to pass the certifying examination of the American Board of Ophthalmology as proof that he has successfully completed this course of retraining. In addition, after this period of suspension has ended, the Respondent should be placed on probation for a period of two years with the standard terms of probation. These standard terms should include the following: the monitoring by another physician of the Respondent's surgical cases (including monitoring the Respondent's pre-operative work-ups to verify that surgery is necessary and monitoring the Respondent's post-operative follow-up) and the review of the Respondent's medical records.

DATED: Cooperstown, New York
March 12, 1990

Respectfully submitted,

Gerald Evans, M.D., Chairperson

Msgr. Peter J. Owens
Paul M. DeLuca, M.D.

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

IN THE MATTER :

OF :

SWAMISARAN BOMMAKANTI, M.D. :

COMMISSIONER'S RECOMMENDATION

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

A hearing in the above-entitled proceeding was held on September 29, 1988, November 7, 1988, December 1, 1988, January 5, 1989, February 23, 1989, February 24, 1989, May 2, 1989, May 3, 1989, June 20, 1989, June 21, 1989, June 28, 1989, August 9, 1989 and October 4, 1989. Respondent, Swamisaran Bommakanti, M.D., appeared by Scott T Johnson, Esq. The evidence in support of the charges against the Respondent was presented by Paul R. White, Esq.

NOW, or ading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

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

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

B. The Recommendation of the Committee should be rejected and, in lieu thereof, Respondent's license to practice should be revoked. In recommending that Respondent be allowed to continue his office practice, the Committee did

not take into account the complexities of office practice particular to ophthalmology. Many ophthalmological procedures commonly performed in the office setting are very hazardous. The pattern of negligence in Respondent's hospital practice found by the Committee clearly demonstrate that he should not now be trusted to perform adequately in his office. If and when Respondent applies for licensure, Respondent's efforts to satisfy the retraining recommendations made by the Committee should be considered.

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

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

DATED: Albany, New York
May 4, 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

SWAMISARAN BOMMAKANTI

CALENDAR NO. 11005

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

SWAMISARAN BOMMAKANTI

CALENDAR NO. 11005

1. That, during the three year period of probation, respondent shall have respondent's practice monitored, at respondent's expense, for the purpose of assuring that respondent is in full compliance with the Order of the Commissioner of Education in this matter including the prohibition of the practice of medicine in the area of surgery, unless the partial suspension is terminated in accordance with said Order of the Commissioner of Education, as well as the permissible practice of medicine by respondent in areas other than surgery, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records, office records, and hospital charts in regard to respondent's practice, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   c. That said monitor shall submit a report, once every three months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct;

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

EXHIBIT "E"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

SWAMISARAN BOMMAKANTI

CALENDAR NO. 11005

1. That, during the two year period of probation following the termination of the partial suspension, respondent shall have respondent's practice monitored, at respondent's expense, for the purpose of reviewing respondent's surgical practice including respondent's pre-operative work-up to verify that surgery is necessary and post-operative follow-up, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records, office records, and hospital charts in regard to respondent's practice, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   c. That said monitor shall submit a report, once every three months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct;

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

The University of the State of New York

IN THE MATTER

OF

SWAMISARAN BOMMAKANTI
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11005

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11005, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (October 19, 1990): That, in the matter of SWAMISARAN BOMMAKANTI, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted, except the first sentence of finding of fact 56 as well as those portions of findings of fact 26, 44, and 90 relating solely to respondent failing to treat the patients should not be accepted;
2. The conclusions of the hearing committee and the recommendation of the Commissioner of Health as to those conclusions be modified;
3. Respondent is, by a preponderance of the evidence, guilty of the first specification based on negligence on more than one occasion as to paragraphs A.1, B.2, C.3, D.1, E.1, and E.2; guilty to the extent indicated by the hearing committee as to paragraph B.1; guilty to the

extent indicated by the hearing committee, except regarding failing to treat, as to paragraphs A.2, B.3, C.2, and D.2; and not guilty as to the remaining paragraphs in the first specification. Additionally, respondent is, by a preponderance of the evidence, guilty of the third and seventh specifications, guilty of the second, fourth, fifth, and sixth specifications, except regarding failing to treat; and is not guilty of the eighth specification and the charges regarding failing to treat;

4. The measure of discipline recommended by the hearing committee be modified and the measure of discipline recommended by the Commissioner of Health not be accepted; and

5. Respondent's license to practice as a physician in the State of New York be partially suspended in the area of surgery upon each specification of the charges of which respondent is guilty until respondent submits written proof to the satisfaction of the Executive Director of the Office of Professional Discipline, New York State Education Department, that respondent has successfully completed a course of retraining, at respondent's expense, to consist of a course in surgery taken in the United States or Canada and previously approved by the American Board of Ophthalmology; and respondent be placed on probation for three years as set forth under the terms of probation prescribed by the Regents Review Committee under its Exhibit "D". Upon the termination of the aforesaid indefinite suspension of respondent's license to practice as a physician in the State of New York, respondent then be placed on probation for a period of two years as set forth under the terms of probation

prescribed by the Regents Review Committee under its Exhibit "E";

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 26th day of October 1990.

Thomas Sobol

Commissioner of Education