STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

July 28, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin Donovan, Esq.
NYS Department of Health
Corning Tower - Room 2503
Empire State Plaza
Albany, New York 12237-0032

Atif Wahba, M.D.
6 Valley Meadow Drove
Spencerport, New York 14559

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville road
Lake Success, New York 11042

RE: In the Matter of Atif Wahba, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-185) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER

OF

ATIF WAHBA, M.D.

DETERMINATION

AND

ORDER

ORDER # 99-185

JOHN H. MORTON, M.D., Chairperson, **JOSEPH G. CHANATRY, M.D.** and **GEORGE C. SIMMONS, Ed.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. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG,** General Counsel, **KEVIN P. DONOVAN, ESQ.**, Associate Counsel of Counsel. The Respondent appeared by **KERN, AUGUSTINE, CONROY & SCHOPPMANN, P.C., T. LAWRENCE TABAK, ESQ.** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged fifteen (15) specifications of professional misconduct, including allegations of negligence on more than one occasion, incompetence on more than one occasion, practicing with gross negligence, practicing with gross incompetence, fraudulent practice and moral unfitness.

The charges are more specifically set forth in the Statement of Charges dated March 4, 1999, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

WITNESSES

For the Petitioner:

Patient D
Donna M. DuPont, R.N.
Carole Black, RN.
Laura Baumbach, RN
Patient E
Husband of Patient E
Elisa Gramza, RN
Husband of Patient F
Patient F
Bonita D. Day (Rowley), RN
Rachel Trombley, RN
Anthony Levatino, M.D. ,J.D.

For the Respondent:

Atif Wahba, M.D.
T.K. Oates, M.D
Ila G.Hughes, RPA
Robert Blackburn, M.D.
Rachel Trombley, RN
Lauren A. Miller
Kimberley A. Craig
Virginia M. Wilson

FINDINGS OF FACT

1. Atif Wahba, M.D., the Respondent, was authorized to practice medicine in New York State on July 16, 1984, by the issuance of license number 141742 by the New York State Education Department. (Petitioner's Ex. 1, not denied in Respondent's Answer [Respondent's Exhibit A], therefore admitted, Ex. 2)[1].

[1]T. ____ and Ex. _____ indicate a reference to the transcript of the hearing or to an exhibit in evidence.

2. Respondent was prohibited from practicing medicine in New York State by an Order issued pursuant to NYS Public Health Law §230(12) dated March 4, 1999 (Ex. 1).

PATIENT A

3. Patient A, was 27 years old when she went to Respondent's office on July 12, 1996. Her presenting complaint was "right breast swollen, leaking pus substance, blood times one month getting worse" (Ex. 3 at 10). The complaint portion of that office visit note was written by his medical assistant (T. 927).
4. Respondent noted pelvic and breast examinations to be negative and ordered an ultrasound of the patient's breast (T. 565, Ex. 3 at 10).
5. This history, to an obstetrician/gynecologist practicing within accepted standards of care, is very alarming (T. 566). A patient with complaint of bleeding from the breast or nipple has a 1/3 chance of breast cancer (T. 566).
6. If the cancer is caught and treated at an earlier stage, survivability of the patient if greater (T. 569).
7. Neither the patient nor the Respondent was able to palpate a lump or mass on July 12, 1996 (Ex. 4 at 17, T. 569, 934).
8. On August 9, 1996 another office visit occurred at which the ultrasound report was discussed with the patient (Ex. 3 at 10, T. 571). The ultrasound ordered by Respondent detected no masses (T. 570, Ex. 3 at 20).
9. Respondent noted no positive findings concerning the patient's breast, yet he prescribed an antibiotic (Ex. 3 at 10, T. 936-937).

10. On March 21, 1997, the patient presented to Respondent's office with a complaint of "right breast swollen, getting worse since March 17." (Ex. 3 at 10, T. 939).

11. Respondent diagnosed the patient as having mastitis, no signs of abscess, and prescribed an antibiotic (T. 573, 943).

12. Respondent did not physically palpate the breast of Patient A on the visit of March 21 (T. 575, Ex. 4 at 34).

13. On June 30, 1997, the patient presented to Respondent questioning whether the infection in her breast ran through her system (T. 576, Ex. 3 at 8).

14. Respondent did not perform a breast examination of the patient on June 30, 1997 (T. 946). This was a deviation from accepted standards (T. 577, 652).

15. On September 30, 1997, Patient A presented to Respondent's office with a complaint of skin infection in her right breast (T. 949). Respondent noted a right breast examination as being negative, meaning no masses (Ex. 3 at 8, T. 950), with folliculitis (T. 579).

16. Patient A again saw Respondent on October 29, 1997. Respondent did not perform a breast examination of Patient A on that visit or refer her to a surgeon (Ex. 3 at 5).

17. On February 3, 1998, Patient A was seen by a nurse practitioner in another physician's office (T. 588). The patient reported a long term infection in her right breast for which she saw Respondent, and was on amoxicillin (T. 588, Ex. 5 at 39).

18. On physical examination, the nurse found a 12 centimeter, roughly circular mass behind the nipple and areola. The area was hard and hot, and there was no discharge

from the nipple (T. 589). The nurse practitioner recommended that the patient see a surgeon (T. 590).

19. At a follow-up visit on March 10, 1998, Dr. Maronian noted that the fine needle aspiration revealed malignant cells, and he set up an oncology consultation as soon as possible (T. 597). A follow-up core biopsy confirmed the presence of cancer in the breast (T. 598).

20. Patient A was diagnosed as having stage IV breast cancer. (T. 583, Ex. 3 at 7).

PATIENT B

21. Patient B presented to Lakeside Memorial Hospital on August 3, 1998, for delivery of a known fetal death in utero (Ex. 9 at 21, T. 661).

22. At 11:00 a.m., Respondent was notified by the obstetrics nurse supervisor, who was assigned to this patient (T. 52) that the caput was in sight, and Respondent arrived (Ex. 9 at 21, T. 54). At 11:05, he delivered a stillborn baby girl (T. 661).

23. The third stage of labor is the period between delivery of the baby and delivery of the placenta (T. 662).

24. The most dangerous stage of delivery for the mother is the third stage (T. 672-673).

25. Following delivery of the fetus at about 11:10, Respondent left the patient's room and went back to his office (T. 56).

26. At 11:28, Nurse Dupont removed the patient's placenta from the vagina (T. 5). After attending to the patient's care and assessing the patient's condition, she went to the nursing station, telephoned Respondent at his office, told Respondent that the

placenta had been delivered, and asked him to return to the patient (T. 57-58).

27. Respondent returned to the patient after the call (T. 57).

28. The nursing notes state that after removal of the placenta at 11:28, Respondent was notified and was "over to examine the patient and placenta" (Ex. 9 at 21).

29. Respondent admitted that he left the delivery room after delivery of the fetus but before delivery of the placenta (T. 1028).

30. In most situations, the placenta would deliver spontaneously without assistance but a physician needs to be present (T. 675). If a physician is not monitoring the situation, the patient can be severely harmed (T. 663). Lack of prompt response by a physician can result in excessive blood loss requiring transfusion (T. 664).

31. Respondent believes that it is acceptable to leave a patient during the third stage of labor for an emergency with another patient, to complete records or to change scrubs (T. 1030, 1063).

32. The importance of having a physician in attendance during the third stage of labor is basic knowledge (T. 666).

33. Respondent believes that in the absence of a written protocol requiring the physician's presence, it is acceptable to leave a patient during the third stage of labor (T. 1057-1058).

34. Respondent completed and signed the labor record for this patient (Ex. 9 at 10).

PATIENT C

35. Patient C presented to Lakeside Memorial Hospital on May 15, 1995, at 7:30 a.m. for induction of labor (T. 676, Ex. 10 at 41). She was admitted to the birthing room, which was also used as a labor, delivery and recovery room as all these events took place in the same room (T. 1112).

36. At 18:30 hours, Respondent was attempting to deliver the patient's baby using vacuum extraction then forceps (T. 677). Delivery of the head was at 18:58 and delivery of the rest of the baby was at 19:00 (T. 677). Respondent repaired the patient's episiotomy.

37. At approximately 19:15 hours Respondent left the delivery room (T. 105-106).

38. After Respondent left the delivery room, but before delivery of the placenta, Respondent dictated his operative delivery note (T. 1063).

39. Respondent's operative delivery note states that the patient was escorted to the recovery room in satisfactory condition (Ex. 10 at 19, T. 684). The patient was not transferred to a recovery room but to an operating room and she was not in satisfactory condition (T. 684).

40. One of the nurses notified Respondent, whom she located sitting at the obstetrics nurses station, that the placenta was not separating (T. 107). He returned to the patient at about 19:45 hours, approximately one half hour after he left the patient and 45 minutes after delivery of the baby (T. 107, 124).

41. After Respondent returned to the patient, he informed her that she would have to have

her placenta removed manually and again left the room (T. 107-108). This procedure was explained to the patient by the obstetrical nurse (Ex. 10 at 44, T. 107).

42. Respondent said he left the room after the baby's delivery because his scrubs were bloody and it wasn't proper to stay with the patient like that (T. 1120-1121).

43. In most cases, the placenta separates and delivers in 3-5 minutes after delivery of the baby. A placenta that has not delivered within 30 minutes of delivery is considered a prolonged third stage of labor (T. 679). In this case, as of 19:30 hours, the fact that the placenta had not delivered would mean the patient was having a prolonged third stage of labor. This means there is a problem, yet Respondent was not present at that time and did not appear until 15 minutes after that, only after being called back to the patient by a nurse (T. 679).

44. Simply because the patient's vital signs are normal at 19:30 does not indicate the patient is not bleeding (T. 707),

45. After Respondent left the patient after 9:45, he was not with the patient at any other time until he saw her in the operating room (T. 109).

46. The record of the third stage of labor shows the patient as being of normal status in the labor room. However, eight minutes later when she arrived in the operating room, she has a blood pressure of 64/36, was noted as being pale, bluish, and not responding well to questions, was given oxygen by mask, and fluids were pushed. (T. 730, 731).

47. During the third stage of labor, this patient's hematocrit dropped to 17 (T. 731-732). This patient was transfused with two units of blood (T. 739).

48. The operating crew was called in the night of May 15 for a cesarean section by another obstetrician (T. 429). The other obstetrician agreed to permit Respondent to use her operating team since this patient was experiencing post-partum hemorrhage and had a retained placenta (Ex. 12 at 27).

49. The O.R. nurse went to another operating room to set up for a D&C (dilatation and curettage) for Patient C. After 5 to 10 minutes when the other O.R. nurse had not returned with the patient, she went to see if she could help (T. 431). When she entered the patient's room, she noticed piles of bloody blankets on the floor. The patient seem frightened, pale, and was lying in a pool of blood (T. 432). The O.R. nurse noted that Respondent was not present and that she did not see him until they were in the operating suite (T. 433).

50. This patient had excessive bleeding before entering the O.R. She was pale and bluish and not responding well to questions. Her blood pressure was 64 over 36, and her pulse was over 150 (Ex. 10 at 20).

51. The case was a matter of life and death (T. 438). The normal pre-operative information about the patient was not obtained due to the urgency of getting her into the operating room (Ex. 10 at 45, T. 438).

52. Respondent knew that the anesthesiologist had to provide anesthesia for the cesarean section for which she had been originally called in (T. 443). The anesthesiologist told Respondent during the procedure that Respondent needed to stay and care for the patient because she needed to provide anesthesia for a cesarean section for which she

had originally been called in. Respondent replied in the affirmative (T.443).

53. Post-operatively, the patient was moved to the post anesthesia care unit (PACU) which was staffed only by a night supervisor nurse since it was after hours (T. 143). That nurse had significant obstetrical experience and was familiar with the amount of bleeding after removal of the placenta (T. 172-173). On moving the patient to the PACU, the anesthesiologist told Respondent that she had to go immediately into the next case and that Respondent would need to remain with the patient (T. 147).

54. The patient's blood pressure on entry to the PACU had moved within the normal range, but her pulse was rapid, meaning she was still hypovolemic (T. 145, 687, 691-692).

55. Respondent left the hospital after the patient was moved to the PACU (T. 1141-1142).

56. The patient was not yet stable, and Respondent knew that the anesthesiologist would not be available to evaluate the patient (T. 689).

57. When checking the patient's vital signs after 5 minutes in the PACU, the nurse noted a drop in blood pressure, an increase in heart rate, and an increase in her flow of blood from the vagina (T. 148-151, 698). She had Respondent paged but he did not respond, and he could not be located in the obstetrical unit (T. 149-150). She also called the physician assistant who ordered a stat hematocrit and a type and cross match in preparation for a transfusion (T. 150).

58. After leaving Lakeside Memorial Hospital, Respondent was located by the obstetrical nursing staff. He called back on his car phone and spoke to the nurse in the post-

anesthesia care unit (PACU) (T. 151). She told him of the findings of deteriorating vital signs and increased flow of blood.

59. She asked Respondent if he were going to come in to see the patient. Respondent said it was not necessary (T. 152). Respondent concurred with the orders of the physician assistant for a type and cross, and a hematocrit (T. 152).

60. Respondent refused to return to see the patient after specifically asked by the nurse supervisor to do so (T. 697).

61. The nurse supervisor had another conversation with Respondent after she received the laboratory results on the hematocrit. She had told him the patient's hematocrit was 17. She again reported that the patient had unstable vital signs, and that she thought the patient was spurting blood from her vagina (T. 151-154).

62. She again requested that Respondent return to the hospital to see the patient (T. 153). He again refused (T. 153).

63. The nurse supervisor directed that the patient be transferred to the obstetrical unit to have obstetrical nursing care and assured that there would be appropriate intensive monitoring (T. 155-156).

64. Once on the obstetrical unit, the nurse supervisor had a third telephone conversation in which she again asked Respondent to come in (T. 157). Respondent said the nurse did not know what she was talking about (T. 157, 168) and asked to speak with an obstetrical nurse and hung up on the nurse supervisor (T. 158).

65. Respondent then called the obstetrical nursing station, a few feet away, and spoke to

an obstetrical nurse. Respondent asked that nurse if he needed to come in (T. 114). She told him he did not need to because there was nothing he could do, but Respondent did not ask about the patient's vital signs or amount of bleeding (T. 114-115).

66. The nurse supervisor took the telephone from the obstetrical nurse and requested that Respondent come in to assess the patient. He again refused (T. 159).

PATIENT D

67. Respondent treated Patient D, who was pregnant, with an estimated date of confinement (EDC) of November 26, 1998 (T. 746, Ex. 13 at 6).

68. In his office record, Respondent wrote a note dated September 18, 1998 which states "discussed with patient today VBAC (vaginal birth after cesarean section) versus a repeat cesarean section. Risks and benefits all discussed. Patient declined VBAC. Wants repeat cesarean section." (Ex.13 at 10, T. 746-747).

69. On September 29, 1998, the patient reported to Lakeside Memorial Hospital complaining of contractions. She was transferred to Buffalo Children's Hospital for management of pre-term labor (T. 752, Ex. 14 at 12, 15), and was admitted to Children's Hospital (Ex. 15) as having pre-term labor 32 weeks (Ex. 15 at 12).

70. Children's Hospital obtained the patient's permission to get her previous delivery record to determine the type of uterine incision Patient D had in the previous cesarean section (Ex. 15 at 27, 54, 55).

71. During the admission for pre-term labor that began September 29, the patient was

treated and discharged on October 2, 1998 (T. 756, Ex. 15 at 8).

72. On October 3, the patient called Respondent to complain about shooting, popping feelings in her abdomen and mucus from her vagina. He told her not to worry because it was part of the pregnancy. He also told her to stay off her feet and continue to take the Procardia to decrease the contractions (T. 33, 756-757).

73. At a later admission, the patient did successfully give birth vaginally at Children's Hospital (T. 755).

PATIENT E

74. Patient E was treated by Respondent for a twin pregnancy as a result of artificial insemination with an estimated date of confinement of August 22, 1996 (Ex. 17 at 47, T. 777). Patient E had been on Aldomet, an anti-hypertensive, during her pregnancy (Ex. 17 at 48, T. 778-779).

75. The patient was admitted to Lakeside Memorial Hospital on August 3, 1996, with a history of leaking fluid in early labor (Ex. 17 at 14, T. 778).

76. After 20:40 hours, the patient was noted as having contractions and leaking clear fluid since 06:30. She was found to have 2+ protein in her urine, 2+ pitting edema, and blood pressure of 180/94 (Ex. 17 at 14, T. 778-779).

77. The proteinuria (protein in the urine), in addition to the findings of edema and elevated blood pressure, indicate that the patient had pre-eclampsia (T. 779-780).

78. Patient E complained of blurry vision at 00:12 and at 01:10 on August 4 (Ex. 17 at 14-15, T. 781).

79. Pre-eclampsia can move to eclampsia or seizures without a lot of warning (T. 782). One warning sign of impending seizures is blurry vision (T. 782-783).

80. Prevention of seizures is important as morbidity and mortality for both mother and child increase with seizures (T. 782).

81. The patient was discharged from the hospital on Tuesday, August 6. After discharge, the patient made at least two telephone calls to Respondent (T. 214). She first called Respondent on Wednesday or Thursday and told him she was having continued massive headaches, swelling of her body, chest pains, and difficulty breathing when trying to walk to the bathroom (T. 205). Respondent did not respond to Patient E's complaints, and he did not ask her to come in for an assessment (T. 206). He told her this was normal (T. 209).

82. In the second telephone call, she told Respondent of the same complaints and told him that her chest pains were getting worse, not better (T. 214). Respondent again told her this was normal and it would take time for her body to return to normal (T. 214-215).

83. Respondent failed to appropriately evaluate Patient E for her complaints of headaches, edema and chest pain post-partum (T. 784). Symptoms of pre-eclampsia can return after delivery (T. 784).

84. A patient with those symptoms should have an in-office evaluation (T. 784-785).

85. On August 10, Patient E's husband called Respondent and informed Respondent that he was taking his wife to the Emergency Department (T. 216, 267). On admission to

the emergency department, the patient had a blood pressure of 180/119 with 4+ pitting edema (Ex. 18 at 5). She was treated with Lasix and Procardia (Ex. 18 at 6). She had about 5 liters of urine output in the first hour or two of treatment (Ex. 18 at 6).

PATIENT F

86. Respondent treated Patient F for a pregnancy with an estimated date of confinement of February 22, 1993 (T. 808, Ex. 19, 13).

87. On February 13, 1993, after 12:30 a.m., Patient F was awakened when she felt a "pop" in her abdomen and wetness on her legs. When she uncovered herself, she saw blood on her bed (T. 343-344).

88. Her husband and she saw a circle of blood eight to twelve inches in diameter (T. 305). She went to the bathroom and noted that she dripped blood on the carpet as she walked (T. 343-344). She sat on the toilet and saw blood in the toilet (T. 349).

89. Patient F's husband telephoned Respondent and told him that his wife was bleeding a lot (T. 305-306, 344)

90. Respondent stated that the patient's water had broken. He said it looked like blood only because he had examined her the day before, on February 12, and there can be bleeding after an examination (T. 306). Her husband replied that he thought it was more than that (T. 306).

91. Respondent stated that it was normal, and that they should call when the contractions started (T. 327, 345).

92. Respondent did not ask Patient F's husband any questions about how long she had been bleeding or about the quantity of fluid (T. 307).

93. Patient F and her husband returned to bed to see if the bleeding would stop (T. 307).

94. Following that first telephone call, the patient's husband made another telephone call to Respondent. He told Respondent basically the same information as in the first call and told Respondent that the bleeding was not stopping (T. 307-308).

95. Respondent again stated that Patient E's water had broken and that it was not necessary to call a ambulance (T. 308, 344

96. After an additional period of time at home, the patient and her husband decided to go to the hospital, although they still believed there was no emergency (T. 309-310).

97. At the hospital, the patient gave the obstetrics nurse her history of having bled for some period of time at home (Ex. 20 at 46, T. 293, 302).

98. Upon examination, the nurse noted that the patient was bleeding a large amount and that the fetal heart rate was in the 60's (T. 294-295). She called for a doctor stat, who ordered an immediate cesarean section due to the patient's hemorrhaging (T. 296).

99. Upon cesarean delivery, the physician found a severe abruption of the placenta (Ex. 20 at 14, 31, T. 812,).

100. The baby was severely depressed at birth (ex. 21 at 8, T. 815).

101. After delivery, Respondent saw Patient F in the hospital. She asked him if it would

not have been better if she had gone to the hospital sooner (T. 362). Respondent stated that would not have made any difference, that when things like that happen, the results are disastrous and there is nothing that could have been done (T. 362).

PATIENT G

102. Respondent treated Patient G during a pregnancy with an estimated date of confinement (EDC) of November 21, 1996 (Ex. 22 at 12, T. 861). The EDC was determined by an early ultrasound that was performed at about eight weeks gestation (T. 861). This same EDC was reported by another ultrasound done at 27 weeks gestation (T. 862).

103. During an office visit on October 30, 1996, Respondent noted that the patient was complaining of increasing contractions, feeling uncomfortable, and would like a cesarean section as soon as possible. Respondent's treatment plan was to move the appointment for a cesarean section to the next week (Ex. 22 at 15, T. 863).

104. Respondent performed an elective cesarean section on Patient G on November 6, 1996 (Ex. 23 at 15, T. 864), when the baby was 37 and 6/7 weeks gestational age. Respondent did not perform any testing to determine maturity of the lungs of the fetus (T. 864).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(3,19-20)
Paragraph A.1:	(3-7)
Paragraph A.2:	(10-12)
Paragraph A.3:	(13-14)
Paragraph A.4:	(15)
Paragraph A.5:	(16)
Paragraph B:	(21-22)
Paragraph B.1:	(25, 29-33)
Paragraph B.2:	Not Sustained
Paragraph C:	(35-36)
Paragraph C.1:	(37-43)
Paragraph C.2:	Not Sustained

Paragraph C.3:	Not Sustained
Paragraph C.4:	(46-51)
Paragraph C.5:	(52-53)
Paragraph C.6:	(54-66)
Paragraph D:	(67)
Paragraph D.1:	Not Sustained
Paragraph D.2:	Not Sustained
Paragraph D.3:	Not Sustained
Paragraph D.4 :	Not Sustained
Paragraph E:	(74-75)
Paragraph E.1:	Withdrawn
Paragraph E.2:	Not Sustained
Paragraph E.3:	(81-85)
Paragraph F:	(86-101)
Paragraph G:	Not Sustained

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise. The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

First Specification: (Paragraphs B and B.1; C and C.1, C.4, C.5 and C.6; E and E.3)

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Second Specification: (Paragraphs B and B.1 and E and E.3)

PRACTICING WITH GROSS NEGLIGENCE

Third Specification: (Paragraphs A and A.1 through A.5)

Eighth Specification: (Paragraph F)

PRACTICING WITH GROSS INCOMPETENCE

Ninth Specification: (Paragraphs A and A.1 through A.5 and Paragraph F)

PRACTICING FRAUDULENTLY

NOT SUSTAINED

MORAL UNFITNESS

NOT SUSTAINED

The Hearing Committee further concluded that the following specifications should not be sustained:

Fourth through Seventh Specifications

Tenth through Fifteenth Specifications

DISCUSSION

Respondent is charged with fifteen (15) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraud is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that five (5) of the fifteen (15) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the witnesses presented by the parties. The Department presented a total of twelve witnesses. Respondent presented a total of eight witnesses.

Anthony Levitano, M.D., J.D., testified as an expert witness for the Department. Dr. Levitano is board certified in obstetrics and gynecology. (T. 553) He is an Assistant Professor of Obstetrics and Gynecology at the Albany Medical College, Albany, New York and also practices medicine in this area.(Ex. 24,T. 553-554) The Hearing Committee found Dr. Levitano to be an overall credible witness, but was sometimes "too rigid" with the standard of care, particularly in the cases of Patients D and G.

The Hearing Committee also found all of the nurses that testified to be credible with respect to the facts they offered, even Nurse DuPont who had an apparent dislike for Respondent. They further found the testimony of Patients D and E to be credible. The husband of Patient E was credible with respect to the information he relayed to Respondent, again notwithstanding his dislike of Respondent. The Hearing Committee also found Investigator Trombley to be a credible witness. The Hearing Committee further found the testimony of Patient F and her husband to be credible, particularly with respect to the number of times they telephoned the Respondent.

The Hearing Committee found that Respondent was often evasive and not straightforward in his testimony. They found his frequent defensiveness as offensive. As a result, his credibility was greatly diminished. The Hearing Committee found Dr. Oates to be a credible witness. They further found Dr. Blackburn, Ila Hughes, RPA and three of Respondents satisfied patients to be credible witnesses, but that their testimony was not significant to the charges at hand.

PATIENT A

Respondent treated Patient A, born July 15, 1968, from around July 1992 through around October 1997. Following her care by Respondent, Patient A was diagnosed with breast cancer, stage IV. It is alleged that Respondent failed to appropriately evaluate Patient A for complaints concerning her right breast on July 12, 1996, March 21, 1997, June 30, 1997, September 30, 1997 and October 29, 1997.

Dr. Levitano testified that when a patient presents with bleeding from the nipple, there's an approximate 33% chance of breast cancer. The patient should have been referred to a surgeon for an open breast biopsy. (T. 567) Even Dr. Oates testified that after the negative ultrasound he would have repeated the examination to try to express fluid from the patient's breast. (T. 1473) He also stated that if the patient complains about her breast on several occasions and the gynecologist has not found the source of the problem, the patient should be referred for consultation. (T. 1475-1476) He further stated that a surgeon would be in a better position to evaluate these complaints than a

gynecologist. (T. 1483)

The Hearing Committee concurs with the above opinions. They conclude that Respondent should not have relied on the negative sonogram and should have referred her to a surgeon for a breast biopsy. They find that in this instance, Respondent acted with gross negligence and gross incompetence. Therefore, the Hearing Committee sustains the Eighth and Ninth Specifications.

PATIENT B

Respondent provided care to Patient B during a pregnancy with an estimated date of confinement (EDC) of August 19, 1998.

It is alleged that on or around August 3, 1998, Respondent inappropriately left the delivery room and/or Lakeside Memorial Hospital after delivery of a fetal death in utero but before the delivery of the placenta. Dr. Leviatno testified that leaving the patient prior to the delivery of the placenta does not meet the reasonable standard of care for an obstetrician.(T. 662-663) Even if the patient is stable before delivery of the placenta, the physician's leaving "shows an alarming disregard for the patient and lack of knowledge on the part of the doctor." Dr. Levitano further stated that postpartum hemorrhage can occur at any time. (T. 666-667) The Hearing Committee concurs with Dr. Levitano's opinion. They find that Respondent's belief that in the absence of a written hospital policy, it is acceptable to leave a patient during the third stage of labor to be incorrect. Thus, they find Respondent's actions in this instance to constitute both negligence and incompetence.

It is also alleged that Respondent fraudulently or inappropriately made notations in the hospital record which give the impression that he was present at time of the delivery of the placenta. The Hearing Committee finds that the Department did not prove that Respondent acted negligently, fraudulently or that he committed an act of moral unfitness when he completed and signed the labor record for Patient B. Therefore, only charge B.1 is sustained in the First and Second Specifications.

PATIENT C

Respondent treated Patient C during a pregnancy with an EDC of April 25, 1995. It is alleged that Respondent inappropriately left the delivery room after delivery of Patient C's infant but before delivery of the placenta. For the same reasons discussed in Charge B. 1, the Hearing Committee finds that Respondent's conduct did not meet acceptable standards of care in this instance (T. 678-679).

It is further alleged that Respondent waited too long to begin removal of the placenta and that Respondent fraudulently or inappropriately reported in his delivery note that Patient C was escorted from the delivery room to the recovery room in satisfactory condition. The Hearing Committee finds that the Department made "much ado about nothing" on these issues and that there is no persuasive evidence to support the allegations in Charges C.2 and C.3.

Charge C.4 alleges that Respondent inappropriately left Patient C and Lakeside Memorial Hospital after delivery of the placenta despite the patient's bleeding and abnormal vital signs during removal of the placenta and information that Patient C's vital signs had not adequately stabilized. Dr. Levitano testified that although Patient C's blood pressure was within normal limits, her pulse rate was very high. "This patient was likely still hypovolemic or behind on her fluids. Probably also reflecting the amount of blood loss that she sustained at that point." (T. 687) Dr. Levitano concluded that it was against reasonable standards of care for Respondent to leave the hospital because the patient was not yet stable and Respondent knew that the anesthesiologist would not be available to evaluate the patient. (T. 689-692) The Hearing Committee concurs with Dr. Levitano's opinion and sustains Charge C.4.

Charge C.5 alleges that Respondent inappropriately left Lakeside Memorial Hospital after being told by the anesthesiologist to be available as the anesthesiologist had to be present at another procedure. Dr. Levitano testified that this did not meet acceptable standards of care, again because the patient was not yet stable. (T. 692) The Hearing Committee concurs with Dr. Levitano and sustains Charge C.5.

Charge C.6 alleges that Respondent inappropriately refused to return to Lakeside Memorial Hospital despite the nursing supervisor's request that he return and attend to the patient and the nurse's statements to him concerning bleeding, low hematocrit, and/or unstable vital signs of the patient. Dr. Levitano testified that Respondent should have returned immediately based on his knowledge of Patient C's post delivery problems and that the nurse now noted signs of worsening and was requesting his return.(T. 697) Respondent argued that Nurse Baumbach, the nurse supervisor, was not as qualified to assess the patient because she was not an experienced OB nurse. (T.1155, 1157-1158,1592) The Hearing Committee rejects this and finds that Respondent should have returned regardless of the type of nurse conveying the information.

As a result, the Hearing Committee finds Respondent was negligent with respect to Patient C and thus sustains the First Specification.

PATIENT D

Respondent provided care to Patient D during a pregnancy with an EDC of November 27, 1998. Charge D.1 alleges that Respondent failed to appropriately discuss with Patient D the options of cesarean section versus attempted vaginal birth after cesarean section (VBAC). The Hearing Committee finds that there is no proof in the record to sustain this charge.

Charge D.2 alleges that Respondent fraudulently or inappropriately wrote in his record that he had discussed VBAC versus repeat C-section with Patient D when he had not done so. The Hearing Committee finds that there is no proof in the record to sustain this charge.

Charge D.3 alleges that Respondent failed to appropriately evaluate Patient D on or around September 18, 1998, after complaints of pre-term contractions. The Hearing Committee finds that Respondent made a proper evaluation of Patient D's pre-term labor at Lakeside Hospital and then had her transferred to Children's Hospital in Buffalo which had a better intensive care unit for newborns under 35 weeks . (Ex. 15, p12, T. 1281-1282) The Hearing Committee does not sustain this allegation.

Charge D.4 alleges that Respondent failed to appropriately evaluate Patient D on or around October 3, 1998, after complaints of contractions following discharge from Children's Hospital of Buffalo for treatment of pre-term labor. On October 3, 1998, Patient D called Respondent to complain about shooting, popping feelings in her abdomen and mucus from her vagina. Patient D testified that Respondent told her to stay off her feet and to keep taking her pills, (T.33), which was the Procardia that had been prescribed to decrease contractions. (T. 756) The Hearing Committee finds that Respondent appropriately recognized these contractions as Braxton Hicks and not real labor. They believe that his telephone diagnosis was appropriate and it was not necessary for Respondent to have seen Patient D in his office. The Hearing Committee further notes that Patient D testified that she was satisfied with the way Respondent took care of her during her pregnancy and she did not know why a complaint had been made in this instance. (T. 49, 50)

As a result, none of the above charges for Patient D are sustained.

PATIENT E

Respondent treated Patient E from around 1984 through around August 1996. Respondent provided care to Patient E during a pregnancy with an EDC of August 22, 1996. Charge E.1 was withdrawn by the Department. Charge E.2 alleges that Respondent failed to appropriately treat Patient E for pre-eclampsia during her labor on or about August 3, 1996. Dr. Levitano opined that Respondent's care deviated from the accepted standard of care because he failed to administer magnesium sulfate to prevent risk of seizures, after Patient E complained of blurry vision, which is a symptom of pre-eclampsia. (T. 781-783) Respondent explained that he ordered Apresoline to lower the patient's high blood pressure. He did not order magnesium sulfate, because he did not want to slow down labor. Respondent noted that the Apresoline effectively lowered Patient E's blood pressure and he thought it more important to deliver her two babies as soon as possible. (T. 1322-1328)

The Hearing Committee notes that Dr. Levitano acknowledged that Respondent

appropriately controlled Patient E's blood pressure and delivered the babies "very well." (T. 780-781) The Hearing Committee finds that it was a reasonable judgment call to forego the magnesium sulfate to expedite the labor. Therefore, they find that Respondent acted within acceptable standards of care and this allegation is not sustained.

Charge E. 3 alleges that Respondent failed to appropriately evaluate Patient E for complaints of headache, edema and/or chest pain post-partum, after discharge from the hospital. Dr. Levitano testified that Patient E suffered from post delivery pre-eclampsia and that Respondent should have physically examined her symptoms. Respondent should have checked her weight and blood pressure and compared them to her status at discharge. He should also have obtained blood studies. Dr. Levitano concluded that Respondent's lack of care fell below the reasonable standard.(T.783-785) The Hearing Committee believes that Patient E had telephoned Respondent to complain about her symptoms prior to her eventual ER admission. (T. 205-206, 214) They concur with Dr. Levitano that Respondent was negligent in not requiring Patient E to come in for a physical examination. Therefore, Charge E.3 is sustained in support of the First Specification.

PATIENT F

Respondent treated Patient F from around 1986 through around February 22, 1993. Patient F's baby was born with a diagnosis of asphyxia and neurological damage. Dr. Levitano stated that Respondent should have advised Patient F to go to the hospital for a physical examination after he received two telephone calls from Patient F's husband about continued vaginal bleeding during the night. (T. 809-812). Respondent had told the husband that Patient F's water had broke and that they should call back when the contractions start. (T. 306-308) Dr. Levitano further testified that the hospital record indicates that upon cesarean delivery, the physician found a severe abruption of the placenta. (Ex. 20, p.31, T. 812-8-13) Dr. Levitano concluded that the compromised outcome of this infant at birth is exactly what one would expect from an abruption and that an abruption is the kind of risk incurred when a woman has significant bleeding in the third trimester.(T. 815) Dr. Levitano

stated that Respondent's handling of the information reported to him about Patient F was a very severe deviation from a reasonable standard of care. (T. 815-816)

The Hearing Committee believes the information conveyed by Patient F's husband to be the truth and not Respondent's version that he was informed only that Patient F was "spotting." (T. 1400-1402) They concur with Dr. Levitano that this was a serious deviation from the standard of care. They find gross negligence and gross incompetence on part of Respondent in this case.

As a result, the Eighth and Ninth Specifications are sustained.

PATIENT G

Respondent treated Patient G from around September 1994 through at least January 1997. Respondent provided care to Patient G during a pregnancy with an EDC of November 21, 1996. It is alleged that Respondent performed an elective cesarean section on November 6, 1996, without adequate assessment and/or proof of fetal maturity.

Respondent testified that because he was concerned with Patient G's low weight gain, he did 3 ultrasounds to check on the baby's growth. (T. 1439) The last one was performed on 10/22/96, which showed normal growth and no evidence of intrauterine growth retardation. (T. 1441) He also testified that he was not required to perform any fetal lung maturity testing after 35 weeks as per the policy of Lakeside Hospital. (T. 1493, 1500-1501) Respondent further testified that Patient G complained of increasing cramps and requested that her C section date be moved up. (T.1496) Respondent delivered a healthy baby on November 6, 1996. (T. 1497-1498) The Hearing Committee does not agree with Dr. Levitano's opinion in this instance (T.864-866) and finds that Respondent acted within the reasonable standard of care.

Therefore, these charges were not sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent shall be placed on probation. The complete terms of probation are attached to this Determination and Order in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee continued the summary suspension at the end of the hearing because they were concerned with the cases involving Patients A and F. After full deliberation of all of the charges, they do not believe that the Department should have brought this matter as a summary action. The Hearing Committee therefore lifts the summary suspension against Respondent's license.

The Hearing Committee was primarily concerned with Respondent's handling of Patient's A and F. In the matter of Patient A, Respondent relied on a negative sonogram when he should have promptly referred her to a surgeon for a biopsy. With respect to Patient F, Respondent missed the reported symptoms of an abruption and put Patient F and her baby at risk. The Hearing Committee believes however, that by electing to bypass the closest hospital, the parents may have been a factor to the ultimate outcome of this case. The Hearing Committee further notes that Respondent acted within the standard of care with respect to Patients D and G. They believe that the Department overreached by charging Respondent with fraud as there was no proof of fraud or moral unfitness in the record.

Although Respondent must be held accountable for his professional misconduct for the charges that were sustained, the Hearing Committee believes his testimony demonstrates that he is a solo practitioner with a busy practice that by and large does good work. They believe that Respondent has been appropriately trained to practice obstetrics and gynecology. It is therefore the consensus of the Hearing Committee that Respondent can practice safely under supervision of a practice monitor and that the public will be adequately protected. They believe that revocation and monetary penalty as requested by the Department are too severe in this instance. They further note that Respondent's license has been suspended since March 4, 1999 and that he has already incurred substantial pecuniary punishment.

Under the totality of the circumstances, the two year stayed suspension with a practice monitor and probation is the appropriate sanction in this instance.

ORDER

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

1. The First, Second, Third, Eighth and Ninth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Fourth through Seventh, and Tenth through Fifteenth Specifications are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **two (2) years**, said suspension to be **STAYED.**

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order.

5. The Summary Suspension in effect since March 4, 1999 is **LIFTED.**

DATED: Rochester, New York
July 26, **1999**

John H Morton
JOHN H. MORTON, M.D.
(Chairperson)

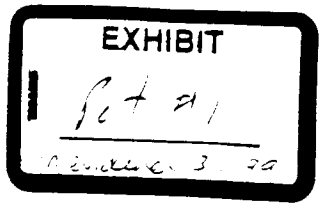
JOSEPH G. CHANATRY, M.D.
GEORGE C. SIMMONS, Ed.D

TO: Kevin P. Donovan, Esq.
NYS Department of Health
Corning Tower- 25th Fl.
Empire State Plaza
Albany, New York 12237

T. Lawrence Tabak, Esq.
Kern, Augustine, Conroy & Schoppmann, P.C.
420 Lakeville Road
Lake Success, New York 11042

Atif Wahba, M.D.
6 Valley Meadow Drive
Spencerport, New York 14559

APPENDIX I



STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	: COMMISSIONER'S
OF	: ORDER AND
ATIF WAHBA, M.D.	: NOTICE OF HEARING

----------X

TO: ATIF WAHBA, M.D.
6 Valley Meadow Drive
Spencerport, New York 14559

The undersigned, Dennis P. Whalen, Executive Deputy Commissioner of the New York State Department of Health, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by ATIF WAHBA, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12), that effective immediately ATIF WAHBA, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 11th day of March, 1999, at 10:00 a.m., at the offices of Alliance Court Reporting, The Alliance Building, 15th Floor, 183 East Main Street, Rochester, New York, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the

Statement of Charges with the below-named attorney for the Department of Health.

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

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180 (518-402-0751), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR

SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
March 4, 1999

DENNIS P. WHALEN
Executive Deputy Commissioner

Inquiries should be directed to:

Kevin P. Donovan
Associate Counsel
NYS Department of Health
Division of Legal Affairs
Corning Tower Building
Room 2509
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	: STATEMENT
OF	: OF
ATIF WAHBA, M.D.	: CHARGES

----------X

ATIF WAHBA, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 16, 1984, by the issuance of license number 159233 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. The Respondent treated Patient A (patients are identified in Appendix A), born July 15, 1968, from around July 1992 through around October 1997. Following her care by Respondent, Patient A was diagnosed with breast cancer, stage IV. Respondent's care of Patient A did not meet acceptable standards of care in that:

1. Respondent failed to appropriately evaluate Patient A for her July 12, 1996, presenting complaint of "swollen right breast, leaking pus, blood times one month, getting worse," and/or failed to refer her to a surgeon for open biopsy.
2. Respondent failed to appropriately evaluate Patient A for her March 21, 1997, complaints concerning her right breast.
3. Respondent failed to appropriately evaluate Patient A for her June 30, 1997, complaints concerning her right breast.
4. Respondent failed to appropriately evaluate Patient A for her September 30, 1997, complaints concerning her right breast.
5. Respondent failed to appropriately evaluate Patient A when she presented at his office on October 29, 1997.

B. The Respondent provided care to Patient B during a pregnancy with an estimated date of confinement (EDC) of August 19, 1998. Respondent's care of Patient B did not meet acceptable standards of care in that:

1. On or around August 3, 1998, Respondent inappropriately left the delivery room and/or Lakeside Memorial Hospital after delivery of a fetal death in utero but before delivery of the placenta.

2. Respondent fraudulently or inappropriately made notations in the hospital record which give the impression that he was present at time of delivery of the placenta.

C. The Respondent treated Patient C during a pregnancy with an EDC of April 25, 1995. Respondent's care of Patient C on or around May 15, 1995, did not meet acceptable standards of care in that:

1. Respondent inappropriately left the delivery room after delivery of the patient's infant but before delivery of the placenta.

2. Respondent waited too long to begin removal of the placenta.

3. Respondent fraudulently or inappropriately reported in his delivery note that Patient C was escorted from the delivery room to the recovery room in satisfactory condition.

4. Respondent inappropriately left Patient C and Lakeside Memorial Hospital after delivery of the placenta despite the patient's bleeding and abnormal vital signs during removal of the placenta and information that the Patient's vital signs had not adequately stabilized.

5. Respondent inappropriately left Lakeside Memorial Hospital after being told by the anesthesiologist to be available as the anesthesiologist had to be present at another procedure.

6. Respondent inappropriately refused to return to Lakeside Memorial Hospital despite the nursing supervisor's request that he return and attend to the patient and the nurse's statements to him concerning bleeding, low hematocrit, and/or unstable vital signs of the patient.

D. The Respondent provided care to Patient D during a pregnancy with an EDC of November 27, 1998. Respondent's care of Patient D did not meet acceptable standards of care in that:

1. Respondent failed to appropriately discuss with Patient D the options of Caesarean section versus attempted vaginal birth after Caesarean section (VBAC).

2. Respondent fraudulently or inappropriately wrote in his record that he had discussed VBAC versus repeat c-section with Patient D when he had not done so.

3. Respondent failed to appropriately evaluate Patient D on or around September 18, 1998, after complaints of pre-term contractions.

4. Respondent failed to appropriately evaluate Patient D on or around October 3, 1998, after complaints of contractions following discharge from Children's Hospital of Buffalo for treatment of pre-term labor.

E. The Respondent treated Patient E from around 1984 through around August 1996. Respondent provided care to Patient E during a pregnancy with an EDC of August 22, 1993. Respondent's care of Patient E did not meet acceptable standards of care in that:

1. Respondent failed to appropriately respond to symptoms of pre-eclampsia, including reports of chest pain, edema, and elevated blood pressure toward the end of Patient E's pregnancy.

2. Respondent failed to appropriately treat Patient E for pre-eclampsia during her labor on or about August 3, 1996.

3. Respondent failed to appropriately evaluate Patient E for complaints of elevated blood pressure and/or chest pain post-partum, after discharge from the hospital.

F. The Respondent treated Patient F from around 1986 through around February 13, 1993. Respondent provided care to Patient F during a pregnancy with an EDC of February 22, 1993. Patient F's baby was born with a diagnosis of asphyxia and neurological damage. Respondent's care of Patient F did not meet acceptable standards of care in that Respondent failed to appropriately respond to reported vaginal bleeding during the early morning hours of February 13, 1993.

G. The Respondent treated Patient G from around September 1994 through at least January 1997. Respondent provided care to Patient G during a pregnancy with

an EDC of November 21, 1996. Respondent's care of Patient G did not meet acceptable standards of care in that Respondent performed an elective Caesarean section on November 6, 1996, without adequate assessment and/or proof of fetal maturity.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law § 6530(3) in that Petitioner charges two or more of the following:

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

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion within the meaning of N.Y. Educ. Law § 6530(5) in that the Petitioner charges two or more of the following:

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

THIRD THROUGH EIGHTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of N.Y. Educ. Law § 6530(4) in that the Petitioner charges:

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

4. The facts in paragraphs B and B.1 and/or B and B.2.

5. The facts in paragraphs C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, and/or C and C.6.

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

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

8. The facts in paragraph F.

NINTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Educ. Law § 6530(6) in that Petitioner charges:

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

TENTH THROUGH TWELFTH SPECIFICATIONS

PRACTICING FRAUDULENTLY

The Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law § 6530(2) in that the Petitioner charges:

10. The facts in paragraphs B and B.2.

11. The facts in paragraphs C and C.3.

12. The facts in paragraphs D and D.2.

THIRTEENTH THROUGH FIFTEENTH SPECIFICATIONS

MORAL UNFITNESS

The Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of N.Y. Educ. Law § 6530(20) in that the Petitioner charges:

13. The facts in paragraphs B and B.2.

14. The facts in paragraphs C and C.3.

15. The facts in paragraphs D and D.2.

DATED: March 4, 1999
Albany, New York

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

APPENDIX II

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board, addressed to the Director, Office of Professional Medical Conduct ("OPMC"), 433 River Street, Suite 303, Troy, New York 12180-2299 regarding any change in employment, practice, address, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's practice of medicine shall be monitored by a physician monitor, board certified in obstetrics and gynecology, ("practice monitor") approved in advance, in writing, by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. An approved practice monitor shall be in place **within (30) days of the effective date of this Order.** Any practice of medicine prior to the submission and approval of the proposed practice monitor will be determined to be a violation of probation.

(a) Respondent shall cause the practice monitor to report quarterly in writing to the Director of the Office of Professional Medical Conduct or his/her designee. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's hospital and medical office practice at each and every location, on a random, unannounced basis at least monthly and shall examine no less than 10 records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's hospital and office medical practice is conducted in accordance with the generally accepted standards of professional medical care, **including standards set forth in ACOG.** Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to the Office of Professional Medical Conduct by the monitor.

(b) Any change in practice monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

(c) It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.

7. Respondent shall maintain legible and complete hospital and office medical records which accurately reflect evaluation and treatment of patients. All hospital and office medical records shall contain a comprehensive history, physical examination

findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record shall contain all information required by state rules and regulations regarding controlled substances.

8. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

9. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with §230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

10. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against the Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.