

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

Richard Yaldizian, Physician
133-34 87th Street
Ozone Park, New York 11417

November 15, 1991

Re: License No. ~~151585~~
151575

Dear Dr. Yaldizian:

Enclosed please find the order of the Deputy Commissioner for the Professions No. 12226. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation, surrender, or an actual suspension (suspension which is not wholly stayed) of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. 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. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations

By:


GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Anthony Rattoballi, Esq.
147 S. Franklin Avenue
Valley Stream, New York 11580

REPORT OF THE
REGENTS REVIEW COMMITTEE

RICHARD YALDIZIAN

CALENDAR NO. 12226



The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

RICHARD YALDIZIAN

No. 12226

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

REPORT OF THE REGENTS REVIEW COMMITTEE

RICHARD YALDIZIAN, 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.

This disciplinary proceeding was properly commenced and on January 29, 1991, March 8, 1991 and March 15, 1991, a hearing was held 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, including the statement of charges and excluding the appendix of patient names, is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee unanimously concluded that respondent was guilty of the third, fifth, sixth, ninth, tenth, eleventh, and thirteenth specifications of the charges to the extent indicated

RICHARD YALDIZIAN (12226)

in its report, and recommended that respondent's license to practice medicine be partially suspended with his practice limited to that provided as a resident in an accredited internal medicine training program for one year, restored contingent on the satisfactory completion of a residency program and a \$5,000 fine.

The Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted in full, and further recommended that the penalty recommended by the hearing committee be modified and that, in lieu of the limitation on respondent's practice recommended by the hearing committee and a fine, respondent's license to practice medicine should be revoked. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "B".

On August 22, 1991 respondent appeared before us in person and was represented by his attorney, Anthony Rattoballi, Esq., who presented oral argument on behalf of respondent. Jean C. Bressler, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was revocation of respondent's license.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was

RICHARD YALDIZIAN (12226)

a fine plus a probationary period and community service. At our hearing, respondent's attorney suggested a short suspension and a fine.

We have considered the record as transferred by the Commissioner of Health in this matter. Such review has also included the transcripts from a pre-hearing conference of January 29, 1991 and an intra-hearing conference of March 15, 1991, which transcripts were received on August 22, 1991, which review was encouraged by respondent and not objected to by petitioner.

We note that according to the letter of Tyrone T. Butler, Director of the Bureau of Adjudication of the Department of Health, dated August 21, 1991, the Commissioner of Health, who reviewed the record which reflects the existence of the transcripts of the conferences, did not, in fact, review these two transcripts. We do not view the absence of review of these transcripts, to which the Commissioner of Health had access, to indicate a failure by the Commissioner of Health to fulfill his statutory duties with regard to this disciplinary matter. See, Matter of Smith, Cal. No. 11657. Cf., DiMarsico v. Ambach, 424 N.Y.S.2d 107, reargument denied 425 N.Y.S.2d 1029, on remand 425 N.Y.S.2d 894.

With regard to the thirteenth specification of fraud, it is our unanimous opinion that the hearing committee's conclusion of guilt is supported by the record and that the record establishes, by a preponderance of the evidence, that respondent knew that he

RICHARD YALDIZIAN (12226)

was not board certified as a diplomate in internal medicine at the time that he represented himself to be so certified and that he knowingly and intentionally misrepresented his circumstances.

We further conclude that the conduct set forth in paragraph F1 of the statement of charges, which the hearing committee and the Commissioner of Health concluded constituted gross negligence under the sixth specification, also constitutes negligence under the ninth specification.

Likewise, we conclude that the conduct set forth in paragraphs D1, D2 and H1 of the statement of charges, which the hearing committee and the Commissioner of Health concluded constituted gross incompetence under the tenth specification, also constitutes incompetence under the eleventh specification.

Finally, we note that it was undisputed at our hearing that respondent's license number is 151575, not 151515 as stated in the statement of charges, and we deem the charges so corrected.

We unanimously recommend that:

1. The findings of fact of the hearing committee and the Commissioner of Health's recommendation as to those findings be accepted;

2. The following additional finding of fact be accepted:

Respondent knew that he was not board certified by the American Board of Internal Medicine as a diplomate in internal medicine at the time that he represented himself to be so certified to the Catholic Medical Center of Brooklyn and Queens and knowingly and intentionally misrepresented his circumstances;

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3. The conclusions of the hearing committee as to guilt and the recommendation of the Commissioner of Health as to those conclusions be accepted, except that they be modified by the additional guilt under the ninth and eleventh specifications as hereinabove set forth, and respondent be found guilty, by a preponderance of the evidence, of three specifications of gross negligence (third, fifth, and sixth), involving the diagnosis and treatment of three emergency patients; negligence on more than one occasion (ninth), involving the diagnosis and treatment of five emergency patients; gross incompetence (tenth), involving the diagnosis and treatment of two emergency patients; incompetence on more than one occasion (eleventh), involving the diagnosis and treatment of seven emergency patients; and fraud (thirteenth), involving respondent's representing that he was certified as a diplomate in internal medicine when he knew that he was not so certified; and respondent be found not guilty of the remaining specifications and charges;
4. The recommendations of the hearing committee and Commissioner of Health as to the measure of discipline not be accepted; and
5. Respondent's license to practice as a physician in the

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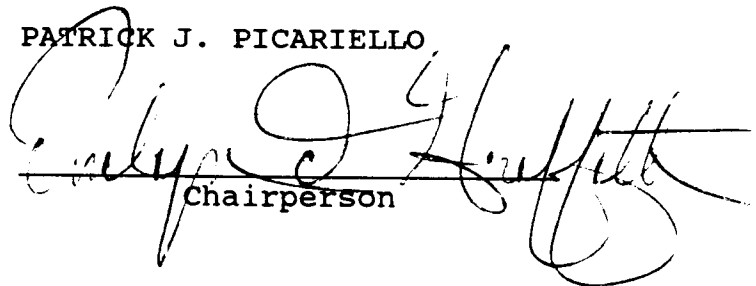
State of New York be suspended for three years upon each specification of the charges of which we recommend respondent be found guilty as aforesaid, said suspensions to be imposed concurrently, that execution of the last two years of said suspensions be stayed, and that respondent be placed on probation for the entire three years of said concurrent suspensions in accordance with the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "C", which include the requirement that respondent perform coursework and that his practice be monitored.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO


Chairperson

Dated: 10/15/91

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

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IN THE MATTER : REPORT OF THE
OF : HEARING
RICHARD YALDIZIAN, M.D. : COMMITTEE

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

Daniel W. Morrissey, O.P., Chairman, Erwin Lear, M.D.
and David T. Lyon, 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. Michael P. McDermott, Esq., Administrative
Law Judge, served as Administrative Officer for the Hearing
Committee

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

Notice of Hearing and
Statement of Charges dated: December 19, 1990

Pre-Hearing conferences: January 29, 1991

Intra Hearing conference: March 15, 1991

Hearing Dates:

January 29, 1991
March 8, 1991
March 15, 1991

Place of Hearing

N.Y.S. Dept. of Health Offices
1/29/91 - 8 East 40th Street
New York, N.Y.
3/8/91 - 5 Penn Plaza
New York, N.Y.
3/15/91 - 5 Penn Plaza,
New York, New York

Deliberation Date:

April 15, 1991

Petitioner appeared by:

Peter J. Millock, Esq.
General Counsel
New York State
Department of Health
By: Jean Bressler, Esq.
Associate Counsel

Respondent appeared by:

Anthony Rattoballi, Esq.
118-10 101st Avenue
Richmond Hill, New York 11419

WITNESSES

FOR THE PETITIONER:

1) Mark Henry, M.D.

FOR THE RESPONDENT:

- 1) Regina Grilli, R.N.
- 2) M [REDACTED] M [REDACTED]
- 3) Richard Yaldizian, M.D.
- 4) Robert Labison, M.D.

STATEMENT OF CHARGES: Essentially the Statement of Charges charges the Respondent with Profession Misconduct by reason of practicing the professional of medicine with gross

negligence; with negligence on more than one occasion, with gross incompetence and with incompetence in his treatment of eight patients.

The Statement of Charges also charges that the Respondent practiced the profession fraudulently in that he represented in a letter that he was certified by the American Board of Internal Medicine as a diplomat in internal medicine when in fact he was not so certified.

The charges against the Respondent are more specifically stated in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

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.

FINDINGS OF FACT
AS TO PATIENT A

1. The Respondent treated Patient A at the Emergency Department of Mary Immaculate Hospital on June 23, 1989 (Pet's Ex. 2; Tr. 18).
2. The triage notes indicate Patient A complained of burping, gas pain in the chest for three hours and numbness in the left elbow only (Pet's Ex. 2; Tr. 20).
3. Patient A gave a history of hypertension and stated that he was taking beta blockers (Pet's Ex. 2; Tr. 22).
4. The Respondent ordered an EKG which was performed and evaluated by him (Pet's Ex. 2, Tr. 21).
5. The Respondent read the EKG as showing no acute changes (Pet's Ex. 2; Tr. 21).
6. In fact, the EKG suggests acute myocardial ischemia injury pattern, or ischemic heart disease, precursor to a myocardial infarction (Pet's Ex. 2; Tr. 22)

7. The Respondent discharged Patient A but failed to arrange for follow-up care (Tr. 23, 26).
8. The Respondent admitted misreading Patient A's EKG. He stated that at the time he read the EKG he thought it was within normal limits but now agrees that this was a mistake (Tr. 257, 261).

CONCLUSIONS AS TO PATIENT A

Given Patient A's condition, the Respondent should have admitted the patient to the hospital to rule out myocardial ischemia or myocardial infarction.

The Respondent misinterpreted Patient A's EKG and in discharging the patient he placed the patient at serious risk.

Having inappropriately discharged the patient, the Respondent was further remiss in not providing for further follow-up care.

FINDINGS OF FACT AS TO PATIENT B

1. Patient B, a 62 year old man, presented to the Emergency Department of St. John's Hospital on July 1, 1988 complaining of pain radiating across his back with

diaphoresis. He had taken nitroglycerin sublingually (Pet's Ex. 3; Tr. 85).

2. Patient B had a past medical history of myocardial infarction (Pet's Ex. 3; Tr. 85).
3. According to the medical record, the Respondent examined Patient B, made a diagnosis of left scapula strain and discharged him (Pet's Ex. 3; Tr. 86).
4. Patient B died later that day (Pet's Ex. 3).
5. The Respondent acknowledges speaking with Patient B, writing a history, physical, making a diagnosis, recommending treatment and authorizing the patient's discharge (Tr. 284-285).

CONCLUSIONS AS TO PATIENT B

Given Patient B's prior history; and current symptoms, the Respondent should have taken a complete cardiovascular system history; should have had a high suspicion of ischemic heart disease; and should have ordered an EKG.

Patient B was the Respondent's responsibility and the Respondent did not properly discharge his responsibility to this patient.

FINDINGS OF FACT AS TO PATIENT C

1. Patient C, presented to the Emergency Department of St. John's Hospital on July 8, 1988 (Pet's Ex. 4)
2. At that time, Patient C's temperature was 100.5, pulse was 112 and respiration was 24. His weight was 120 pounds (Pet's Ex. 4; Tr. 110).
3. The patient complained of weakness, weight loss, fever, chills, cough, nausea and shortness of breath (Pet's Ex. 4; Tr. 111).
4. The Respondent noted that the patient was cachectic, had a respiratory rate of 30, bibasilar rales, and tachycardia (Pet's Ex. 4; Tr. 112).
5. The Respondent made a diagnosis of pneumonia, signed the patient's chart, prescribed erythromycin and made a

discharge plan before reviewing the chest X-ray he had ordered. (Pet's Ex. 4; Tr. 112, 115).

6. The chest X-ray evidenced a markedly enlarged cardiac silhouette in conjunction with advanced congestive changes. The X-ray raised the possibility of a pericardial effusion and/or the possibility of congenital heart disease (Pet's Ex. 4; Tr. 113).

CONCLUSIONS AS TO PATIENT C

It was inappropriate for the Respondent to have made a diagnosis of pneumonia and to prescribe an antibiotic without first having evaluated the chest x-ray he had ordered.

The Respondent's own findings of abnormal vital signs and cachetic appearance should have prompted him to admit this patient to the hospital.

FINDINGS OF FACT ON PATIENT D

1. Patient D, presented to the Emergency Department of Mary Immaculate Hospital on June 23, 1989 (Pet's Ex. 5).

2. The Respondent examined Patient D and noted a pulse of 40, respiratory rate of 16 and blood pressure of 100/60 (Pet's Ex. 5; Tr. 48).
3. The Respondent reviewed the EKG which he had ordered and diagnosed cardiac arrhythmia/failure to thrive (Pet's Ex. 5; Tr. 48).
4. The Respondent admitted Patient D to the general floor in an unmonitored bed. The patient was later transferred to the ICU by a another physician (Pet's Ex. 5; Tr. 59).
5. The Respondent incorrectly evaluated the EKG. The EKG evidenced a ventricular rate of 35, first degree heart block, second degree heart block with 2 to 1 block and right bundle branch block (Pet's Ex. 5; Tr. 48-49).
6. The Respondent acknowledged that Patient D should have been provided with a standby external pacemaker and that he failed to order one (Tr. 340).

CONCLUSIONS AS TO PATIENT D

The Respondent's interpretation of Patient D's EKG failed to identify second degree heart block.

Given Patient D's abnormal EKG, the Respondent should have ordered monitoring and a stand-by pacemaker. He failed to do so.

PROPOSED FINDINGS OF FACT OF PATIENT E

1. The Respondent treated Patient E on February 22, 1989 at the Emergency Department of St. John's Hospital (Pet's Ex. 6).
2. The Ambulance call report states that Patient E was picked up in her doctor's office where she complained of chest pain, onset at rest, the pain was accompanied by nausea and shortness of breath (Pet's Ex 6; Tr. 131, 132).
3. She was given nitroglycerin five times with no relief. The paramedics then gave her three milligrams of morphine sulfate which relieved the pain (Pet's Ex. 6; Tr. 131-132).
4. In the emergency room, Patient E stated, "I have a crushing vice-like chest pain" (Pet's Ex. 6; Tr. 132).

5. The patient had a history of a heart attack in 1970, diabetes and hypertension (Pet's Ex. 6; Tr. 132).
6. The Respondent examined the patient and ordered several tests including an EKG which he read as old interior wall myocardial infarction (Pet's Ex. 6; Tr. 133).
7. The Respondent failed to contact Patient E's private physician who had referred her to the emergency room (Tr. 133).
8. The Respondent gave the patient Maalox, made a diagnosis of esophagitis and discharged the patient (Pet's Ex. 6; Tr. 133).

CONCLUSIONS AS TO PATIENT E

Given Patient E's complaint of crushing pain, her prior history (hypertension, diabetes, and old M.I.), the fact that she was not relieved by nitroglycerine but by morphine, the patient should have been admitted to the hospital to rule out myocardial infarction. Instead, the Respondent either ignored or did not recognize the risk and discharged her.

Patient E was sent to the hospital in an ambulance by her private physician. The Respondent should have called this physician before attributing the damage shown on the EKG to old damage and before discharging her.

Considering that Patient E was given nitroglycerine five times with no relief and that the paramedics then gave her three milligrams of morphine sulfate, the Respondent should not have attributed the patient's relief of chest pain to the Maalox.

FINDING OF FACT AS TO PATIENT F

1. On October 7, 1988 Patient F was transported by ambulance to Saint Johns Hospital Emergency Department complaining of sharp substernal chest pain (Pet's Ex. 7; Tr. 144).
2. Patient F had a past history of angina (Pet's Ex. 7; Tr. 144).
3. The triage note indicates that the patient complained of chest pain (Pet's Ex. 7; Tr. 145).

4. Patient F's past medical history is noted as angina, diverticulitis and meningitis (Pet's Ex. 7; Tr. 145)
5. Patient F was seen by the Respondent who noted that the patient presents for chills, generalized aches, vague anterior chest pain without nausea, vomiting, shortness of breath or diaphoresis. Positive sore throat. Denies cough, stiff neck, diarrhea, abdominal pain. After a physical exam, the patient's chest X-ray is noted as negative. The Respondent discharged this patient with a diagnosis of pharyngitis. (Pet's Ex. 7; Tr. 145-146).
6. The radiologist report of the X-Ray states "Diffuse chronic lung changes and cardiomegaly are present. There is prominence of the pulmonary vasculature and atelectatic changes or infiltrates at both lung bases (Pet's Ex. 7).
7. The Respondent failed to evaluate the EKG he had ordered (Pet's Ex. 7; Tr. 148, 353)

CONCLUSIONS AS TO PATIENT F

The Respondent misinterpreted Patient F's chest X-ray and failed to evaluate the patient's EKG.

He also failed to adequately address Patient F's chief complaint of substernal chest pain and failed to adequately characterize the patient's patterns of chest pain.

FINDINGS OF FACT AS TO PATIENT G

1. On October 19, 1988, Patient G presented via EMS ambulance to the Emergency Department of St. John's Hospital complaining of severe pain on the left side of his head. The family stated that the patient had had four seizures and that he might have migraine headaches (Pet's Ex. 8; Tr. 155)
2. The Respondent's notes state that "the patient presents for several seizures today and over the past week." He notes Cafegot for headache and a history of encephalitis and seizure disorder (Pet. Ex. 8; Tr. 156).
3. The Respondent ordered lab tests and gave the patient 5 milligrams of Valium IV push. His notes go on to state "Dr. Abir notified, case presented, agrees with discharge if stable" (T. 156).

4. No temperature is recorded in Patient G's chart (Pet's Ex. 8)
5. The patient was discharged with instructions to continue seizure medications and Xanax (Pet's Ex. 8; Tr. 156)
6. The lab results, which returned after the patient's discharge, indicated no Dilantin present and Tegretol was well below the therapeutic range (Pet's Ex. 8; Tr. 157)

CONCLUSIONS AS TO PATIENT G

Valium was not indicated in this case since this patient was not in actual seizure at the time he was seen by the Respondent.

Valium is not effective in treating any long term aspects of seizure disorders.

The Respondent should have noted whether the patient was still shaking or having headaches on discharge.

The Respondent should have insured that prompt follow-up be provided for this patient once serum levels were available in order to provide adequate anticonvulsant therapy.

FINDINGS OF FACT AS TO PATIENT H

1. On November 30, 1988, Patient H presented to the Emergency Department at St. John's Hospital with complaints associated with an assault which occurred on November 27, 1988 (Pet's Ex. 9; Tr. 171).
2. After the assault, Patient H felt drowsy, nauseated and her head ached (Pet's Ex. 9; Tr. 171).
3. The Respondent noted on physical exam, swelling, tenderness, ecchymosis on the left side facial area, tender on the cervical spine C-4 through C6, bruising of the right shoulder, swelling in the left foot, tender left hip. The Respondent ordered X-rays of the cervical and lumbar spine, right shoulder and left foot (Pet's Ex. 9; Tr. 171).
4. The Respondent noted that the X-rays were negative, diagnosed right shoulder, left facial and foot contusions, and cervical lumbar strain. The Respondent discharged the patient and signed the chart (Pet's Ex. 9; Tr. 171-172).

5. The cervical spine X-rays reviewed by the Respondent indicated fractures on C-7 and T-1 (Pet's Ex. 10; Tr. 173-174).
6. The Respondent acknowledged reviewing the X-rays and missing these fractures. He also now acknowledges that the fractures are obvious (Pet's Ex. 10; Tr. 320)

CONCLUSIONS AS TO PATIENT H

The Respondent failed to detect obvious fractures in patient H's cervical spine.

FINDINGS OF FACT RELATIVE TO THE RESPONDENT'S ALLEGED CERTIFICATION IN INTERNAL MEDICINE

On or about August or September 1989 the Respondent represented in a letter to Catholic Medical Center of Brooklyn and Queens 88-25 153rd Street, Jamaica, N.Y. 11432, that he was certified by the American Board of internal medicine as a diplomat in internal medicine. The Respondent has never been board certified in internal medicine. (Pet's Ex. 12 and 13; Tr. 254, 264, 280.)

CONCLUSIONS AS TO THE RESPONDENT'S BOARD CERTIFICATION

The Respondent has never been certified as a diplomat in internal medicine, but he represented that the was so certified.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously (3-0) as follows:

FIRST THROUGH EIGHTH SPECIFICATIONS
PRACTICING WITH GROSS NEGLIGENCE

SUSTAINED as to paragraphs C1, C2, E1, F1,

NINTH SPECIFICATION
NEGLECT ON MORE THAN ONE OCCASION

SUSTAINED as to paragraphs A3, A4, B1, B2, B3, C1, C2, E1, E3

TENTH SPECIFICATION
PRACTICING WITH GROSS INCOMPETENCE

SUSTAINED as to paragraph D1, D2, H1

ELEVENTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

SUSTAINED as to paragraphs A1, A2, A3, A4, C2, E1, F1, G3

TWELFTH AND THIRTEENTH SPECIFICATION
FRAUD

SUSTAINED as to paragraph I

The Hearing Committee is aware that paragraph I of the Statement of Charges alleges that "on or about June or July 1988", the Respondent falsely represented that he was board certified in internal medicine, and that the evidence in the case indicates that the false representation actually took place on or about August or September 1989.

In sustaining the charge of fraud as specified in paragraph I, the Hearing Committee was of the opinion that the language of paragraph I gave the respondent sufficient notice of the specific allegation of fraud against him. The essence of the charge is that he misrepresented that he was board certified. The error in dates worked no prejudice against him and should not defeat the charge.

RECOMMENDATIONS

After reviewing the entire record in this matter, the Hearing Committee is very concerned with the recurring pattern of negligence and incompetence in the Respondent's practice.

During the hearing, the Respondent demonstrated an alarming indifference and little remorse for his accumulated record of serious failures.

The Hearing Committee was troubled by the Respondent's defensive posture in which he was quick both to blame others for his mistakes and to excuse his own culpable behavior.

In the hope of awakening the Respondents sense of responsibility and in the best interest of patient care, the Hearing Committee recommends a partial suspension of the Respondent's license to practice medicine, such that his practice of medicine be limited to that provided as a resident in an accredited internal medicine training program for a period of one year. Full restoration of the Respondent's licence should be contingent upon satisfactory completion of the residency program.

It is a further recommendation of the Hearing Committee that it is appropriate in this case and salutary for the Respondent to assess a penalty of Five Thousand (5,000.00) Dollars.

It is hoped that the penalties recommended by the Hearing Committee will impress upon the Respondent the seriousness of the numerous offenses committed this early in his medical career.

Daniel W. Morrissey, O.P.
Daniel W. Morrissey, O.P., Chairman
Erwin Lear, M.D.
David T. Lyon, M.D.

4/29/91

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

-----X

IN THE MATTER : STATEMENT
OF : OF
RICHARD YALDIZIAN, M.D. : CHARGES

-----X

RICHARD YALDIZIAN, M.D., the Respondent, was authorized to practice medicine in New York State on May 24, 1982 by the issuance of license number ¹⁵¹⁵²⁵~~151515~~ by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991 at 82-12 151st Street Howard Beach, New York 11414-0000.

FACTUAL ALLEGATIONS

PATIENT A

A. Respondent treated Patient A, a 61 year old male, at the Emergency Department of Mary Immaculate Hospital, 152-11 89th Avenue, Jamaica, New York, on or about June 23, 1989. The patient complained of burping and pain in the chest and epigastic area. He gave a history of heart disease and hypertension. An EKG was performed and read by the Respondent as showing no acute changes. Respondent diagnosed acute gastroesophagitis and discharged the patient. Later the same day Patient A was admitted to the hospital by his private

attending physician with an acute myocardial infarction. Respondent's care and treatment of Patient A deviated for acceptable medical standards in that:

- ✓ 1. Respondent misread the EKG. He failed to recognize acute changes consistent with myocardial ischemia.
2. Respondent failed to take an adequate history related to Patient A's complaints of chest pain.
- ✓ 3. Respondent failed to admit the patient to the hospital.
4. Respondent discharged the patient without any provision for follow-up care.

PATIENT B

B. Respondent treated Patient B, a 62 year old male at the Emergency Department of Saint Johns Hospital 90-20 Queens Blvd., Elmhurst, New York, on July 1, 1988. He was complaining of pain in the left shoulder radiating to his right arm "with diaphoresis". Patient B gave a history of myocardial infarction

in 1975. The patient reported taking Nitroglycerin sublingually "with good relief". After examining Patient B, Respondent wrote "pt presenting for L scapular pain P E tender L strap muscle". He diagnosed "L scapular strain" and wrote a discharge note ordering warm compresses, cervical collar and gentle message. Patient B died later the same day. Respondent's care and treatment of Patient B deviated from acceptable medical standards in that:

1. The information obtain by the Respondent from Patient B, related to his anginal history and current complaints of chest pain, was inadequate.
2. Respondent's physical examination of Patient B was inadequate.
3. Respondent failed to order an E.K.G.

PATIENT C

C. Respondent treated Patient C, an 18 year old male, at the Emergency Department of Saint John's on or about July 8, 1988. He was complaining of difficulty breathing for one week, coughing, and nausea for over a week. His temperature was between 100.3 and 100.5, his pulse was between 110 and 112, his

respiration was between 24 and 30 and his weight was 120 pounds. The nurse noted recent weight loss, shortness of breath, coughing and sweating. Respondent noted weakness, weight loss, fever, chills, shortness of breath, nausea and cough with production of yellow sputum. Respondent's physical examination of Patient C revealed a cachectic appearing male with bibasilar rales and tachycardia. Respondent ordered CBC, chest X-ray and sputum culture. Respondent diagnosed pneumonia and discharged the patient on antibiotics. Respondent's care and treatment of Patient C deviated from acceptable medical standards in that:

1. Respondent's diagnosis and treatment of Patient C's condition, without reviewing the chest X-ray and blood results, was presumptive in light of the results of the history obtained and physical exam performed, by the Respondent.
2. Respondent failed to admit this patient whose clinical symptoms warranted admission.

PATIENT D

D. Respondent treated Patient D, an 87 year old male, at the Emergency Department of Mary Immaculate Hospital on June 23, 1989. He complained of nausea, anorexia and constipation. His pulse was 40 and blood pressure 100/60. Respondent ordered CBC, SMA 6, urinalysis, chest X-ray and E.K.G. Respondent diagnosed cardiac arrhythmia and failure to thrive. Respondent read the E.K.G. as sinus bradycardia. Respondent's care and treatment of Patient D deviated from acceptable medical standards in that:

1. He failed to correctly interpret the E.K.G. which demonstrates heart block.
2. He failed to arrange for immediate cardiac monitoring and a temporary pacemaker.
3. He failed to note that the patient was taking Digoxin in the history or diagnosis. Digoxin excess should have been considered as a possible cause of his heart block.

PATIENT E

E. Respondent treated Patient E, a 57 year old female who was transferred by ambulance from her private medical doctor's office to the Emergency Department at Saint John's Hospital on February 22, 1989. She complained of crushing chest pain. She was noted to have had a history of myocardial infarction in 1970, diabetes and hypertension. Respondent noted that she was given nitroglycerin in the ambulance three times with no relief but was relieved by taking morphine. Respondent ordered an E.K.G. and read it as showing an old inferior wall M I. The patient was given Mylanta, and a second nursing note stated pain relieved after Mylanta. Respondent diagnosed esophagitis and discharged the patient with instructions to see her private medical doctor for blood tests and to take maalox 2 tsp. every 6 hours. Respondent's care and treatment of Patient E deviated from acceptable medical standards in that:

1. He failed to admit the patient to rule out myocardial ischemia as the cause of her chest pain.
2. He failed to order a second E.K.G. The original is of suboptimal quality and may suggest acute changes in the inferior leads.

3. Respondent failed to contact her private medical doctor who had her transferred to the Emergency Department. If the E.K.G. findings were to be attributed to old disease, this physician should have been contacted for information about prior E.K.G's.

PATIENT F

F. Respondent treated Patient F an 86 year old male at the Emergency Department of Saint John's Hospital on October 7, 1988. He was complaining of sharp substernal pain. The Emergency Medical Technician noted pain in the a.m. with shivering which stopped and returned in the p.m. He was treated with oxygen and transported to the hospital. Nurses notes indicated that he presented with complaints of chest pain and "took NTG with relief". He had a past medical history of angina, diverticulitis and meningitis. Respondent's notes indicate "patient presents' for chills, generalized aches, vague anterior chest pain without nausea, vomiting, shortness of breath and diaphoresis. Positive sore throat. Denies cough, stiff neck, diarrhea, abdominal pain GU complaints". He had a temperature of 102. Respondent diagnosed pharyngitis, prescribed antibiotics, Tylenol and cough syrup and discharged the patient.

Respondent's care and treatment of Patient F deviated from acceptable medical standards in that:

1. Respondent failed to adequately address the patient's chief complaint of chest pain. No cardiac history or history related to anginal pattern was taken.

PATIENT G

G. On or about October 19, 1988 Patient G, a 48 year old male presented to the Emergency Department of Saint John's Hospital complaining of severe pain on the left side of his head. His family reported that he had 4-5 seizures. He gave a history of seizures and migraine headaches. Medications are listed as Tegretol, Cafergot and Dilantin. Respondent noted "voluntary" shaking, history of several seizures. After taking a history and performing a physical examination Respondent ordered 5 mg. IV Valium. He ordered a CBC as well as Dilantin and Tegretol levels. There is no note in the chart to indicate that Respondent reviewed the blood levels of Tegretol and Dilantin before he discharged the patient with orders to continue his seizure medication. Respondent diagnosed seizure disorder. Upon

discharge at 8:30, no condition is noted. Respondent's care and treatment of Patient G deviated from acceptable medical standards in that:

1. No temperature is recorded.
2. No condition at discharge is noted.
3. I.V. Valium was not indicated.
4. No inquiry was made as to the cause of his presenting complaints of head pain or seizures.
5. Respondent discharged the patient with inadequate levels of anticonvulsants.

PATIENT H

H. On or about November 30, 198⁸~~9~~, Respondent treated Patient H a 32 year old female, who came to the Emergency Department of Saint John's Hospital complaining of an assault on November 27, in which she had been struck on the left ear, head, neck, left shoulder and had injured her back after being knocked down. After the attack she felt drowsy and nauseated and

complained of headaches. Respondent's physical exam revealed swelling of the face and tenderness of the cervical spine.

Respondent ordered X-rays of the cervical spine, lumbrosacral spine, shoulder, and left face. Respondent's notes indicate that he read the X-rays as negative. Respondent discharged the patient with a diagnosis of cervical and lumbar sprain. Respondent's care and treatment of Patient H deviated from acceptable medical standards in that:

1. Respondent failed to detect fractures evident in the cervical spine X-rays.
2. Respondent knowingly made a false representation in Patient H's chart: Respondent represented in the chart that he read Patient H's X-rays and that they were negative X-rays. In fact Respondent did not read the patient's X-rays before discharging her and writing up her chart.

I. On or about June or July of 1988, Respondent represented in a letter to Catholic Medical Center of Brooklyn and Queens, 88-25 153rd Street, Jamaica, N.Y., 11432, that he was certified, by the American Board of Internal Medicine, as a diplomat in internal medicine. Respondent is not and has never been board certified in the field of internal medicine. Respondent knew at the time he made this representation that it was false.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHT SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) in that Petitioner charges:

1. The facts in paragraphs A, A2, A3 and/or A4.
2. The facts in paragraphs B, B1, B2 and/or B3.
3. The facts in paragraphs C, C1 and/or C2.

4. The facts in paragraphs D and D2.
5. The facts in paragraphs E, E1 and/or E2.
6. The facts in paragraphs F and F1.
7. The facts in paragraphs G, G1, G2, G3, G4 and/or G5.
8. The facts in paragraphs H, and H2.

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

9. The facts in paragraphs A and A1, A2, A3, and/or A4; B and B1, B2, and/or B3; C and C1, and/or C2; D and D1, D2, and/or D3; E and E1, E2, and/or E3; F and F1; G and G1, G2, G3, G4, and/or G5; and/or H and H1.

TENTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that the Petitioner charges:

10. The facts in paragraphs A and A1, A2, A3, and/or A4; B and B1, B2, and/or B3; C and C1, and/or C2; D and D1, D2, and/or D3; E and E1, E2, and/or E3; F and F1; G and G1, G2, G3, G4 and/or G5; and/or H and H1.

ELEVENTH-SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that th Petitioner charges that Respondent committed two or more of the following:

11. The facts in paragraphs A and A1, A2, A3 and/or A4; B and B1, B2 and/or B3; C and C1 and/or C2; D and D1, D2 and/or D3; E and E1, E2 and/or E3; F and F1; G

and G1, G2, G3 and/or G4; and/or H, and
H1.


TWELTH AND THIRTEENTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that Petitioner charges the following:

12. The facts in paragraphs H and H2.
13. The facts in paragraph I.

DATED: New York, New York
December 19, 1990



CHRIS STERN HYMAN
COUNSEL
Bureau of Professional
Medical Conduct

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

-----X
IN THE MATTER :

OF :

RICHARD YALDIZIAN, M.D. :
-----X

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 January 29, 1991, March 8, 1991 and March 15, 1991. Respondent, Richard Yaldizian, M.D., appeared by Anthony Rattoballi, Esq. The evidence in support of the charges against the Respondent was presented by Jean Bressler, Esq.

NOW, on reading 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:

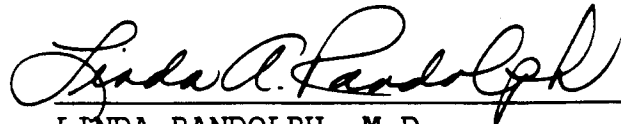
- A. The Findings of Fact and Conclusions of the Committee should be accepted in full;
- B. The Recommendation of the Committee should be modified. In lieu of the limitation on Respondent's practice recommended by the Committee and a fine, Respondent's license to practice medicine should be revoked. The Committee correctly concludes that the Respondent's practice showed an "accumulated record of serious failures." I perceive the state's primary role as protecting his prospective patients from poor care. Respondent has not demonstrated the skill or commitment necessary to protect and aid patients. He should not be practicing medicine; and

- 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 described above.

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

DATED: Albany, New York
June , 1991

July 5, 1991

A handwritten signature in cursive script, reading "Linda A. Randolph", written over a horizontal line.

LINDA RANDOLPH, M.D.
Director, Office of Public Health
New York State Department of Health

EXHIBIT "C"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

RICHARD YALDIZIAN

CALENDAR NO. 12226

1. That respondent shall not practice, offer to practice, or hold himself out as being able to practice as a physician during the first year of the period of suspension and the first year of the period of probation;
2. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:
 - a. That respondent, during the period of probation, shall be in compliance with the standards of conduct prescribed by the law governing respondent's profession;
 - b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;
 - c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and
 - d. That respondent shall submit written proof to the New York State Department of Health,

addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

3. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, and to be satisfactorily completed during the first year of the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct;
4. That, during the second two years of the period of probation, respondent shall have respondent's practice monitored, at respondent's expense, 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 four months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct; and
5. 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.

**ORDER OF THE DEPUTY COMMISSIONER FOR
THE PROFESSIONS OF THE STATE OF NEW YORK**

RICHARD YALDIZIAN

CALENDAR NO. 12226



The University of the State of New York

IN THE MATTER

OF

RICHARD YALDIZIAN
(Physician)

**DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 12226**

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12226, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (November 15, 1991): That, in the matter of RICHARD YALDIZIAN, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the Commissioner of Health's recommendation as to those findings be accepted;
2. The following additional finding of fact be accepted:
Respondent knew that he was not board certified by the American Board of Internal Medicine as a diplomate in internal medicine at the time that he represented himself to be so certified to the Catholic Medical Center of Brooklyn and Queens and knowingly and intentionally misrepresented his circumstances;
3. The conclusions of the hearing committee as to guilt and the recommendation of the Commissioner of Health as to those conclusions be accepted, except that they be modified by the additional guilt under the ninth and eleventh specifications as hereinabove set forth, and

respondent is guilty, by a preponderance of the evidence, of three specifications of gross negligence (third, fifth, and sixth), involving the diagnosis and treatment of three emergency patients; negligence on more than one occasion (ninth), involving the diagnosis and treatment of five emergency patients; gross incompetence (tenth), involving the diagnosis and treatment of two emergency patients; incompetence on more than one occasion (eleventh), involving the diagnosis and treatment of seven emergency patients; and fraud (thirteenth), involving respondent's representing that he was certified as a diplomate in internal medicine when he knew that he was not so certified; and respondent is not guilty of the remaining specifications and charges;

4. The recommendations of the hearing committee and Commissioner of Health as to the measure of discipline not be accepted; and
5. Respondent's license to practice as a physician in the State of New York be suspended for three years upon each specification of the charges of which respondent was found guilty as aforesaid, said suspensions to be imposed concurrently, that execution of the last two years of said suspensions be stayed, and that respondent be placed on probation for the entire three years of said

RICHARD YALDIZIAN (12226)

concurrent suspensions in accordance with the terms prescribed by the Regents Review Committee, which include the requirement that respondent perform coursework and that his practice be monitored;

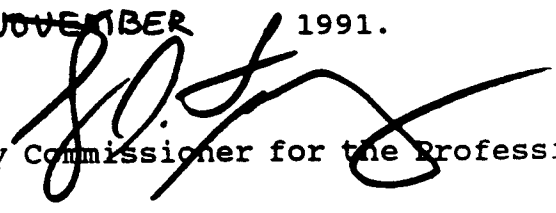
and that the Deputy Commissioner for the Professions be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

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, Henry A. Fernandez, Deputy Commissioner for the Professions 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, at the City of Albany, this 15th day of ~~NOVEMBER~~ 1991.


Deputy Commissioner for the Professions