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

August 10, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
New York State Department of Health
Division of Legal Affairs
5 Penn Plaza – Sixth Floor
New York, New York 10001

Salvatore Zelano, M.D.
201 East 21st Street
New York, New York 10010

Ronald James D'Angelo, Esq.
1432 86th Street
Brooklyn, New York 11228

RE: In the Matter of Salvatore Zelano, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-203) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:nm
Enclosure

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

IN THE MATTER

OF

SALVATORE ZELANO, M.D.

RESPONDENT

COPY

DECISION

AND

ORDER

BPMC 99-203

The undersigned Hearing Committee consisting of **MICHAEL R. GOLDING, M.D.**, Chairperson, **DUANE M. CADY, M.D.**, and **ALAN KOPMAN,** was duly designated and appointed by the State Board for Professional Medical Conduct. **RALPH A. ERBAIO, ESQ.**, Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230 (10) of the New York Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure act. The purpose of the hearing was to receive evidence concerning alleged violations of Section 6530 of the New York State Education Law by **SALVATORE ZELANO, M.D.** (hereinafter referred to as Respondent).

The New York State Board For Professional Medical Conduct (hereinafter referred to as the State or Petitioner) appeared by **TERRENCE SHEEHAN, ESQ.**, Senior Attorney, of counsel to **HENRY M. GREENBERG, ESQ.**, General Counsel, New York State Department of Health (hereinafter referred to as DOH). Respondent appeared in person and by **RONALD JAMES**

D'ANGELO, ESQ., and FREDERICK **J. MOTORELL, ESQ**. of counsel to Ronald James D'Angelo, Esq.

Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record. The Committee has considered the entire record in the above captioned matter and hereby renders their decision.

AFFIRMATION OF MEMBER OF THE HEARING COMMITTEE

Michael R. Golding, M.D., a duly appointed member of the State Board for Professional Conduct and Chairperson of its Hearing Committee designated to hear the matter of Salvatore Zelano, M.D., hereby affirms that he was absent from the hearing session conducted on April 12, 1999. Dr. Golding affirms that he has read and considered the transcript of the proceeding of, and the evidence received at, such hearing day prior to deliberations of the Hearing Committee on May 27, 1999.

STATEMENT OF CASE

Petitioner has charged Respondent with twenty-seven specifications of professional misconduct. Eight of the specifications relate to Respondent's medical care and treatment of four patients. The allegations include gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, failure to obtain consent and failure to maintain records. Nine specifications relate to fraudulent practice, nine specifications relate to the making of a false report and one specification relates to moral unfitness.

A copy of the Notice of Hearing and the Statement of Charges is attached to this Determination and Order as Appendix I.

Significant Legal Rulings

The Respondent submitted certain documentation with his Proposed Findings of Fact and Conclusions of Law. This documentation had not been offered during the hearing and the Respondent did not make a proper application to reopen the record to introduce additional evidence. This documentary material was not received into evidence and was not considered by the Hearing Committee in reaching its determination.

FINDINGS OF FACT

The findings of fact which follow, were made after review of the entire record. References to transcript pages (Tr.__) and/or exhibits (Ex.__) denote evidence that was found persuasive in determining a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

1. Respondent, Salvatore Zelano, M.D., (Dr. Zelano) is authorized to practice medicine in New York State, having been issued license number 124660 by the New York State Education Department on July 24, 1975. (Pet. Ex. 2)

PATIENT A

2. On April 10, 1987, Respondent performed an endoscopic retrograde cholangiopancreatography (ERCP) on Patient A. (Pet. Ex. 4, Tr. 17-18)

3. Bleeding is a known complication of ERCP's. (Tr .20)

4. Whenever this procedure is performed, either the physician himself must be available to handle post-operative complications, or coverage with another competent physician must be arranged. (Tr. 21-22).

5. After the operation Patient A experienced bleeding. The Respondent was not available to handle this complication nor had he obtained competent coverage. This is a departure from accepted practice. (Pet. Ex. 4, Tr.22-26)

6. Respondent failed to document in the chart the nature of the coverage he had instituted. This is a departure from accepted practice. (Tr.26)

7. Respondent's testimony that he never documented that type of information is shocking to the Committee. (Tr. 135-36, 147)

PATIENT B

8. On July 19, 1996, Patient B was admitted to Beth Israel Medical Center. Patient B was jaundiced with a bilirubin level of 11.7. The normal bilirubin level is 0.3 to 1.2. (Pet. Ex. 5, Tr. 31)

9. The Respondent was called in as a consultant and was actively involved in the management of the patient's jaundice. (Pet. Ex. 5)

10. Prior to the patient's discharge on July 25, 1996, Respondent failed to provide any treatment or reach any definitive diagnosis. (Tr.33-34)

11. Patient B was discharged on July 25, 1996. This discharge was not indicated. The cause of the jaundice had not been ascertained and the patient had not improved clinically. (Tr. 33)

12. The discharge instructions that were given to Patient B were inadequate. They contained no instruction to the patient to cease taking Voltaren, which may have been the cause of the patient's condition. (Tr. 180).

13. Patient B was readmitted three days after he was discharged. During this admission Respondent failed to delineate the likely diagnostic possibilities. The Respondent alighted on the diagnosis of toxic hepatitis without any explanation or discussion. He improperly failed to consider other reasonable diagnoses including obstructive jaundice. (Pet. Ex. 5; Tr. 37-40)

14. The Respondent attempted to perform an ERCP. It was unsuccessful. He should have considered ordering other tests which provide the same information or transferring Patient B to another facility where these tests could have been performed. The other tests are endoscopic ultrasound, magnetic resonance cholangiopancreatography and transhepatic cholangiogram. (Tr. 40-43, 71-72)

15. A liver biopsy is an important test that could have been offered this patient during the first or second admission. Nevertheless, Respondent never discussed the pros and cons of performing this test, nor did he document the reason for never performing this test. (Tr. 43-44)

16. Throughout Patient B's two hospitalizations, especially the second, he followed a relentlessly downhill course, ending in his death. At no point did the Respondent document cognizance of the gravity of the patient's condition. (Tr. 44-45)

17. The Respondent failed to maintain a record which accurately reflected the care and treatment of this patient. (Tr. 44-45)

PATIENT C

18. Patient C was a 98 year old woman. She was treated by Respondent between September 6, 1996 and September 20, 1996. (Pet. Ex. 6)

19. On September 10, 1996, an abdominal ultrasound had been performed on this patient. It revealed, among other things, a diffuse metastasis to the liver of a cancer which had started elsewhere in the body, most likely in the GI tract. Such a cancer is uniformly fatal in a 98 year old woman. (TR. 81-82)

20. A CAT Scan was performed which confirmed the findings of the ultrasound and which added the further dire prognosis that ascites was present, indicating a likely peritoneal carcinomatosis or spread of the tumor to the peritoneum. (Tr.82-83)

21. Despite these findings, Respondent undertook an extensive series of invasive procedures. These included an upper endoscopy, an ERCP, and a colonoscopy. (Tr.82-83)

22. These procedures were not indicated and did not offer any benefit for either cure or palliation. The procedures could only impose additional, unnecessary risk and discomfort for Patient C. (Tr.83-84)

23. The Respondent did obtain an informed consent for performing these procedures. (Pet. Ex. 6, Tr. 91-92)

24. The Respondent failed to maintain a record which accurately reflected the care and treatment of this patient. (Tr.87)

PATIENT D

25. On September 23, 1996, Patient D presented at Beth Israel Hospital with massive gastrointestinal hemorrhage associated with shock. Initial blood work revealed severe problems with blood coagulation and likely cirrhosis. (Pet. Ex. 7, Tr. 101)

26. The Respondent performed an upper endoscopy which revealed very large varicies, which are frequently present with cirrhosis. Taken together with the presence of Patient D's severe bleeding disorder, it is clear that the liver disease was of the near fatal variety. (Tr. 102-3)

27. In this setting the Respondent did something which is hazardous, he performed a biopsy. It was reckless to introduce another source of bleeding in a patient who was already suffering a major gastro-intestinal bleed. (Pet. Ex. 7, Tr. 103-5)

STATEMENTS ON APPLICATIONS

28. In a proceeding with the State Board for Professional Medical Conduct in 1987, the Respondent, in an application for a consent order, stated "I cannot successfully defend against the allegations contained in specifications set forth in paragraphs five and six of the Statement of Charges." Paragraphs five and six alleged that the Respondent practiced the profession negligently and/or incompetently on more than one occasion, and that he practiced the profession fraudulently by knowingly backdating entries in a patient's chart. The Respondent received a censure and reprimand. (Pet. Ex.2).

29. In several reappointment and enrollment applications to various hospitals and health plans, the Respondent fraudulently concealed his disciplinary history. (Pet. Ex. 9, 10, 11, 12, 13, 14)

30. The Respondent presented no testimony at the hearing to contest this finding.

31. The Respondent presented a FOJP with his applications detailing his malpractice history. (Resp. Ex. A)

CONCLUSIONS OF LAW

Respondent is charged with 27 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 does not provide definitions of various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a Memorandum prepared by Henry M. Greenberg, Esq., 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:

Fraudulent Practice of Medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

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

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that nineteen of the

specifications had been sustained. The Committee further concluded that eight of the specifications were not sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee assessed the credibility of witnesses presented by the parties. The Petitioner presented one witness-David Markowitz, M.D. The Committee found Dr. Markowitz, to be well credentialed and his testimony to be clear, lucid and very persuasive.

In contrast, the Committee found the Respondent's testimony to be incomplete, evasive, less than forthcoming and generally not worthy of belief. Particularly disturbing was his inability to admit even the most glaring error in his treatment of these four patients.

The Committee was also troubled by his failure to present any witnesses on his behalf. Although, the Respondent did present hearsay statements from Dr. Fisse, Dr. Charnof and Nurse Jean Dixone, these statements were given little weight because they were unsworn and the makers were not subject to cross examination.

PATIENT A

The Committee concluded that all factual allegations regarding Patient A were sustained. The Respondent performed an ERCP on Patient A on April 10, 1997. The Respondent did not obtain competent medical coverage for the patient even though bleeding was a known complication of this procedure. There was no notation in the Respondent's patient chart as to coverage. Dr. Fisse, whom the Respondent alleges was providing coverage for his patients, was not credentialed to perform ERCPs and another physician had to be called to operate and treat the patient's bleeding. The Respondent's failure to arrange for appropriate coverage was a deviation from medical standards. His failure to document patient coverage arrangements in the patient chart was also

a deviation from medical standards. The Respondent's attempts to blame hospital administrators for this incident was found by the Committee to be unpersuasive.

The Hearing Committee concluded that Respondent's treatment of Patient A demonstrated negligence (Third Specification), incompetence (Fourth Specification), and failure to maintain records (Twenty-Fourth Specification).

PATIENT B

The Committee concluded that all factual allegations regarding Patient B were sustained. This was an 88 year old male who was first admitted to Beth Israel Hospital on July 19, 1996 with jaundice. The patient stayed in the hospital for six days. During this time the Respondent, who was actively involved in the management of the patient's jaundice, inexplicably, failed to provide any treatment or reach any definitive diagnosis. The patient was discharged on July 25th. This discharge was not indicated because the cause of the jaundice had not been ascertained and the patient had not improved clinically. The discharge instructions contained no mention of Voltaren, which may have been causing the patient's condition. The patient was readmitted on July 28, 1996. The Patient's workup revealed abnormal liver chemistries and negative virus tests for hepatitis B and C. The Respondent made a diagnosis of toxic hepatitis. The Respondent did not consider any other diagnosis such as obstructive jaundice. The Respondent attempted to perform an ERCP which was unsuccessful. The Committee concluded that he should have conducted other tests, such as an endoscopic ultrasound, magnetic resonance cholangiopancreatography and transhepatic cholangiogram, which provide the same information. The Respondent neither ordered these tests nor transferred the patient to another facility where these tests could have been performed.

The Respondent also did not discuss the pros and cons of a liver biopsy, an important test which could have been offered this patient. The patient chart contains no explanation as to why he did not perform this test. Throughout Patient B's two hospitalizations, especially the second, he followed a relentlessly downhill course ending in his death. The Hearing Committee was very troubled by the Respondent's failure to respond to this downward spiral of the patient's condition.

The Hearing Committee unanimously concluded that the Respondent's medical care and treatment of Patient B constituted negligence (Third Specification), incompetence (Fourth Specification) and failure to maintain records (Specification 25).

PATIENT C

Patient C was a 98 year old woman. An abdominal ultrasound performed on the patient revealed a diffuse metastasis to the liver of a cancer which had started elsewhere in the body. Such a cancer is uniformly fatal in a 98 year old woman. The findings of the ultrasound were later confirmed by a CAT Scan which added the further dire prognosis that ascites was present, indicating a likely peritoneal carcinomatosis or spread of the tumor to the peritoneum. Despite these findings, the Respondent undertook a series of invasive procedures, including an upper endoscopy, an ERCP and a colonoscopy. The Committee concluded that performing these tests, which imposed unnecessary risk and discomfort to the patient without offering any benefit for either cure or palliation, constituted a departure from medical standards. The Respondent's chart contains no documentation as to a review of the patient's prognosis, why these tests were ordered and no indication what would be done with the information received from these procedures. The chart is simply devoid of this critical information.

The Hearing Committee concluded that the Respondent's treatment of Patient C demonstrated negligence (Fourth Specification), incompetence (Fourth Specification) and failure to maintain

records (Twenty Sixth Specification). However, the Hearing Committee concluded that the Respondent did obtain informed consent for these procedures. Accordingly, the Hearing Committee dismissed the charge of failure to obtain informed consent (Twenty Third Specification).

PATIENT D

The Hearing Committee unanimously voted to sustain the factual allegations raised concerning Patient D. Patient D was admitted to Beth Israel Hospital on September 23, 1996 with massive gastrointestinal bleeding associated with shock. An upper endoscopy revealed very large varices, which are frequently present with cirrhosis. The Respondent performed a biopsy on this patient. There was no reason for performing this hazardous procedure in a patient that is critically ill. The Respondent introduced another source of bleeding into this patient with major gastrointestinal bleeding. This action of the Respondent was reckless and hazardous to the patient.

The Hearing Committee concluded that Respondent's treatment of Patient D demonstrated gross negligence (First Specification), gross incompetence (Second Specification), negligence (Third Specification) and incompetence (Fourth Specification).

APPLICATIONS TO HEALTH ORGANIZATIONS

The Hearing Committee voted to sustain all factual allegations relating to the Respondent's fraudulent concealment of his disciplinary history. The Respondent was censured and reprimanded by the State Board For Professional Medical Conduct in 1987. Yet when completing reappointment and enrollment applications for various hospitals and health plans, such as Kings Highway Hospital, Brooklyn Hospital, Chubb Health, Sanus Managed Care, Magna Care and Cigna he made false statements concerning this disciplinary history. The Hearing Committee

concluded that Respondent knew the representations were false and that he intended to mislead. There can be absolutely no doubt that the respondent knew that he had been censured and reprimanded by the Board for Professional Medical Conduct. A fair reading of each of these applications makes it clear that absent the intention to deceive there was but one correct answer for Respondent in response to the questions concerning disciplinary action. Respondent also made these misrepresentations on not just one, but several applications. It is concluded that the Respondent intentionally misled these organizations in order that his applications be approved. The Respondent's assertion in his Answer that he provided a letter, a copy of which he submitted with his answer, explaining his disciplinary history to each entity is rejected. It is noteworthy in this regard that his reappointment applications to Kings Highway Hospital Center and Brooklyn Hospital Center both pre-date the letter. The Department has proven a knowing and intentional deception by Respondent. The facts fit squarely within the definition of fraudulent practice of medicine. The factual allegations have been sustained and therefore Specifications Five through Ten and Fourteen through Nineteen have been sustained.

However, the Department did not prove the factual allegations relating to the Respondent's failure to disclose his malpractice history. The Respondent did provide an FOJP disclosing his malpractice history with each application. Accordingly, fraudulent practice (Specifications Eleven, Twelve and Thirteen) and false report (Specifications Twenty, Twenty One and Twenty Two) have not been sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in

New York State should be revoked. 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 evidence establishes that the medical care the Respondent provided to these four patients was grossly substandard. He did not arrange for competent coverage for a patient upon whom he had just performed a risky procedure. In another instance he did not respond to the downhill course of the patient's medical condition. He exposed another patient to the risks of unnecessary procedures when the information gained from the procedures would not aid in either treatment or palliation of the patient's condition. Respondent also performed a biopsy, introducing another possible source of bleeding, on a patient who was already suffering from massive bleeding. Respondent failed to maintain records which accurately reflected the care and treatment of his patients. The Respondent also repeatedly, knowingly and with intent to deceive, concealed his professional disciplinary history from various health organizations. The Committee views the fraud committed by the Respondent to be of the utmost seriousness. The Committee also noted that the Respondent did not contest this finding in his testimony at the hearing. There were six separate instances of either material omission or misstatement. The Committee views such conduct as evidence of a lack of moral fitness for the practice of medicine. When considered together, these actions present a compelling argument for revocation.

The Committee found particularly disturbing the fact that the Respondent provided this substandard care and fraudulently concealed his disciplinary history even after having gone through the disciplinary procedure before and having received a censure and reprimand. This prior disciplinary history coupled with the Respondent's failure to acknowledge even the most glaring errors leads to the conclusion that he is not a suitable candidate for retraining. In light of

the lack of suitability for retraining, the egregious nature of the Respondent's acts, particularly the fraudulent statements concerning his disciplinary history, the Hearing Committee unanimously determined that revocation is the only sanction which will adequately protect the public.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby ORDERED that:

1. The First through Tenth , the Fourteenth through NineteenthAND Twenty-Fourth through Twenty-Seventh Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix One) are **SUSTAINED;**
2. The Eleventh through Thirteenth and the Twentieth through Twenty-Third Specifications are **DISMISSED**;
3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** commencing on the effective date of this Determination and Order;

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED:

TROY, New York

9/9 **, 1999**

MICHAEL R. GOLDING, M.D. (CHAIR)

DUANE CADY, M.D.

ALAN KOPMAN

TO:

Terrence Sheehan. Esq.
Associate Counsel
Bureau of Professional Medical Conduct
5Penn Plaza
New York. New York 10001

Salvatore Zelano, M.D.
201 East 21st Street
New York, New York 10010

Ronald James D'Angelo, Esq.
1432 86th Street
Brooklyn, New York 11228

APPENDIX ONE

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

IN THE MATTER
OF
SALVATORE ZELANO, M.D.

NOTICE
OF
HEARING

TO: SALVATORE ZELANO, M.D.
201 East 21st Street
New York, NY 10010

EXHIBIT
Petitioner / Ev-
S
Date 3-11-99

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1999) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1999). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on MARCH 2, 1999, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1999) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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 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 OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1999). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
~~January~~ Feb 2, 1999

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Terrence Sheehan
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2615

APPENDIX TWO

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

IN THE MATTER

OF

SALVATORE ZELANO, M.D.

STATEMENT

OF

CHARGES

SALVATORE ZELANO, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 24, 1975, by the issuance of license number 124660 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about April 7, 1997 and on or about April 25, 1997 Patient A was treated for jaundice at Beth Israel Medical Center, Kings Highway, Brooklyn, New York. (The names of the Patients are contained in the attached Appendix.)

1. On or abut April 10, 1997 Respondent performed an ERCP (endoscopic retrograde cholangio pancreatography). A blockage was seen in the bile duct and a stent was therefore inserted. After the surgery Respondent failed to arrange for appropriate coverage for Patient A.

2. Several hours after the surgery Patient A experienced gastrointestinal bleeding, a known complication of the ERCP. The Respondent was unavailable, no competent coverage had been arranged and the treating physicians had to locate another

surgeon experienced in endoscopic surgery to operate and stop the bleeding.

3. Respondent failed to maintain a medical record for Patient A which accurately reflects the nature of the coverage, if any, Respondent had arranged for Patient A after the April 10, 1997 ERCP.

B. Between on or about July 19, 1996 and on or about August 14, 1996 Patient B, an 88 year old woman, was treated for jaundice at Beth Israel.

1. Patient A's work-up on July, 19, 1996 revealed abnormal liver chemistries and negative virus tests for hepatitis B and C. Respondent made a diagnosis of toxic hepatitis or drug induced hepatitis. This diagnosis is not medically indicated.

2. Patient B was discharged on July 25, 1996. Respondent improperly failed, in the discharge orders, to make any mention of patient follow-up, further out-patient work-up or what medications the patient should or should not take.

3. It was not medically appropriate to discharge Patient A on July 25, 1996

4. Three days after discharge, the patient was readmitted with progressive jaundice. Throughout this final admission Respondent failed to clearly delineate the likely diagnostic

possibilities and his underlying reasoning.

Respondent also fails to outline and pursue any coherent therapeutic approach.

5. At one point an ERCP was attempted in order to image the biliary tree. Although the ERCP was unsuccessful, Respondent failed to order other non-invasive tests to achieve the same end. Nor does Respondent ever address these alternatives or explain why they are left unpursued.

6. On several occasions, Respondent considers performing a liver biopsy. Such a procedure would be ill advised in the context of rapidly progressing jaundice. Respondent fails to explain the pros and cons of the procedure and why it was not performed.

7. Throughout the patient's hospital stay, he followed a relentless downhill course. Respondent fails to address or discuss this fact until the day of the patient's death.

C. Between on or about September 16, 1996 and on or about September 22, 1996, Patient C, a 98 year old woman, was treated for cancer at Beth Israel.

1. On or about September 10, 1996 an abdominal ultrasound revealed diffuse metastases to the liver. After the ultrasound results were available, Respondent embarked on an extensive, invasive diagnostic work-up to locate a primary source of the cancer. This work-up included an upper endoscopy, ERCP

and a colonoscopy. These procedures were contraindicated. The data to be obtained from these procedures could have no conceivable value in the management of this 98 year old patient; the procedures could only expose her to additional risks.

2. Respondent failed to obtain an informed consent from Patient C or her family for these three procedures.

3. Respondent failed to maintain a medical record for Patient C which accurately reflects his treatment plan and rationales for performing procedures.

D. On or about September 23, 1996 Patient D was treated for massive gastrointestinal bleeding at Beth Israel.

1. Patient D was admitted in shock. The laboratories revealed markedly disordered coagulation and impaired liver function. She was aggressively transfused. Respondent performed an emergency upper endoscopy to evaluate the massive bleeding. He noted large esophageal varices due to severe underlying liver disease. Yet he proceeded to perform a biopsy. This is absolutely contraindicated in the setting of esophageal varices and profound coagulopathy.

E. Between 1990 and 1997 Respondent submitted numerous reappointment or membership applications to various health organizations. In each of the

applications listed below. Respondent fraudulently, and with intent to deceive, concealed his professional disciplinary history by falsely stating either that he was never the subject of a misconduct investigation, never had findings made against him and/or had never been actually disciplined. In fact, on May 3, 1997, Respondent pled no contest to charges that he had negligently failed to see or treat a patient at Maimonides Medical Center for a period of two weeks and that he had practiced fraudulently by backdating entries in the patient's medical chart. He received a censure and reprimand. The following documents contain the fraudulent statements:

1. Kings Highway Hospital reappointment application dated November 25, 1991

2. Brooklyn Hospital reappointment application dated December 18, 1990.

3. Chubb Health reappointment application dated January 19, 1994.

4. Sanus Managed Care application of Professional Status dated May 19, 1994.

5. Magna Care participating physician application dated September 9, 1997.

6. Cigna recredentialing form dated February 23, 1994.

F. Between 1990 and 1994 Respondent submitted several reappointment or

membership applications to various health organizations. In each of the applications listed below, Respondent fraudulently, and with intent to deceive concealed his medical malpractice litigation history by falsely stating that he had no pending or settled medical malpractice actions in which he was a defendant. The following documents contain the false statements:

1. Kings Highway Hospital reappointment application dated November 25, 1991

2. Brooklyn Hospital reappointment application dated December 18, 1990.

3. Sanus Managed Care application of Professional Status dated May 19, 1994.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following paragraphs:

1. D and D(1).

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

2. D and D(1).

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

3. A, A(1), A(2); B, B(1), B(2), B(3), B(4), B(5), B(6); C, C(1), C(2); D and D(1).

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

4. A, A(1), A(2); B, B(1), B(2), B(3), B(4), B(5), B(6); C, C(1), C(2); D and D(1).

FIFTH THROUGH THIRTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following paragraphs:

5. E, E(1).
6. E, E(2).
7. E, E(3).
8. E, E(4).
9. E, E(5).
10. E, E(6).
11. F, F(1).
12. F, F(2).
13. F, F(3).

FOURTEENTH THROUGH TWENTY-SECOND SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 1998) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of paragraphs:

14. E, E(1).
15. E, E(2).
16. E, E(3).

17. E, E(4).

18. E, E(5).

19. E, E(6).

20. F, F(1).

21. F, F(2).

22. F, F(3).

TWENTY-THIRD SPECIFICATION

FAILURE TO OBTAIN INFORMED CONSENT

Respondent is charged with committing professional misconduct under N.Y. Educ.. Law §6530(26) (McKinney Supp. 1998), in that he performed professional services which had not been duly authorized by the patient or his or her legal representative as alleged in the following paragraphs:

23. C, C(2).

TWENTY-FOURTH THROUGH TWENTY-SIXTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the following paragraphs:

24. A, A(3).

25. B, B(2), B(4), B(5), B(6), B(7).

26. C, C(3).

TWENTY-SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1999) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the following paragraphs:

27. E, E(1), E(2), E(3), E(4), E(5), E(6), F, F(1), F(2), F(3).

DATED: February 2, 1999
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct