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., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 6, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin Donovan, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Mahmood Yoonessi, M.D.
REDACTED

Mahmood Yoonessi, M.D.
355 Linwood Avenue
Buffalo, New York 14209

Gerald Walsh, Esq.
404 Cathedral Place
298 Main Street
Buffalo, New York 14202

RE: In the Matter of Mahmood Yoonessi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-188) 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 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,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

----------X

IN THE MATTER

OF

MAHMOOD YOONESSI, M.D.

----------X

DETERMINATION

AND

ORDER

BPMC #02-188

COPY

JOHN W. CHOATE, M.D., Chairperson, LAWRENCE B. STERNBERG, M.D. and **ANN FORD FRICKE**, 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(10)(e) of the Public Health Law.

TIMOTHY J. TROST, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing, Statement of Charges And Summary Suspension:	November 26, 2001
Pre-Hearing Conferences:	December 3, 2001 December 4, 2001

Hearing Dates:	December 4, 2001 January 30, 2002 February 5, 2002 February 6, 2002 February 12, 2002 March 21, 2002 March 22, 2002 March 27, 2002 March 28, 2002 April 20, 2002
Place of Hearings:	NYS Dept. of Health Buffalo Area Office 584 Delaware Avenue Buffalo, New York Airport Radisson Hotel Genesee Street Buffalo, New York Courtyard by Marriott 13 Corporate Woods Rochester, New York
Deliberation Date:	May 11, 2002
Petitioner appeared by:	Donald P. Berens, Jr. General Counsel By: Kevin Donovan, Esq. NYS Department of Health Corning Tower Room 2512 Empire State Plaza Albany, New York 12237
Respondent appeared pro se and by:	Richard Collins, Esq. Nicholas Sargent, Esq. Colleen Fahey, Esq. Gerald Walsh, Esq.

Witnesses for the Petitioner	Transcript	Hearing Dates	Index
Michelle Marzec, R.N.	T. 121-170	12/4/01	Patient C hospital stay
N.D.	T. 174-221	12/4/01	Daughter of Patient E
J.G.	T. 223-239	12/4/01	Husband of Patient E (Name misspelled in Transcript)
Daniel Kredentser, M.D. Expert for Petitioner	T. 299-1231		
	T. 299-346	1/30/02	Patient A
	T. 347		Patient B
	T. 424-550	2/05/02	Cross-examination by Respondent
	T. 553-596		Patient C
	T. 597-659		Patient D
	T. 660-700		Patient E
	T. 716-752	2/06/02	Patient F
			Patient G
			Patient H
	T. 834-968		Cross-examination by Respondent
	T. 975-1231	2/12/02	Cross-examination by Respondent
C.E.	T. 1244-1286	3/21/02	Daughter of Patient C
Mahmood Yoonessi, M.D.	T. 1302-1398		Respondent

Witnesses for Respondent	Transcript	Hearing Dates	Index
Clementina Lewis, M.D.	T. 1399-1450	3/21/02	Attending physician for Patient A
Constance Butler, R.N.	T. 1485-1537	3/22/02	Office Nurse of Respondent
Carolyn Jane Brandt	T. 1537-1560		Office Assistant of Respondent

Mahmood Yoonessi, M.D.	T. 1561-1667 T. 1667-1697	3/22/02	Patient A Patient B
Brian D'Arcy, M.D.	T. 1702-1747	3/27/02	Medical Director of Mercy Hospital regarding Patient E
George F. Loehfelm, M.D.	T. 1748-1808	3/27/02	Consultant to Patient C
Sixto Maceda, M.D.	T. 1808-1867		Attending physician to Patient D
Michael F. Noe, M.D.	T. 1869-1926		Medical Director of Buffalo General Hospital regarding Patient G
Tariq S. Malik, M.D.	T. 1928-1966		Attending physician to Patient H
Kazem Behnam, M.D. (Expert for Respondent)	T. 1980-2179	3/28/02	See Index in Transcript for reference to specific patients
Shams Yoonessi, M.D.	T. 2196-2204	3/28/02	Respondent's wife
Mahmood Yoonessi, M.D.	T. 2217-2485	4/20/02	See Index in Transcript for reference to specific patients

STATEMENT OF CHARGES

The Statement of Charges charges Respondent with negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, and lack of proper consent relating to the treatment of eight (8) patients. Additionally, Respondent is charged with two (2) instances of fraud, four (4) instances of moral unfitness and five (5) instances of failure to maintain records.

INSTRUCTIONS TO THE COMMITTEE

The Administrative Law Judge issued the following instructions to the Committee with regard to the issues in this proceeding.

1. The standard of proof in this proceeding is a preponderance of the evidence. This means that the State must prove the elements of the charges to a level wherein the trier of fact finds that a given event is more likely than not to have occurred.

2. The Committee was instructed that in deciding the issues of this case the members may consider only the Exhibits which have been admitted in evidence and the testimony of the witnesses as it was heard in this Hearing. Arguments and remarks of the attorneys or the Administrative Law Judge are not evidence.

3. Negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state.

4. Incompetence is defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice in this state.

5. Gross negligence is defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct.

6. Gross incompetence would be a single act of incompetence of egregious proportions, or multiple acts of incompetence that cumulatively amount to egregious conduct.

7. The term egregious means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

8. There is one standard of medical care in this state. A prudent, competent physician is expected to consider the same medical issues regardless of where he practices. Whether a physician practices in a major teaching hospital, with all the most modern facilities and staff or in a rural or inner city clinic with less facilities and assistance available, the prudent, competent physician must consider all relevant medical issues.

9. To sustain an allegation of moral unfitness, the State must show Respondent committed acts which "evidence moral unfitness." There is a distinction between a finding that an act "evidences moral unfitness" and a finding that a particular person is, in fact, morally unfit. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct is suggestive of, or would tend to prove, moral unfitness. The Committee is not called upon to make an overall judgement regarding the moral character of any Respondent. It is noteworthy that an otherwise moral individual can commit an act "evidencing moral unfitness" due to a lapse in judgement or other temporary aberration.

10. The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust which is bestowed upon one by virtue of his licensure as a physician. Physicians have privileges that are available solely due to the fact that one is a physician. The public places great trust in physicians solely based upon the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients are asked to place themselves in potentially compromising positions with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon him by virtue of his professional status. This leads to the second aspect of the standard: Moral unfitness can be seen as a violation of the moral standards

of the medical community which the Committee, as delegated members of that community, represent.

11. The fraudulent practice of medicine can be sustained when it is proven that Respondent made an intentional misrepresentation or concealment of a known fact, in connection with the practice of medicine. The fraudulent practice of medicine is present when:

(a) A false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;

(b) Respondent knew the representation was false; and

(c) Respondent intended to mislead through the false representation.

12. Where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the Hearing Committee. However, the Committee must specifically state the inferences and the basis for the inferences it is drawing regarding knowledge and intent.

13. With regard to the expert testimony herein, including Respondent's, if any, each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

14. With regard to a finding of medical misconduct, the Committee must first review Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response.

15. Where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.

SIGNIFICANT LEGAL RULINGS

In addition to rulings made on formal motions which are found in the separate intra-hearing conference transcripts, the following rulings and the discussion are noted:

1/30/02, T. 265. Denial of motion to reconsider original omnibus motion of 12/03/01.

2/05/02, T. 548. Limitation of Respondent's cross-examination.

2/06/02, T. 701-708

2/12/02, T. 969-970 and T. 1232-1233

3/22/02, T. 1478-1485. Limitation of time generally.

3/21/02, T. 1458. Matter of reviewing the summary suspension.

1. The Administrative Officer, with the concurrence of the members of the Hearing Committee, controlled the length and scope of Respondent's cross-examination of various witnesses. His cross-examination of Patient C's daughter was terminated after Respondent repeatedly returned to topics which the Administrative Officer had ruled were not relevant. He additionally ignored repeated requests of the Administrative Officer to direct his questions of the witness to the topic of her testimony, namely the conversations he had with the patient's daughter and family members concerning treatment of their mother and the statements the witness testified Respondent made to them, namely that the children were being "Kevorkian", "playing God", etc.

The Administrative Officer also curtailed the cross examination of Respondent's wife by the State's attorney.

Respondent's cross-examination of expert witness Dr. Kredentser was also curtailed. It is noteworthy that the direct examination of Dr. Kredentser concerning all eight charged patients covered approximately 310 pages. Respondent and/or his attorney's cross-examined Dr. Kredentser for 560 or more pages on the first two patients and on chemotherapy. Further, mere reference to number of pages does not give a true picture of the amount of time available to Respondent for cross-examination. There were many significant delays in his cross-examination because he was not adequately prepared with accurate references to the specific portion of the medical record about which he was questioning the witness.

Parties do not have an unlimited right to cross-examination. It is beyond doubt that they have the right to an opportunity to cross-examine witnesses, but that right can be waived. Respondent effectively waived his right to continue cross-examination by his course of conduct and his use of his time for cross-examination.

Furthermore, Respondent's questioning of the expert witness had only limited relevance and no real materiality to the charges. For example, he would repeatedly question the expert witness concerning what drugs were being used for chemotherapy in the 1970's and early 1980's, when the cases at issue ranged from the mid to late 80's to the mid 1990's. He failed to address the expert's opinion concerning the actual chemotherapy at issue despite admonitions by the Administrative Hearing Officer and the Chair of the Committee that he do so. At no point did he attempt to confront the expert with any facts or studies that directly related to his specific combination of chemotherapy.

He disregarded multiple directions to focus questions on the charges at issue and to use cross-examination to point to facts or information inconsistent with the expert's theory. He was told that was not the time to argue his case but he continued to do so. On February 6, he was notified that, in view of his previous pattern of improper cross-examination, he would be given one additional day for cross-examination, and could use that time as he wished. Despite all of these admonitions, after his 560 pages of cross-examination, Respondent did not even concede that he had completed cross-examination on two patients. Respondent's improper cross-examination, taking more than one day for each patient, would have required that the expert witness be available for an additional 6, 7 or 8 more hearing days. This would be clearly unreasonable in view of the inappropriateness of his previous cross-examination. Respondent apparently was of the belief that cross-examination can be conducted in the form of a filibuster. His approach was clearly inappropriate and limiting his cross-examination was appropriate.

2. A few days after the briefs were received Mr. Donovan telephoned the ALJ to object to Respondent having included matter and argument in his brief which were not in evidence. Mr. Donovan was instructed to reduce his concern to writing and was given leave to write directly to the Committee because there was no time for judicial review of the objections before the Committee would have the opportunity to read the objectionable brief. Furthermore, the objections involved procedural matters only and were found to be incontestable. Mr. Donovan's letter was dated May 6, 2002 and was sent to all interested parties. Thereafter, Mr. Walsh and Dr. Yoonessi objected in writing and the Respondent sent a "rebuttal" brief to the ALJ asking for leave to forward copies to the Committee. This rebuttal brief was not authorized, did not address Mr. Donovan's objections but rather addressed matters of substance contained in Mr. Donovan's original brief and once again included references to matters not in evidence.

Permission to forward this brief to the panel was therefore denied.

3. Allegation G.6 was amended so that the charged date of March 5, 1997 was changed to March 5, 1993 to conform to the proof in the hospital records. (T. 782)

FINDINGS OF FACT

Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous.

INTRODUCTORY FINDINGS

1. Mahmood Yoonessi, M.D., the Respondent, was authorized to practice medicine in New York State on November 21, 1973, by the issuance of license number 118540 by the New York State Education Department. (Ex. 2 at 2) On November 27, 2001, Respondent was personally served with a Commissioner's Summary Order, Statement of Charges, and Summary of Department of Health Hearing Rules (Ex. 1).

2. Respondent's answer denied wrongdoing of all charges (Ex. B).

3. Gynecologic oncology is a branch of obstetrics and gynecology which deals with management of women with gynecologic cancer, specifically of the vulva, vagina, cervix, uterus, fallopian tubes, and ovaries. It includes surgery, chemotherapy and medical management of complications (T. 278) (Kredentser).

4. Daniel Kredentser, M.D., testified as an expert for Petitioner. Dr. Kredentser was licensed in New York State in 1993 (Ex. 28; T. 277) (Kredentser). His written report concerning the patients in this case was available to the Committee (Ex. 29).

5. Dr. Kredentser was trained in gynecologic oncology at Stanford University and Mt. Sinai Medical Center (Ex. 28; T. 278-279) (Kredentser). From 1987 through 1991 he was the Director of GYN Oncology at Memorial University of Newfoundland, Canada. In 1991, he joined Albany Medical Center as an Associate Professor and Co-Director of Gynecologic Oncology. From 1996 to the present, he has been in private practice as a gynecologic oncologist. Recently, he has again taken over the duties of Residency Director in the Department of Obstetrics and Gynecology at Albany Medical Center (T. 279-280) (Kredentser).

6. Dr. Kredentser sees on average eight to ten new patients and performs six to ten major operations a week (T. 281) (Kredentser). All but two of the patients at issue in this proceeding had ovarian cancer. Dr. Kredentser sees one or more new ovarian cancer cases a week (T. 282) (Kredentser).

7. He was certified by the Royal College of Physicians and Surgeons of Canada, with specialty of Obstetrics and Gynecology in 1986 (Ex. 28; T. 289) (Kredentser).

8. He was board certified in obstetrics and gynecology in 1989, and received a special certification in gynecologic oncology in 1991. Dr. Kredentser was recertified in 1999 (T. 285) (Kredentser). He is a member of U.S. Oncology (T. 284).

PATIENT A

9. Patient A was a 76 year old white female who presented to DeGraff Memorial Hospital on August 20, 1997 (Ex. 3 at 6; T. 299-300) (Kredentser).

10. Patient A had co-morbid conditions of chronic renal failure, routine dialysis, a coronary artery bypass in 1996, hypertension, depression and anorexia (Ex. 3 at 6, 11; T. 300, 312) (Kredentser).

11. She presented at DeGraff with new onset vaginal bleeding of one day's duration (Ex. 3 at 6; T. 300-301) (Kredentser). Physical examination revealed an enlarged uterus (Ex. 3 at 10; T. 300-301) (Kredentser).

12. The attending physician brought Respondent into the case (Ex. 3 at 18; T. 303).

13. A dilatation and curettage (D&C) and hysteroscopy were performed by Respondent (T. 303-304) (Kredentser).

14. The pathology report noted no cancerous pathology (Ex. 3 at 68-69; T. 314) (Kredentser).

15. Following the D&C, the patient's bleeding slowed and then stopped. (Ex. 3 at 20-24; T. 306) (Kredentser). This can be one result of a D&C. (T. 1426, 1427) (Lewis)

16. Respondent and Lewis scheduled the patient for a total abdominal hysterectomy, bilateral salpingo-oophorectomy (TAH-BSO) due to persistent bleeding (Ex. 3 at 74; T. 307) (Kredentser).

17. Respondent did not perform a physical examination of the patient between the D&C and the TAH-BSO (Ex. 3 at 24; T. 1619) (Respondent).

18. The anesthesiologist rated this patient as a risk level 4, the highest risk, patient with severe medical conditions (Ex. 3 at 73; T. 340-341) (Kredentser). For this patient, this was an elective procedure (T. 341) (Kredentser).

19. The TAH-BSO performed on August 25, 1993, on this patient was major surgery, exposing the patient to the risk of anesthesia, bleeding, infection, damage to other internal organs, blood clots, death (Ex. 3 at 74-75; T. 315) (Kredentser).

20. Any minor bleeding after the D&C was inadequate to justify an operative procedure because the patient's hemoglobin and hematocrit were normal and stable (T. 315-316) (Kredentser). A thorough evaluation of the patient's bleeding would be necessary before deciding to perform a TAH-BSO (T. 2018, 2020) (Benham).

21. There was not adequate indication to undertake the TAH-BSO of Patient A on August 25, 1997 (T. 313-314) (Kredentser).

22. Once Respondent was operating on Patient A, he observed what he believed to be appendicitis (Ex. 3 at 74-75; T. 1650) (Respondent). This would mean that he was operating in an infected field (T. 1652) (Respondent, Benham).

23. It was inappropriate to continue to perform the TAH-BSO in an infected field (T. 318) (Kredentser) (Benham).

24. This patient had chronic renal failure and required dialysis two or three times a week (T. 321) (Kredentser).

25. It was very foreseeable that this patient would not be able, a few days after this major surgery, to be either discharged or in such a condition as to be able to be dialyzed at an outpatient center (T. 322) (Kredentser).

26. Respondent elected to perform the TAH-BSO at DeGraff Memorial Hospital, which did not have dialysis services. Post operatively, the patient required an emergency transfer to a hospital that performed dialysis (Ex. 3 at 30; T. 321) (Kredentser).

27. It did not meet acceptable standards of care for Respondent to perform the August 25, 1997 TAH-BSO on the patient at a hospital that did not provide dialysis on site (T. 321-322) (Kredentser).

28. Respondent failed to obtain appropriate authorization or informed consent for the TAH-BSO from Patient A (T. 325-326) (Kredentser).

29. He failed to g: . e the patient the alternatives to make an informed decision based on her actual bleeding after the D&C, her normal blood counts, and the lack of DeGraff Memorial Hospital to perform dialysis on site (T. 326-327) (Kredentser). Without discussing the risks, complications and expected outcome, there can be no true informed consent, meaning patient authorization for the procedure (T. 326) (Kredentser).

30. Before the August 25 surgery, this patient required assessment by a nephrologist because she was on dialysis, and by a cardiologist because she had a coronary bypass and had peripheral vascular disease (T. 328-329) (Kredentser).

31. It did not meet acceptable standards of care to fail to obtain cardiology and nephrology consults (T. 328) (Kredentser).

32. Patient A was transferred from DeGraff Memorial Hospital to Buffalo General Hospital as an emergency for hemodialysis (T. 328-330) (Kredentser). She was being transferred to Dr. Yoonessi's care at that hospital (Ex. 3 at 182). She had been in an ICU at DeGraff (T. 1746) (D'Arcy).

33. At the time she was being transferred she had a blood pressure of 93/34 while on a Dopamine drip, which acts to raise blood pressure (Ex. 3 at 182; T. 330) (Kredentser). She was unstable (T. 334) (Kredentser). A patient who needs Dopamine to sustain blood pressure is by definition unstable (T. 954, 960) (Kredentser).

34. On arrival at Buffalo General Hospital she required suctioning and intubation, and placement of a right femoral line (Ex. 4 at 19; T. 332) (Kredentser).

35. The risk in transferring an unstable patient is that there is no way to respond to the unstable patient during transfer (T. 334-335) (Kredentser). There is always a risk in moving a patient even within a facility, much less than moving them out of one facility, into an ambulance, and into another facility (T. 327-328) (Kredentser).

36. It did not meet acceptable standards of care for Patient A to be transferred in her unstable condition and without adequate stabilization (T. 332, 334) (Kredentser).

37. Respondent's care of this patient deviated substantially from accepted standards and posed grave risks to the patient (T. 346) (Kredentser).

Conclusions of Law

A.1 Respondent undertook and continued a total abdominal hysterectomy-bilateral salpingo-oophorectomy at DeGraff Memorial Hospital on August 25, 1997, despite co-morbid conditions and without adequate indication. This constitutes negligence.

A.2 Respondent inappropriately planned for and performed on August 25, 1997, a total abdominal hysterectomy, bilateral salpingo-oophorectomy on Patient A, who required regular dialysis services, at a hospital which did not provide dialysis on site. This constitutes negligence.

A.3 Respondent failed to obtain appropriate informed consent from Patient A before performing the surgery on August 25, 1997. This constitutes negligence and failure to obtain proper authorization from the patient.

A.4 Respondent failed to obtain appropriate nephrology and cardiology consults prior to the surgery on August 25, 1997. This constitutes negligence.

A.5 Respondent inappropriately ordered and concurred with transfer of Patient A from DeGraff Memorial Hospital in unstable condition and without adequate stabilization. This constitutes negligence.

DISCUSSION

Respondent cross-examined Dr. Kredentser for an extraordinary amount of time regarding Patient A's CA125 level, when this was not a factor in the decision making for surgery (T. 1423) (Lewis). This patient wanted no surgery if she had cancer (T. 1435-1436) (Lewis).

Respondent claimed that the patient was bleeding profusely after the D&C. This was contradicted by all objective evidence: the nursing notes that showed a slowing and then a stopping of bleeding, the stable blood counts, and the fact that there was no clots in her uterus when that was opened at the time of the TAH-BSO (T. 1436-1437) (Lewis).

Respondent's defense to the charge of performing major surgery in a facility that could not dialyze the patient was that as a consultant he could not recommend to the primary physician that her patient have surgery at another hospital (T. 1391) (Respondent). However, Dr. Lewis, as did the other primary physicians, was relying on Respondent's expertise and would have transferred the patient if Respondent suggested it (T. 1422) (Lewis). The issue ran through several of the cases. Respondent would perform major surgery on patients without making his own determination of the need or risk/benefit for the surgery. For this surgery, he relied on the statement of the attending that Patient A was still bleeding, but he did not evaluate the patient himself, nor are there any specifics in the chart about what the Respondent explained to this very sick patient on 8/24/97 about the risks and benefits of the recommended surgery. Respondent also felt is was not his responsibility as a consultant to tell the attending that it would be better for the patient to have the surgery at a hospital with more capabilities such as one that would dialyze the patient.

As the consulting surgeon, Respondent became primarily responsible for the patient. It was not appropriate for Respondent to rely entirely on the attending physician and possible discussions which she had with consultants as adequate preparation for a major surgical procedure.

This patient was not medically stable prior to the transfer to Buffalo General Hospital because of her vital signs. A patient who requires medication to stabilize blood pressure is not stable. A ride in an ambulance under the circumstances is contraindicated.

Taking this patient to surgery in any hospital much less one without dialysis services and then transferring the patient in an unstable condition cannot be said to be a mere error in judgment under these circumstances. This was negligence and thus professional misconduct.

PATIENT B

38. The standard for obtaining informed consent for chemotherapy in the period 1989 through 1995, was to explain the disease the patient is suffering from and the treatment options, the natural course of the disease if nothing were undertaken, the various chemotherapeutic agents, then making a recommendation about what treatment should be undertaken and why, and the risks and benefits (T. 349-350) (Kredentser).

39. In addition, concerning informed consent, the physician who is not using standard treatment has an obligation to discuss with a patient the risks and benefits of the standard treatment versus what is proposed (T. 364-365) (Kredentser).

40. The standard of care would require documentation that these pieces of information were discussed with the patient (T. 352) (Kredentser).

41. Respondent's written consent forms from his office record do not contain adequate information concerning risks or consequences for chemotherapy (see Ex. 5 at 77, 83, 320; T. 350-351) (Kredentser).

42. Respondent did not obtain adequate informed consent for the chemotherapy to be administered to Patient B (T. 350-352) (Kredentser).

43. In the early 1980's standard chemotherapy would have included Cytoxan, Adriamycin, and Cisplatin. As time went on Adriamycin was dropped because of its cardiotoxic effects (T. 354) (Kredentser).

44. By 1989, when this patient was started on chemotherapy, standard therapy would have been the combination of Cytoxan and Carboplatin (T. 354) (Kredentser). By the mid-80's it was learned that Carboplatin was as effective as Cisplatin but was better tolerated by patients, so Carboplatin and Cytoxan became the standard treatment (T. 355) (Kredentser).

45. In the 1990's, Taxol was introduced and Taxol-Carboplatin was found to have superior results to Cytoxan-Carboplatin (T. 355-356) (Kredentser).

46. The chemotherapy treatment regimen Respondent administered to Patient B is unique to his practice and is supported by only one reference in the literature, an article authored by Respondent. Respondent's study was not a properly conducted scientific double blind study comparing two different treatment arms. (Ex. 5, 6; T. 356) (Kredentser).

47. Respondent's drug regimen included the following drugs: Cisplatin, Cytoxan, Depo Provera, Adriamycin, 5 FU, methotrexate, Vepesid, and Hexalan (Ex. 5, 6; T. 356-357) (Kredentser).

48. All of those drugs have been used over time to treat ovarian cancer however, when new drugs arrive, the best combination is found and less effective drugs are removed from treatment regimens (T. 357) (Kredentser).

49. Respondent's chemotherapy regimen, administered to this patient, did not meet acceptable standards of care (Ex. 6; T. 353-354) (Kredentser).

50. Chemotherapeutic agents are designed to kill cancer cells but unfortunately affect many cells, and can cause low platelet counts which can be quite serious (T. 353) (Kredentser).

51. Respondent's paper included a five drug regimen namely Adriamycin, Cisplatin, 5 FU, Methotrexate, and Cytoxan (T. 407) (Kredentser).

52. The risk in using additional chemotherapeutic agents is that you add the increased risk of damaging the patient's blood counts for no established therapeutic gain (T. 358) (Kredentser).

53. The standard regimen by 1989 would be to administer Cytoxan and Cisplatin to the patient every three weeks, not on a weekly basis as done by Respondent (T. 358) (Kredentser).

54. Patients would receive chemotherapy in Respondent's office for the better part of the day, many starting at 9:00 a.m. and completing it between four or six p.m. (T. 359-360) (Kredentser). This has a adverse affect on the patient's quality of life (T. 360) (Kredentser).

55. Respondent raised and lowered chemotherapy dosing but Respondent's office records do not explain why he changes the doses (T. 362) (Kredentser).

56. Regarding the drugs in Respondent's regimen, such as methotrexate and Hexalen, when Cisplatin became available, those agents were dropped (T. 405-406) (Kredentser).

57. The regimen Respondent used with this patient did not follow his protocol from his own paper.

58. Respondent's paper has never been cited as a treatment protocol by any institution or person (T. 408-409, 2181, 2193) (Kredentser, Benham).

59. Respondent prescribed Ergamisol to the patient in 1991 through 1994 (Ex. 6).

60. This does not meet acceptable standards of care. Ergamisol has never been used or documented as effective in ovarian cancer (T. 365, 402-403) (Kredentser).

61. In his 1995 chemotherapy for this patient, Respondent added Taxol (T. 366) (Kredentser).

62. The 1995 regimen did not meet acceptable standards of care, it includes eight drugs. There is no documentation that establishes the regimen as effective, there could be drug interactions, and the regimen is likely to be expensive (T. 367) (Kredentser).

63. Respondent's record does not demonstrate that his regimen was being given as part of an authorized study or that the patients were aware that there was such a study (Ex. 5; T. 368-369) (Kredentser).

64. The patient was found to have a small amount of ascites by a CT scan dated November 28, 1994 (Ex. 5 at 412-413; T. 375) (Kredentser). The patient had an elevated CA 125 (45.8 versus a reference range of up to 35) (Ex. 5 at 420), and no abdominal masses (Ex. 5 at 416, 425, 442, 445; T. 378-381) (Kredentser).

65. Since the patient was asymptomatic and had no identifiable mass or an obstruction, there was no therapeutic goal to be achieved by surgery (T. 383-384) (Kredentser).

66. Respondent performed an exploratory laparotomy on February 6, 1995, and performed major surgery upon the patient (Ex. 5 at 451-453; T. 381-382) (Kredentser).

67. There was no adequate indication for this exploratory laparotomy (T. 382) (Kredentser).

68. Once Respondent opened the patient's abdomen he saw multiple small seedlings of cancer throughout the abdominal cavity (Ex. 5 at 451-453; T. 386) (Kredentser).

69. Since cancer was spread throughout the patient's abdomen there would be no way to remove it all (T. 387) (Kredentser).

70. With a secondary cancer surgery such as this, leaving any cancer behind does not change the patient's prognosis (T. 387) (Kredentser). Removing some of the implants but leaving multiple little ones does not improve the patient's response to chemotherapy (T. 388) (Kredentser).

71. The pathology report from this procedure demonstrated that only a small amount of tumor was removed, primarily described by the pathologist as 0.1 centimeter nodules (Ex. 5 at 454-457; T. 389-390) (Kredentser).

72. In contrast to the fact that there would be no benefit from such a procedure, there are multiple serious risks, such as anesthesia, damage to other organs, post-operative bowel obstructions, bleeding, infection, pulmonary emboli (T. 389) (Kredentser).

73. Performing second surgeries on ovary cancer patients has a high complication rate and the average life expectancy is not long. A physician always must weigh

benefits and risks and try to maximize the benefits and give the patients quantity and quality of life (T. 413) (Kredentser). After an operation there will be six weeks of the patient not feeling good, and complications just add to that (T. 413-414) (Kredentser). Whenever you undertake a treatment, whether it is chemotherapy, surgery or radiation, there are side affects and you need to be able to tell the patient that you are giving them a certain amount of benefit in the future for the side affects now (T. 414) (Kredentser).

74. Post-operatively, this patient did develop a bowel obstruction, which required an additional operative procedure on February 25, 1995 (Ex. 5 at 477-478; T. 390-391) (Kredentser).

75. In the bowel procedure of February 25, 1995, tissue submitted to pathology contained cancer, demonstrating that all of this patient's cancer had not been removed during the February 6 procedure (Ex. 5 at 479; T. 391-392) (Kredentser).

76. As a result of this patient's 1995 operation, she had persistent diarrhea, due to bypassing the large portion of her small bowel and right colon (Ex. 5 at 33; T. 393-394) (Kredentser).

77. In 1996, this patient had an elevated CA 125 and a CAT scan showing bowel thickening (Ex. 7 at 7, 33; T. 393-395) (Kredentser). She was otherwise asymptomatic (T. 395) (Kredentser).

78. On March 7, 1996, Respondent performed another procedure on this patient (Ex. 5 at 77-79; T. 395-396) (Kredentser). If Respondent was unable to optimally reduce the cancer in 1995, it would not be logical to think it could be done in 1996 (T. 411).

79. Before the 1996 procedure, Respondent told the patient that radiation and chemotherapy were not viable options (Ex. 5 at 7; T. 396-397) (Kredentser). There is no role for cytoreductive surgery if chemotherapy and radiation are not options (T. 400, 2161-2162, 2165) (Kredentser, Benham). There was no therapeutic goal for this procedure. There was no mass to remove and the patient had no symptoms to palliate (T. 398) (Kredentser).

80. The procedure had no adequate indication (T. 397) (Kredentser).

81. As part of the procedure, Respondent removed more of the patient's small bowel. This would make her diarrhea worse. (Ex. 7 at 78; T. 401-402) (Kredentser).

82. This patient was known to have had radiation treatment which would have made it more difficult to operate on her abdominal area (T. 398-399) (Kredentser). In a patient who has had this much chemotherapy, surgery and radiation, there was a chance the bowel anastomosis would not heal because the blood supply would not be adequate (T. 402) (Kredentser).

83. Respondent's performance of the operations on this patient in 1995 and 1996 are serious deviations from the standard of care. They were major surgery with the risk of death (T. 403-404) (Kredentser).

Conclusions of Law

B.1 Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient B in the period 1989 through 1995. This constitutes negligence.

B.2 Respondent administered inappropriate chemotherapy to Patient B in the period 1989 to 1995. This constitutes gross negligence.

B.3 Respondent's use of Ergamisol in the period 1991 through February 1994 was inappropriate. This constitutes gross negligence.

B.4 Respondent performed an exploratory laparotomy and cancer reduction surgery on February 6, 1995, without adequate indication. This constitutes negligence.

B.5 Respondent performed an exploratory laparotomy and cancer reduction surgery on March 7, 1996, without adequate indication. This constitutes negligence.

DISCUSSION

Respondent's view is that there is no standard for treating epithelial ovarian cancer, either primary or recurring (T. 2364). Respondent agreed that no one else in the country uses the regimen he does (T. 2388). His specific chemotherapy regimen had no support either by scientific reports or by usage of other professionals. The drugs he was using, Methotrexate, Ergamisol, 5 FU, Vepesid, Depo-Provera, were not intended by their manufacturers for use with ovarian cancer (T. 2323-2326) (Respondent).

The aberrance of his protocol from accepted standards was shown by the dispute he had with SUNY Buffalo, from which he eventually lost his tenured faculty position (T. 2308). While he repeatedly referred to the Roswell protocols to justify his own (T. 2287), the actual Roswell protocols were shown to not be what he followed (compare Exs. J and K with Exs. 6, 10, 13) (chemotherapy charts). Respondent stated he would "definitely" use the same chemotherapy today (T. 2371-72).

Despite lack of any proper scientific study to justify his regimen, Respondent told patients that his regimen was better, far superior, and has fewer side effects (T. 1349, 2344). However, Respondent did not even tell patients that they were not receiving the same doses as the patients in his own study (T. 2347-2348).

Respondent contended that the state's case totally ignored the differences in chemotherapy for primary versus recurrent disease. However, the only differences he could point to was his elimination of Adriamyacin in one patient, but that was due to a concern about cardiotoxicology (T. 2221, 2359, 2360).

What was striking about Respondent's expert's testimony was the length to which Respondent avoided having his expert witness address the topic of chemotherapy. When the state's attorney or a member of the Hearing Committee attempted to do so, Respondent said it should be done later (T. 2138-2139, 2155). Respondent waited until there was only a short time left in the hearing day to address chemotherapy and he did not have his expert return for further testimony. Once Respondent's expert did address it, the reason for this avoidance became obvious - the expert could name no one, including the expert, who used Respondent's regimen (T. 2180) (Benham). Respondent's entire examination of his expert on chemotherapy, a topic he was told was of great interest to the Committee, was six questions all contained in only three pages of transcript (T. 2176-2178). Respondent never asked the expert any question directly addressing his specific chemotherapy regimen (t. 2176-2178) (Benham).

Respondent's expert did not know why Respondent continued to use Adriamycin with his patients (T. 2183). Since the early 90's, it was known it added no benefit but had cardiotoxic effects (T. 1993) (Benham). Respondent's expert stated that no one in the world used a regimen like Respondent's (T. 2191) (Benham).

Respondent's expert does not use Levamisole (Ergamisole) with his ovarian cancer patients (T. 2133) (Benham).

Respondent went into great detail concerning the doses for chemotherapeutic agents (T. 1312-1320). However, the record shows that he used pre-printed doses on many occasions and in part a comparison of Patient B and D demonstrated that Patient D received either as much or higher doses than Patient B, even though Patient B weighed substantially more (T. 2331-2336).

It seems that Respondent surely knew his science well but he was a very poor scientist. He seems to be saying "more is better" in relation to the several chemotherapeutic agents which he prescribed together in the same patient. However, he failed to prove or even discuss any sort of evaluation of his unique chemotherapy regimen, scientific or otherwise. He did not establish a positive outcome or the effectiveness of the regimen nor any scientific indication for safe and effective use of any specific combination. Could there be harm by way of increased toxicity related to the combination? Could there be a reduction of effectiveness of the therapy because the effectiveness of any individual drug could be compromised by several other drugs in combination?

It is adding insult to injury that the record keeping of the actual dosage given to each patient was poorly done nor was there any rationale or regular schedule of when the various drugs in the combination were to be given. The degree of deviation from the standard regimen of the day was significant and there were absolutely no safeguards employed to assure patient safety nor standards established to test effectiveness. Regardless of the fact that the science of chemotherapy is still a work in progress, any advances can only be sought or accomplished in a tightly controlled scientific atmosphere which first guarantees the safety of patients as well as the highest degree of their informed consent and provides the means to measure and evaluate results.

Furthermore, even the very concept of experimentation requires pre-approval by an Institutional review Board. This deviation from the standard of care constitutes gross negligence.

Regarding the surgeries, Respondent insistently referred to the obvious shortcomings of a retrospective review as providing perfect vision of the untoward events allowed by hindsight. However, especially in the case of Patient B, the professional criticism was based on all the facts available to the Respondent at the time which showed, especially for the surgery of March 1996, that there was nothing to gain by the surgeries. Respondent argues that there were signs of recurring cancer, but the patient was asymptomatic and surgery is a major physical and emotional insult fraught with risk, which should only be undertaken for some therapeutic gain which was not present in this case. As in other cases there was a more acceptable option available to Respondent to effectively treat this patient in the form of chemotherapy. However, the Respondent seemed to go after the cancer with a vengeance by way of surgery when he knew, or should have known, that it was highly unlikely that he could have excised every last carcinoma from the body. In this case, not only were the two surgeries unsuccessful but injury was added to the surgical insult by damaging and disabling the bowel. These surgeries were not indicated and this departure from the standard of care constitutes negligence.

PATIENT C

84. Patient C, a 67 year old female, was admitted to Our Lady of Victory Hospital with a history of increasing abdominal girth and anemia (Ex. 8 at 25; T. 554) (Kredentser).

85. The attending physician sought a gynecologic consult (Ex. 8 at 26, 27, 71; T. 555) (Kredentser).

86. The gynecologist discussed the case with Respondent on the 8th or 9th of May 1993, making sure he was available for surgery the 11th (Ex. 8 at 27; T. 555, 1768) (Loehfelm).

87. The gynecologist's assessment was that Patient C almost certainly had an advanced ovarian cancer and that Respondent would be the surgeon performing the procedure with the gynecologist assisting (T. 558, 1775) (Kredentser, Loehflem).

88. On May 10, the day before surgery, Respondent telephoned an order into the patient's chart (Ex. 8 at 276; T. 557) (Kredentser).

89. On May 11, 1993, Respondent and Dr. Loehfelm took this patient to the operating room, confirmed that she had advanced ovarian cancer, and performed an extensive surgical procedure (Ex. 8 at 120-123; T. 8) (Kredentser).

90. Prior to the May 11 surgery, Respondent did not perform any pre-operative history, physical examination or assessment of the patient (Ex. 8 at 27-29; T. 559) (Kredentser).

91. Performing an adequate pre-operative assessment may preclude some problems post-operatively (T. 589) (Kredentser). It would not be appropriate to show up to perform the surgery without this assessment (T.589-590) (Kredentser).

92. The rule is that the physician taking the patient to surgery must do a thorough assessment and inform the patient before proceeding (T. 2049, 2057) (Benham). Meeting the patient in the operative holding area, as Respondent did here, is unacceptable (T. 2057-2059) (Benham).

93. In a patient such as this, with a 6 x 8 centimeter mass, ascites and pleural effusion, it would be mandatory for the surgeon to do a pre-operative assessment (T. 584) (Kredentser).

94. The pre-operative evaluation should include the patient's history, physical and an assessment of all other available laboratory and radiographic data (T. 564-565) (Kredentser).

95. The primary gynecologist assumed Respondent would do whatever he needed preoperatively (1766-1767) (Loehfelm); a preoperative history and physical would be necessary for risk assessment and obtaining informed consent (T. 1770) (Loehfelm).

96. There was a pre-operative assessment by the gynecologist, but he would not be performing this surgery as the primary surgeon (T. 558) (Kredentser).

97. As the person who would be performing the surgery, Respondent was the physician to decide whether the patient is a suitable surgical candidate (T. 560) (Kredentser).

98. Respondent did not perform an adequate pre-operative assessment of Patient C before the May 11 surgery (T. 559, 568, 2070-2071) (Kredentser, Benham).

99. After the evaluation, the physician would then need to discuss factors obtained from the pre-operative assessment with the patient, inform her of the risks and potential benefits, the expected time line post-operatively, and potential post-operative complications (T. 565) (Kredentser).

100. Since Respondent did not evaluate the patient pre-operatively, he could not have obtained informed consent from the patient for the procedure (T. 564) (Kredentser).

101. There was a signed patient consent in the record, but that does not constitute adequate consent if Respondent did not discuss these matters with the patient (T. 565) (Kredentser).

102. Post-operatively, this patient had bleeding from the colostomy that was formed during the procedure of May 11 (T. 566) (Kredentser).

103. On May 15, Respondent coagulated the colostomy stoma edges and wrote that there was no more active bleeding (Ex. 8 at 36, T. 566) (Kredentser).

104. After that treatment by Respondent, the Respondent left town and was not available to treat the patient (Ex. 8 at 36-55, Ex. 25 at 12) (Respondent, Kredentser).

105. Respondent entered no order in the chart designating coverage for the patient's post-surgical care while he was unavailable (Ex. 8 at 136; T. 567-568) (Kredentser). There is no evidence in the record that he saw the patient between May 15 and May 21 (T. 569) (Kredentser).

106. The patient's ostomy continued to bleed while Respondent was unavailable. A surgeon was consulted to revise the ostomy to stop the bleeding (Ex. 8 at 42; T. 568-569) (Kredentser).

107. Respondent should have arranged for coverage because he had performed involved gyn/oncologist surgery on this patient. She had numerous potential complications. She underwent a radical dissection for ovarian cancer including a hysterectomy, bilateral salpingo-oophorectomy, bisection of the rectal sigmoid with a reanastomoses, lysis of adhesions, cystotomy with repair, resection of the omentum and pelvic and peri-aortic lymph nodes (T. 570) (Kredentser).

108. Even though Respondent was not the attending physician, he would be responsible for following the patient post-operatively since he was the primary surgeon on the case (T. 591-592, 1794) (Kredentser, Loehfelm). Once a physician performs major surgery on a patient, that patient is automatically the operating physician's patient. (T. 592, 1958) (Kredentser, Malik).

109. The fact that there were other physicians in the hospital that could be called to see the patient during the absence of Respondent does not negate Respondent's obligation to arrange for coverage (T. 571) (Kredentser).

110. Respondent failed to appropriately arrange for adequate coverage for the patient for several days beginning on May 15, 1993 (T. 569) (Kredentser).

111. Post-operatively, the patient developed multiple problems and her condition deteriorated. She had dozens of transfusions but continued to bleed (Ex. 8).

112. The patient was no longer capable of health care decision making and her daughter and son were making those decisions (Ex. 8 at 268-270).

113. After a lengthy discussion with the attending physician, and on his recommendation, the family authorized entry of a do not resuscitate order (DNR) into the patient's record and that their mother receive no more transfusions (Ex. 8 at 61, 268, 330; T. 1249-1251) (Patient C's daughter).

114. After that order was entered, and after the family had decided not to authorize additional transfusions, Respondent approached them (T. 1251) (Patient C's daughter). He wanted to further aggressively treat the patient, but the family told him that "enough was enough" and they wanted to have the patient be comfortable as she was dying (T. 136) (Nurse).

115. Respondent then told the family members that they were being like Jack Kevorkian, that if this was his mother he wouldn't allow this to happen, and that they were playing God by not allowing their mother to have further treatment (T. 136-139, 1252) (Nurse, Patient C's daughter).

116. Dr. Jack Kevorkian is the physician in the State of Michigan who is known for performing euthanasia (T. 579, 1252) (Patient C's daughter).

117. The daughter of the patient interpreted this statement of Respondent as meaning that they were helping to kill their mother (T. 1253) (Patient C's daughter).

118. Respondent's statements to the family were most inappropriate (T. 578, 1763) (Kredentser, Loehfelm). It is unheard of for gynecologic oncologists to make statements such as Respondent did to a patient's family (T. 581) (Kredentser).

119. Patient autonomy concerning health care decisions is a fundamental principle (T. 1908) (Noe). A patient or their designated family member always has the right to refuse any therapy.

120. If a physician disagrees with a family's choice, the issue can be brought to an ethics board, the hospital board, the chief of service or even to court (T. 579) (Kredentser).

121. It is extremely difficult for family members to make end of life decisions concerning their mother. Respondent's comments and behavior would only make it more difficult for the family members (T. 580-581, 1764) (Kredentser, Loehfelm).

122. Respondent's care of this patient was a severe deviation from acceptable standards of care (T. 581) (Kredentser). He failed to properly assess the patient pre-operatively, did not obtain a informed consent, did not have adequate coverage when he was unavailable, and made inflammatory statements to the patient and hospital staff (T. 581) (Kredentser).

Conclusions of Law

C.1 Respondent failed to perform and record an adequate pre-operative assessment of patient C before the surgery on May 11, 1993. This constitutes negligence and failure to maintain records.

C.2 Respondent failed to obtain adequate patient consent before the surgery on May 11, 1993. This constitutes negligence and lack of proper consent.

C.3 Respondent failed to arrange and designate adequate coverage of Patient C when he did not see the patient on successive days beginning on or around May 15, 1993. This constitutes negligence.

C.4 Respondent inappropriately made statements to the children of Patient C to the effect that they were being "Kevorkian like", were playing God, and would be responsible for their mother's death due to their decisions concerning their mother's health care during her final days. This constitutes gross negligence and moral unfitness.

DISCUSSION

Respondent stated that he had no authority to take action concerning the patient pre-operatively, since there was no order for him to act as consultant (T. 2485). However, this testimony is contradicted by his entry of an order in the chart the day before surgery (Ex. 8 at 276). This order alone proves that his Answer to the charges (Ex. B at 5, par. 12), which states that he was consulted the day of surgery, is false. Amazingly, Respondent wants this Committee to find that he can be called in to act as primary surgeon on an advanced cancer case, but he had no authority to see the patient pre-operatively to assess her (T. 2409, 2485). In fact, this remains his practice regarding surgery (T. 2487-88).

In Respondent's answer (Ex. B), he indicates that the patient's primary physician wrongly attributed the patient's abdominal distention to diabetes. Respondent particularly should have done a pre-operative assessment if he had questions about the medical judgement and abilities of the patient's internist (T. 564) (Kredentser).

Yoonessi claimed the primary surgery was done by the gynecologist (T. 562) (Kredentser). Respondent claims he was only asked to assist him in surgery (T. 562) (Kredentser). This was disputed by the gynecologist, who testified that the plan was for Respondent to be the primary surgeon. Despite Respondent's contention that he was the assisting surgeon, the record reflects that Respondent was the primary surgeon and Dr. Loehfelm assisted (T. 586) (Kredentser). Dr. Loehfelm was clear that he did not wait until the day of surgery, and contacted Respondent days before (T. 1805) but Respondent refused to change his Answer which stated that he was not consulted until the time of surgery (T. 2486).

Respondent's version of his authority as a consultant was inconsistent. He claimed he had no authority to examine patients pre-operatively because that was not authorized, even though he would be the primary surgeon. However, the record was clear this Respondent did not act in accord with this version of his authority. He was not shy about approaching the family of Patient C to disagree with the treatment plan developed by the attending physician and the family. When they would not authorize his proposed treatment, he accused them of being "Kevorkian". Likewise, even after he told the family of Patient E that he would be no longer involved in her care, he then approached the daughter to claim the other physician's pain medications were wrong. Not only do these not show that Respondent acted differently than his testimony, they show that he is a bully to patients and families.

No physician other than Respondent felt aggressive treatment would help this patient (T. 1764-1766, 1787-1788) (Loehfelm). When informed that the family wanted no further transfusions, Respondent said "I don't care what the family wants" and ordered blood anyway (T. 129, 131) (Nurse).

Respondent's own physician witnesses testified that they would never tell a family they are "Kevorkian", or the other comments Respondent made. The comments would be inappropriate and would be at a very difficult time for the family (T. 1763-1764) (Loehfelm).

Respondent denied telling the patient's family that they were "Kevorkian". His testimony was that there was merely a discussion regarding possible treatment (T. 2484). Respondent offered no explanation, and none was developed on cross-examination of the patient's daughter, regarding what would be the motive for the family to make up a story in which Respondent said these things. Furthermore, the daughter immediately reported the statements to a nurse.

Dr. Loehfelm had no formal coverage arrangements with Respondent and for this case there was no note that he was to cover for Respondent during his absence (T. 1759-1760,1800) (Loehfelm).

Respondent's intemperate conduct was directed at the patient's family members who were already distraught by following this patient's failing course. The testimony of the patient's daughter was most compelling and credible. This conduct was a grave breach of the public trust and ethical principles, not to mention, common courtesy. A physician is a healer and a servant of his patients and their families. One expects some assurances of competence and a high degree of certainty in the judgment of a person who occupies such a position of trust. A physician is trusted with the very life of a patient and all the privileges of most intimate access to that patient in order to carry out the healing trust. If the physician does not approach this high moral trust with humility then there can be no trust because the physician will be viewed as reckless and uncaring. The very concept of healing includes caring and concern for the patient who is by definition vulnerable and frightened because of a physical malady. Thus, physicians do not

argue with or malign each other in the presence of a patient for this would be inappropriate as raising questions of their competence or judgment. Nor do physicians confront or malign their patients or their choices, including patient's family members, because this exhibits insensitivity and raises questions of the degree of concern of the physician for the patient. The Respondent's conduct in relation to the patient's family in this case was a grave breach of trust which constitutes moral unfitness to practice medicine and gross negligence.

PATIENT D

123. Patient D presented to St. Joseph's Hospital on April 24, 1994, with a history of ascites and a palpable mass in her left mid-abdomen (Ex. 11 at 8-12; T. 597-598) (Kredentser).

124. Patient D's physician wrote a note that Respondent was informed and the appropriate procedure will be performed if cancer is found (Ex. 11 at 10; T. 598) (Kredentser).

125. On April 24, 1994, Respondent was contacted concerning the surgery (T. 598-600, 1843) (Maceda). Patient D's physician did not wait until the patient was at surgery to consult with Respondent (T. 1844).

126. On April 25, 1994, surgery was performed on this patient with Respondent as the primary surgeon (Ex. 11 at 42-44; T. 600-601) (Kredentser).

127. For the reasons stated with concerning Patient C, it is important that the operating surgeon perform a pre-operative assessment (T. 600-601, 2048-2049) (Kredentser, Benham).

128. Respondent did not perform a pre-operative assessment of this patient (T. 601) (Kredentser).

129. Respondent did not record an adequate pre-operative assessment of this patient (T. 601) (Kredentser).

130. Optimal cytoreduction is removal of a tumor until there is less than 1 cm maximum diameter remaining (T. 604) (Kredentser).

131. If a surgeon can achieve optimal cytoreduction, it has been demonstrated that patients will have a better response to chemotherapy and a better prognosis (T. 604) (Kredentser).

132. Due to the extensive spread of cancer in this patient, Respondent was not able to achieve optimal cytoreduction (Ex. 11 at 42-43; T. 603) (Kredentser). Respondent did not address any of the tumor he noted being on the patient's diaphragm (Ex. 11at 42-44).

133. Respondent performed two bowel resections on this patient (Ex. 11 at 43; T. 604) (Kredentser).

134. These resections were without adequate indication since the work-up of the patient's gastrointestinal (GI) tract failed to reveal a GI lesion (T. 604) (Kredentser). There was no pre-existing or impending obstruction documented (T. 608) (Kredentser). The operative note did not state that the sigmoid colon was so involved in the tumor that removal of tumor also required removal of the sigmoid colon (T. 609) (Kredentser).

135. The bowel resections in this case were not appropriate (T. 608) (Kredentser).

136. As mentioned in the previous case, one of the risks of an operative procedure is the patient may have a bowel obstruction post-operatively. This patient did develop a bowel obstruction (T. 611) (Kredentser).

137. Respondent administered chemotherapy to Patient D (Ex. 9, 10).

138. As with Patient B, neither the hospital progress notes nor the signed consent forms detail the types of chemotherapeutic agents used, their risks or benefits, or the specific chemotherapeutic regimen Respondent proposed for treating this patient (T. 612-613) (Kredentser).

139. The chemotherapy Respondent administered to Patient D did not meet acceptable standards of care (T. 614-615) (Kredentser). He did not obtain adequate informed consent for the chemotherapy (T. 612-613) (Kredentser).

140. Because chemotherapy agents have toxic side affects, it is inappropriate to give them unless the benefits are established (T. 615) (Kredentser). Respondent's protocol consists of eight or nine drugs (Exh. 10). One of the drugs was Ergamisol (Exh. 10). Even Respondent did not know if anyone else was using Ergamisol in ovarian cancer patients (T. 1691).

141. Respondent published an article in which he reported a 100 percent response rate with his chemotherapy regimen (T. 649) (Kredentser). Other standard protocols have a far lower response rate, yet Respondent's protocol has not been studied anywhere else in the United States, Canada or industrialized world (T. 650) (Kredentser).

142. Respondent's regimen is not patterned on any standard regimen in the United States, Canada or any developed country (T. 656-657) (Kredentser).

143. There are no studies that support the use of Respondent's specific chemotherapy regimen (T. 1328) (Respondent). His protocol was not approved by the NYS Department of Health or any hospital (T. 1366,1380) (Respondent).

144. The administration of Adriamycin to this patient could have caused cardio-toxicity and have contributed to her rapid decline (T. 655) (Kredentser).

145. The known side affects of 5FU and Methotrexate are stomatitis, which this patient developed. Adding additional chemotherapeutic drugs causes added toxicity (T. 656) (Kredentser).

146. In 1994, either of two regimens for chemotherapy would be appropriate, Cytoxan and Carboplatin or Taxol and Cisplatin (T. 648) (Kredentser).

147. Respondent's records are not accurate or consistent concerning the chemotherapeutic agents given to the patient. For example, his office chart has one entry for chemotherapy for August 10, 1994 that lists Methotrexate, Cytoxan, and Depo-Provera as being given (Ex. 10, Ex. 9 at 5). However, the order sheet for August 10 includes Methotrexate and Depo-Provera, but not Cytoxan (Ex. 9 at 111; T. 621-622) (Kredentser).

148. A physician needs to maintain documentation, such as a chemotherapy flow sheet which contains the patient's vital signs, height, weight, blood counts and chemotherapy regimen. This makes it easier to follow chemotherapy given the patient and the patient's response, and to avoid errors (T. 623) (Kredentser).

149. The question marks listed on the chemotherapy chart in Ex. 10 show references to a drug being given on a particular date but there is no documentation of the doses given in Respondent's office chart (compare Ex. 9 and Ex. 10; T. 624) (Kredentser).

150. Respondent did not keep accurate records of the chemotherapy treatment for this patient (T. 622) (Kredentser).

151. Respondent did not keep adequate records of the patient's response to chemotherapy. This can be done by physical examination, CT scans and CA 125 tests (T. 624) (Kredentser).

152. Adriamycin can cause deterioration of left ventricular ejection fraction of the patient's heart (T. 626, 2183) (Kredentser, Benham).

153. Respondent did obtain a left ventricular ejection fraction by echo cardiogram.

154. The electro cardiogram provided sufficient data to evaluate the function.

155. On January 16, 1995, Patient D presented to St. Joseph's Hospital with sores in her mouth and oral thrush (a fungal infection) (Ex. 11 at 949; T. 628) (Kredentser).

156. Chemotherapy causes immuno-suppression and can result in a higher incidence of opportunistic infections like thrush (T. 628) (Kredentser). Respondent examined the patient and found that she had stomatitis, inflammation of the mouth, which can affect a patient's ability to eat and drink because it becomes extremely difficult to swallow (T. 629) (Kredentser).

157. During the course of this hospitalization, the patient developed a colovaginal fistula (an opening between the colon and the vagina), and an entero cutaneous fistula (an opening between the bowel and the skin) (T. 633) (Kredentser).

158. Respondent performed a transverse loop colostomy to divert the fecal material from the fistulas (Ex. 11 at 1101; T. 632) (Kredentser).

159. He did not take adequate steps to assure that the colostomy he formed was proximal to (above), both of the fistulas. If the colostomy he created was in the GI tract below either of the fistulas, it would provide no benefit to the patient as she would still have leakage from a fistula (T. 632-633) (Kredentser).

160. Respondent failed to adequately determine the origin of the fistula before performing the colostomy (T. 632-633) (Kredentser).

161. There was no adequate indication for performing a diverting colostomy on this patient (T. 635) (Kredentser).

162. The patient's fistula was already covered with a colostomy bag. Respondent simply created another opening in the patient's abdomen that moved the colostomy bag in a different location (T. 636) (Kredentser).

163. This patient was terminally ill and her family did not want any further heroic treatment (T. 636) (Kredentser). If she were going home it would be easier to manage with a surgically created colostomy, but it was clear this patient was not going to be leaving the hospital alive (T. 636-637) (Kredentser).

164. On January 20, 1995, a physician covering for Respondent noted that authorization for a DNR (do not resuscitate) order was signed by the husband and the family (Ex. 11 at 1035; T. 637-638) (Kredentser). All documentation was appropriate and the DNR was never rescinded (T. 1839-1841) (Maceda).

165. The DNR order was entered into the chart on January 20, 1995 (Ex. 11 at 1223; T. 640) (Kredentser).

166. On March 7, 1995, Respondent attempted resuscitation of Patient D by intubating her, performing cardiac compressions, administering epinephrin (Ex. 11 at 1205, 1206, 1977; T. 641-642) (Kredentser).

167. It is not appropriate to attempt resuscitation of a patient who has requested a Do Not Resuscitate order (Ex. 11 at 968-969; T. 644, 1841) (Kredentser, Maceda).

168. A physician should read the notes made by a physician who is covering in his absence (T. 639, 1837) (Kredentser, Maceda). The wishes of the family concerning the DNR were noted by other physicians (Ex. 11 at 958-960; T. 639) (Kredentser).

169. Initiating resuscitation on someone who has a DNR status is an assault (T. 659) (Kredentser).

170. Respondent claimed in his answer (Ex. B) that the DNR order was improperly executed, and that it was rescinded, but offered no proof of this.

171. If Respondent thought the DNR order was inappropriate or there was a question of its validity, there was a procedure the hospital had (Ex. 11 at 968-969; T. 1908-1909) (Noe). Respondent did not follow this procedure and he made no chart entry stating that the DNR was improperly executed or had been rescinded.

172. Respondent's care of this patient deviated considerably from accepted standards (T. 647) (Kredentser).

Conclusions of Law

D.1 Respondent failed to perform and record an adequate preoperative assessment of Patient D before surgery on April 25, 1994. This constitutes negligence and failure to maintain records.

D.2 Respondent performed multiple bowel resections on April 25, 1994, without adequate indication. This constitutes negligence.

D.3 Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient D for ovarian cancer beginning in 1994. This constitutes negligence and lack of proper consent.

D.4 Respondent administered inappropriate chemotherapy for Patient D. This constitutes gross negligence.

D.5 Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and the patient's response. This constitutes negligence and a failure to keep records.

D.6 Respondent obtained an adequate left ventricular ejection fraction prior to starting Adriamycin in May 1994.

D.7 Respondent failed to adequately determine the origin of the fistula before performing a diverting colostomy. This constitutes negligence.

D.8 Respondent performed a diverting colostomy without adequate indication on March 6, 1995, the day before this patient died. This constitutes negligence.

D.9 Respondent inappropriately attempted and ordered resuscitation of Patient D despite the existence of a DNR order. This constitutes gross negligence and lack of proper consent.

DISCUSSION

Respondent asserted that he was consulted at surgery, as the reason for no pre-operative evaluation (Exh. B). It was clear Respondent was contacted the day before surgery (T. 1843, 1844) (Maceda).

The Respondent, at various times, used pre-printed dosages for chemotherapy, using rounded doses rather than the exact one his regimen called for (T. 1357-1358) (Respondent). He did not tell patients that they were not receiving the doses he described in his article (T. 2347-2348).

Respondent's opinion is that the studies of the Gynecologic Oncology Group (GOG), the pre-eminent organization in that field, are flawed (T. 1353) (Respondent). Respondent tells his patients that his regimen is "far superior" (T. 1349) (Respondent). Respondent saw himself as on the cutting edge for chemotherapy (T. 1691-92) (Respondent), yet no data supported his specific protocol.

Respondent tried to assert that the DNR was no longer valid because the order had not been reviewed. However, the law puts the responsibility for reviewing the order on the attending physician - in this case Respondent - and it was he who violated the review responsibility (T. 2480). The statute provides that the DNR remains in effect if the required reviews are not done [PHL § 2970(1)]. The physician who initiated the DNR, while covering for Respondent, expected it to be effective and Respondent to be aware of it (T. 1836-1839) (Maceda).

Respondent has offered multiple conflicting versions of events regarding his resuscitation of a patient with a DNR order. In his interview (Ex. 25 at 14, 15), he first said he did not resuscitate the patient, he only suctioned material from her mouth. He then argued that he had attempted to resuscitate her but was unaware of the DNR order, even though he was the attending physician. Finally, at hearing, he testified that he either believed the DNR was invalid or that the patient's husband did not want to give up. (T. 2477-2479). However, this testimony about the husband's wishes is shown to be false by the fact that the husband was the designated person who authorized the DNR order (Ex. 11 at 969). Additionally, Respondent never made a chart entry that he believed the DNR to be invalid, or that he thought the husband did not want the DNR, or that he initiated any appeal concerning the DNR (T. 2482). In fact, the evidence was that Respondent, as the attending, totally ignored his legal responsibility under the Public Health Law 2970 to review the DNR order for his patient (T. 2480-2481).

Assaulting a patient is reckless disregard for the patient's rights. It is gross negligence.

PATIENT E

173. A physician should inform the patient of the standard treatment for the disease. He did not do this (T. 664) (Kredentser).

174. The chemotherapy Respondent administered to this patient did not meet acceptable standards of care (Ex. 12, 13; T. 665) (Kredentser), for the same reasons mentioned concerning the other patients.

175. Respondent did not obtain adequate informed consent for the chemotherapy he ordered for this patient (T. 662-663) (Kredentser). He did not discuss each chemotherapy drug with the patient, their side effects, potential benefits and alternatives (T. 663) (Kredentser).

176. Respondent's office record for this patient contains a page which lists drugs given for chemotherapy on specific dates (Ex. 12 at 6). However, the actual order for administration of those drugs as well as their dosing could not be located in Respondent's chart (T. 662) (Kredentser). Those gaps in Respondent's record are indicated on Ex. 13 as question marks (T. 662) (Kredentser). This constitutes inadequate records. Respondent's records were inadequate concerning his chemotherapy treatments for the patient (T. 669-670) (Kredentser).

177. Respondent did not appropriately monitor the effects of this chemotherapy on this patient (T. 665) (Kredentser).

178. Chemotherapy needs to be calibrated depending on each individual, yet Respondent, in his practice, used chemotherapeutic orders that had pre- printed doses (see, for example, Ex. 5 at 280; T. 669) (Kredentser).

179. A reasonably prudent physician would document why there was such an increase or decrease in medication (T. 667) (Kredentser). Respondent changed doses of chemotherapy without explanation. For example, on August 12, 1997, the patient was given 200 mg of Cytoxan, and that increased on September 23 to 500 mg (T. 666-667) (Kredentser). Respondent also varied the dose of Cisplatin between 60 and 70 mgs. without explanation (T. 667-668) (Kredentser).

180. Respondent did not maintain adequate records of this patient's response to chemotherapy (T. 670) (Kredentser).

181. Respondent created an entry in the patient's medical record initially dated February 19, 1992 which he signed (Ex. 12 at 74). That document reports that a hands-on physical examination occurred, including rectal and breast examination (T. 671) (Kredentser). The date, February 19, is crossed out and a post-it note that was stuck on the page that says "no show, postponed" (T. 671) (Kredentser).

182. All patients have vital signs taken when they enter Respondent's office for chemotherapy (T. 1503) (Butler).

183. If a patient did not have chemotherapy as scheduled, the reason would be written in the chart (T. 1507) (Butler).

184. There are no vital signs, no height or weight for this patient on the February 19 chart entry (Ex. 12 at 74; T. 671) (Kredentser).

185. The Committee infers that Respondent had completed the physical examination portion of the patient's chart in anticipation that she would come to the office on February 19 for chemotherapy, but that she did not do so.

186. He created that record intending to document a physical examination on February 19 when he knew he had not yet done one.

187. It is not appropriate to document performance of physical examination when the patient is not physically in before the physician (T. 672) (Kredentser).

188. Respondent's completion of a physical examination without the patient being present raises questions about the validity of all of his documentation (T. 688-689) (Kredentser).

189. On October 17, 1997, Patient E was admitted to Mercy Hospital (Ex. 14 at 5; T. 674-675) (Kredentser).

190. Prior to this hospitalization, this patient had received 500 mg of Cyclophosphamide on September 23, 1997, 500 mg on September 26, 1997, and 400 mg on October 8, 1997. She also received 5FU on September 24, and Methotrexate on September 23 and October 8 (Ex. 13; T. 697-698) (Kredentser).

191. This chemotherapy could easily lead to toxicity due to her chemotherapy, a low white cell count, development of infection, and sepsis resulting in death (T. 698) (Kredentser).

192. On October 19, Respondent asked that the patient be transferred to Buffalo General Hospital to a medical psychiatric floor (Ex. 14 at 37; T. 676) (Kredentser).

193. This patient was not stable for transport when she was transferred. With her medical problems, her destination should have been the I.C.U. (intensive care unit), not a medical psychiatric floor (T. 676-677) (Kredentser).

194. Respondent's order to transfer the patient was inappropriate (T. 677) (Kredentser).

195. At Buffalo General Hospital there was a disagreement between Respondent and another physician concerning how and where the patient should be treated (T. 231) (Patient E's husband).

196. The family decided that to follow the other physician's advice rather than Respondent's (T. 231-232) (Patient E's husband).

197. At that point, Respondent stated that the family would need to find a new doctor and left the room (T. 232) (Patient E's husband).

198. Shortly thereafter, he approached the daughter of the patient and told her that he was concerned with the level of morphine (T. 192) (Patient E's daughter). This confused the patient's daughter. She went to the nurse's station and was assured that everything was fine (T. 192) (Patient E's daughter).

199. It was inappropriate for Respondent to have confronted the patient's daughter at that time and question the other physician's pain medication order because he was no longer a physician involved in the case. He should have discussed it directly with the physician or the Chief of Service rather than a family member (T. 680) (Kredentser).

200. The other physician ordered that the patient receive 4 cc's of morphine sulfate per hour for pain (Ex. 15 at 177; T. 682-683) (Kredentser). That is an appropriate dosage for this patient (T. 683) (Kredentser).

201. Respondent wrote a note in the patient's chart to the effect that Patient E's husband "...states he understands from [the other physician] that this is a case of euthanasia with that he agrees. Will sign off the case" to the other physician (Ex. 15 at 144).

202. The husband never made such a statement to Respondent (T. 233-235) (Patient E's husband, Respondent). Respondent admitted the other physician did not say this was euthanasia (T. 2468).

203. It was inappropriate and unprofessional for Respondent to have made such a chart entry that the other physician was using morphine as euthanasia without first approaching the physician to determine if it was true (T. 683-684) (Kredentser).

204. Respondent prepared a discharge summary for the patient's hospitalization at Buffalo General (Ex. 12 at 459). This was not appropriate since he had either been dismissed from the case or had signed off it (T. 684-685) (Kredentser).

205. Respondent's care concerning this patient was a severe deviation from the standard of care (T. 688) (Kredentser).

Conclusions of Law

E.1 Respondent failed to obtain informed consent for the chemotherapy he ordered for Patient E for ovarian cancer. This constitutes negligence and lack of proper consent.

E.2 Respondent instituted inappropriate chemotherapy for Patient E. This constitutes gross negligence.

E.3 Respondent failed to appropriately monitor the effects of the chemotherapy. This constitutes negligence and failure to maintain records.

E.4 Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and the patient's response. This constitutes negligence and failure to maintain records.

E.5 Respondent fraudulently and inappropriately documented that he performed a physical examination of Patient E on or around February 19, 1992, when the patient was not present. This constitutes negligence and fraud.

E.6 Respondent inappropriately ordered transfer of a patient with major medical issues from Mercy Hospital to a psychiatric floor at Buffalo General Hospital on October 19, 1997. This constitutes negligence.

E.7 Respondent inappropriately questioned another physician's pain medication order directly with the patient's family. This constitutes gross negligence and moral unfitness.

E.8 Respondent inappropriately wrote in the patient's chart words to the effect that another physician had stated that Morphine was being used as euthanasia with which the patient's husband agreed. This constitutes negligence.

E.9 Respondent appropriately wrote a discharge summary in the patient's chart after he was no longer involved in the patient's care.

DISCUSSION

After the family chose to not follow Respondent's advise, Respondent wrote a note accusing Patient E's husband and an attending physician of euthanasia (Ex. 15 at 144). The husband never stated that the other physician mentioned euthanasia (T. 234) (Patient E's husband). The toxicologist made it clear that the dosage of Morphine prescribed and the amount in the patient's blood would not lead to her death (T. 925-934).

Respondent made much of the fact that his opinion was that the order for Morphine at 4 mg per hour caused Patient E to die. However, he had ordered 5-10 mg per hour for Patient A (Ex. 4 at 53; T. 2469). This may simply be another case in which Respondent feels the need to blame a poor patient outcome on another physician.

Regarding the phantom physical, Respondent's staff testified they always took vital signs before Respondent examined the patient. (T. 1551, 1553) (Butler). There were no vital signs for February 19, 1992. Respondent claimed that the patient, on the February 19, 1986 visit refused chemo due to a sore porta cath site (Answer, Exh. B para. 29). However, Respondent did not

note any soreness or redness on exam, and did not note that chemo was canceled although that is the practice in his office (T. 2470-2471) (Respondent). Respondent testified that at the February 19, office visit the patient's dressing was dry and her porta cath site was sore (T. 2455). The record for that date makes no reference to the patient's dressing or a sore operative site (Ex. 15 at 74). The testimony of Respondent's office manager, Mrs. Brandt, was inconclusive and did not support Respondent's explanation. This was fraud but does not rise to the level of moral unfitness.

The rationale for the allegations concerning chemotherapy and intemperate remarks to patients have been discussed above.

It is not misconduct to write germane and appropriate remarks in a patient's chart. However, in the case of factual allegation E-8 the substance and tenor of what was writeen were objectionable and negligent. However, the discharge summary was appropriate since the Respondent had been discharged from the case.

PATIENT F

206. Patient F was a 66 year old white female who presented at Respondent's office on August 30, 1996 (Ex. 17 at 82; T. 716) (Kredentser).

207. She presented with a distended abdomen and was found to have ascites and an abdominal pelvic mass. Respondent's impression was that she had a probable ovarian malignancy (Ex. 17 at 82-83; T. 716) (Kredentser).

208. A cytology study found that the ascitic fluid was positive for adenocarcinoma (Ex. 17 at 67; T. 717) (Kredentser).

209. The patient was a Jehovah's Witness and would not accept any transfusions (Ex. 17 at 9-12; T. 717) (Kredentser).

210. Respondent took the patient to the operating room on September 5, 1996, and performed a procedure of four and a half to five hours long (Ex. 17 at 94-99; T. 718-719) (Kredentser).

211. Respondent reported performing the following operation: exploratory laparotomy, lysis of adhesions, tumor resection with resection of tumor from the omentum and gastrocolic ligament, left and right colic gutters, cystotomy with repair, extended abdominal hysterectomy and bilateral salpingo oophorectomy, bilateral ureterolysis, resection of the rectosigmoid colon with colonic anastamosis, resection of the mid jejunum with jejuno re-anastomosis, resection of the distal ilium and ascending colon with ilio ascending enterocolostomy, bilateral iliac lymphadenectomy (Ex. 17 at 96; T. 722) (Kredentser).

212. With an operation such as this, a surgeon should anticipate significant blood loss, probably four to five units of blood, half of the patient's total blood (T. 723) (Kredentser).

213. Respondent performed too extensive a surgery for a patient who refused transfusions (T. 725) (Kredentser).

214. Pre-operatively, he should have taken steps to maximize the patient's hemoglobin, including medications that do this (T. 723) (Kredentser).

215. Intra-operatively, the scope and timing for the procedure should have been limited to minimize blood loss (T. 724) (Kredentser). For example, the patient had three bowel resections, yet there was no indication in the pre-operative work-up of a bowel obstruction (T. 727) (Kredentser).

216. A pelvic lymphadenectomy was performed. There would be no benefit unless he could eliminate all tumor from the patient (T. 727) (Kredentser). Further, a lymphadenectomy involves surgery near major blood vessels. Damage to these could lead to a catastrophic hemorrhage (T. 728) (Kredentser).

217. Intra-operatively, a physician can also use surgical tools to coagulate bleeders while a tumor is being removed (T. 729) (Kredentser). A physician attempting to minimize blood loss would note those procedures if they were done (T. 730) (Kredentser).

218. Respondent did not note using such techniques in his operative note or during his testimony (Ex. 17 at 94-99).

219. Respondent did not take appropriate steps to limit the blood loss of the patient who refused transfusions (T. 724-725, 736) (Kredentser).

220. Not only did Respondent take inadequate steps to minimize blood loss for this patient, it did not appear that he took any steps to minimize blood loss during surgery (T. 736) (Kredentser).

221. The patient had cancer in the left lobe of her liver which would mean that she could not be optimally cytoreduced (T. 735) (Kredentser). Upon opening the patient's abdomen and noting that she could not be optimally cytoreduced, it would have been appropriate to alleviate any symptoms she had, such as bloating, minimize blood loss and get her off the operating room table as soon as possible (T. 736-737) (Kredentser).

222. One option with this patient would have been to give her pre-operative chemotherapy to have reduced the ascites and the masses, and thereby decrease the amount of surgery needed (T. 750) (Kredentser). The other option would be to perform an exploratory laparotomy but then limit the scope of the procedure to a TAH-BSO, an omentectomy if it was felt the omentum was contributing to the ascites, and then follow her with chemotherapy (T. 750-751) (Kredentser).

223. Chemotherapy was this patient's only chance for treatment. The extensive procedure the Respondent performed precluded her from getting that chemotherapy (T. 751) (Kredentser).

224. Respondent estimated the blood loss of this patient as being 2,000 cc's, the anesthesiologist estimated blood loss as 3,000 (Ex. 18 at 86, 98; T. 731-732) (Kredentser).

225. Post-operatively this patient's hemoglobin and hematocrit were approximately half of what they were pre-operatively (Ex. 18 at 124). Usually the post-operative hemoglobin is higher than the true hemoglobin as it will drift down over the next 24 to 48 hours (T. 734) (Kredentser).

226. Causing such a volume of blood loss would put the patient into a form of shock, cause her to increase her heart output to make up for the loss of blood volume, and could eventually lead to cardiac failure (T. 734-735) (Kredentser).

227. Respondent performed inappropriate tumor reduction for a patient who refused transfusions (T. 736) (Kredentser).

228. Post-operatively, the Respondent recommended that the patient have chemotherapy treatment (Ex. 18 at 37; T. 739) (Kredentser). Cisplatin and Cytoxan were administered to the patient (Ex. 18 at 209; T. 740) (Kredentser).

229. This patient's hemoglobin and hematocrit were already approximately forty percent of normal, and both Cytoxan and Cysplatin can decrease white cells and platelets (T. 740) (Kredentser). Chemotherapy would preclude the patient from increasing her blood counts, prevent progress and cause continuing cardiac high output which can lead to cardiac failure (T. 743-744) (Kredentser).

230. One particularly pertinent expected risk of chemotherapy would be that it would prevent her from improving her health since she could not produce additional blood cells (T. 745-746) (Kredentser).

231. This patient was severely ill at the time Respondent ordered the chemotherapy treatment, and the chemotherapy could be dangerous and was inappropriate for the patient at that time (T. 741-742) (Kredentser). The patient was anemic, had recently undergone a thoracentisis, and perhaps had a bowel obstruction. The chemotherapy would be a further insult which could lead to further injury (T. 742) (Kredentser).\

232. There is no indication the patient was told the chemotherapy could prevent her health from improving (T. 745) (Kredentser).

233. Respondent did not obtain adequate informed consent for the patient's chemotherapy (T. 746) (Kredentser).

234. Respondent administered inappropriate chemotherapy to the patient (T. 742) (Kredentser).

235. Respondent's post-operative progress notes on the patient were inadequate (T. 747-748) (Kredentser). His progress notes indicate the patient is stable; they do not give accurate reflections of the ongoing severity of the patient's condition. (Ex. 18 at 30-36; T. 747-748) (Kredentser).

236. Respondent's care of this patient was a severe deviation from accepted standards of care (T. 749) (Kredentser).

Conclusions of Law

F.1 Respondent inappropriately performed extensive surgery and/or failed to take appropriate steps to minimize blood loss for Patient F, who refused all blood product transfusions. This constitutes negligence.

F.2 Respondent performed inappropriate tumor reduction surgery on Patient F given her refusal of all blood product transfusions. This constitutes negligence.

F.3 Respondent inappropriately administered chemotherapy to a patient who was too debilitated. This constitutes negligence.

F.4 Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient F. This constitutes negligence and lack of proper consent.

F.5 Respondent administered inappropriate chemotherapy to Patient F. This constitutes gross negligence.

F.6 Respondent's post-operative progress notes were inadequate. This constitutes negligence and failure to maintain records.

DISCUSSION

Respondent reduced this patient's blood counts to less than half of normal during the operation. He then further diminished her blood counts by the chemotherapy. Death of the patient was not only foreseeable as a possibility, but a probability.

Respondent's mantra to justify the massive procedure on a patient who refused transfusions was that the patient wanted to be treated aggressively (T. 2447). This would not justify an operation that would result in death (T. 2449).

Respondent contended that the bowel surgery was necessary because the patient was obstructed, but that is not reported in his pre-operative notes (Ex. 18 at 25, 26) or his operative note (Ex. 18 at 96-98).

The findings of fact in this case need no further explanation to support the conclusions herein.

PATIENT G

237. Patient G was 68 years old when she was operated on by Respondent for ovarian cancer (Ex. 19 at 216-218; T. 752-753) (Kredentser).

238. Post-operatively, Respondent gave her chemotherapy (Ex. 19; T. 754) (Kredentser).

239. The consent forms for chemotherapy contained no mention of specific risks or benefits and was not signed by Respondent (Ex. 19 at 208; T. 755-756) (Kredentser).

240. Respondent did not obtain adequate informed consent from the patient before instituting the chemotherapy regimen, for the same reasons stated concerning the other patients (T. 758) (Kredentser).

241. The chemotherapy administered to this patient by Respondent, as reflected in his office chart and as compiled by the expert, does not meet acceptable standards of care (Ex. 29 at 4, Ex. 19; T. 756-757) (Kredentser).

242. If the dose of chemotherapy is not individualized for a patient, the patient could receive a dose that was either inappropriately too high or too low (T. 759) (Kredentser).

243. The patient was admitted to Buffalo General Hospital from October 10 through October 22, 1992 (Ex. 20 at 155; T. 759) (Kredentser). During that stay, she was diagnosed by Respondent as having a pulmonary embolism (Ex. 20 at 155, 182; T. 760) (Kredentser). This is a blood clot that migrates from a major vein into the lungs and can cause death (T. 761) (Kredentser).

244. Following this diagnosis, Respondent continued to prescribe Depo-Provera to the patient on both an in-patient and out-patient basis (Ex. 20 at 215; T. 762-763) (Kredentser).

245. It was inappropriate to prescribe Depo-Provera to her because it is contraindicated in patients with thromboembolic disease since it promotes blood clots (T. 763-764, 2097) (Kredentser, Benham).

246. This patient was on Coumadin, which can thin the blood, but nonetheless, the prescription of Depo-Provera was inappropriate (T. 765, 2097) (Kredentser, Benham).

247. In addition to the fact that Depo-Provera is contraindicated in a patient with thromboembolic disease, there was no indication for the prescription of this drug in any event, as it has not been used as primary treatment of ovarian cancer (T. 765) (Kredentser).

248. Nowhere in the Respondent's records for any patient does he actually lay out a chemotherapy plan (T. 766) (Kredentser).

249. Respondent's records concerning his chemotherapy plan for this patient were inadequate (T. 766) (Kredentser).

250. If another physician took over the patient's care, the physician would need to be able to determine what treatments they had and the dosage. Respondent's records would not permit such information to be obtained (T. 766-767) (Kredentser). The Department's expert needed to sit down and make a spread sheet to attempt to understand it, and even so, errors were made (T. 765-766) (Kredentser).

251. The inability of another physician to determine what Respondent had already given to this patient could impair that physician's ability to properly assess and treat the patient (T. 767)(Kredentser).

252. Respondent did not maintain adequate records of his treatments of chemotherapy of this patient (T. 766) (Kredentser).

253. Respondent did not adequately record the patient's response to treatment (T. 768) (Kredentser).

254. This patient was receiving Adriamycin from Respondent (T. 769) (Kredentser). Adriamycin can have an adverse impact on heart function (T. 769, 2100) (Kredentser, Benham).

255. Obtaining serial ejection fractions of a patient receiving Adriamycin is important because of the known side affect of Adriamycin which can be reflected in the cardiac ejection fraction (T. 770, 2100) (Kredentser, Benham). A decrease in this value may indicated the patient could develop congestive heart failure which could lead to death (T. 770-771) (Kredentser).

256. This patient, while still hospitalized, had a left ventricular ejection fraction of 46 percent (T. 768) (Kredentser). That value is abnormally low (T. 769) (Kredentser).

257. After the Respondent gave the patient Adriamycin, when the patient was admitted again to the hospital, her ejection fraction was 31 percent (Ex. 19 at 54; T. 769-770) (Kredentser). This is a significant decrease in her health status.

258. Respondent did not obtain adequate serial left ventricular ejection fractions while he was administering chemotherapy to this patient (T. 770) (Kredentser).

259. After the patient was admitted to Buffalo General Hospital on March 1, 1993, the covering medical attending addressed with the patient and her family her DNR status (Ex. 20 at 335; T. 773) (Kredentser).

260. The patient and her family thought about it and decided she did not wish to be resuscitated (Ex. 20 at 336-337; T. 773) (Kredentser).

261. On March 5, 1993, Patient G signed the documentation specifying that she did not want to be resuscitated (Ex. 20 at 354; T. 774) (Kredentser).

262. The patient did not require Dr. Yoonessi's consent before signing the DNR consent (T. 780, 1908) (Kredentser, Noe). Once the patient signs the DNR consent, the physician is obliged to follow the patient's request (T. 780) (Kredentser).

263. Respondent wrote an order canceling the DNR order (Ex. 20 at 371; T. 776) (Kredentser).

264. No physician has the right to cancel a DNR without patient consent (T. 1883-1884, 1909) (Noe). If Respondent had a concern about the DNR order, the hospital had review mechanisms, which Respondent did not follow (T. 1911) (Noe).

265. It was inappropriate and did not meet acceptable standards of care for Respondent to cancel the patient's DNR status (T. 779, 1883-1884, 2096) (Kredentser, Noe, Benham).

266. Respondent's management of this patient was a significant deviation from standards of care (T. 781) (Kredentser). Countermanding a DNR order requested by the patient is a very significant deviation (T. 782) (Kredentser).

Conclusions of Law

G.1 Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient G for ovarian cancer. This constitutes negligence and lack of proper consent.

G.2 Respondent administered inappropriate chemotherapy to Patient G. This constitutes gross negligence

G.3 Respondent inappropriately administered medroxyprogesterone acetate (Depo Provera) to Patient G. This constitutes negligence.

G.4 Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and the patient's response. This constitutes negligence and failure to maintain records.

G.5 Respondent failed to obtain adequate serial left ventricular ejection fractions and/or follow up CA 125s during chemotherapy. This constitutes negligence.

G.6 Respondent inappropriately entered an order dated March 5, 1997, in Patient G's medical record canceling her do not resuscitate (DNR) status. This constitutes gross negligence, lack of proper consent and moral unfitness.

DISCUSSION

Respondent's use of Adriamycin, Depo-Provera, and his cancellation of the DNR requested by the patient were all criticized by Respondent's own witnesses, Drs. Noe and Benham. Even after his own witnesses stated that his conduct was wrong, Respondent insisted that he was justified on all three points. This persistence of Respondent is also telling concerning his chemotherapy protocol, which also has no support.

Concerning the DNR order, Respondent's view was that he would cancel it because his patient was being taken care of by physicians he did not know. However, Respondent's first and only objection to involvement of other physicians in care of this patient was when the patient signed a DNR order authorization. He had even written a note stating that the patient was being followed by the MICU team.

Respondent also insisted that the MICU staff were causing the patient to "sign her life away", as he so repetitively and elegantly referred to DNR decisions, by saying she had incurable cancer (T. 2438). The record shows this is untrue. The physicians told the patient her problems were related to heart failure and heart rhythm (Ex. 20 at 335). There was no mention of cancer at all.

Once again the rationale supporting the conclusions in this case is evident from the findings or has been discussed above.

PATIENT H

267. Patient H presented at Mercy Hospital of Buffalo on November 15, 1993 (Ex. 21 at 3, T. 786) (Kredentser). The attending physician requested that Respondent see the patient (Ex. 21 at 229; T. 786) (Kredentser).

268. After obtaining a history and performing a physical examination and certain testing, Respondent concluded the patient had a possible pelvic malignancy (Ex. 21 at 15-16; T. 788) (Kredentser).

269. Once the gyn/oncologist becomes involved in a patient with a malignancy, it is his case (T. 1958) (Malik).

270. An attempted curettage and cervical biopsy of the patient were performed but he was unable to enter the uterine cavity (Ex. 21 at 40; T. 788-789) (Kredentser). Definitive pathology could not be obtained after this procedure (T. 790) (Kredentser).

271. On November 20, 1993, the patient was taken to the operating room with Respondent being the primary surgeon and another physician assisting (Ex. 21 at 50-53; T. 790) (Kredentser).

272. When the patient's abdomen was entered, she had massive ascites, implants on the surface of her liver, omentum, rectosigmoid colon, small bowel (T. 790-791) (Kredentser). The small bowel wall was infiltrated and had the appearance of a snake (T. 791) (Kredentser).

273. The type of cancer a patient has is important in determining the operative approach (T. 792) (Kredentser). The goal of obtaining optimal surgical cytoreduction relates to epithelial ovarian cancers but not all cancers (T. 792) (Kredentser).

274. Eventually it was determined that this patient had a lymphoma. The principal of optimal cytoreduction which is applicable to epithelial ovarian cancer, does not apply to lymphoma (T. 792-795, 1957-1958) (Kredentser, Malik).

275. The cytoreductive procedure performed on this patient was without adequate indication (T. 794-795) (Kredentser).

276. The pathologist was providing frozen section diagnosis to Respondent during surgery (Ex. 21 at 56-60).

277. The pathologist never suggested that the patient had epithelial ovarian cancer (T. 795) (Kredentser). Respondent was not receiving any definitive diagnoses from the pathologist yet he continued with the procedure (T. 795-796) (Kredentser).

278. It was inappropriate to continue the procedure with no definitive diagnosis (T. 795-796) (Kredentser).

279. When the pathologist cannot provide a definitive diagnosis, the physician can look at the pathology himself, call in another pathologist to look at the slides, or stop the procedure, close the patient and wait for a definitive diagnosis (T. 796) (Kredentser).

280. Respondent performed extensive bowel surgery on this patient with multiple reanastamoses (T. 797) (Kredentser). This was inappropriate as the patient was not obstructed pre-operatively (T. 797) (Kredentser).

281. Post-operatively, the patient was having drainage from the Penrose drain that was the same color as rectal drainage (T. 805) (Kredentser). This patient had four anastomoses, any one of them which could be leaking. Two of them were in the small intestine (T. 809-810) (Kredentser). Studies were performed but none of them demonstrated any GI leakage (Ex. 21 at 93). Therefore, they did not specify the site of any drainage (T. 809) (Kredentser).

282. Respondent performed a diverting colostomy (Ex. 21 at 66-67; T. 809) (Kredentser).

283. A colostomy is a surgically created opening between the skin and the patient's colon, or large intestine. By definition it would not divert any leakage from the small bowel which meant the patient would continue to have an internal leak (T. 810) (Kredentser)

284. Prior to performing this colostomy, Respondent did not adequately determine the origin of the patient's drainage (T. 809) (Kredentser)

285. Respondent's performance of the extensive operative procedure on a patient who had a lymphoma and his treatment of this patient was a significant deviation from accepted standards of care (T. 816, 824) (Kredentser)

Conclusions of Law

H.1 On November 20, 1993, Respondent performed cytoreductive surgery and multiple bowel resections without adequate indication. This constitutes negligence.

H.2 Not supported by the evidence.

H.3 On November 28, 1993, Respondent failed to adequately determine the origin of the patient's increased drainage before performing a colostomy. This constitutes negligence.

H.4 Not supported by the evidence.

DISCUSSION

Respondent tried to justify the extensive debulking operative procedure on this patient who had lymphoma for reasons related to the characteristics of lymphoma (T. 2394-2398). However, this after the fact attempt at justification was not his operative diagnosis or plan.

espondent's reason for why he did not seek a urology consult is very revealing. He believes that the patient was in "the best possible hands" and he could handle this urologic surgery better than any urologist (T. 2404). Since he had privileges for this procedure it was appropriate to proceed without a urologist. Moreover, the quotation is also revealing toward his chemotherapy. In his mind, he is the best. It does not matter to him that no scientific studies of his protocol establish its effectiveness or safety. It does not matter that no one else uses his regimen. It does not matter that his own expert does not validate his regimen.

Regarding the allegation that an improper physical was performed, the proof was insufficient to establish this fact. As discussed above it is not inappropriate for a physician to chart his observations and recommendations in a setting where he has been discharged.

Respondent tried to justify his lack of work up of the patient before the colostomy by stating that all of the tests were not available during his training (T. 2406). These tests performed showed no leak, and no e-coli was found at the fistula (T. 2426, 2428). He tried to justify it in hindsight as a protective colostomy (T. 2430), but that was not his stated reason for creating the colostomy.

Respondent's willingness to act as primary surgeon, but his refusal to exercise his own professional judgment as to what facility to operate in or what pre-operative evaluation he should perform (T. 2431-2432) is an abdication of his responsibility. Even Respondent's own witness stated that once a gyn/oncologist becomes involved in a patient with a malignancy, it is his case (T. 1958) (Malik).

The allegations relating to the surgeries are errors of judgment which rise to the level of negligence. The Respondent should have known better. He was careless. Poor operative judgment is another pattern which runs through many of the cases herein.

CREDENTIALS FRAUD

286. By letter dated July 12, 1999, Respondent was notified that he was under investigation by the Office of Professional Medical Conduct (OPMC) because of a complaint filed against him (Ex. 23). By that letter, OPMC requested production of several patient records. All but one of those patients are in the charges at issue.

287. By letter dated August 10, 1999, Respondent noted that he had received the letter from OPMC dated July 12, 1999, and was providing medical records pursuant to that letter (Ex. 24).

288. On an Application for Reappointment to the staff of St. Joseph's Hospital, which he signed on December 27, 1999, Respondent answered "No" to the question "Is there any pending investigation by... the Office of Professional Medical Conduct...?" (Ex. 22 at 15).

289. At the time Respondent signed his privileges re-application form, Respondent was under investigation by the Office of Professional Medical Conduct, as shown by the July 12, 1999 OPMC letter and his August 10, 1999, reply and his answer of "No" to the questions was incorrect.

290. At an interview with OPMC personnel on July 10, 2000, Respondent was asked why he answered no to the question on the application (Ex. 26 at 7-8).

291. Respondent stated that is was an oversight on his part and that he would contact St. Joseph's Hospital and correct the error (Ex. 26 at 7-8).

292. Respondent never contacted St. Joseph's to correct the error (Ex. 30).

293. The Hearing Committee concludes that Respondent's initial incorrect answer was knowingly false and fraudulent.

Conclusions of Law

On a staff reappointment application to St. Joseph Hospital with Respondent's signature dated December 27, 1999, Respondent fraudulently answered "No" to the question, "Is there any pending disciplinary action or investigation involving you by either Office of Professional Medical Conduct, Federal or State Health Authorities?" when he knew that he was being investigated by the Office of Professional Medical Conduct. This constitutes moral unfitness and fraud.

DISCUSSION

Respondent offered no testimony concerning why he signed a false reappointment application. His lack of testimony on this issue should be interpreted as an admission.

CREDIBILITY

Respondent's testimony was not believable when it conflicted with any of the fact witnesses. His testimony concerning his chemotherapeutic regimen and his approach to managing patient s may well have been true to the extent that he believed what he was saying, however the opinions he expressed and the theories he espoused were simply not credible from a scientific background, they were not supported by literature or any of his witnesses.

Evidence of Respondent's unreliable testimony was demonstrated by his demeanor. When testifying, he avoided answering questions, was argumentative during cross-examination and Committee questions, and provided non-responsive answers on both direct and testimony.

Respondent's credibility was doubtful. He resorted to unusual interpretations of facts to support his position. For example, he asserted that it would not be known if Patients B and E had recurrent ovarian cancer "for legal purposes". His logic was as follows: how could they have ovarian cancer when their ovaries had been removed (T. 2221-2223) (Respondent). Respondent was playing word games. His own diagnosis for both of these patients was that they had recurrent ovarian cancer (Ex. 7 at 7, Ex. 14 at 29).

Respondent's opinion was that Dr. Kredentser was not qualified as an expert in gynecologic oncology (T. 1363) (Respondent). Respondent consistently distorted the testimony of Dr. Kredentser, the expert for the state. He claimed that Dr. Kredentser said Respondent had only one article (T. 2240), however, Dr. Kredentser's report states that he could find only one reference to Respondent's chemotherapy regimen (Ex. 29 at 5). He also testified that two articles demonstrated that Dr. Kredentser's testimony about chemotherapy was false (T. 2263-2269), but he had to admit the article did not state Dr. Kredentser or Mt. Sinai had administered the initial chemotherapy-he just assumed that to be the case (T. 2369-2370).

Respondent's view of the patient cases was quite straightforward: He cannot be found to have committed misconduct because he had a theory about why the eventual patient poor outcomes were the fault of other practitioners.

The testimony of Respondent's expert, Dr. Benham, insofar as it validated any of Respondent's case is rejected because Respondent showed his expert only selected pages of the medical records of any patient (T. 1982). For example, the expert had not seen the chart entries concerning post-D&C bleeding of Patient A (T. 2011-2012) and was unaware of the many surgeries Patient B had (T. 2137, 2139-2146). While on direct testimony, he said Respondent's operation on Patient B in 1996 would be justifiable (T. 2124-2125), he then stated he had no

opinion after learning more of the actual facts about the case (T. 2154). Interestingly, Respondent withheld portions of the medical record from his expert despite asserting that it would be unethical for an expert to provide an opinion based on only some of the facts (T. 2342-2343).

Daniel C. Kredentser, M.D., testified as an expert for the Department. He presented his testimony in an even, impartial manner. Dr. Kredentser supported his opinions with sound scientific principles which a physician must follow in patient care. His depth and breadth of knowledge was evident and impressive. He did not rush to judgment but carefully explained the basis for each and every conclusion. His report (Ex. 29) was very well written, thorough and concise. His "global assessment" of the Respondent was eloquent and captured the crux of the problem. It is obvious that he spent a great deal of time preparing his review and opinion because his mastery of the facts and details was complete. His testimony was very convincing and eminently credible.

SPECIFICATIONS

First Specification (Negligence on More than One Occasion) - Sustained.

Second Specification (Incompetence on More than Once Occasion) – Not Sustained.

Third Specification (Gross Negligence) – Not Sustained.

Fourth Specification (Gross Negligence) - Sustained.

Fifth Specification (Gross Negligence) - Sustained.

Sixth Specification (Gross Negligence) - Sustained.

Seventh Specification (Gross Negligence) - Sustained.

Eighth Specification (Gross Negligence) - Sustained.

Ninth Specification (Gross Negligence) - Sustained.

Tenth Specification (Gross Negligence) – Not Sustained.

Eleventh Specification (Gross Incompetence) – Not Sustained.

Twelfth Specification (Fraud) - Sustained.

Thirteenth Specification (Fraud) - Sustained.

Fourteenth Specification (Moral Unfitness) - Sustained.

Fifteenth Specification (Moral Unfitness) - Sustained.

Sixteenth Specification (Moral Unfitness) - Sustained.

Seventeenth Specification (Moral Unfitness) - Sustained.

Eighteenth Specification (Lack of Proper Consent) - Sustained.

Nineteenth Specification (Lack of Proper Consent) - Sustained.

Twentieth Specification (Lack of Proper Consent) - Sustained.

Twenty First Specification (Lack of Proper Consent) - Sustained.

Twenty Second Specification (Lack of Proper Consent) - Sustained.

Twenty Third Specification (Lack of Proper Consent) - Sustained.

Twenty Fourth Specification (Lack of Proper Consent) - Sustained.

Twenty Fifth Specification (Lack of Proper Consent) - Sustained.

Twenty Sixth Specification (Failure to Maintain Records) - Sustained.

Twenty Seventh Specification (Failure to Maintain Records) - Sustained.

Twenty Eighth Specification (Failure to Maintain Records) - Sustained.

Twenty Ninth Specification (Failure to Maintain Records) - Sustained.

Thirtieth Specification (Failure to Maintain Records) - Sustained.

DISCUSSION RELATING TO PENALTY

Respondent's license to practice medicine in New York State should be revoked. Respondent made much of the fact that no case was more recent than 1997. However, Respondent insisted that all of his care of the patients was appropriate, that he would do the same pre-operative evaluation and same chemotherapies. In other words, there is no reason to expect his patient management would be different today or will be in the future.

The principle of patient control and autonomy concerning their own health care decisions is fundamental to the practice of medicine. Respondent has violated that fundamental precept in several ways. Perhaps the most egregious violation is Respondent's disregard of the wishes of the patient or their duly authorized surrogates concerning end of life decisions. Respondent's attitude when patients or their families determine that no further extraordinary measures will be undertaken was revealed in the case of Patient C. At that time the family was the legal decision maker because the patient was incompetent. Respondent was told by a nurse that the family did not want their mother to have additional transfusions. Respondent replied "I don't care what the family wants" (T. 129). He also canceled a valid DNR order requested by one patient and attempted resuscitation of another patient in direct violation of a valid DNR order. When end of life issues arise, Respondent has a disturbing pattern of verbally attacking family members and other physicians.

The second aspect of Respondent's violation of patient autonomy concerns informed consent. Respondent was giving patients a regimen which combined between six and nine drugs. This regimen has not been validated in the scientific literature, yet he causes patients to agree to such therapy by telling them that it is far superior and has fewer side effects. There is no

evidence that the Respondent made full disclosure of the risks and benefits of this highly unusual regimen to his patients. Without such disclosure, the patients were, in essence, being tricked into accepting his treatment. There was absolutely no indication that these patients were told the treatment was out of the ordinary or that they were informed of standard chemotherapy.

Additionally, Respondent's surgical judgment is seriously wanting. Patients undergo extensive operations when there is no indication for the procedure. Concerning Patient A, Respondent claimed that the indication for the procedure was persistent bleeding, yet this patient had stopped bleeding or had no significant bleeding. This was shown by the notes of the nurses and the laboratory reports which demonstrated stable blood counts in the normal range. Respondent seems unable to grasp the concept that a patient's condition can be treated by other than surgery, as evidenced by his question to the Department's expert, concerning denying treatment to patients because they are poor surgical candidates (T. 966-968). The extensive surgery on the patient who refused transfusions shows that Respondent does not modify his approach based on individual circumstances.

As mentioned above, Respondent's license should be revoked. While that is justified based on the entire record, it would be justified solely by: a) the testimony of Respondent and his witnesses; b) the exhibits in evidence; and c) the testimony of the State's witnesses on which Respondent performed cross-examination, as follows:

Respondent's misconduct concerning Patient A was set forth by Dr. Kredentser. Dr. Kredentser's testimony was subject to full cross-examination by Respondent. The charge concerning performing an unindicated TAH-BSO was confirmed by Respondent's own expert.

Misconduct concerning Patient B was set forth by Dr. Kredentser and subject to cross-examination by Respondent. Additionally, his own expert testified that there were no studies supporting the Respondent's chemotherapy protocol, and that it was not used by anyone else in the world. His expert did not use Ergamisol in ovarian cancer patients. His expert also testified that the surgical procedure should not have been done based on positive cytology done (T. 2146). After receiving more facts about the case than Respondent told him, his expert concluded he would not offer an opinion (T. 2154).

Concerning Patient C, the lack of adequate pre-operative assessment and arrangements for coverage were criticized by Respondent's own expert. Dr. Loehfelm testified that it would be inappropriate for a physician to make statements such as Respondent did to the patient's children.

Concerning Patient D, Respondent's lack of pre-operative assessment was criticized by his own expert as was his prescribing Adriamycin to a patient in 1994. Further, as noted above, the expert observed that Respondent's chemotherapy was utilized by no other practitioner. Respondent's witness, Dr. Maceda, testified that performing cardiac compressions on this patient was a violation of the DNR order.

Respondent's misconduct concerning the chemotherapy for Patient E was well set forth by Dr. Kredentser and he was extensively cross-examined. As stated above, Respondent's own expert noted that Respondent was alone in the use of his chemotherapy protocol.

Concerning Patient F, Respondent did not ask his expert any questions, from which the Committee may infer that his expert's testimony would not have been helpful on that point.

Dr. Kredentser also set forth the errors concerning chemotherapy for Patient G, subject to extensive cross-examination. Respondent acknowledged that his medical records were not legible, in reference to paragraph G.4. Concerning continued administration of Depo-Provera after the patient had an embolus, his own expert stated that was inappropriate. Another of the Respondent's witnesses, Dr. Noe, stated that Respondent had no right to cancel Patient G's DNR status, and that did not meet accepted standards of care.

Concerning Patient H, Respondent's own expert stated that he could not justify the November 20, 1993 procedure.

Although some of the patient cases herein could be described as medical disasters, the Committee did not feel that Respondent exhibited a reckless disregard for the safety of his patients such as would indicate surgical gross negligence. He was surely overzealous, which zeal seemed to cloud his surgical judgment but it was not misguided zeal. Perhaps he could be described as quixotic in his naivete of thinking that he could beat cancer. He knew the science and the surgical technique but it was as if he wore blinders as he forged ahead without a proper evaluation of the patient. This is a tragic personal shortcoming but it is not recklessness.

For much the same reasons the Committee found no support for allegations of incompetence. Respondent is a knowledgeable physician and skillful surgeon. This fact only compounds the personal tragedy of the penalty in this case.

Respondent vigorously defended himself in this case to the point of appearing arrogant. It was not so much that he makes the impression of himself as a superior person as in conceit. He does show respect and is not without a sense of humor. Rather, he conveys a sense that he is possessed of such a superior knowledge of the subject matter as to be unassailable in his conclusions, as in obstinate. Only his view is the right one in every case. He is very troubled by

the contrary opinions of others. He rarely, if ever, conceded a point even when the same was established beyond all question, nor was he the least bit contrite even with respect to his conduct with Patients' families. Instead of defending himself against the charges within the legal framework of the hearing, the Respondent argues his position from his high intellectual fortress, often without regard to the legal issues of the case, the rules of procedure and contrary to the frequent admonitions of the ALJ and the Chairman of the Committee. He could not suffer attorneys to represent him because they were obviously not saying the right things in his opinion. He could not accept their advice as to how to defend the case. It was as if he was conducting a seminar or a scholarly debate but he was in the wrong forum.

His professional failures which lead to the charges of misconduct were based on the same personality traits which were observed at the hearing as stated above. Although he does have knowledge of the science he fails to reflect and evaluate in order to properly apply the science to the patient at hand. He did not appear unconcerned for his patients yet he did not convey any thoughtfulness for their well being. He conveyed at most the attitude of a scientist concerned for his science more than the people he was treating.

He appeared to rush to scientific judgment without conducting the requisite inquiry into the history of the patient before him and evaluating diagnostic tests and other data in the context on personal contact with that patient, all of which marks the work of a true professional.

It appears that his personality did not provide him with the ability or the foresight to step back and calmly assess the situation. He blames this failure on others by insisting that he (as the primary surgeon) was only a consultant and the attending had or should have already made the critical evaluations, informed consents, consultations and so on.

The reason for this evaluation of the Respondent's personality and character is to conclude that he is beyond rehabilitation. The pattern of negligence is as persistent as it is remarkable and undeniable. Respondent is devoid of remorse and even stated that he would not change his troubling chemotherapy regimen except to some minor degree as the same would be affected by the Drug Resistant Assay. The Respondent is incorrigible in his errant ways. He must not only be punished but he must be stopped from continuing the exaltation of his blind beliefs over the needs and safety of his patients.

ORDER

IT IS HEREBY ORDERED:

1. The Respondent's license to practice medicine in New York State is hereby **REVOKED**.

2. This **ORDER** shall be effective upon service on the Respondent or Respondent's attorney by personal service or certified or registered mail.

DATED: Austerlitz, New York
JUNE 5, 2002

REDACTED

JOHN W. CHOATE, M.D.
Chairperson

LAWRENCE B. STERNBERG, M.D.
ANN FORD FRICKE

APPENDIX I

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

IN THE MATTER

OF

MAHMOOD YOONESSI, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: MAHMOOD YOONESSI, M.D.
REDACTED

or

355 Linwood Avenue
Buffalo, New York 14209

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by MAHMOOD YOONESSI, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2001), that effective immediately MAHMOOD YOONESSI, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 2001).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 2001), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 2001). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on December 4, 2001, at 10:00 a.m.,

at the New York State Health Department, 584 Delaware Avenue, Buffalo, NY 14202, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the 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,
and by 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact,

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

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 2001). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

November 27, 2001

REDACTED

ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

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

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
MAHMOOD YOONESSI, M.D.	:	CHARGES

----------X

MAHMOOD YOONESSI, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 21, 1973, by the issuance of license number 118540 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided care for Patient A (patients are identified in Appendix A, attached) at DeGraff Memorial and Buffalo General Hospitals, Buffalo, New York, from on or around August 21, 1997, until her death around August 28, 1997. Respondent's care of Patient A did not meet accepted standards of care in that:

1. Respondent undertook and/or continued a total abdominal hysterectomy-bilateral salpingo-oophorectomy at DeGraff Memorial Hospital on August 25, 1997, despite co-morbid conditions and/or without adequate indication.

2. Respondent inappropriately planned for and/or performed on August 25, 1997, a total abdominal hysterectomy, bilateral salpingo-oophorectomy on Patient A, who required regular dialysis services, at a hospital which did not provide dialysis on site.

3. Respondent failed to obtain appropriate informed consent from Patient A before performing the surgery on August 25, 1997.

4. Respondent failed to obtain appropriate nephrology and/or cardiology consults prior to the surgery on August 25, 1997.

5. Respondent inappropriately ordered or concurred with transfer of Patient A from DeGraff Memorial Hospital in unstable condition and/or without adequate stabilization.

B. Respondent provided care for Patient B at his office located at 355 Linwood Avenue, Buffalo, New York, and at Buffalo General Hospital, from on or around June 14, 1989, until at least April 26, 1996. Respondent's care of Patient B did not meet accepted standards of care in that:

1. Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient B in the period 1989 through 1995.

2. Respondent administered inappropriate chemotherapy to Patient B in the period 1989 to 1995.

3. Respondent's use of Ergamisol in the period 1991 through February 1994 was inappropriate.

4. Respondent performed an exploratory laparotomy and/or cancer reduction surgery on February 6, 1995, without adequate indication.

5. Respondent performed an exploratory laparotomy and/or cancer reduction surgery on March 7, 1996, without adequate indication.

C. Respondent provided care for Patient C at Our Lady of Victory Hospital, Lackawanna, New York, from on or around May 7, 1993, until around her death on May 29, 1993. Respondent's care of Patient C did not meet accepted standards of care in that:

1. Respondent failed to perform and/or record an adequate pre-operative assessment of patient C before the surgery on May 11, 1993.

2. Respondent failed to obtain adequate patient consent before the surgery on May 11, 1993.

3. Respondent failed to arrange and/or designate adequate coverage of Patient C when he did not see the patient on successive days beginning on or around May 15, 1993.

4. Respondent inappropriately made statements to the children of Patient C to the effect that they were being Kevorkian like, were playing God, and would be responsible for their mother's death due to their decisions concerning their mother's health care during her final days.

D. Respondent provided care for Patient D at his office and at St. Joseph's Hospital, Cheektowaga, New York, from on or around April 25, 1994, until her death on March 7, 1995. Respondent's care of Patient D did not meet accepted standards of care in that:

1. Respondent failed to perform and/or record an adequate preoperative assessment of Patient D before surgery on April 25, 1994.

2. Respondent performed multiple bowel resections on April 25, 1994, without adequate indication.

3. Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient D for ovarian cancer beginning in 1994.

4. Respondent administered inappropriate chemotherapy for Patient D.

5. Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and/or the patient's response.

6. Respondent failed to obtain and/or record a left ventricular ejection fraction prior to starting Adriamycin in May 1994.

7. Respondent failed to adequately determine the origin of the fistula before performing a diverting colostomy.

8. Respondent performed a diverting colostomy without adequate indication on March 6, 1995, the day before this patient died.

9. Respondent inappropriately attempted and/or ordered resuscitation of Patient D despite the existence of a DNR order.

E. Respondent provided care for Patient E at his office and at Buffalo General and Mercy Hospitals, from around January 1992 until her death on October 25, 1997. Respondent's care of Patient E did not meet accepted standards of care in that:

1. Respondent failed to obtain informed consent for the chemotherapy he ordered for Patient E for ovarian cancer.

2. Respondent instituted inappropriate chemotherapy for Patient E.

3. Respondent failed to appropriately monitor the effects of the chemotherapy.

4. Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and/or the patient's response.

5. Respondent fraudulently and/or inappropriately documented that he performed a physical examination of Patient E on or around February 19, 1992, when the patient was not present.

6. Respondent inappropriately ordered transfer of a patient with major medical issues from Mercy Hospital to a psychiatric floor at Buffalo General Hospital on October 19, 1997.

7. Respondent inappropriately questioned another physician's pain medication order directly with the patient's family.

8. Respondent inappropriately wrote in the patient's chart words to the effect that another physician had stated that morphine was being used as euthanasia with which the patient's husband agreed.

9. Respondent inappropriately wrote a discharge summary in the patient's chart after he was no longer involved in the patient's care.

F. Respondent provided care for Patient F at his office and at Our Lady of Victory Hospital, Lackawanna, New York, from on or around August 30, 1996, until Patient F's death on October 6, 1996. Respondent's care of Patient F did not meet accepted standards of care in that:

1. Respondent inappropriately performed extensive surgery and/or failed to take appropriate steps to minimize blood loss for Patient F, who refused all blood product transfusions.

2. Respondent performed inappropriate tumor reduction surgery on Patient F given her refusal of all blood product transfusions.

3. Respondent inappropriately administered chemotherapy to a patient who was too debilitated.

4. Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient F.

5. Respondent administered inappropriate chemotherapy to Patient F.

6. Respondent's post-operative progress notes were inadequate.

G. Respondent provided care to Patient G at Buffalo General Hospital and at his office, from on or around August 4, 1992, until her death on March 6, 1993. Respondent's care of Patient G did not meet accepted standards of care in that:

1. Respondent failed to obtain adequate informed consent for the chemotherapy he instituted with Patient G for ovarian cancer.

2. Respondent administered inappropriate chemotherapy to Patient G.

3. Respondent's inappropriately administered medroxyprogesterone acetate (Depo Provera) to Patient G.

4. Respondent failed to maintain adequate or adequately legible records of his chemotherapy plan, treatments and/or the patient's response.

5. Respondent failed to obtain adequate serial left ventricular ejection fractions and/or follow up CA 125s during chemotherapy.

6. Respondent inappropriately entered an order dated March 5, 1993, in Patient G's medical record cancelling her do not resuscitate (DNR) status.

H. Respondent treated Patient H at Mercy Hospital of Buffalo, Buffalo, New York, from on or around November 15, 1993, until around December 16, 1993, when she was discharged for hospice care. Respondent's care of Patient H did not meet accepted standards of care in that:

1. On November 20, 1993, Respondent performed cytoreductive surgery and/or multiple bowel resections without adequate indication.

2. On November 20, 1993, Respondent performed urologic surgery without adequate assessment, preoperative and/or intraoperative urologic consult.

3. On November 28, 1993, Respondent failed to adequately determine the origin of the patient's increased drainage before performing a colostomy.

4. Respondent inappropriately examined the patient and/or made entries in the patient's chart after he had been discharged from the case.

I. On a staff reappointment application to St. Joseph Hospital with Respondent's signature dated December 27, 1999, Respondent fraudulently answered "No" to the question, "Is there any pending disciplinary action or investigation involving you by either Office of Professional Medical Conduct, Federal or State Health Authorities?" when he knew that he was being investigated by the Office of Professional Medical Conduct.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, D. and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G. and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more that one occasion as set forth in two or more of the following:

2. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, D. and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G. and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4.

THIRD THROUGH TENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as set forth in the following:

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

4. The facts of paragraphs B and B.1, B and B.2, B and B.3, B and B.4 and/or B and B.5.

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

6. The facts of paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D. and D.5, D and D.6, D and D.7, D and D.8 and/or D and D.9.

7. The facts of paragraphs E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8 and/or E and E.9.

8. The facts of paragraphs F and F.1, F and F.2, F and F.3, F and F.4, F and F.5 and/or F and F.6.

9. The facts of paragraphs G and G.1, G. and G.2, G and G.3, G and G.4, G and G.5 and/or G and G.6.

10. The facts of paragraphs H and H.1, H and H.2, H and H.3 and/or H and H.4.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as set forth in any combination of one or more of the following:

11. The facts of paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, C and C.1, C and C.2, C and C.3, C and C.4, D and D.1, D and D.2, D and D.3, D and D.4, D. and D.5, D and D.6, D and D.7, D and D.8, D and D.9, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, E and E.8, E and E.9, F and F.1, F and F.2, F and F.3, F and F.4, F and F.5, F and F.6, G and G.1, G. and G.2, G and G.3, G and G.4, G and G.5, G and G.6, H and H.1, H and H.2, H and H.3, H and H.4.

TWELFTH AND THIRTEENTH SPECIFICATIONS

FRAUD

Respondent is charged with practicing the profession fraudulently as defined in N.Y. Educ. Law § 6530(2) as set forth in the following:

12. The facts of paragraph E and E.5.

13. The facts of paragraph I.

FOURTEENTH THROUGH SEVENTEENTH SPECIFICATIONS

MORAL UNFITNESS

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

14. The facts of paragraphs C and C.4.

15. The facts of paragraphs E and E.5, E and E.7, E and E.8 and/or E and E.9.

16. The facts of paragraphs G and G.6.

17. The facts of paragraph I.

EIGHTEENTH THROUGH TWENTY FIFTH SPECIFICATIONS

LACK OF PROPER CONSENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(26) by performing professional services which have not been duly authorized by the patient or his or her legal representative as set forth in:

18. The facts of paragraphs A and A.3.

19. The facts of paragraphs B and B.1.

20. The facts of paragraphs C and C.2.

21. The facts of paragraphs D and D.3 and/or D and D.9.

22. The facts of paragraphs E and E.1.

23. The facts of paragraphs F and F.4.

24. The facts of paragraphs G and G.1 and/or G and G.6.

25. The facts of paragraphs H and H.4.

TWENTY SIXTH THROUGH THIRTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

26. The facts of paragraphs C and C.1.

27. The facts of paragraphs D and D.1, D and D.5 and/or D and D.6.

28. The facts of paragraphs E and E.3 and/or E and E.4.

29. The facts of paragraphs F and F.6.

30. The facts of paragraphs G and G.4.

DATED: November 26, 2001
Albany, New York

REDACTED

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