STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

November 4, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Paul Stein, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Niels Helth Lauersen, M.D.
REDACTED

Robert S. Deutsch, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP
757 Third Avenue
New York, New York 10017

RE: In the Matter of Niels Helth Lauersen, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 99-269) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above. As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be

sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla

Enclosure

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

COPY

IN THE MATTER	DETERMINATION
OF	AND
NIELS HELTH LAUERSEN, M.D.	ORDER
	ORDER #99-269

A Notice of Hearing and Statement of Charges, both dated September 15, 1998, were served upon the Respondent, Niels Helth Lauersen, M.D. **BENJAMIN WAINFELD, M.D. (Chair), JAMES J. DUCEY, and DAVID T. LYON, M.D.**[1], duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Paul Stein, Esq., Associate Counsel. The Respondent appeared by Aaronson, Rappaport, Feinstein & Deutsch, LLP, Robert S. Deutsch, Esq. and Lawrence D. Bloomstein, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

---

1 Robert O'Connor, M.D. was originally appointed to the Hearing Committee, but withdrew due to illness during the course of the proceedings. Dr. Lyon replaced Dr. O'Connor.

STATEMENT OF CASE

Respondent is an obstetrician/gynecologist practicing in New York City. Petitioner initially served Respondent with a Notice of Hearing and Statement of Charges alleging twenty-three specifications of professional misconduct concerning Respondent's medical care and treatment of nine patients. Subsequent to the commencement of the hearing, Petitioner withdrew all charges regarding one patient (Patient I) and made numerous other modifications to the charges. An Amended Statement of Charges, dated April 16, 1999 was served on Respondent and incorporated into the record as Petitioner's Exhibit 1A.

Petitioner alleges eighteen specifications of professional misconduct concerning the treatment of the remaining eight patients. The charges include allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, excessive treatment, performing unauthorized services, and failure to maintain records which accurately reflect the evaluation and treatment of the patients. A copy of the Amended Statement of Charges is attached to this Determination and Order in Appendix I. All findings and conclusions of the Hearing Committee are based upon the Amended Statement of Charges.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Niels Helth Lauersen, M.D. (hereinafter, "Respondent"), was authorized to practice medicine in New York State by the issuance of license number 104954 by the New York State Education Department on or about October 16, 1969. (Pet. Ex. #2).

2. Petitioner's expert, Joseph J. Rovinsky, M.D., is a diplomate of the American Board of Obstetrics and Gynecology with extensive experience in his field. He is the director of obstetrics and gynecology at the South Shore Medical Center in New Rochelle, and previously was chairman of obstetrics and gynecology at Long Island Jewish Medical Center for twenty years, and before that director of obstetrics and gynecology at City Hospital Center at Elmhurst for approximately twenty years. (Pet. Ex. #3; T. 67-69).

3. Respondent's expert, Wilfred Reguero, M.D., is the director of obstetrics and gynecology at the Hospital of St. Raphael, New Haven Connecticut, a teaching affiliate of Yale

University Medical School. (T. 913). Dr. Reguero was previously chairman of obstetrics at the Westchester County Medical Center on three different occasions. (T. 910).

Patient A

4. From on or about August 27, 1993 through February , 1995, Respondent treated Patient A, a then 50 year old female, in his New York City offices and at Lenox Hill Hospital, New York City, for cancer. Patient A initially presented with Stage 3 ovarian cancer. On or about September 8, 1993, Respondent performed an examination, fractional dilatation and curettage, exploratory laparotomy, lysis of pelvic adhesions, right ovarian cystectomy, bilateral salpingo-oophorectomy, omentectomy, and pelvic lavage on Patient A, under general anesthesia. The pathologist reported poorly differentiated papillary serous cystadenocarcinoma of both ovaries and the omentum. On June 13, 1994, Respondent performed an examination, exploratory laparotomy, lysis of pelvic adhesion, excision of pelvic mass, excision and debulking of recurrent ovarian carcinoma, total abdominal hysterectomy, omental biopsy, and pelvic lavage, again under general anesthesia. (Pet. Ex. 4, pp. 3, 95; Pet. Ex. #5, pp. 30-31; Pet. Ex. 6, pp. 149-151; T. 192-195).

5. Dr. Rovinsky acknowledged that a physician doe not have to be board-certified in gynecologic oncology to be qualified to treat a patient such as Patient A. He further

admitted that he did not know Respondent's qualifications. (T. 243-244).

6. Respondent testified that he had experience with such patients, and that he had privileges at the hospital to perform the planned surgery. In addition, Respondent testified that it was his custom and practice to bring such surgical cases to the department chairman's attention prior to surgery, and the other specialists were available for consultation and assistance if necessary. (Pet. Ex. #19; T. 577-578, 586, 629-631, 668).

7. Dr. Reguero testified that it was not necessary for Patient A's surgery to have been performed by a gynecologic oncologist. He further testified that most of the gynecologic cancer surgery performed in this country is not performed by a gynecologic oncologist. (T. 934-936).

8. Respondent testified that during the course of the September 8, 1993 surgery, an ovarian cyst hindered his ability to visualize the operative field. He removed the cyst. (T. 584-585).

9. Dr. Rovinsky acknowledged that the removal of the cyst under these circumstances was a matter of judgement on the part of the operating surgeon. (T. 248).

10. Respondent testified that pursuant to the FIGO classification of cancer staging, Patient A was Stage III-C, particularly because there were abdominal lesions greater than

two centimeters. (T. 580-583).

11. Dr. Reguero testified that it is not necessary to sample pelvic and para-aortic lymph nodes in the presence of two centimeter lesions. (T. 943-945).

12. Dr. Reguero further testified that a total omentectomy need not have been performed during the September 8, 1993 surgery. The omentum is comprised of two sections (superior and inferior) and more frequently than not only the inferior omentum is removed. (T. 940-941). Dr. Reguero further testified that decision on whether or not to perform a hysterectomy on Patient A was a clinical judgement on the part of Respondent, and within the standard of care. (T. 941-942).

13. On June 13, 1994, Respondent performed an examination, exploratory laparotomy, lysis of pelvic adhesion, excision of pelvic mass, excision and debulking of recurrent ovarian carcinoma, total abdominal hysterectomy, omental biopsy and pelvic lavage on Patient A, under general anesthesia. (Pet. Ex. #5).

14. There was radiologic evidence of a possible bowel obstruction on the second postoperative day. (Pet. Ex. #5; T. 227).

15. The patient's clinical condition during the first few postoperative days was consistent with a postoperative ileus. In response to the possible ileus, Respondent inserted a

nasogastric tube. This was an appropriate treatment for a possible ileus. (T. 271, 273).

16. If the patient's bowel had been perforated during the June 13, 1994 surgery, she would have exhibited symptoms of peritonitis within 48 hours of surgery. (T. 278). Dr. Rovinsky acknowledged that there no indications for bowel surgery until the fifth postoperative day. (T. 272-273).

17. Dr. Reguero testified that there was nothing evident in the patient's clinical picture to warrant a surgical consultation before the third postoperative day. (T. 976-981).

18. On the fifth postoperative day, Respondent ordered a soap suds enema. (Pet. Ex. #5; T. 229-230). Respondent testified that he did so in order to stimulate the bowel due to a lack of peristalsis in the colon. (T. 598).

Patient B

19. From on or about October 10, 1989 through on or about May 18, 1991, Respondent treated Patient B, a 25 year old (in 1991) female. Patient B presented in Respondent's office on May 18, 1991 with a chief complaint of lower abdominal pain. An office ultrasound examination showed a right ovarian cyst 3 x 2 centimeters in diameter and questionable blood in the cul-de-sac. Respondent took a cervical cytological smear. Approximately 24 hours later, Patient B presented in the Mount Sinai Hospital emergency room with fever and increased abdominal pain. She was

taken to the operating room for the exploration of a possible ectopic pregnancy. (Pet. Ex. #7, pp. 2, 25, 26; Pet. Ex. #8, pp. 5, 11-16, 38; T. 156-161).

20. Respondent's office medical record for Patient B contains the date of the patient's last menstrual period. (Pet. Ex. #7; T. 188-189). The records also demonstrate a number of complaints of abdominal pain during prior visits. Respondent testified that the patient's complaints on May 18, 1991 were in the same location and similar in nature to her prior complaints. (T. 686-687).

21. The ultrasound performed by Respondent demonstrated an ovarian cyst and fluid in the cul-de-sac. It did not reveal any gestation in the uterus, in the fallopian tube, or any evidence of an adnexal mass that could be construed as a pregnancy. (T. 1069).

22. Dr. Reguero testified that under the circumstances, Respondent's diagnosis of a ruptured ovarian cyst was a reasonable and appropriate diagnosis. He further testified that it was appropriate to simply watch the patient for further developments. (T. 1066-1067).

23. Respondent testified that following admission to Mount Sinai, the physicians at the hospital found no sign of rupture or ectopic pregnancy when inspecting the patient's remaining fallopian tube. (T. 692-694).

24. Dr. Reguero testified that there was no conclusive evidence that Patient B had an ectopic pregnancy. He stated that declining hormone levels taken at the hospital showed a dying and nonviable pregnancy; a hospital sonogram suspicious for an early intrauterine pregnancy; an internally inconsistent pathology report, and the surgeon's operative report which refers to "a presumed tubal abortion or still intrauterine pregnancy in situ." (Pet. Ex. #8, p. 71; T. 1147-1154).

25. There is a notation in the Mount Sinai medical record that the patient reported being prescribed Flagyl, an antibiotic, by Respondent. (Pet. Ex. #8). There is no evidence in Respondent's medical records for Patient B indicating that Flagyl was prescribed for Patient B on May 18, 1991. Respondent testified that he had no recollection of prescribing the drug for the patient at that time, but that he typically uses the drug for patients with pelvic inflammatory conditions. (Pet. Ex. #7; T. 698-700). Flagyl was prescribed for Patient B by the physicians at Mount Sinai during her inpatient admission. (Pet. Ex. 8).

26. Respondent's handwritten notes contained in his office medical record for Patient B are largely illegible. (Pet. Ex. #7).

Patient C

27. From on or about October 25, 1990 through on or about July 26, 1991, Respondent treated Patient C, a 31 year old (in 1990) female for infertility. On or about January 9, 1991, Respondent performed a dilatation and curettage and a tubal perfusion procedure on Patient C in his office. On or about February 5, 1991, Patient C spontaneously passed bloody decidual tissue containing immature chorionic villi. (Pet. Ex. #9, pp. 2, 6-8, 12; T. 75, 92-94).

28. When Patient C first presented to Respondent on October 25, 1990, she had pain and discomfort on examination. By January 9, 1991 the pain had increased in severity. The patient had an ovarian cyst on her remaining ovary. (T. 732-733).

29. Respondent testified that it was routine to perform an endometrial biopsy during the second half of the menstrual cycle when treating infertility. (T. 746-747).

30. Prior to the surgery on January 9, 1991, Patient C informed Respondent that she was expecting her menses that day. (T. 24).

31. Before surgery, Respondent performed a urine pregnancy test, which was negative. The test performed was sensitive enough to detect an early pregnancy, had one been present. It can detect a pregnancy approximately ten days after

ovulation, or one to two days prior to the menses. Patient C was not pregnant on January 9, 1991 at the time of surgery. (Pet. Ex. #9; Resp. Ex. I; T. 734-736; 1175-1184).

32. Dr. Reguero testified that preoperative bloodwork need not be performed in Patient C, given her age and otherwise good health. (T. 1195; 1214-1215).

33. Magda Binion, M.D., an anesthesiologist who provided anesthesia services to surgical patients at Respondent's office testified that preoperative bloodwork is unnecessary in healthy people under 40 years of age. (T. 1594).

34. Respondent failed to perform an appropriate preoperative physical examination of Patient C, including but not limited to, a failure to perform a breast examination, and a failure to perform an abdominal examination prior to the surgery on January 9, 1991. (Pet. Ex. #9; T. 83-84).

35. Respondent obtained appropriate informed consent from Patient C for the operative procedure performed on January 9, 1991. (T. 37-40; Resp. Ex. E).

36. There was no record of postoperative monitoring contained in Patient C's medical record. Responsibility for post-operative monitoring rests with the anesthesiologist, rather

than the surgeon. (Pet. Ex. #9; T. 1501; 1592).

37. During the January 9, 1991 surgery, Respondent resected an ovarian cyst. He sent the fluid, as well as endometrial tissue, to a laboratory for analysis. The collapsed cyst was vaporized. As a result, there was no remaining tissue to be sent for pathological analysis. (Pet. Ex. #9; T. 742, 780-781, 1200).

38. Respondent's handwritten records for Patient C were illegible. Respondent failed to maintain an adequate record for the patient. (Pet. Ex. #9; T. 90-92, 106-108, 120).

Patient D

39. From on or about August 7, 1980 through on or about January 23, 1992, Respondent treated Patient D, a 31 year old (in 1989) female. On or about April 26, 1989, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On May 17, 1990, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On January 23, 1992, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. (Pet. Ex. #10, pp. 2, 25-26, 69-70, 79-81, 83; T. 318, 320, 328-329, 332-333).

40. None of the narrative sections of the three operative reports describe a fractional D&C. (Pet. Ex. #10, pp. 25-26, 69-70, 79-81; T. 319-320, 325, 328-329, 332-333).

41. Respondent admitted that each of the above three procedures was a regular D&C, not a fractional D&C. He testified that a regular D&C was indicated in each case, that he intended to perform a regular D&C, and that he described a regular D&C in the operative reports. (T. 787-790).

42. The anesthesia records for each of the three surgical procedures reflect the preoperative evaluations performed on Patient D, including bloodwork. Dr. Binion testified that Respondent's office had its own laboratory for routine blood work. For this reason, she stated that she reviewed lab values and recorded "WNL" without noting specific values. (Pet. Ex. #10; T. 793, 796-798; 1596).

43. Dr. Reguero testified that with regard to the April 26, 1989 surgery, the preoperative bloodwork was adequate, especially when viewed in conjunction with blood values obtained eight weeks earlier in February, 1989. Blood work for the second surgery was performed on May 15, 1990, two days prior to surgery. The January 23, 1992 surgery was also preceded by appropriate blood work as seen on the anesthesia record. Dr. Reguero further

testified that urine testing, hemoglobin, potassium, sodium, creatinine, EKG and chest x-ray were all tested and noted to be within normal limits. (Pet. Ex. #10; T. 1293-1295, 1299, 1302-1303).

44. Respondent's office medical record for Patient D contains a pathology report, dated April 26, 1989, concerning the tissue obtained during the first surgery. No tissue was removed during the May 17, 1990 and January 23, 1992 procedures, as noted in the operative reports. Accordingly, no pathology reports were obtained. (Pet. Ex. #10; T. pp. 798-800, 1375-1376).

45. Anesthesia records for the three D&C's performed on Patient D are included in the medical record and documented evidence of the postoperative management of the patient. (Pet. Ex. #10; T. 793).

46. Respondent's record-keeping for Patient D was inconsistent. In the first operation, the operative note describes a congenitally absent right tube and ovary. In the second operative note, there is a description of a removal of a right ovarian cyst, and a normal uterus. In the third operation, the uterus is described as being unicollis. Unicollis means that only one horn of the uterus is developed. This would not be inconsistent with an absent right tube and ovary, but was not

mentioned in any of the previous notes. (Pet. Ex. #10, pp. 26, 70, 80; T. 338-339).

47. Respondent's handwritten notes in Patient D's medical record are illegible. (Pet. Ex. #10).

Patient E

48. From on or about March 1, 1983 through on or about November 8, 1993, Respondent treated Patient E, a 24 year old (in 1983) female, for various medical conditions. On or about May 30, 1989, Respondent performed a termination of pregnancy on Patient E. On or about February 24, 1990, Respondent performed a termination of pregnancy on Patient E. In or about January 23, 1993, Respondent performed a termination of pregnancy on Patient E. On or about August 9, 1993 Respondent performed a D&C on Patient E. On or about December 9, 1992, Respondent performed an artificial insemination procedure on Patient E. (Pet. Ex. #11, pp. 2, 12, 17-18, 32-33, 48; T. 376, 382, 384).

49. The patient initially presented with a specific complaint of a pilonidal cyst on her back. An adequate medical history was taken during the first office visit on March 1, 1983, as demonstrated by Respondent's note for that date and a two page history form completed at that visit. The history form covered gynecological history, obstetrical history, medical history and a

personal and family profile. (Pet. Ex. #11; Resp. Ex. O; T. 815-816).

50. Given the presenting complaint of a pilonidal cyst on the back, the physical examination performed by Respondent at the initial visit on March 1, 1983 was adequate. (T. 816, 1391).

51. Respondent failed to obtain pathologic examination of tissue removed from Patient E during the February 24, 1990 termination of pregnancy. (Pet. Ex. #11, p. 17; T. 384-387, 818-820).

52. Respondent's handwritten notes for Patient E are illegible. (Pet. Ex. #11).

Patient F

53. From on or about July 27, 1990 through on or about August 4, 1994, Respondent treated Patient F, a 37 year old (in 1994) female, for various medical conditions. Patient F had been treated by Respondent on multiple occasions prior to July 27, 1990. A complete history and physical examination were obtained at the time of her initial visit to Respondent's office. On or about September 9, 1992, Respondent performed a fractional dilatation and curettage and diagnostic/therapeutic laparoscopy under general anesthesia on Patient F. (Pet. Ex. #12, p. 24; T.

408, 833-834).

54. Patient F signed a consent form, dated September 9, 1992, which was counter-signed by Respondent and witnessed by a third person. (Resp. Ex. F).

55. The responsibility for post-operative monitoring rests with the anesthesiologist and not the operating surgeon. (T. 1501, 1592).

56. The anesthesia record for Patient F reflects that the patient was monitored in the recovery room. (Pet. Ex. #12; T. 837, 1501-1502).

57. On April 9, 1993, Respondent performed a colposcopy and cervical biopsy, primarily because the patient's cervix appeared abnormal during an office visit on March 18, 1993. A Pap smear taken on March 18 was abnormal in that it showed cellular change that could be associated with inflammation. (Pet. Ex. #12; T. 839-840).

58. Dr. Reguero testified that the colposcopy and cervical biopsy were medically indicated, based upon Respondent's observations and the pathologist's description of the Pap smear taken on March 18, 1993. (Pet. Ex. #12; T. 1504-1505, 1513-1517).

59. Respondent purported to describe the findings of the colposcopy through a drawing in the medical record. The drawing was illegible. (Pet. Ex. #12, p.41; 843-845, 849).

60. For a colposcopy and cervical biopsy, there should be a written description of the cervix, notation of whether any abnormalities were seen, whether the transitional zone was completely visualized, and what areas were suspicious enough to require a biopsy. (T. 424-425).

61. Respondent's handwritten notes in the medical record for Patient F are illegible. (Pet. Ex. #12).

Patient G

62. From on or about November 8, 1984 through on or about July 1, 1994 Respondent treated Patient G, a 28 year old (in 1984) female for various medical conditions. In or about January 1985, June 1986, and December 1988, Respondent performed first trimester abortions on Patient G. In or about 1984 Respondent began to prescribe the diuretic spironolactone (Aldactone) for Patient G due to complaints of premenstrual tension. In or about March 1986, Respondent began to prescribe Synthroid and Ionamin for weight control. In or about 1988 Respondent began to prescribe Xanax for anxiety. In or about January 1988, Respondent prescribed Retin-A for Patient G at her

request. Patient G moved to Maryland, in or about January 1988, and had visited Respondent only five times since. Patient G was last examined by Respondent in or about September 1990. (Pet. Ex. #13; T. 450-453).

63. Following Patient G's 1988 move to Maryland, Respondent issued prescription renewals to her by mail for the above-mentioned medications, without appropriate monitoring or supervision. (Pet. Ex. #13, pp. 20-22; T. 452-455).

64. Synthroid is a synthetic thyroid hormone which, if taken to excess can make the patient hyperactive. A physician must watch the patient for symptoms of hyperthyroidism and check the level of circulating thyroid hormone. (T. 453-454).

65. Spirinolactone, a diuretic with possible side effects of disturbance in electrolyte balance, must be periodically checked. (T. 453).

66. Xanax is a psychoactive drug used mainly to treat anxiety. Careful monitoring of the patient is required. (T. 453-454).

67. There is no indication that Respondent performed any monitoring tests or saw the results of any tests performed by any other physician who may have also treated Patient G. (t.

454).

68. Patient G acknowledged in her letter of January 26, 1988 that Respondent sent her prescriptions for Synthroid, Ionamin, spironolactone, and Xanax with the words "I'd like to thank you for your note and prescriptions." (Pet. Ex. #13, pp. 20-22).

69. Respondent admitted that he must have sent the prescriptions to Patient G as requested in her January 13, 1988 letter. (Pet. Ex. #13, pp. 20-22; T. 555).

70. The fact that Patient G sent four letters requesting prescriptions by mail, after the initial letter, with no complaint that Respondent failed to send her the previously requested prescriptions provides evidence that Respondent did, in fact, send the prescriptions to her. (Pet. Ex. #13; T. 459-460).

71. The notation "Sent 7/1/94" on the June, 1994 postcard from Patient G to Respondent confirms that Respondent did send the requested prescriptions to Patient G. (Pet. Ex. #13, p. 40).

72. Following Patient G's last examination by Respondent in or about September 1990, Respondent inappropriately issued prescription renewals to her for the above-mentioned

medications, without appropriate monitoring or supervision. (Pet. Ex. #13, pp. 38-40; T. 453-455).

73. Respondent's handwritten notes are illegible. Respondent failed to maintain an adequate record for Patient G. (Pet. Ex. #13;1 T. 455).

Patient H

74. From on or about March 4, 1993 through on or about January 31, 1995, Respondent treated Patient H, a 47 year old (in 1993) female for endometriosis and extremely painful dysmenorrhea. On or about April 28, 1993, Respondent performed a fractional D&C, exploratory laparoscopy, lysis of pelvic adhesions, second puncture laparoscopy, left ovarian cystectomy, bisection of uterosacral ligaments, tubal perfusion, and pelvic lavage on Patient H. (Pet. Ex. #14, pp. 4-6; T. 465-466, 469).

75. Respondent obtained informed consent from Patient H prior to the April 28, 1993 surgery. (Resp. Ex. Q).

76. Dr. Binion provided anesthesia care to Patient G and monitored her post-operative course as reflected in the anesthesia record. (Pet. Ex. #14).

77. Respondent's handwritten progress notes are illegible. (Pet. Ex. #14).

CONCLUSIONS OF LAW

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

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

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

DISCUSSION

Respondent is charged with eighteen specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg,

Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

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

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

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

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the charge of negligence on more than one occasion (Fifth Specification) and

the failure to maintain accurate records (Eleventh through Eighteenth Specifications) should be sustained. The remaining specifications should all be dismissed. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

Credibility Issues

At the outset, the Hearing Committee considered the credibility of the witnesses presented by both sides. The principal witness presented by Petitioner was Joseph J. Rovinsky, M.D. Dr. Rovinsky, a board-certified obstetrician/gynecologist. Dr. Rovinsky, has had a distinguished career. He is currently the director of obstetrics and gynecology at the South Shore Medical Center, and previously was chairman of obstetrics and gynecology at Long Island Jewish Medical Center for 20 years. Before that, Dr. Rovinsky was director of obstetrics and gynecology at City Hospital Center at Elmhurst for approximately 20 years.

Nevertheless, there were aspects of Dr. Rovinsky's testimony which were troubling to the Hearing Committee. On several occasions, Dr. Rovinsky testified that consent forms were missing from patient records received into evidence or that there was no evidence of post-operative monitoring. Upon cross-examination, this was shown not to be the case. Dr. Rovinsky also acknowledged that he was personally not qualified to have

performed surgery on Patient A, yet opined that Respondent was unqualified to perform oncologic surgery on the patient without actually knowing Respondent's qualifications or the extent of his hospital privileges. As a result, the Hearing Committee determined to place lesser weight on Dr. Rovinsky's testimony.

In contrast, Respondent presented the expert testimony of Wilfred Reguero, M.D. Dr. Reguero is currently the director of obstetrics/gynecology at the Hospital of St. Raphael, in New Haven Connecticut. He has previously served as chairman of obstetrics at the Westchester County Medical Center, and has practiced at Sloan Kettering and Lenox Hill Hospital.

Dr. Reguero presented strong testimony on behalf of Respondent. He demonstrated extensive experience in the areas of practice at issue. The Committee was somewhat troubled by his tendency to excuse Respondent's poor records, yet on balance found him to be a highly credible witness. Overall, the Hearing Committee determined to give substantial weight to Dr. Reguero's testimony.

Respondent also presented the testimony of Magda Binion, M.D. Dr. Binion is an anesthesiologist, and provided the anesthesia and post-operative care to patients at Respondent's office. Dr. Binion testified regarding the procedures for monitoring patients during surgery and in the recovery room post-operatively. The Committee found her testimony to be credible.

Patient A

Patient A was a 50 year old female with Stage 3 ovarian cancer when she initially presented to Respondent. On September 8, 1993, Respondent operated on the patient, performing an examination, fractional dilatation and curettage, exploratory laparotomy, lysis of pelvic adhesions, right ovarian cystectomy, bilateral salpingo-oophorectomy, omentectomy, and pelvic lavage.

Petitioner alleged that Respondent inappropriately failed to refer Patient A to a specialist in gynecologic oncology, and inappropriately undertook the September 8, 1993 surgery, which was allegedly beyond his expertise. Petitioner based it these allegations on testimony of Dr. Rovinsky. However, Dr. Rovinsky admitted that a physician did not have to be a board-certified gynecologic oncologist to treat this patient. He further admitted that he had no knowledge of Respondent's qualifications, nor the extent of his surgical privileges.

During the course of the September 8, 1993 surgery, Respondent performed an ovarian cystectomy before he performed the bilateral oophorectomy. Respondent testified that the cyst hindered his ability to visualize the operative field. Dr. Reguero testified that it was appropriate to perform the cystectomy in order to properly carry out the rest of the surgery. Dr. Rovinsky admitted that the decision to remove a

cyst under such circumstances was a judgment within the purview of the operating surgeon.

Respondent did not perform a total abdominal hysterectomy, total omentectomy, pelvic and para-aortic lymph node sampling, and removal of all tumor greater than one centimeter in diameter during the September 8, 1993 surgery. Respondent testified that he found abdominal lesions greater than two centimeters in size. According to the FIGO classification of cancer staging (a nationally and internationally recognized method used to stage ovarian cancers), such a finding classifies the patient's carcinoma as Stage III-C. Under the FIGO classification, resection of the nodes was not indicated. In addition, Dr. Reguero testified that in his experience, pelvic and para-aortic lymph nodes are not sampled in the presence of two centimeter lesions. Dr. Reguero further testified that the decision to perform a total hysterectomy and total omentectomy were matters of surgical judgment. He opined that Respondent's decision in this instance was within the standard of care. The Hearing Committee gave credence to this testimony.

The remaining allegations address the patient's post-operative course following her second surgery on June 13, 1994. Petitioner alleged that Respondent perforated Patient A's bowel during the second surgery and failed to timely discover and treat such perforation. However, the patient's clinical course does

not support Petitioner's contentions. Had the patient's bowel been perforated during the surgery, she would have demonstrated symptoms of infection by the third post-operative day. However, Dr. Rovinsky acknowledged that there were no indications for surgical intervention until the fifth post-operative day. There was nothing evident in the patient's clinical picture to warrant a surgical consultation on or before the third post-operative day. Under the circumstances presented, the Committee also found that the soap suds enema ordered by Respondent did not represent a deviation from accepted standards of practice. The Committee also found that the record maintained for this patient was adequate.

Based upon the above, the Hearing Committee unanimously voted to dismiss all factual allegations and the First, Second, Sixth and Eleventh Specifications of professional misconduct regarding Patient A.

Patient B

Patient B had presented to Respondent on several occasions with complaints of lower abdominal pain. She presented on May 18, 1991 with complaints similar to those in the past. Respondent examined the patient, and performed an ultrasound. The ultrasound examination revealed a right ovarian cyst 3 x 2 centimeters in diameter, and questionable blood in the cul-de-sac. The ultrasound did not reveal any gestation in the uterus

or in the fallopian tube, nor any evidence of an adnexal mass that could be construed as a pregnancy. Respondent diagnosed a ruptured ovarian cyst.

Approximately 24 hours later, Patient B presented in the Mount Sinai Hospital emergency room with fever and increased abdominal pain. She was ultimately taken to surgery for the exploration of a possible ectopic pregnancy. No conclusive evidence of an ectopic pregnancy was found.

The patient's last reported menses was on May 7, 1991, eleven days prior to her office visit. She did not report any missed or irregular periods, nor any unusual bleeding. Accordingly, it was not a deviation from accepted standards to omit a pregnancy test. Moreover, given her past history, her clinical condition, as well as the objective evidence presented by the ultrasound examination, Respondent's diagnosis of a ruptured ovarian cyst was reasonable.

There is a notation in the Mount Sinai medical record that the patient reported being prescribed Flagyl, an antibiotic, by Respondent. There is no evidence in Respondent's medical records for Patient B indicating that Flagyl was prescribed on May 18, 1991, nor did Respondent have any recollection of prescribing the drug at that time. He did testify that he typically uses Flagyl for patients with pelvic inflammatory conditions. Indeed, Flagyl was prescribed for Patient B during

her inpatient admission at Mount Sinai. If Respondent did prescribe Flagyl for Patient B on May 18, 1991, it was of no consequence to the patient. Based on the foregoing, the Hearing Committee did not sustain Factual Allegations B.1 through B.5. Further, the Committee dismissed the Second, Fourth and Sixth Specifications of professional misconduct regarding Patient B.

Respondent's handwritten progress notes contained in Patient B's medical record (and in the records for Patients C through H as well) are virtually illegible. Respondent argued that there is no evidence that any patient care was affected by the illegibility of the notes, and since the treatments at issue were almost exclusively related to in-office care, it was only Respondent who needed to read the records. We disagree. Medical records (even office records) are not solely for the use of the author alone. The records must be maintained in such a manner that a subsequent treating physician (or a regulatory agency such as the Board) may review and understand the contents. Respondent may not always be available to translate his writing. The Hearing Committee unanimously concluded that illegible notes result in an inadequate and inaccurate record of the medical care and treatment rendered to a patient. Accordingly, the Hearing Committee unanimously voted to sustain Factual Allegation B.6 and the Twelfth Specification of professional misconduct.

Patient C

Respondent treated Patient C for infertility from October 25, 1990 through July 26, 1991. When the patient first presented to Respondent, she had pain and discomfort on examination. By January 9, 1991 the pain had increased in severity. The patient was found to have an ovarian cyst on her remaining ovary. Respondent performed a D&C and a tubal perfusion procedure on Patient C on January 9, 1991. Respondent obtained appropriate informed consent from the patient prior to the surgery.

The patient informed Respondent that she was expecting her menses that day. Respondent performed a urine pregnancy test. The results were negative. He then proceeded with the surgery. Respondent failed to perform an appropriate pre-operative physical examination of Patient C, including a breast examination and abdominal examination. No evidence of any pre-operative bloodwork was found in the medical record, although Respondent testified that it would have been performed as a matter of course. No record of post-operative monitoring was found in the medical record.

During the course of the surgery, Respondent resected an ovarian cyst. He sent the fluid, as well as endometrial tissue, to a laboratory for analysis. The collapsed cyst was vaporized.

Patient C was subsequently found to be pregnant. A beta HCG value of 1401 obtained at a pre-natal visit on January 29, 1991. On February 5, 1991, Patient C spontaneously terminated the pregnancy.

It was not inappropriate for Respondent to perform the surgery during the second half of Patient C's menstrual cycle. Indeed, Respondent testified that it was routine to perform an endometrial biopsy during the secretory phase of the menstrual cycle as part of the work-up for infertility cases. Petitioner alleged that Respondent failed to perform an appropriate pregnancy test prior to surgery. However, the evidence established that the ICON pregnancy test used by Respondent was sensitive enough to have detected a pregnancy, had one been present. It can detect a pregnancy approximately ten days after ovulation, or one to two days prior to the menses. Moreover, the low beta HCG value obtained on January 29, 1991 proved that Patient C could not have been pregnant at the time of surgery.

There was no evidence of pre-operative bloodwork in the patient's medical record. However, both Dr. Reguero and Dr. Binion testified that pre-operative bloodwork would not be required in this case, given the patient's age (31) and otherwise good health. Thus, the absence of the bloodwork did not constitute a deviation from accepted standards of practice.

Respondent did not send the resected ovarian cyst to a

laboratory for analysis, along with the fluid and endometrial tissue. Respondent testified that after the cyst was punctured, and the fluid removed, the cyst collapsed and was vaporized. As a result, there was nothing remaining to be examined. The Committee accepted this explanation for the absence of pathology analysis of the cyst.

There was no evidence of post-operative monitoring in the medical record. Dr. Binion, an anesthesiologist who provides anesthesia care to patients at Respondent's office, testified that the monitoring is the responsibility of the anesthesiologist, rather than the operating surgeon. Dr. Reguero also testified to this effect. Dr. Binion described the procedures for post-operative monitoring, including vital sign monitoring and use of pulse oximetry to measure oxygen saturation. (*See*, T. 1597-1603). The Hearing Committee concluded that Respondent did not fail to appropriately monitor the patient's post-operative recovery.

Respondent's handwritten progress notes were illegible, as noted with regard to Patient B. Based upon the illegibility of the notes, the Hearing Committee concluded that Respondent failed to maintain an accurate medical record for Patient C.

Given the foregoing, the Committee concluded that Factual Allegations C.5 and C.7 should be sustained. The Committee further concluded that the Fifth and Thirteenth

Specifications should be sustained, and that the Sixth and Ninth Specifications should be dismissed.

Patient D

The allegations concerning Patient D primarily relate to three surgical procedures performed by Respondent on April 25, 1989, May 17, 1990 and January 23, 1992. In each instance, Respondent's operative note identifies the procedure performed as a "fractional D&C". In each case, however, the body of the note describes a regular D&C. Respondent admitted that each of the three procedures was a regular D&C, although he attributed the mistakes to a "typist's mistake". This appears at first blush to be a plausible explanation. However, there are other problems with the operative records. In the first operation, the operative note describes a congenitally absent right tube and ovary. In the second surgical note, there is a description of the removal of a right ovarian cyst, and a normal uterus. In the third operation, the uterus is described as being unicollis (only one horn of the uterus is developed). While this would not be inconsistent with an absent right tube and ovary, it was not mentioned in any of the previous notes.

These errors go beyond mere typographical mistakes. It is Respondent's responsibility to assure the accuracy of his reports. The Hearing Committee concluded that these errors represent a deviation from accepted standards of practice

sufficient to warrant a finding of negligence. Accordingly, the Committee voted to sustain the Fifth Specification with respect to this patient.

Petitioner has also charged Respondent with failing to perform appropriate preoperative evaluations of Patient D for each of the surgical procedures, including the failure to obtain preoperative bloodwork. However, the medical record, including the anesthesia records for all three procedures, contains evidence of the preoperative evaluations. The Committee concluded that this allegation should not be sustained.

Petitioner charged Respondent with failing to obtain pathological examination of the tissue removed in each of the three procedures. However, the medical record clearly contains a pathology report, dated April 26, 1989, which relates to the D&C performed the day before. Moreover, the operative reports for the remaining D&Cs state that no tissue was obtained. Accordingly, the Committee concluded that this allegation should not be sustained.

The patient's medical record contains the anesthesia records for each of the three surgical procedures. These records provide documented evidence of the post-operative monitoring of the patient. Accordingly, the allegation of failure to monitor must also be dismissed.

As was found with the records for Patients B and C, Respondent's handwritten progress notes are illegible. Given that fact, as well as the inaccuracies in the operative notes described earlier, the Hearing Committee concluded that the Fourteenth Specification should be sustained. The Committee further concluded that the Sixth Specification (incompetence) should not be sustained.

Patient E

Patient E first presented to Respondent on March 1, 1983 with a complaint of a pilonidal cyst on her back. An adequate medical history was taken during the first office visit, as demonstrated by Respondent's note for that date and a two page history form completed on that date. The history form covered gynecological history, obstetrical history, medical history and a personal and family profile. Given the patient's presenting complaint, the physical examination conducted by Respondent at the initial visit was adequate.

On February 24, 1990, Respondent performed a termination of pregnancy on Patient E. Respondent testified that tissue was removed and sent to the pathology lab. However, no pathology report is contained in the medical record. The record does not reflect the fact that the tissue was sent, nor does it document any effort to obtain the laboratory report. It is not sufficient to send tissue to the laboratory and not to follow-up

on the results. The Hearing Committee concluded that the failure to obtain the pathologic examination of the tissue removed from Patient E was a deviation from accepted standards of practice constituting negligence. Accordingly, the Committee voted to sustain the Fifth Specification with regard to Patient E.

As in the preceding cases, the handwritten progress notes contained within the patient's medical record were so illegible that Respondent felt constrained to provide a typed transcript for his expert's testimony. Accordingly, the Committee concluded that the Fifteenth Specification should be sustained. The Committee voted to dismiss the Sixth Specification (incompetence) as regards this patient.

Patient F

Respondent treated Patient F, a 37 year old (in 1994) female, from some date prior to July 29, 1990 through on or about August 4, 1994. Contrary to Petitioner's allegations, Patient F had been treated on multiple occasions prior to her visit to Respondent's office on July 27, 1990. Respondent explained that a number of medical records had been irreparably damaged by a water leak in the basement of his office. Consequently, the records reflecting his initial treatment of this patient were lost. The Hearing Committee accepted this explanation.

When the patient presented on July 27, 1990, she complained of irregular bleeding since April. The history and

physical examination performed by Respondent were adequate and appropriate to the patient's presenting complaint. (Pet. Ex. #12; Resp. Ex. N; T. 833-835).

On September 9, 1992 Respondent performed a fractional D&C and diagnostic/therapeutic laparoscopy under general anesthesia on Patient F. Respondent obtained informed consent from the patient prior to surgery. (Resp. Ex. F). Following surgery, Patient F was monitored in the recovery room by the attending anesthesiologist.

On April 9, 1993, Respondent performed a colposcopy and cervical biopsy on Patient F. He performed the procedures because the patient's cervix had appeared abnormal during an office visit on March 18, 1993. Moreover, a Pap smear taken on that date showed cellular change that could be associated with inflammation. This provided an adequate basis for the performance of the procedures.

Based upon the above, the Hearing Committee voted not to sustain Factual Allegations F.1 through F.5. The Committee further voted to dismiss the Fifth and Sixth Specifications as concern Patient F, as well as the Tenth Specification.

Following the colposcopy, Respondent purported to describe his findings through a drawing in the medical record. The drawing was illegible. Respondent should have recorded a written description of the cervix, notation of whether any

abnormalities were seen, whether the transitional zone was completely visualized, and what areas were suspicious enough to require a biopsy. In addition, Respondent's handwritten progress notes for Patient F were illegible as well. As a result, the Committee voted to sustain the Sixteenth Specification, for failing to maintain a record which accurately reflected the medical care and treatment rendered to the patient.

Patient G

Respondent treated Patient G, a 28 year old (in 1984) female, from on or about November 8, 1984 through on or about July 1, 1994. In 1984, Respondent began to prescribe the diuretic spironolactone for Patient G due to complaints of premenstrual tension. In or about 1986, Respondent began to prescribe Synthroid and Ionamin for weight control. In or about 1988, Respondent began to prescribe Xanax for anxiety.

Patient G moved to Maryland sometime in January, 1988. She had visited Respondent five times after her move. She was last examined by Respondent in or about September, 1990. Following Patient G's move to Maryland, Respondent issued prescription renewals to her by mail. The exact number of renewals issued is unclear, since Respondent's progress notes contain no record of the prescriptions. Nevertheless, a review of the correspondence from the patient indicates that Respondent sent prescriptions on a minimum of two occasions (January 1988

and July 1994), and perhaps more.

The drugs prescribed by Respondent require periodic monitoring for safe usage. There is no evidence in the record that Respondent either performed such monitoring or reviewed the results of any tests performed by any other physician who may have also treated Patient G.

There is no indication in the record of any improper m motive on Respondent's part for the prescriptions sent by mail. Nevertheless, the Hearing Committee concluded that this conduct represented a deviation from accepted standards of medical practice. As a result, the Committee sustained the Fifth Specification as regards Patient G. The Committee also sustained the Seventeenth Specification, based upon the illegibility of Respondent's handwritten notes, and the lack of information regarding the prescriptions sent to the patient. The Committee dismissed the Sixth Specification (incompetence) as well as the Seventh Specification (excessive treatment) because there was no proof indicating a lack of skill or knowledge on Respondent's part, nor was any proof presented that the medications were not medically indicated.

Patient H

From on or about March 4, 1993 through on or about January 31, 1995, Respondent treated Patient H, a 47 year old (in 1993) female for endometriosis and extremely painful

dysmenorrhea. On April 28, 1993, Respondent performed a fraction D&C, exploratory laparoscopy, lysis of pelvic adhesions, second puncture laparoscopy, left ovarian cystectomy, bisection of uterosacral ligaments, tubal perfusion and pelvic lavage on Patient H.

Respondent obtained informed consent from Patient H prior to the surgery. Dr. Binion provided anesthesia care to Patient H and monitored her post-operative course as reflected in the anesthesia record. Based upon the foregoing, the Hearing Committee voted to dismiss Factual Allegations H.2 and H.3.

Petitioner also charged Respondent with inappropriately prescribing a continuing course of controlled substances for Patient H. However, no proof on this charge was placed before the Hearing Committee. As a result, the Committee dismissed Factual Allegation H.1. The Committee further voted to dismiss the Fifth and Sixth Specifications with regard to Patient H, as well as the Eighth Specification.

Respondent's handwritten notes for Patient H, as reflected in the medical record, were illegible. As a result, the Committee voted to sustain the Eighteenth Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine as a physician in New York State should be placed on probation for a period of two years following the effective date of this Determination and Order. The terms of probation shall include monitoring of Respondent's medical records for their adequacy. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

It became apparent during the course of these proceedings that the core issues in the cases presented revolved around the poor quality of Respondent's medical records. His handwritten progress notes are so incomprehensible that it became necessary to provide typed transcripts in order to decipher them. Respondent also carelessly mislabeled surgical procedures performed (i.e., fractional v. regular D&Cs). Consent forms were found separately from the patient's medical records. Respondent's poor record-keeping practices may be a function of the fact that he has a very active medical practice. This is,

however, an explanation, but not an excuse.

Moreover, some of Respondent's actions went beyond mere record-keeping problems. He failed to perform an appropriate preoperative examination for Patient C and failed to follow-up on Patient E's pathology specimens after they were sent to the laboratory. Respondent also issued renewal prescriptions for Patient G by mail without appropriate follow-up (although it was impossible to determine the exact number of prescription due to his poor records).

The Hearing Committee unanimously determined that Respondent's conduct, although negligent was not egregious enough to warrant revocation or any period of either active or stayed suspension. The Committee believes that a period of probation, coupled with monitoring, will accomplish the goal of convincing Respondent of the need to pay greater attention to his medical records and not to cut corners in his daily practice.

ORDER

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

1. The Fifth, and Eleventh through Eighteenth Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Petitioner's Exhibit # 1A) and described more particularly above, are **SUSTAINED;**

2. The First through Fourth, and Sixth through Tenth Specifications of professional misconduct, as set forth in the Amended Statement of Charges are **DISMISSED;**

3. Respondent's license to practice medicine as a physician in New York State be and hereby is placed on **PROBATION** for a period of two (2) years commencing on the effective date of this Determination and Order. The complete terms of probation attached to this Determination and Order in Appendix II and incorporated herein;

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

DATED: Albany, New York
11/11 , 1999

REDACTED

BENJAMIN WAINFELD, M.D. (CHAIR)

DAVID T. LYON, M.D.
JAMES J. DUCEY

TO: Paul Stein, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Niels Helth Lauersen, M.D.

REDACTED

Robert S. Deutsch, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP
757 Third Avenue
New York, New York 10017

APPENDIX I

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

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

AMENDED

STATEMENT

OF

CHARGES

MSB / Petitioner #28159 1A Signed

NIELS HELTH LAUERSEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969 by the issuance of license number 104954 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about August 27, 1993 through in or about February, 1995, Respondent treated Patient A (Patient A and all other patients are identified in the attached appendix), a 50 year old (in 1993) female, in his New York City offices and at Lenox Hill Hospital, New York City, for cancer. Patient A initially presented with the presumptive diagnosis of ovarian carcinoma, clinically Stage 3. On or about September 8, 1993, Respondent performed an examination, fractional dilatation and curettage, exploratory laparotomy, lysis of pelvic adhesions, right ovarian cystectomy, bilateral salpingo-oophorectomy, omentectomy, and pelvic lavage on Patient A, under general anesthesia. Pathology reported poorly differentiated papillary serous cystadenocarcinoma of both ovaries and the omentum. On or about June 13, 1994, Respondent performed an

examination, exploratory laparotomy, lysis of pelvic adhesion, excision of pelvic mass, excision and debulking of recurrent ovarian carcinoma, total abdominal hysterectomy, omental biopsy, and pelvic lavage on Patient A, under general anesthesia.

1. Respondent inappropriately failed to refer Patient A to a specialist in gynecologic oncology when she initially presented.

2. Respondent inappropriately performed an ovarian cystectomy before performing a bilateral oophorectomy on Patient A.

3. Respondent inappropriately undertook the operative procedures of on or about September 8, 1993, which he knew or should have known were beyond his expertise.

4. Respondent inappropriately failed to perform a total abdominal hysterectomy, total omentectomy, pelvic and para-aortic lymph node sampling, and removal of all tumor greater than one centimeter in diameter as part of the initial operative procedure on or about September 8, 1993.

5. Respondent inappropriately failed to discover and treat the bowel perforation that occurred during Patient A's surgery of on or about June 13, 1994.

6. Respondent inappropriately managed Patient A following her June 13, 1994 surgery.

7. Respondent inappropriately failed to request surgical consultation on or before the third postoperative day following the June 13, 1994 surgery, when radiologic suggestions of intestinal obstruction first appeared.

8. Respondent inappropriately ordered a soap suds enema for Patient A.

9. Respondent failed to keep an adequate record for Patient A.

B. From on or about October 10, 1989 through on or about May 18, 1991, Respondent treated Patient B, a 25 year old (in 1991) female in his New York City offices. Patient B presented in Respondent's offices in New York City on or about May 18, 1991 with a chief complaint of lower abdominal pain. An office ultrasound examination showed a right ovarian cyst 3x2 centimeters in diameter and questionable blood in the cul-de-sac. Respondent took a cervical cytological smear. Approximately 24 hours later, Patient B presented in the Mount

Sinai Hospital emergency room with fever and increased abdominal pain. She was taken to the operating room for the indication of a possible ectopic pregnancy, and the postoperative diagnosis of tubal abortion was made.

1. Respondent failed to obtain an appropriate history from Patient B, including, but not limited to a failure to obtain a menstrual history and a failure to obtain appropriate information regarding location and radiation of her abdominal pain.

2. Respondent inappropriately failed to carry out a pregnancy test on Patient B.

3. Respondent inappropriately diagnosed Patient B as having a ruptured ovarian cyst.

4. Respondent inappropriately failed to include an ectopic pregnancy in his differential diagnosis of Patient B.

5. Respondent inappropriately prescribed Flagyl for Patient B.

6. Respondent failed to keep an adequate record for Patient B.

C. From on or about October 25, 1990 through on or about July 26, 1991, Respondent treated Patient C, a 31 year old [illegible] female in his New York City offices for infertility. On or about January 9, 1991, Respondent performed a dilatation and curettage and a tubal perfusion procedure on Patient C in his New York City offices. On or about February 5, 1991, Patient C spontaneously passed bloody decidual tissue containing immature chorionic villi.

1. Respondent inappropriately performed a dilatation and curettage and a tubal perfusion on Patient C during the second half of the menstrual cycle of Patient C who was trying to become pregnant.

2. Respondent failed to perform an appropriate preoperative evaluation of Patient C, including, but not limited to, a failure to determine Patient C's last menses, a failure to perform an appropriate pregnancy test on Patient C, and a failure to do preoperative blood work.

3. Respondent failed to perform an appropriate preoperative physical examination of Patient C, including, but not limited to, a failure to perform a breast examination, and a failure to perform an abdominal examination.

4. Respondent failed to obtain appropriate informed consent from Patient C for the operative procedures.

5. Respondent failed to appropriately monitor Patient C's postoperative recovery.

6. Respondent failed to obtain a pathological examination of Patient C's resected ovarian cyst.

7. Respondent failed to keep an adequate record for Patient C.

D. From on or about August 7, 1980 through on or about January 23, 1992, Respondent treated Patient D, a 31 year old (in 1989) female in his New York City offices for various medical conditions. On or about April 25, 1989, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On or about May 17, 1990, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On or about January 23, 1992, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D.

1. Respondent inappropriately called each of the three surgical procedures a "fractional D&C".

2. Respondent failed to perform an appropriate preoperative evaluation of Patient D for each of the three surgical procedures, including, but not limited to the failure to obtain preoperative blood work.

3. Respondent failed to obtain appropriate pathological examination of the tissue removed in each of the three surgical procedures performed on Patient D.

4. Respondent failed to appropriately monitor Patient D's postoperative recovery for each of the three surgical procedures.

5. Respondent failed to accurately and appropriately record the three operative procedures he performed on Patient D.

6. Respondent failed to keep an adequate record for Patient D.

E. From on or about March 1, 1983 through on or about November 8, 1993, Respondent treated Patient E, a 24 year old (in 1983) female in his New York City offices for various medical conditions. On or about May 30, 1989, Respondent performed a termination of pregnancy on Patient E. On or about February 24, 1990, Respondent performed a termination of pregnancy on Patient E. On or about January 26, 1993, Respondent performed a termination of pregnancy on Patient E. On or about August 7, 1993 Respondent performed an unidentified procedure on Patient E. On or about December 9, 1992, Respondent performed an artificial insemination procedure on Patient E.

1. Respondent failed to obtain an adequate history of

Patient E at her visit on or about March 1, 1983.

2. Respondent failed to conduct an adequate physical examination of Patient E at her visit on or about March 1, 1983.

3. Respondent failed to obtain pathologic examination of tissue removed from Patient E on or about February 24, 1990.

4. Respondent failed to keep an adequate record for Patient E.

F. From on or about July 27, 1990 through on or about June 16, 1994, Respondent treated Patient F, a 37 year old (in 1994) female in his New York City offices for various medical conditions. On or about September 9, 1992, Respondent performed a fractional dilatation and curettage and diagnostic/therapeutic laparoscopy under general anesthesia on Patient F.

1. Respondent failed to obtain an adequate history of Patient F at her initial visit on or about July 27, 1990.

2. Respondent failed to conduct an adequate physical examination of Patient F at her initial visit on or about July 27, 1990.

3. Respondent failed to obtain appropriate informed consent from Patient F before the September 9, 1992 surgery.

4. Respondent failed to appropriately monitor Patient F's postoperative recovery following the September 9, 1992 surgery.

5. On or about April 9, 1993, Respondent inappropriately performed a colposcopy and a colposcopically-directed cervical biopsy on Patient F that were not medically indicated.

6. Respondent inappropriately failed to record the colposcopic visual findings of the April 9, 1993 procedure on Patient F.

7. Respondent failed to keep an adequate record for Patient F.

G. From on or about November 8, 1984 through on or about July 1, 1994, Respondent treated Patient G, a 28 year old (in 1984) female, in his New York City offices for various medical conditions. In or about January 1985, June 1986, and December 1988, Respondent performed a first trimester abortion on Patient G. In or about 1984 Respondent began to prescribe the diuretic spironolactone for Patient G for complaints of premenstrual tension. In or about March, 1986, Respondent

began to prescribe Synthroid and Ionamin for Patient G for weight control. In or about 1988, Respondent began to prescribe Xanax for Patient G for anxiety. In or about January 1988, Respondent prescribed Retin-A for Patient G at her request. Patient G moved to Maryland, in or about January 1988, and has visited Respondent only four times since (once for an abortion). Patient G was last examined by Respondent in or about September 1990.

1. Following Patient G's 1988 move to Maryland, Respondent inappropriately issued prescription renewals by mail to her for the above-mentioned medications, without appropriate monitoring or supervision of Patient G.

2. Following Respondent's last examination by Respondent in or about September 1990, Respondent inappropriately issued prescription renewals by mail to her for the above-mentioned medications, without appropriately monitoring or supervision of Patient G.

3. Respondent failed to keep an adequate record for Patient G.

H. From on or about March 4, 1993 through on or about March 17, 1994, Respondent treated Patient H, a 47 year old (in 1993) female in his New York City offices for endometriosis and extremely painful dysmenorrhea. On or about April 28, 1993,

Respondent performed fractional dilatation and curettage, exploratory laparoscopy, lysis of pelvic adhesions, "second puncture laparoscopy" (sic), left ovarian cystectomy, bisection of uterosacral ligaments, tubal perfusion, and pelvic lavage procedures on Patient H, and started the patient on an extended course of prescription analgesic medications.

1. Respondent inappropriately prescribed a continuing course of controlled substances for Patient H, including Percocet, Dilaudid, Levo-Dromoran, and Demerol.

2. Respondent failed to obtain appropriate informed consent from Patient H before surgery.

3. Respondent failed to appropriately monitor Patient H's postoperative recovery.

4. Respondent failed to keep an adequate record for Patient H.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-9.
2. Paragraphs B and B1-6.

THIRD AND FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A and A1-9.
4. Paragraphs B and B1-6.

FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

5. Paragraphs A and A1-9; B and B1-6; C and C1-7; D and D1-6; E and E1-4; F and F1-7; G and G1-3; and/or H and H1-4.

SIXTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraphs A and A1-9; B and B1-6; C and C1-7; D and D1-6; E and E1-4; F and F1-7; G and G1-3; and/or H and H1-4.

SEVENTH THROUGH EIGHTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct

as defined by N.Y. Educ. Law §6530(35)(McKinney Supp. 1998 by the ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient as alleged in the facts of the following:

7. Paragraphs G and G1-2.

8. Paragraphs H and H1.

NINTH THROUGH TENTH SPECIFICATIONS

PERFORMING UNAUTHORIZED SERVICES

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(26)(McKinney Supp. 1998) by performing professional services which have not been duly authorized by the patient or his or her legal representative as alleged in the facts of the following:

9. Paragraphs C and C4.

10. Paragraphs F and F3.

ELEVENTH THROUGH EIGHTEENTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

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

11. Paragraphs A and A9.

12. Paragraphs B and B6.

13. Paragraphs C and C7.

14. Paragraphs D and D5-6.

15. Paragraphs E and E4.

16. Paragraphs F and F6-7.

17. Paragraphs G and G3.

18. Paragraphs H and H4.

DATED: New York, New York
April 16, 1999

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II
TERMS OF PROBATION

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

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

3. Dr. Lauersen shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

4. Dr. Lauersen shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of his compliance with the terms of this Order. Dr. Lauersen shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

6. Dr. Lauersen's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Dr. Lauersen and his staff at practice locations or OPMC offices.

7. Dr. Lauersen shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Dr. Lauersen shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Dr. Lauersen as may be authorized pursuant to the law.

TO: Paul Stein, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Niels Helth Lauersen, M.D.

REDACTED

Robert S. Deutsch, Esq.
Aaronson, Rappaport, Feinstein & Deutsch, LLP
757 Third Avenue
New York, New York 10017

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

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

AMENDED

STATEMENT

OF

CHARGES

MSB / Petitioner's Exhibit #28 1/99 In Evid

NIELS HELTH LAUERSEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969 by the issuance of license number 104954 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about August 27, 1993 through in or about February, 1995, Respondent treated Patient A (Patient A and all other patients are identified in the attached appendix), a 50 year old (in 1993) female, in his New York City offices and at Lenox Hill Hospital, New York City, for cancer. Patient A initially presented with the presumptive diagnosis of ovarian carcinoma, clinically Stage 3. On or about September 8, 1993, Respondent performed an examination, fractional dilatation and curettage, exploratory laparotomy, lysis of pelvic adhesions, right ovarian cystectomy, bilateral salpingo-oophorectomy, omentectomy, and pelvic lavage on Patient A, under general anesthesia. Pathology reported poorly differentiated papillary serous cystadenocarcinoma of both ovaries and the omentum. On or about June 13, 1994, Respondent performed an

examination, exploratory laparotomy, lysis of pelvic adhesion, excision of pelvic mass, excision and debulking of recurrent ovarian carcinoma, total abdominal hysterectomy, omental biopsy, and pelvic lavage on Patient A, under general anesthesia.

1. Respondent inappropriately failed to refer Patient A to a specialist in gynecologic oncology when she initially presented.

2. Respondent inappropriately performed an ovarian cystectomy before performing a bilateral oophorectomy on Patient A.

3. Respondent inappropriately undertook the operative procedures of on or about September 8, 1993, which he knew or should have known were beyond his expertise.

4. Respondent inappropriately failed to perform a total abdominal hysterectomy, total omentectomy, pelvic and para-aortic lymph node sampling, and removal of all tumor greater than one centimeter in diameter as part of the initial operative procedure on or about September 8, 1993.

5. Respondent inappropriately failed to discover and treat the bowel perforation that occurred during Patient A's surgery of on or about June 13, 1994.

6. Respondent inappropriately managed Patient A following her June 13, 1994 surgery.

7. Respondent inappropriately failed to request surgical consultation on or before the third postoperative day following the June 13, 1994 surgery, when radiologic suggestions of intestinal obstruction first appeared.

8. Respondent inappropriately ordered a soap suds enema for Patient A.

9. Respondent failed to keep an adequate record for Patient A.

B. From on or about October 10, 1989 through on or about May 18, 1991, Respondent treated Patient B, a 25 year old (in 1991) female in his New York City offices. Patient B presented in Respondent's offices in New York City on or about May 18, 1991 with a chief complaint of lower abdominal pain. An office ultrasound examination showed a right ovarian cyst 3x2 centimeters in diameter and questionable blood in the cul-de-sac. Respondent took a cervical cytological smear. Approximately 24 hours later, Patient B presented in the Mount

Sinai Hospital emergency room with fever and increased abdominal pain. She was taken to the operating room for the indication of a possible ectopic pregnancy, and the postoperative diagnosis of tubal abortion was made.

1. Respondent failed to obtain an appropriate history from Patient B, including, but not limited to a failure to obtain a menstrual history and a failure to obtain appropriate information regarding location and radiation of her abdominal pain.

2. Respondent inappropriately failed to carry out a pregnancy test on Patient B.

3. Respondent inappropriately diagnosed Patient B as having a ruptured ovarian cyst.

4. Respondent inappropriately failed to include an ectopic pregnancy in his differential diagnosis of Patient B.

5. Respondent inappropriately prescribed Flagyl for Patient B.

6. Respondent failed to keep an adequate record for Patient B.

C. From on or about October 25, 1990 through on or about July 26, 1991, Respondent treated Patient C, a 31 year old (in 1990) female in his New York City offices for infertility. On or about January 9, 1991, Respondent performed a dilatation and curettage and a tubal perfusion procedure on Patient C in his New York City offices. On or about February 5, 1991, Patient C spontaneously passed bloody decidual tissue containing immature chorionic villi.

1. Respondent inappropriately performed a dilatation and curettage and a tubal perfusion on Patient C during the second half of the menstrual cycle of Patient C who was trying to become pregnant.

2. Respondent failed to perform an appropriate preoperative evaluation of Patient C, including, but not limited to, a failure to determine Patient C's last menses, a failure to perform an appropriate pregnancy test on Patient C, and a failure to do preoperative blood work.

3. Respondent failed to perform an appropriate preoperative physical examination of Patient C, including, but not limited to, a failure to perform a breast examination, and a failure to perform an abdominal examination.

4. Respondent failed to obtain appropriate informed consent from Patient C for the operative procedures.

5. Respondent failed to appropriately monitor Patient C's postoperative recovery.

6. Respondent failed to obtain a pathological examination of Patient C's resected ovarian cyst.

7. Respondent failed to keep an adequate record for Patient C.

D. From on or about August 7, 1980 through on or about January 23, 1992, Respondent treated Patient D, a 31 year old (in 1989) female in his New York City offices for various medical conditions. On or about April 25, 1989, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On or about May 17, 1990, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D. On or about January 23, 1992, Respondent performed what he called a "fractional D&C" under general anesthesia on Patient D.

1. Respondent inappropriately called each of the three surgical procedures a "fractional D&C".

2. Respondent failed to perform an appropriate preoperative evaluation of Patient D for each of the three surgical procedures, including, but not limited to the failure to obtain preoperative blood work.

3. Respondent failed to obtain appropriate pathological examination of the tissue removed in each of the three surgical procedures performed on Patient D.

4. Respondent failed to appropriately monitor Patient D's postoperative recovery for each of the three surgical procedures.

5. Respondent failed to accurately and appropriately record the three operative procedures he performed on Patient D.

6. Respondent failed to keep an adequate record for Patient D.

E. From on or about March 1, 1983 through on or about November 8, 1993, Respondent treated Patient E, a 24 year old (in 1983) female in his New York City offices for various medical conditions. On or about May 30, 1989, Respondent performed a termination of pregnancy on Patient E. On or about February 24, 1990, Respondent performed a termination of pregnancy on Patient E. On or about January 26, 1993, Respondent performed a termination of pregnancy on Patient E. On or about August 7, 1993 Respondent performed an unidentified procedure on Patient E. On or about December 9, 1992, Respondent performed an artificial insemination procedure on Patient E.

1. Respondent failed to obtain an adequate history of

Patient E at her visit on or about March 1, 1983.

2. Respondent failed to conduct an adequate physical examination of Patient E at her visit on or about March 1, 1983.

3. Respondent failed to obtain pathologic examination of tissue removed from Patient E on or about February 24, 1990.

4. Respondent failed to keep an adequate record for Patient E.

F. From on or about July 27, 1990 through on or about June 16, 1994, Respondent treated Patient F, a 37 year old (in 1994) female in his New York City offices for various medical conditions. On or about September 9, 1992, Respondent performed a fractional dilatation and curettage and diagnostic/therapeutic laparoscopy under general anesthesia on Patient F.

1. Respondent failed to obtain an adequate history of Patient F at her initial visit on or about July 27, 1990.

2. Respondent failed to conduct an adequate physical examination of Patient F at her initial visit on or about July 27, 1990.

3. Respondent failed to obtain appropriate informed consent from Patient F before the September 9, 1992 surgery.

4. Respondent failed to appropriately monitor Patient F's postoperative recovery following the September 9, 1992 surgery.

5. On or about April 9, 1993, Respondent inappropriately performed a colposcopy and a colposcopically-directed cervical biopsy on Patient F that were not medically indicated.

6. Respondent inappropriately failed to record the colposcopic visual findings of the April 9, 1993 procedure on Patient F.

7. Respondent failed to keep an adequate record for Patient F.

G. From on or about November 8, 1984 through on or about July 1, 1994, Respondent treated Patient G, a 28 year old (in 1984) female, in his New York City offices for various medical conditions. In or about January 1985, June 1986, and December 1988, Respondent performed a first trimester abortion on Patient G. In or about 1984 Respondent began to prescribe the diuretic spironolactone for Patient G for complaints of premenstrual tension. In or about March, 1986, Respondent

began to prescribe Synthroid and Ionamin for Patient G for weight control. In or about 1988, Respondent began to prescribe Xanax for Patient G for anxiety. In or about January 1988, Respondent prescribed Retin-A for Patient G at her request. Patient G moved to Maryland, in or about January 1988, and has visited Respondent only four times since (once for an abortion). Patient G was last examined by Respondent in or about September 1990.

1. Following Patient G's 1988 move to Maryland, Respondent inappropriately issued prescription renewals by mail to her for the above-mentioned medications, without appropriate monitoring or supervision of Patient G.

2. Following Respondent's last examination by Respondent in or about September 1990, Respondent inappropriately issued prescription renewals by mail to her for the above-mentioned medications, without appropriately monitoring or supervision of Patient G.

3. Respondent failed to keep an adequate record for Patient G.

H. From on or about March 4, 1993 through on or about March 17, 1994, Respondent treated Patient H, a 47 year old (in 1993) female in his New York City offices for endometriosis and extremely painful dysmenorrhea. On or about April 28, 1993,

Respondent performed fractional dilatation and curettage, exploratory laparoscopy, lysis of pelvic adhesions, "second puncture laparoscopy" (sic), left ovarian cystectomy, bisection of uterosacral ligaments, tubal perfusion, and pelvic lavage procedures on Patient H, and started the patient on an extended course of prescription analgesic medications.

1. Respondent inappropriately prescribed a continuing course of controlled substances for Patient H, including Percocet, Dilaudid, Levo-Dromoran, and Demerol.

2. Respondent failed to obtain appropriate informed consent from Patient H before surgery.

3. Respondent failed to appropriately monitor Patient H's postoperative recovery.

4. Respondent failed to keep an adequate record for Patient H.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS
PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-9.
2. Paragraphs B and B1-6.

THIRD AND FOURTH SPECIFICATIONS
PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A and A1-9.
4. Paragraphs B and B1-6.

FIFTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

5. Paragraphs A and A1-9; B and B1-6; C and C1-7; D and D1-6; E and E1-4; F and F1-7; G and G1-3; and/or H and H1-4.

SIXTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraphs A and A1-9; B and B1-6; C and C1-7; D and D1-6; E and E1-4; F and F1-7; G and G1-3; and/or H and H1-4.

SEVENTH THROUGH EIGHTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct

as defined by N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by the ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient as alleged in the facts of the following:

7. Paragraphs G and G1-2.

8. Paragraphs H and H1.

NINTH THROUGH TENTH SPECIFICATIONS

PERFORMING UNAUTHORIZED SERVICES

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(26)(McKinney Supp. 1998) by performing professional services which have not been duly authorized by the patient or his or her legal representative as alleged in the facts of the following:

9. Paragraphs C and C4.

10. Paragraphs F and F3.

ELEVENTH THROUGH EIGHTEENTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

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

11. Paragraphs A and A9.

12. Paragraphs B and B6.

13. Paragraphs C and C7.

14. Paragraphs D and D5-6.

15. Paragraphs E and E4.

16. Paragraphs F and F6-7.

17. Paragraphs G and G3.

18. Paragraphs H and H4.

DATED: New York, New York
April 16, 1999

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

APPENDIX II
TERMS OF PROBATION

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

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

3. Dr. Lauersen shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

4. Dr. Lauersen shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of his compliance with the terms of this Order. Dr. Lauersen shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

6. Dr. Lauersen's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Dr. Lauersen and his staff at practice locations or OPMC offices.

7. Dr. Lauersen shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Dr. Lauersen shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Dr. Lauersen as may be authorized pursuant to the law.