STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

January 9, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anne H. Gayle, Esq.
& Marcia Kaplan, Esq.
NYS Department of Health
5 Penn Plaza - 6th Floor
New York, New York

Louis A. Piccone, Esq.
245 North Gannon Avenue
Staten Island, New York 10314

Safwat Attia Youssef, M.D.
410 Bard Avenue
Staten Island, New York 10310

RE: In the Matter of Safwat Attia Youssef, M.D.
Amended Decision and Order of the Hearing Committee, No. BPMC-02-191

Dear Parties:

Attached please find a new version of the Amended Decision and Order in the Youssef matter. Further examination after release of the former version revealed changes that had to be made. The two decisions can be distinguished by the date in the footer, January 9, 2003. Please destroy any versions of the Decision in your possession which do not have the January 9, 2003 footer.

Your inconvenience is sincerely regretted.

Sincerely,

JMB:djh
Enclosure

Jonathan M. Brandes, Esq.
Administrative Law Judge

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

COPY

IN THE MATTER

OF

SAFWAT ATTIA YOUSSEF, M.D.

AMENDED DECISION AND ORDER OF THE HEARING COMMITTEE

ORDER NO. BPMC 02___191__

The undersigned Hearing Committee consisting of **WILLIAM K. MAJOR, JR., M.D., CHAIRPERSON, DAVID HARRIS, M.D.,** and **REVEREND EDWARD J. HAYES** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, ESQ.,** Administrative Law Judge, served as Administrative Officer.

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

A Decision and Order in this matter, dated June 8, 2002, was issued by this Committee. Respondent appealed the Committee Decision and Order to the Administrative Review Board (ARB). In a Determination and Order (02-191), dated September 27, 2002, the ARB remanded this matter to the Committee for further proceedings. This Amended Decision and Order arises from the September 27 order of the ARB.

RECORD OF PROCEEDING

Notice of Hearing and Statement of Charges dated / served:	November 10, 2000
Notice of Hearing returnable:	December 6, 2000
First Amended Statement of Charges Dated:	January 9, 2001
Respondent's Answer Dated / Served:	December 26, 2000
Pre-Hearing Conference held:	January 11, 2001
90/120 days ends:	April 15, 2001 May 15, 2001
License Registration Number:	145667
License Registration Date:	April 03 1981
License Registration Expiration Date	
State Board PMC appeared by:	Anne H. Gayle, Esq., Associate Counsel Marcia Kaplan, Esq., Associate Counsel Division of Legal Affairs Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York 10001
Respondent represented on appeal by:	Anthony Z. Scher, Esq. Wood and Scher The Harwood Building Scarsdale, New York, 10583
Respondent's Present Address:	410 Bard Avenue, Staten Island, New York
Conferences Held	January 16, March 8, 22 and 23, 2001
Location of Hearing	5 Penn Plaza
Hearing Dates	January 16,17,18, 2001, March 8, 22, April 23, 24, July 10,11,17
State Rests	March 22, 2001
Respondent Rests:	July 17, 2001
Closing Briefs Due:	September 10, 2001
Closing Brief From State Received:	September 7, 2001
Closing Brief From State Received:	September 10, 2001
Closing Brief From Respondent Received:	September, 2001
Record Closed:	September 10, 2001
Deliberations Scheduled:	September 12 and 13, 2001
Deliberation on Remand Held:	November 12, 2002

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges twenty-eight grounds of misconduct:

SPECIFICATION NUMBER	SPECIFICATION DESCRIPTION
First	(3) negligence on more than one occasion
Second Through Ninth	(4) gross negligence
Tenth	(5) incompetence on more than one occasion
Eleventh	(6) gross incompetence
Twelfth through Sixteenth	(2) fraud
Seventeenth through Twenty-Fourth	(32) failure to maintain patient records
Twenty Fifth and Twenty-Sixth	(43) Failure to complete forms required for reimbursement
Twenty-Seventh and Twenty-Eighth	(31) willful harassment, abuse, or intimidation

The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

The State called these witnesses:

Judith J. Levine, M.D.	(01/16,17,18/01 3/08/01, 3/22)	Expert
Patient J	(03/22)	Fact
Patient J's Wife	(03/22)	Fact
Patient I	(03/23	Fact

Respondent testified in his own behalf and called these witnesses:

Geraldine Hosea, RN	March 23, 2001	Fact
Vincent A. Piccone, M.D.	March 23, 2001	Fact/Character
Marvin L. Shelton, M.D	April 23, July 11, and 17 2001	Expert
Ronald M. Selby, M.D.	April 24, 2001)	Expert

SIGNIFICANT LEGAL RULINGS:

INSTRUCTIONS

The following instructions were given to the panel by the Administrative Law Judge. The parties had received a copy of these instructions prior to the trial. The parties were invited to submit proposed instructions. None of the submitted instructions were accepted.

1. Negligence is the failure to demonstrate that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state. There is a distinction between a finding that an act demonstrates negligence and a finding that a particular physician is a negligent practitioner. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct demonstrates a failure to exhibit appropriate care and diligence. It is only in the final, or penalty stage of the proceeding that the Committee is called upon to make an overall judgement about the character of the Respondent's practice abilities. It is noteworthy that an otherwise prudent physician can commit an act of negligence due to a temporary aberration.

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

3. Incompetence can arise where a practitioner does not have the knowledge necessary to appropriately provide a given course of care and treatment. It may also arise where a practitioner has the requisite training and knowledge for a course of treatment but acts as if he or she does not have the appropriate level of training and knowledge.

4. As with the issue of negligence, there is a distinction between a finding that an act demonstrates incompetence and a finding that a particular physician is an incompetent practitioner. It is to be noted that an otherwise competent physician can commit an act of incompetence due to a lapse in judgement or other temporary aberration.

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

6. A finding of gross incompetence can be based upon a single act of incompetence of egregious proportions, or multiple acts of incompetence that cumulatively amount to egregious conduct.

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

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

9. There are some issues which reasonable minds may consider to be non-medical in nature. Such issues include, but are not limited to, patient cost, patient inconvenience, patient discomfort, anticipated patient compliance and other relevant issues. The prudent, competent physician is expected to consider these questions as they relate to the individual episode of medical care.

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

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

12. Patient harm need never be shown to establish negligence or incompetence in a proceeding before the Board For Professional Medical Conduct.

13. The New York State Education Law, Section 6530, subdivision (32) requires a physician to "maintain a record for each patient which accurately reflects the evaluation and treatment of the patient...." The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given entry or set of entries and be able to understand a practitioner's course of treatment and the basis for same.

14. The findings of fact in this decision were made after review of the entire record. Numbers in parentheses (T._) refer to transcript pages or numbers of exhibits (Ex._) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony may have been rejected as irrelevant.

15. The standard of proof in this proceeding is "preponderance of the evidence." This means that the State must prove the elements of the charges to a level wherein the trier of fact finds that a given event is more likely than not to have occurred. All findings of fact made herein by the Hearing

Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

16. The Committee was instructed that in deciding this case, the members may consider only the exhibits which have been admitted in evidence, and the testimony of the witnesses as it was heard in this hearing.

17. The Committee was instructed that remarks of the attorneys or the Administrative Law Judge are not evidence.

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

19. Character evidence is testimony by Respondent or others regarding the overall character or reputation of a Respondent. Character evidence may include a description, of a Respondent's appointments to various positions and his/her various accomplishments.

20. Character evidence cannot be considered when deliberating whether or not the acts alleged were proven. Nor can character evidence be considered with regard to whether the acts proven constitute medical misconduct as charged.

21. Where the Committee makes a finding of misconduct, the Committee members may, but need not, consider character evidence when determining what, if any, penalty to impose.

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

23. The standard for moral unfitness in the practice of medicine is twofold: First, there may be a finding that the accused has violated the public trust which is bestowed upon one solely by virtue of earning a license to practice medicine in this State. Physicians have privileges that are available to them solely due to the fact that one is a physician. The public places great trust in physicians based solely upon the fact that they are physicians. For instance, physicians have access to controlled substances and billing privileges that are available to them solely because they are physicians. Patients are asked to place themselves in potentially compromising situations with physicians, such as when they disrobe for examination or treatment. Hence, it is expected that a physician will not violate the trust the public has bestowed upon them by virtue of their professional status.

24. Moral unfitness can also be seen as a violation of the moral standards of the medical community. The Committee, as delegated members of that community, represent it. Therefore, their collective consideration constitutes a reflection of the moral standards of their community.

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

a.) In the practice of medicine, a false representation is made by Respondent, whether by words, conduct or concealment of that which should have been disclosed accurately;

b.) Respondent knew the representation was false; and

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

26. Where fraud is alleged, Respondent's knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences and the basis for the inference.

27. The Committee was instructed that they could use the ordinary English definitions of the terms "physical harassment, abuse, or intimidation".

28. The Committee was instructed that if it is found that any witness has willfully testified falsely as to any important matter, the law permits the trier of fact to completely disregard the entire testimony of that witness. This concept is based upon the principle that one who testifies falsely about one important matter is likely to testify falsely about everything. The Committee was told that they are not required, to consider a witness who has testified falsely as to one important matter as totally unworthy of belief. The trier of fact may accept so much of the testimony of the witness as is deemed true and disregard what they find to be false.

29. The Trier of Fact was told they are the sole judges of the facts. They decide which of the witnesses they will believe, what portion of their testimony will be accepted and what weight it will be given.

30. The Committee was further instructed that occasionally, the weight to be given evidence is a matter of Law. The Committee was instructed that in such a case, the Administrative Law Judge would issue specific instructions to them.

31. Proposed instructions were submitted by both parties. All proposed instructions were considered by the Administrative Law Judge. Instructions which were found to be consistent with the interpretation of the law held by the Administrative Law Judge were included in the above instructions. Those which were redundant or inconsistent with the interpretations by The Administrative Law Judge were considered and rejected.

FINDINGS OF FACT

GENERAL FINDINGS

1. Safwat Attia Youssef, M.D., the Respondent, was authorized to practice medicine in New York State on April 3, 1981, by the issuance of license number 145667, by the New York State Education Department. (Dept's Ex. 2)

2. To be consistent with minimum standards of care, all physicians, including orthopaedists, must make a written record of the patient's history at the initial office visit. Such a history must include the following to meet the minimum standard of care:

A. The patient's chief complaint

B. The duration of the complaint
C. Any past treatment, especially procedures relevant to the same body
D. A social and family history as is relevant to the particular complaint.

3. At the initial visit, the practitioner may rely upon recent findings by other medical personnel in the patient's record. However, if the prior findings are relied upon, the new practitioner must so state in the patient record. (T. 51-53, 134-137, 775-776)

4. Minimum standards of care require that a history should be taken and noted in the patient's chart. At subsequent visits, there should be an interim history or notes of any changes since the previous visit or treatment. (T. 51-53, 134-137, 775-776)

5. To meet the minimum standard of care for an orthopedic visit, a full and comprehensive physical examination, at least of the body part involved, must be done. (T. 52-54, 135)

6. To meet the minimum standard of care, a physical examination must be done by the orthopedist at subsequent visits. The practitioner must make a record of the interim examination. The interim examination does not have to be as complete as the initial examination. (T. 52-54, 135)

7. All physical examinations performed by an orthopedist, both the initial examination and subsequent examinations must be noted in the patient's chart. (T. 52-54, 135)

8. Minimum standards of care require that a comprehensive orthopedic examination includes the following:

A. A detailed description of the relevant body area by observation;
B. A description of any tenderness or problem upon palpation;
C. A description of the patient's range of motion with an indication of whether or not it was comfortable or associated with pain or could be done passively or actively.
D. A brief description of the neurovascular status of the body part in issue.

E. An examination of the musculoskeletal, vascular, and nervous systems, and the skin.

9. Where a physician files a bill for a comprehensive rather than a routine examination, notation of the above is particularly important. (T. 499-501, 1403-1405)

10. In the record of an immediate postoperative visit, particularly before the patient might be allowed any motion, there should be a description of the wound.

11. For the period of time that the physician found it was inappropriate to put the patient through an active or passive range of motion, a range of motion examination need not be performed.

12. In subsequent visits to the patient, as healing progresses, there should be a notation of range of motion examinations.

13. To meet the minimum standard of care, there should be a stated impression and a plan for care. (T. 53, 135-136)

FINDINGS OF FACT WITH REGARD TO PATIENT A

14. Respondent treated Patient A, a male, date of birth 2/17/30, at his office, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for osteoarthritis of the right and/or left knee, from approximately July 19, 1989 to October 17, 1991. There may have been additional treatment. (Dept's Ex. 3, 4, 5, 6, 7, 8, 8a, 8b, 8c, 8d, 8e, 8f, 8g, 9, 82)

15. On May 16, 1991, Patient A's presenting problem was a painful left knee. The condition was described as grinding, giving way, and locking. (Ex. 3, p. 19, 41, Ex. 4, p. 8, Ex. 5, p. 4) (T. 55-59, 148-151, 170)

16. An MRI was performed approximately six months prior to the May 16 visit. To meet minimal standards of medical care, the MRI should have been referred to in the record of the patient's first visit. (Ex. 3, p. 19, 41, Ex. 4, p. 8, Ex. 5, p. 4) (T. 55-59, 148-151, 170)

17. Respondent made no mention of this MRI or any other tests which may have been performed prior to May 16. (Ex. 3, p. 19, 41, Ex. 4, p. 8, Ex. 5, p. 4) (T. 55-59, 148-151, 170)

18. To meet minimum acceptable standards of care, a more complete patient history was required.

19. Respondent's record for this patient mentions a previous arthroscopy in January by a Dr. Bonamo. There is also a mention of an MRI. However, there was no discussion of the procedure in Respondent's record. In addition, there is no mention of any tests performed in preparation for the Bonamo procedure.

20. To meet the minimum standards of care, an extensive consideration of the previous arthroscopy, which gives information about the objective tests that were performed, should have been undertaken and recorded in the patient record.

21. When a patient gives a history of a recent procedure done by another physician, it is the responsibility of the subsequent physician to obtain either a full copy of the record or at least conduct a full discussion of the prior treatment with the prior physician.

22. If, after due diligence, the information about the prior treatment cannot be obtained, at the very least, there must be documentation in the chart to establish that the effort was made.

23. To meet the minimum standards of care, a physician must set forth the basis for any surgical decision in the patient's record.

24. To meet the minimum standards of care, the patient record must include a summary of any discussion with the patient regarding what the possible procedure will be and why it should be done. (Ex. 3, p. 19, 41, Ex. 4, p. 8, Ex. 5, p. 4) (T. 55-59, 148-151, 170)

25. Respondent failed to do either. (T. 174-176, 179-180)

26. Patient A's next visit to Respondent was on May 20, 1991. Respondent's note states that the patient had an effusion (fluid in knee joint). The record further indicates that an aspiration of the knee (removal of fluid) was performed. No further explanation or discussion of the relevant medical issues appears in the record. (Ex. 4, p. 9) (T. 59-60)

27. The failure to provide a basis for Respondent's treatment of this patient is a violation of minimum standards of care. (Ex. 4, p. 9) (T. 59-60)

28. The plan set forth in the patient record states, "will need Coventry osteotomy". To meet the minimum acceptable standards of care, Respondent must have recorded the reason for his choice of the Coventry osteotomy. (Ex. 3, p. 19, 41, Exh. 4, p. 8, Exh. 5, p. 4) (T. 55-59, 148-151, 170)

29. A Coventry osteotomy is used to correct a varus deformity (bowleggedness) or a valgus (knock-kneed) problem by bringing the knee back into a more appropriate alignment. (EX. 3-9) (T162-163, 1275, 1330-1331[1], 1369-1375)

30. A Coventry osteotomy could be done in place of a total knee replacement in limited circumstances. A Coventry osteotomy is indicated for unicompartmental disease, where only one of the three described compartments of the knee is involved. It's not indicated where there is bi-compartment or tri-compartment disease.

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[1]The transcript read (on page 1330, lines 24-25) "unique compartmental disease"; it should have read "unicompartmental disease"; page 1331, lines 4-5 read "any compartmental disease"; it should have read, "unicompartmental disease".

31. The Coventry osteotomy is usually used in patients younger than Patient A. However, if it is documented that a patient of Patient A's age had unicompartmental disease, the Coventry could be justified. (Ex. 3-9) (T162-163, 1275, 1330-1331, 1369-1375)

32. Under accepted standards of medical practice, arthroscopy is done:

A. To investigate and examine the state of a knee;
B. To perform a debridement.

33. Under minimum accepted standards of care, an arthroscopy is not necessary for an orthopedic surgeon to determine whether to perform a total knee replacement or an osteotomy.

34. Under minimum accepted standards of care, the MRI, the X-ray films, and the complaints of Patient A are sufficient to decide whether a knee replacement or an osteotomy is required.

35. Respondent made no effort to obtain the relevant information from the practitioner who had performed the arthroscopy. (Ex. 6) (T. 60-64, 90-94, 107-109, 161-162, 171)

36. On June 7, 1991 Respondent performed an arthroscopy. Subsequent to the arthroscopy of June 7, 1991, Respondent continued to treat Patient A.

37. Based upon Respondent's records, the follow-up visits did not meet minimum standards of care:

A. The June 10, 1991 record merely states that the patient was doing very well. There was no physical examination recorded;

B. The June 19, 1991 visit is also lacking in any description of an examination and objective findings or conclusions. (Ex. 4, p. 11) (T. 64-66)

38. On June 21, 1991, Patient A was admitted to St. Vincent's Medical Center of Richmond where Respondent performed a total knee replacement.

39. Within five days of the total knee replacement, performed by Respondent, it was necessary to change the prosthesis parts. (Ex. 7) (T. 66-69, 78-81, 163-165, 173-174, 1331-1342, 1375-1378-1381, 1387-1389)

40. Respondent billed for his care and treatment of Patient A as follows:

A. Respondent billed for a left total knee replacement;

B. A medial and lateral meniscectomy of the left knee;

C. Arthroscopy with total synovectomy left knee.
(Ex. 3, p. 16) (Ex. 7) (Ex. 80, p. 24, 26, 28) (T. 83-86, 180)

41. Since the meniscectomy and synovectomy were done as part of the total knee replacement, everything should have been billed as a total knee replacement and not billed as 3 separate procedures. (Ex. 3, p. 16) (Ex. 7) (Ex. 80, p. 24, 26, 28) (T. 83-86, 180)

42. Respondent billed for 11 inpatient visits for the period June 22 through July 2, 1991. In fact, Respondent visited the patient only 7 times:

A. 6/22 (Ex. 3, p. 15)

B. 6/25 (Ex. 3, p. 15)

C. 6/27 (Ex. 3, p. 18)

D. 6/28 (Ex. 3, p. 18)

E. 6/29 (Ex. 3, p. 18)

F. 7/1 (Ex. 3, p. 19)

G. 7/2 Ex. 3, (p. 19).

43. Respondent additionally billed for a revision of a total knee arthroscopy. (Ex. 3, p. 13)

44. There are three components involved in a revision of a total knee arthroscopy: a femoral component, a tibial component which has two parts to it, and a patella component. (Ex. 3, p. 13) (Ex. 7, p. 33) (Exh. 80, p. 27) (T86-87, 180-181)

45. In the surgery performed by Respondent he did not meet acceptable standards because:

A. The femoral component was not changed, it was removed;

B. Other bony work was done, but it was then replaced;

C. Just one of the parts of the tibial component was replaced

D. Nothing was done to the patella component. (Ex. 3, p. 13) (Ex. 7, p. 33) (Ex. 80, p. 27) (T86-87, 180-181)

46. The bill submitted by Respondent represented that all the components were replaced. The bill was therefore false. (Ex. 3, p. 13) (Ex. 7, p. 33) (Ex. 80, p. 27) (T. 86-87, 180-181)

47. Respondent billed for one inpatient visit on June 8 th. Patient A was not in the hospital on June 8th. He was discharged on June 7, 1991, at 7:30 p.m. (Ex. 3, p. 33, Ex. 6, p. 3, 24, 37, 38, 39) (Ex. 80) (T. 87-90, 181-182, 192)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT A

Allegation A.1 alleges Respondent performed unnecessary arthroscopic surgery on Patient A. Respondent does not deny he performed an arthroscopy on Patient A. However, he argues that the procedure was necessary and prudent. The Committee disagrees. Respondent's record for this patient mentions a previous arthroscopy performed in January by a Dr. Bonamo. There is also a mention of an MRI. However, there was no discussion of these tests in Respondent's record. In addition, there is no mention of any tests performed in preparation for Bonamo procedure. There is no reason to think Respondent consulted with Dr. Bonamo at all.

The arthroscopy performed by Respondent was unwarranted and unnecessary because one had already been performed and an MRI of the location existed. Had Respondent some reason to doubt the

findings of the prior physician or the quality of the MRI, or if the prior physician was uncooperative, all Respondent was required to do was to enter a note in the patient record. Respondent made no notation at all regarding a consultation with the prior physician or a request for a copy of the patient's file. The failure to consult with a prior physician is a serious violation of accepted standards of medical practice. Patient A had to endure a medical procedure, with all the inherent discomfort and risks, which was unnecessary.

In the facts associated with this charge, we begin to see a pattern of sloppy, and negligent medicine which will continue to develop as each charge is discussed.

Therefore,
Allegation A. and A.1. is SUSTAINED

In Allegation A.2., Respondent is charged with the failure to recognize and correct a misalignment of the patient's knee. The patient needed subsequent surgical correction. The State argued that where a subsequent surgery is required, it is proof that the initial treatment was not successful. However, even the State's expert testified that good doctors sometimes have bad results. Therefore, a subsequent surgery is not, in and of itself, evidence that a surgeon has made an error. Other than the stated strategy, the State had no actual evidence that Respondent's initial surgery did not meet accepted standards.

Therefore,
Allegation A.2. is <u>NOT</u> SUSTAINED

Allegation A.3. asserts Respondent failed to date or have the patient X-Rays dated. The Committee finds insufficient evidence to convince them that Respondent was the person responsible for dating the films.

Therefore,
Allegation A.3. is <u>NOT</u> SUSTAINED

In Allegation A.4., the Committee is asked whether Respondent appropriately billed for the services provided to Patient A. The Committee finds clear evidence that Respondent did not bill appropriately for the services received by this patient.

It has been established that Respondent billed for the total knee replacement and then billed separately for each of the procedures included in the total knee replacement. Accordingly, Respondent billed twice for his treatment of Patient A. Furthermore, Respondent billed for more after care visits than the total number he provided.

As to matters addressed in testimony by Respondent, the Committee found Respondent to be evasive in his answers. Furthermore, the Committee notes that Respondent did not testify about Patient A. Therefore, the Committee has applied the negative inference rule. This rule holds that where a Respondent refuses to testify in an Administrative Law proceeding, the trier of fact may (but need not) infer the most negative conclusion that the established evidence supports[2]. Therefore, as to those matters wherein Respondent did not testify, the Committee infers that if Respondent had testified truthfully, his answers would not have established supportive testimony regarding the billing allegations. Therefore, the Committee concludes that Respondent did not commit an error in his billings but rather billed with intent to falsify his claims to obtain unwarranted profits.

Therefore,
Allegation A and A.4. and A.4.a. is SUSTAINED

The gravamen of Allegation A.4.b. is that Respondent billed for services to Patient A separately for each hospital visit. Payment for these visits were included in the global payment he received for the procedure. Therefore it was alleged that Respondent double billed for at least some of his postoperative visits. The Committee does not sustain this charge.

The Committee recognizes that in surgery many procedures include aftercare visits. Therefore, when a practitioner bills for a procedure, he is paid both for the actual surgery plus a certain number of after-care visits. In this case however, the State did not establish precisely how many aftercare visits were included in the charge for the procedure. It follows that the Committee would be guessing how many, if any, of the 11 aftercare visits were paid for in the global fee for the surgery.

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[2](See *DeBonis v. Corgisiero*, 155 A.D.2nd 299, 547 N.Y.S.2nd 276 and 279 citing *Baxter v. Palmigiano* 425 U.S. 308 (1976)

The States's expert was able to explain the overall billing and payment system, but she was unable to be specific with regard to how many aftercare visits were included in the charge for this procedure. Furthermore, since each time the universal billing codes are published (annually), the associated number of after-care visits for a given surgical procedure may differ. The State's witness could not base her answer on the recognized billing codes today. The Committee needed to know what was included at the time the procedure was performed. The State did not provide such information.

Therefore,
Allegation A.4. and A.4.b. is NOT SUSTAINED

In Allegation A.4.c., Respondent is cited for submitting a bill for a hospital visit on a day after the Patient had been discharged. The Committee has previously set forth conclusions regarding Respondent's lack of testimony regarding Patient A, and his tendency to be evasive in other testimony. Consistent with those conclusions, the Committee finds Respondent did not submit a bill for the June 8 hospital visit in error. While Respondent was in the hospital on June 8 and did sign one of the post-discharge documents on June 8, he also knew that a visit to the institution at which one merely signs a routine document, does not constitute a billable patient visit.

Therefore,
Allegation A. and A.4. is SUSTAINED
Allegation A and A.4.c. is SUSTAINED

Finally, in Allegation A.5., Respondent is accused of failing to keep an appropriate record for this patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given entry or set of entries and be able to understand a practitioner's course of treatment and the basis for same. The Committee finds that for each of the patients in this case, by any reasonable interpretation of the guidelines set forth in Section 6530 (32) of the Education Law, Respondent kept substandard patient records. In fact, the clinical files kept by Respondent were virtually vacant. It is not possible for a present practitioner to understand the prior treatment for any of the patients listed in this proceeding.

At one point Respondent offered the defense that he only records "positive findings." Therefore, if the record was blank, that meant all was normal for that patient. However, in some of the files offered in this matter, both positive and negative remarks appear.

It is the conclusion of this Committee that Respondent was aware of and understood appropriate record keeping standards. However, he was apparently of the opinion that record keeping was for others, but not for him. A majority of the committee finds Respondent was demonstrating arrogance in his choice to fail to keep minimally acceptable records. Furthermore, in his failure to keep virtually any patient records, Respondent was demonstrating contempt for the statutes and regulations promulgated by the State. Apparently, in Respondent's view, such standards do not apply to him.

Therefore,
Allegation A and A.5. is SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT B

48. Respondent treated Patient B, a then 51 year old female, at his office, located at 410 Bard Avenue, Staten Island, New York, for thumb pain and soft tissue swelling. This patient was seen from approximately February 4, 1991 to February 13, 1991. (Dept's Ex. 10, 11, 61) (Resp's Ex. 1007, 1012)

49. Respondent first treated Patient B on February 4, 1991. At the time of this first office visit, Patient B complained of Right thumb pain.

50. The medical history taken by Respondent, consists of a single line: "[Patient] complaining of swelling of right thumb and pain" (Ex. 10) (T. 203-204, 216-217, 270-272)

51. Neither a family history nor a social history were taken. (Ex. 10) (T. 203-204, 216-217, 270-272)

52. A single blood uric acid value is not in and of itself sufficient to establish a diagnosis of gout; the other clinical features in either history or physical which ought to be present to make a presumptive diagnosis of gout are the duration of the symptoms, whether anything had been done to treat them, possibly multiple blood tests and in the case of gout at a joint, either x-ray findings and/or aspirations to see if anything can be found. (Ex. 10) (T. 203-204, 216-217, 270-272)

53. The physical examination recorded by Respondent states "swelling of right thenar eminence, tender ++". Such a sparse statement does not constitute a physical examination consistent with the minimum standards of care.

54. Accepted standards of practice dictate that after the examination at the February 4 visit, the patient record should include:

A. Specific reference to the joint and a notation of which joint is referred to;

B. Whether or not there was any tenderness specifically at that joint;

C. Active and passive range of motion should also have been recorded;

D. An examination of the joint.

(Ex.10, p. 3, Ex. 11, p. 1) (T. 204-207, 261-262, 264-268, 273)

55. Respondent failed to do such examinations or make any such notations. No diagnosis or differential diagnosis was made of this patient at this first visit. (Ex.10, p. 3, Ex. 11, p. 1) (T. 204-207, 261-262, 264-268, 273)

56. At the first visit, Respondent ordered four laboratory tests. The patient was compliant. The results of the four laboratory tests were:

A. The sedimentation rate was elevated, but could have been elevated for many reasons such as a cold, infection, tumor, injury, or cough;

B. The uric acid, which was 6.8, was within the normal limits for the reference range of that laboratory, *i.e.*, 3 to 9;

C. The ANA was negative

D. The latex fixation for rheumatoid arthritis was negative. (Ex.10, p. 6-7, Ex. 1007, p.167-169) (T. 207-209, 215-216)

57. Patient B returned to Respondent's office on February 13, 1991. Minimum accepted standards of medical practice require Respondent to have recorded a history for the period since the last visit. Such a history must have described any changes in the condition of this patient during the period since the previous visit. The record is silent as to any change in the condition of this patient. (Ex.10, p. 4, Ex. 11, p. 2) (T. 209-210, 268-270)

58. To meet the minimum accepted standards of medical practice, a diagnosis or differential diagnosis should have been made and recorded at this visit, but it was not. (Ex.10, p. 4, Ex. 11, p. 2) (T. 209-210, 268-270)

59. At the second visit on February 13, 1991, Respondent prescribed Allopurinol for this patient to be taken over a four week period. Respondent prescribed the medication but did not record any diagnosis whatsoever. (Ex.10, p. 4, Ex. 11, p. 2, Ex. 1007, p. 165) (T. 210-212, 214-215, 244-248, 256)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT B

In Allegations B., B.1 and B.2., Respondent is alleged to have failed to take and record an adequate history for this patient (B); and to have failed to take and record an adequate physical examination of this patient. It would suffice to say that this record is as devoid of information as those submitted in regard to Patient A. Furthermore, a majority of the Committee finds that the history and physical examination were not performed as opposed to them having been performed and not recorded.

Therefore,

Allegations B. and B.1. are SUSTAINED
Allegations B. and B.2. are SUSTAINED

In Allegations B, B.3., B.4., and B.5., Respondent is charged with

(a) A failure to appropriately diagnose Patient B's malady;
(b) Performing inappropriate and incorrect treatment;
(c) Inappropriately and incorrectly prescribing Allopurinol.

The Committee does not sustain these charges. The fact is that Respondent recorded no diagnosis whatsoever. He never recorded his findings or conclusions. He leaves open the question whether his treatment was based upon any objective findings. The Committee finds it cannot fairly evaluate what does not exist. The Committee does not in any way endorse the care given to this patient. However, there is an insufficient amount of information for the Committee to sustain the charges as drafted.

Therefore,
Allegations B. and B.3. are NOT SUSTAINED
Allegations B. and B.4. are NOT SUSTAINED
Allegations B. and B.5. are NOT SUSTAINED

Allegation B. 6 charges Respondent did not keep an appropriate record for Patient B. The Committee has already cited the various violations of accepted standards of medical practice in the record of this patient. Once again, Respondent explains nothing and does not integrate the test results with his choice of treatment. The complete paucity of information requires future practitioners and reviewing bodies to infer the basis for Respondent's treatment. This is a clear violation of accepted minimum standards for medical records.

Therefore,
Allegations B. and B.6. are SUSTAINED

FINDINGS OF FACT WITH REGARD TO PATIENT C

60. Respondent treated Patient C, a female, born on July 20 1956, at his office, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York From approximately December 2, 1992 to September 6, 1994. (Ex. 14, 15, 16, 17, 19, 83, 83a, 83b, 83c, 83d, 84, T. 1010, 1013)

61. Respondent's care was directed at a left hip fracture-dislocation involving a severe acetabulum fracture, and various other complaints. (Ex. 14, 15, 16, 17, 19, 83, 83a, 83b, 83c, 83d, 84, T. 1010, 1013)

62. There is no handwritten version of Respondent's notes for this patient. (Ex. 14, 15, 16, 17, 19, 83, 83a, 83b, 83c, 83d, 84, T. 1010, 1013)

63. On December 2, 1992, Patient C was admitted to St. Vincent's Medical Center of Richmond following a motor vehicle accident. At the time of her admission, Patient C suffered from multiple pelvic fractures, lower back and left leg pain. She also displayed decreased range of motion at her left hip and at the left knee. (Ex. 14, p. 2, Ex. 15, p. 20-22, 25, 81-82, 94, 105) (T. 279-286, 332-333, 374-376, 1250-1255)

64. Respondent became involved in the case when an orthopedic consultation was requested by another physician. (Ex. 14, p. 2, Ex. 15, p. 20-22, 25, 81-82, 94, 105) (T. 279-286, 332-333, 374-376, 1250-1255)

65. Patient C's injury was quite severe and complex. An orthopaedist practicing consistent with generally accepted medical standards would subject all the available information to careful thinking and planning. Some of the issues to be considered and decided were:

A. Whether to perform the surgery in one procedure or two;

B. Whether the surgery needed to be done from the front or the back;

C. Which way to go first;

D. The anticipated goals of any part of the procedure

E. Accepted standards of medicine require that each of these considerations be reflected in a detailed pre-operative note.

(Ex. 14, p. 2, Ex. 15, p. 20-22, 25, 81-82, 94, 105) (T. 279-286, 332-333, 374-376, 1250-1255)

66. Respondent failed to make such entries. (Ex. 14, p. 2, Ex. 15, p. 20-22, 25, 81-82, 94, 105) (T. 279-286, 332-333, 374-376, 1250-1255)

67. Respondent planned to perform an open reduction and internal fixation in two parts on December 4, 1992 and December 9, 1992. There is no record of the basis for this decision. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

68. On December 31, 1992; Respondent inserted a Steinmann pin in this patient. A Steinmann pin is used for traction. The pin was inserted in the operating room under general anesthesia. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

69. Customarily, this type of procedure is performed using a local anesthetic in the patient's room, an orthopedic cast room, or a treatment room. General anesthesia in the operating room is usually not used to install a Steinmann pin because this procedure is considered very minimal. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

70. Generally accepted standards of medicine lean toward the use of local anesthesia as opposed to general anesthesia. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

71. General anesthesia has risks that must be considered prior to its use. These risks include:

A. Systemic harm which could be more serious than the placement of the pin.

B. The procedure is brief. Therefore the period of time needed to administer the general anesthesia and re-awaken the patient may be far greater than the time the needed to perform the procedure.
(Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

72. A properly given conduction anesthetic can anesthetize every effected part of the body except the bone and some of the periosteum. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

73. To meet the minimum accepted standards of care, where a patient requests general anesthesia for the placement of the pin, the physician should discuss it with the patient to see that the patient is advised of the risks. If the patient insists upon general anesthesia, there must be documentation in the chart to memorialize that the physician advised against it and patient insisted upon the use of general anesthesia. Respondent made no such notation. (Ex. 15, p. 106) (T. 291-294, 352-353, 356, 359-361, 365, 368-372, 376-377, 380-381, 1206)

74. Respondent's office note of May 24, 1993 indicates a plan for right elbow x-rays. There were no entries in the chart indicating that Patient C made any complaints about her elbow. (Ex. 14, p. 13) (T. 1583-1584)

75. Respondent's chart notes are inconsistent with radiological and other studies. Respondent's notes reflected better outcomes than the x-rays revealed:

A. Respondent's notes described better anatomic position at the hip joint than was seen upon review of x-rays. Two intra-operative x-rays showed persistent central protrusion of the femoral head and no concentric hip joint.

B. The intra-operative x-ray identified as "stage two" showed that the femoral head was not reduced under a concentrically fixed and reduced acetabulum.

C. The x-ray labeled "Portable pelvis" and dated December 26th, showed a mal-position in that the femoral head was persistently displaced with persistent displacement of the acetabular fragments.

D. The x-ray revealed that the femoral head appeared to be moving medially, or had moved medially with those fragments

E. Further studies established that the femoraL head was not sitting under the acetabular roof.

76. Respondent's operative report, states that there was "good position." However, this is contradicted by the x-rays.

77. Respondent's operative report from the first surgery performed on December 4, 1992 indicated that he could not align the acetabulum appropriately, therefore, he would do a second operation. (Ex. 14, p. 7)

78. Following the second surgery on December 9, 1992, Respondent wrote in his operative report, "This ensured proper alignment of the acetabulum and proper internal fixation." (Ex. 14, p. 7)

79. Subsequently, on December 30, 1992 Respondent states "Consequently the good result which was obtained her second surgery had not kept and the head of the femur pressed on the repair of the open reduction of left acetabulum and she got subluxation of the head of the femur and ½ shortening of the left lower limb." (Ex. 14, p. 7)

80. Respondent's notes are inconsistent with radiological evidence. There was no x-ray confirmation that the femoral head was indeed within the acetabular cavity after the second operation. (Ex. 14, p. 7) (Ex. 15, p. 94, 105) (Ex. 84) (T. 318-325, 333-338, 366, 376, 1552-1553, 1571, 1593-1613)

81. Respondent attributed the damage to the patient's hip to the use of crutches and unauthorized walking by the patient. There was no documentation anywhere in the chart that the patient did walk against orders. (Ex. 14, p. 7) (Ex. 15, p. 94, 105) (Ex. 84) (T. 318-325, 333-338, 366, 376, 1552-1553, 1571, 1593-1613)

82. Respondent's note for 6/2/93 on page 14 of Exhibit 14 does not meet the minimum standard of care. The note includes a date, the length of time since the total hip replacement, but does not give any information from the patient about her condition. (Ex. 14, p. 14) (T. 316-318)

83. The only note about examination states the range of motion and it gives two numbers. It does not say what plane those were in. When describing hip range of motion, there is flexion, extension, internal and external rotation, possibly both in flexion and extension, as well as abduction and adduction. Therefore, a note consistent with accepted medical standards should have recorded a minimum of six and possibly eight range of motion results.(Ex. 14, p. 14) (T. 316-318)

84. There was no indication of a neurovascular status of the limb. The note also says "XRAY showed excellent result" however there are no details about the hip joint, or the fixation, or the prosthesis. (Ex. 14, p. 14) (T. 316-318)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT C

In Factual Allegation C.1., the State alleges Respondent did not make and record a detailed pre-operative note. Findings of Fact 65 through 67 establish that the allegation is true. Once again, Respondent shows his pattern of failing to produce even a sparse note. There are virtually no relevant pre-operative comments. In order to establish the considerations Respondent relied upon, one had to study the procedures actually performed and then intuit what Respondent had been thinking.

The Committee has already discussed the standards for record keeping in this state. By any reasonable study of the patient record herein, it would be virtually impossible to find that Respondent kept notes sufficient to allow another physician or reviewing body to understand what he did and why he did it.

Therefore,
Allegations C. and C.1 are SUSTAINED

Allegations C.2. was withdrawn

The Committee next turns its attention to Allegation C.3. The outcome was not unanimous. The majority agreed with the State that absent careful documentation to the contrary, general anesthesia is unwarranted for the placement of a Steinmann pin. Respondent defended his choice to use general anesthesia by stating the patient was non-compliant with his orders; that she was difficult and had psychiatric disorders. However, this explanation is after the fact: Respondent did not state anywhere in the record that why he was using general anesthesia. Furthermore, objective evidence, the psychiatric follow-up report of 12/15/92 found Patient C to be "calm, cooperative,... more relaxed, non tearful, denies suicide/homicidal and any formal thought disorder and with good insight and judgment, and satisfactory impulse control". In addition, the nursing notes for the period prior to the surgery show no observations that the patient is disturbed or non-compliant.

The Committee finds that in this case, as in others, Respondent was not truthful. The Committee concludes Respondent was more interested in protecting himself at this proceeding than he was in reporting the actual facts. The Committee did not find Respondent to be a credible spokesperson.

Therefore,
Allegation C and C.3. are, by a 2 to 1 vote, SUSTAINED

In Allegation C.4., Respondent is charged with failure to accurately reflect the condition of Patient C. The allegation refers to the radiological and other studies and asserts that Respondent's notes were not consistent with the objective evidence. Therefore Respondent's notes were inaccurate. The Committee finds that the State has established this allegation.

As set forth in Statement of Fact 77 et al, the limited notes written by Respondent spoke of much better conditions than those shown in the x-rays and other studies, which are objective information. Respondent lost further credibility. The notes he wrote were, once again, designed to make him seem successful rather than efforts at reports of objective findings.

Therefore,
Allegation C and C.4. are SUSTAINED

Allegation C.5. asserts Respondent performed a fourth, unnecessary surgery on Patient C. The Committee finds the State has not presented sufficient proof to sustain this charge. There can be no question that a fourth operation was necessary for this patient. Indeed, the State's other allegations point toward conditions requiring further surgical attention.

The Committee finds that the only question raised by the fourth procedure, was one of timing. After the third procedure, how much time would minimum accepted standards of medicine require the competent prudent practitioner to wait before going on with a subsequent procedure? The Committee finds the State did not answer this question. Consequently, this charge cannot be sustained.

Therefore,
Allegation C and C.5. are NOT SUSTAINED

Allegations C.5.a. was withdrawn

Allegation C.6. charges Respondent with inappropriately planning for an X-Ray of Patient C's right elbow. The Committee finds that the State did not establish that the X-Ray was, in and of itself, inappropriate. The State established that there was no reason given for the X-ray. However, the failure to justify a plan does not establish that the plan was inconsistent with accepted standards of medical practice. The Committee cannot sustain this charge as drafted.

Therefore,
Allegation C. and C.6. are NOT SUSTAINED

Finally, in Allegation C.7., the State again charges Respondent with maintaining substandard records. As has been pointed out in the discussion of other charges arising from the care and treatment of Patient C, Respondent continued his pattern of failure to record essential information.

Therefore,
Allegation C. and C.7. are SUSTAINED

FINDINGS OF FACT
ARISING FROM THE CARE AND TREATMENT
OF PATIENT D

85. Respondent treated Patient D, a female, born November29, 1953, at his office, located at 410 Bard Avenue, Staten Island, New York. He also treated this patient at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, as well as at Doctors Hospital of Staten Island, 1050 Targee Street, Staten Island, New York, from approximately May 25, 1988 to August 17, 1989. The patient was seen for right shoulder pain and dislocation,(Dept's Ex. 20, 21, 22, 23, 24, 25, 88, 89)

86. Patient D first visited Respondent was on May 25, 1988. Her presenting problem was of painful swelling of the right shoulder. She had been injured in a motor vehicle accident on February 2, 1988. She had had a brace for six weeks. She was nine months pregnant at the time of her first visit with Respondent.

87. The physical examination recorded for this day was one line that read "Grade IV dislocation of rt AC joint". Such a record of a physical examination does not meet the minimum standards of care. There is no information regarding tenderness, range of motion, or neurologic status of the upper extremity.

88. To meet minimum accepted standards of care, a competent prudent physician must describe the acromioclavicular joint and the clavicle. Only by assessing these two body parts can the physician conclude what grade to assign to a dislocation. The mere conclusion that the dislocation is Grade IV is insufficient without a description of the acromioclavicular joint and the clavicle.

89. The chart entry for the May 25, 1988 visit also reads, "for x-ray right shoulder". There was no notation of what that x-ray showed. (Ex. 20, p. 37, Ex. 21 p. 2) (T. 384-386, 473-474, 488)

90. Patient D was subsequently hospitalized at St. Vincent's Medical Center of Richmond from July 4 through July 8, 1988. The admission was to perform an open reduction internal fixation using K-wires, and transfer of the ligament for her dislocated right acromioclavicular joint.

91. By the time of the admission, Patient D's dislocation was chronic. While the procedure undertaken by Respondent was one usually associated with acute dislocations, it was nevertheless one of many procedures that were appropriate for the patient's condition.

92. There were many other procedures to use for the treatment of a chronic acromioclavicular separation which would have met the minimum standard of care at that time. (Ex. 22, p. 27-28) (T. 387-389, 1676-1677)

93. Patient D received follow up care with Respondent postoperatively. Her first postoperative visit was on July 18, 1988.

94. Minimum accepted standards of medical record keeping dictate that at the first postoperative visit, the patient record must set forth:

A. The date of the surgery;

B. The procedure that was performed;

C. The patient's complaint

D. A brief description of the extremity

None of the components described above was recorded by Respondent.

95. Minimum accepted standards of medical record keeping require that the practitioner record an interim note, that is, a description of what has taken place, if anything, since the last visit. This standard was not met by Respondent in his patient record for Patient D.

96. Patient D's next visit was on August 3, 1988. This visit did not meet minimum acceptable standards of care because:

A. There are conflicting comments in the chart; e.g. the chart reads, "patient doing very well," then it says that she has pain;

B. There is no information about the cause or location of the pain;

C. The record states a wire was pushed out, however, no description of how Respondent came to that conclusion is given, *i.e.*, by x-ray or physical examination;

D. Minimum accepted standards of care required Respondent to perform or order an interval x-ray. There is no mention of such a procedure in Patient D's chart.

97. The Records of both the August 3, 1988 visit and the August 24, 1988 visit did not meet the minimum accepted standards of care because:

A. There was no mention of a physical examination;

B. Respondent gave no basis for his decision to remove the orthopedic hardware;

C. Respondent stated that a wire had pushed out. However, he gave no basis for his conclusion.

98. The notes for subsequent visits (July 18, 1988, August 3, 1988 or August 24, 1988) make no mention of the care plan for this patient. They also did not include instructions to the patient regarding what level of activity was appropriate. (Ex. 20, p. 27, 29, 31, Ex. 21, p. 3, 4, 5) (T. 384-385, 389-393 485-488, 501-502, 1633-1658 and see in particular T. 1652-1656,, 1686, 1708-1711, 1717-1720, 1727-1745)

99. On August 30, 1988, Patient D had ambulatory surgery at St. Vincent's Medical Center of Richmond to remove the wires that had been placed during the first surgery.

100. Patient D continued to see Respondent for postoperative follow up visits. She was seen in Respondent's office.

101. Her first post operative follow up visit was on September 1, 1988. This was two days after the procedure.

102. Respondent's notes for this visit did not meet the minimum accepted standards of care because:

A. There was no description of the wound;

B. Respondent recorded a dressing change. Respondent did not state the basis for the change;

C. There was no documentation of instructions to the patient regarding limitation of activities;

D. There was no mention of range of motion, and/or whether there was any tenderness or redness. (Ex. 20, p. 22, Ex. 21, p. 6, Ex. 23) (T. 393-395)

103. Patient D's next postoperative visits were on September 7, 1988 and September 22, 1988. The care recorded did not meet the minimum accepted standards of care for surgical after-care visits because:

A. The notes give a history of the patient having lifted her child and tearing the repair of the right acromioclavicular joint, but they do not indicate the basis for Respondent's conclusion;

B. There is no documentation of the position of the acromioclavicular joint;

C. There is no documentation, referring to pain or the lack thereof;

D. There is no documentation of any tenderness in the area of treatment;

E. There is no comment referring to the surgical site at all.

104. Patient D's next two postoperative visits were on October 17, 1988 and December 1, 1988, and they did not meet the minimum standard of care for after-care visits because:

A. There was no entry regarding a history;

B. There was no entry which referred to any physical examination;

C. There was no entry describing any complaints of the patient.

105. On the record for the October 17 visit, the sole notation is just one written line. This line states there is a dislocation of the right acromioclavicular joint. However, it does not give any indication of a physical examination or how Respondent arrived at his diagnosis.

106. On the December 1 visit, the notes read, "redislocation right AC joint," and "for reconstruction of rt AC joint." Yet again, Respondent fails to describe the basis this diagnosis. There is also no record of patient complaints, if any, a physical examination, or a range of motion description.

107. None of the notes for the patient's postoperative care from September 7th to December 1st indicate what aftercare therapy this patient was to follow subsequent to her ambulatory surgery of August 30, 1988. Some description of limitation of activity, if any, is required for Respondent to have met the minimum standards of care. (Ex. 20, p. 15, 17, 19, 21, Ex. 21, p. 7, 8, 9, the 1st page 10) (T. 398-402)

108. Patient D's next hospitalization was at Doctors' Hospital of Staten Island from January 20, 1989 to January 23, 1989. Surgery was performed on January 20, 1989. (Ex. 24, p. 19-20) (T.402-403, 461-462)

109. The surgery was described as a "re-exploration, open reduction of the dislocated right AC joint and internal fixation using an AO compression screws with washers and a bolt." (Ex. 24, p. 19-20) (T. 402-403, 461-462)

110. Patient D received follow up care with Respondent postoperatively.

111. Her first postoperative visit occurred on January 30, 1989. The record of this visit is not consistent with accepted standards of medical record keeping:

A. Respondent did not state why the patient was in the office (was the visit routine or urgent);

B. Respondent did not include even a brief description of the recent surgery, or the healing process;

C. Respondent did not state what, if any, postoperative instructions were given to the patient. (Ex. 21, the 2nd page 10) (T. 404-405)

112. Patient D's next postoperative visit took place on March 8, 1989. The record of this visit is not consistent with accepted standards of medical record keeping:

A. The record may contradict itself depending on the meaning of these two entries: "all well", and "still tender on the rt AC joint." A satisfactory record would leave no question;

B. There is no description of the wound;

C. There is no description of any range of motion;

D. There is no reference to whether x-rays were needed;

E. There is no description of any instructions to the patient.

113. Patient D's next two postoperative visits were on May 25, 1989 and July 19, 1989.

114. The record of the visit on July 19, 1989, approximately two months since the last visit consisted of one note describing an x-ray, and a second note suggesting a treatment plan. The note read "advise about surgery." These entries did not meet the minimum standards of record keeping for an aftercare visit:

A. No presenting complaint was set forth;

B. There was no reference to previous treatment;

C. There was no reference to any physical examination;

D. The note failed to state what kind of surgery was planned or why there was a need for the procedure. (Ex. 21, p. 11, 12, 13) (T. 405-407)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT D

The Committee is now asked to determine whether the facts established support any of the accusations regarding Patient D. In Allegations D.1. and D.2., Respondent is again charged with a failure to take an adequate history and record same in his patient notes. He is also charged with a failure to perform

adequate physical examinations through out his treatment of this patient (D.2.). Clearly Respondent noted virtually no history or physical examinations at all. He suggested that he took the requisite histories and performed the necessary examinations but simply failed to record them. The Committee finds that this argument does not in any way insulate Respondent from the charges.

In so finding a majority of the Committee relied upon two theories: First, it is axiomatic in medicine that activities which are not recorded are perceived as not performed. Second, Respondent has been caught in a number of mis-statements in this proceeding. He has lost all credibility. Therefore, a majority of the Committee finds that the histories and physical examinations were not recorded because they were not performed.

Therefore,
Allegation D. and D.1. are SUSTAINED
Allegation D. and D.2. are SUSTAINED

In Factual Allegations D.3., D.3.a. and D.4, Respondent is cited for performing the wrong surgical procedures and not performing those procedures properly. The Committee does not find the evidence presented to warrant a finding of medical misconduct.

As set forth in the findings of fact, the State's expert admitted that the procedures performed were within the universe of appropriate responses to this patient' condition. The mere fact that the first procedures were not successful does not mean that the former procedure or the corrective procedure are inappropriate. It is well settled that sometimes, despite the most professional conduct, physicians have bad results. Furthermore when pressed about the performance of the procedure, the State's expert could not render an opinion stating, with any reasonable certainty, that the procedure was performed improperly. As drafted, these charges cannot be sustained.

Therefore,
Allegation D. and D.3 are <u>NOT</u> SUSTAINED;
Allegation D. and D.3.a. are <u>NOT</u> SUSTAINED;
Allegation D. and D.4. are <u>NOT</u> SUSTAINED

Factual Allegations D.5, D.5a. and D.5b. Refer to the manner in which Respondent billed for services rendered in the care and treatment of Patient D. While it is true that Respondent did not bill for a global surgical fee and billed for each separate service, the State could not establish just how much post surgical activity would have been covered by the global fee. Since the panel does not know how many, if any, post surgical days are covered by a global fee, they could not conclude Respondent had billed for the same activity more than once. It follows that Factual Allegation D.5.a. must be sustained (Respondent did not, in fact, submit a global fee) however, the finding of fact cannot be used to support an allegation of misconduct.

Therefore,
Allegation D. and D.5 are NOT SUSTAINED;
Allegation D. and D.5.a. are SUSTAINED;
Allegation D. and D.5.b. are NOT SUSTAINED

Finally, Respondent is cited for substandard record keeping. The Committee sustains this charge. The Committee will not re-state the reasons set forth for each of the former patients. Suffice to say that the patient record for Patient D is of the same substandard quality as each of the other charts were found to be.

Therefore,
Allegation D. and D.6 are SUSTAINED;

FACTUAL ALLEGATIONS
ARISING FROM
THE CARE AND TREATMENT OF
PATIENT E

115. Respondent treated Patient E, a female, born on December 22, 1938, at his office, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York.

116. This patient was treated for left wrist fractures, and various other complaints, from approximately January 2, 1994 to May 13, 1994. (Ex. 26, 27, 28, 29, 30, 32, 1015, 1016)

117. Patient E saw Respondent to treat left Colles fracture from a fall. A Colles fracture is a fracture involving the distal radius and possibly the ulnar styloid at the wrist.

118. Before Patient E saw Respondent, she had been treated at the emergency room of St. Vincent's Hospital in Staten Island. Patient E had been admitted to the hospital. Respondent was called in because Patient E needed an orthopaedist. Respondent saw her the day after her admission, and Respondent performed a closed reduction in the operating room under general anesthesia. (Ex. 30, p. 87, 88) (T. 519-521, 564)

119. Where a patient is seen in an emergency room, a history is taken and a physical examination is performed. The subsequent treating physician may, consistent with generally accepted standards of medicine, rely upon the initial history and physical examination. This is so whether the initial medical professional is a physician an RPA, an NP, an intern and so on.

120. However, to meet minimum accepted standards of medicine, the subsequent treating physician must also examine all notes written by others about the patient. In addition, if the subsequent physician relies upon the notes of others, that subsequent physician must make a note of his or her own indicating that he or she had read the notes of others and was relying upon them. Respondent failed to do so in this case.

121. Notwithstanding that the prior notes by others are adequate, the subsequent physician has an obligation to perform at least a brief history and physical examination upon the areas within his or her specialty and document same. (Ex. 26, Ex. 29, p. 12, Ex. 30, p. 84, 86, 88) (T. 519, 564-574, 589-590, 594-596)

122. The histories and physical examinations performed by Respondent upon Patient E did not meet minimum accepted standards of care:

A. There is no history taken by Respondent at his first hospital visit with Patient E;

B. There is no record of even the most cursory physical examination;

C. There is no notation by Respondent that he reviewed the emergency room record.

123. Respondent's hospital note dated January 8, 1994 did not meet the minimum accepted standards of care for a patient history or physical examination for the same reasons set forth in the previous finding of fact.

124. Patient E had surgery on January 9th, 1994.

125. The next visit by Patient E took place on January 10th. The sole note mentions only "swelling." The notes for this visit did not meet minimum accepted standards of medicine. There is no notation as to the location or the severity of the swelling. There is also no mention of any sensory examination or a review of the motion of her fingers. To be consistent with minimum accepted standards of medicine, such notes were essential to a record of a visit with the patient the day after surgery.

126. The next visits by Patient E took place on January 11, 12, 13 and 14, 1994. These were postoperative visits. Once again there are no notes of even the most cursory physical examinations on January 11th, 12th, or the 14th. The closest Respondent came to writing a note about the condition of the patient occurred on the 13th. The note merely says "moving finger better."

127. To be consistent with minimum accepted standards of care for a postoperative patient, Respondent was required to perform range of motion studies (since he could not examine the wrist) and the sensation of the fingers. In addition, it is required that the physician examine and record any discoloration of the skin and swelling that is visible beyond the limits of a cast. Finally, the physician

is required to examine the temperature of the skin on the fingers. Respondent did none of this. (Ex. 26, Ex. 29, p. 4, 10, 11, 12, Ex. 30, p. 84, 86, 88, 142, 146, 147, 149) (T. 519, 521-525, 579-582, 590-591, 596-597)

128. Respondent did not perform any range of motion testing on this patient's fingers until March 9, 1994, when the cast was removed. (Ex. 26, Ex. 29, p. 4, 10, 11, 12, Ex. 30, p. 84, 86, 88, 142, 146, 147, 149) (T. 519, 521-525, 579-582, 590-591, 596-597)

129. Respondent then saw the patient in his office beginning on January 19, 1994. Respondent's note for this visit reads "53-year-old," and then "ov, suture removal." Such a note does not meet minimum accepted standards of care.

130. Respondent next saw the patient on February 14, 1994. His notes for this visit do not meet minimum accepted standards of medicine:

A. There is no interim history;

B. There is no documentation of any sensory examination;

C. There is no mention of any follow-up on this patients carpal tunnel release and complaints of sensory changes.

131. Patient E's next visit of March 9, 1994 did not include any note of a sensory examination.

132. Patient E next visited Respondent on March 21, 1994 and March 28, 1994. The only physical examination recorded for either date is a range of motion study of her wrist on March 21st and of her wrist and fingers on March 28th. There is no sensory examination noted for either visit.

133. The next and last visit by Patient E took place on May 13, 1994. The record and care for this visit were inconsistent with accepted standards of medicine:

A. Bier blocks had apparently been applied to the patient;

B. The record is silent as to why they were installed, who installed them, where they were installed, and what the results were.

C. The note reads "back to normal" but there was no indication of what was back to normal, upon what grounds did Respondent make this conclusion, or where he made it.

D. There was no physical examination;

E. There was no listing of patient complaints;

F. There was no interim history of any kind. (Ex. 26, p. 5, 8, 14-15, 18, 23, Ex. 28, p. 13, Ex. 29, p. 2, 4, 6, 7, 8, 12, Ex. 30, p. 84, 86, 88) (T. 519, 522-530, 564-574, 579-582, 589-591, 594-597)

134. The note for March 3, 1994 reads "Patient canceled, bad weather conditions, rescheduled 3/10". In addition to the cancellation note, there are three additional documents. Each of the three is written on separate pages from a prescription pad. Each is dated March 3, 1994. They are described more specifically:

A. The first appears in Respondent's handwriting. But it is written on a page from someone else's prescription. It reads, in part, "For EMG left [undecipherable]".

B. The next two are written on pages from Respondent's prescription pad. The second one reads, "CT scan, left wrist".

C. The final document bears Respondent's signature. It reads, in part, "plan [undecipherable] left wrist and fingers," twice a week for one month.

135. In order to comply with accepted standards of medicine, where a patient does not appear at an office visit, a note must explain the reason for the issuance of orders. The note must include a decipherable description of what was being done and why.

136. The previous appointment for Patient D had been on February 14, 1994. (Ex. 26, p. 9, 10, 11, 14, Ex. 29, p. 4) (T. 530-533)

137. Respondent provided care for Patient E for the early stages of these fractures that did not meet minimum standards of care:

A. Patient E was not seen the week after the sutures were removed;

B. Respondent did not document a physical examination;

C. Respondent did not document any patient complaints;

D. Respondent did not order an interim x-ray;

E. Respondent did not document recommendations to the patient for follow-up; (Ex. 26, 30) (T. 533-537)

138. A Kirschner wire (also called a K-wire) is a smooth wire of about 10 inches which is installed through skin into a bone or installed through an open incision into bone. The purpose of a K wire is to hold fracture fragments in position. Generally K-wires are eventually removed. However sometimes they are not removed.

139. Whether the K-wire is removed or not, it is incumbent upon a physician, acting according to minimal accepted standards of medicine, to note whether the K wire has been removed or not and why. Respondent's chart notes do not disclose whether the K-wire had been removed or not. There is also no disclosure regarding Respondent's intention to leave it installed indefinitely or not.

140. The decision to leave or remove a K wire must be made by the surgeon in the patient chart. The decision about removing the K-wire would generally be made at the time it's placed.

141. A final x-ray film from the operating room showed the K-wire protruding through the skin. Customarily, the exposure of the K-wire indicates a plan to eventually remove it. However, subsequent users of the patient chart should not be required to deduce whether there was a plan for removal or not. Finally, there is no record of when he had removed the K-wire. (Ex. 30, p. 143, 156) (T. 537-539, 591-592, 597-600, 602-603)

142. To meet the minimum standard of care, it's the responsibility of the physician doing the surgery to order or assure that the proper number of x-rays were done.

143. On page 161 of Exhibit 30, there is a radiological report dated January 9, 1994, which indicates that a lateral view of left wrist in plaster was submitted on January 9, 1994, but there is no report of any

AP x-ray, which would have been the least that would be necessary since there should be at least two views. Therefore, there are an inadequate number of x-rays.

144. The structures are three-dimensional, and an x-ray is a two-dimensional picture, therefore at least two pictures in different views are necessary because anatomy in one view does not mean there is anatomy in another view. Respondent failed to take or order an adequate number of x-rays for this patient. (Ex. 30, p. 161, 32) (T. 552-556, 586-589, 592-594)

145. To meet the minimum accepted standards of care, the discharge summary and report of operation must disclose what type of cast was applied.

146. In the report of the operation for Patient E's second surgery on pages 143 and 156 of Exhibit 30, there is conflicting information offered by Respondent as to what type of cast was applied; i.e., on page 143, at the top under "Operation performed," Respondent's note reads, "Application of long arm cast". And in Respondent's note on page 156, the last sentence of the first paragraph read, "A short arm cast was applied."

147. In Respondent's discharge summary of January 14, 1994, on page 128, under "hospital course" he wrote, "application of long arm cast."

148. It is impossible to tell what type of cast was applied from the report of operation and the discharge summary. (Ex. 30, p. 128, 143, 156) (T. 541-542, 606-607, 609)

149. The chart written by Respondent for Patient E, both in the hospital and in the office violate minimum accepted standards of care:

A. The patient was treated for a left Colles fracture which is at the wrist, not at the elbow;

B. Respondent's note dated January 3rd (Ex. 30, page 88), mentions the left radial head;

C. On page 119 in the discharge note under "Diagnoses," number 1 is listed as a fracture of the left radial head.

D. There is no indication of any complaint, examination or x-ray finding referring to the left elbow.

150. The notes on page 2 of Exhibit 26 and page 92 of Exhibit 30 are noteworthy: The note on page 92 is in the hospital record, and the note on page 2 was in Respondent's chart. These records contain what appear to have been errors in the dictation that were hand corrected in the hospital record. (Ex. 26, p. 2) (Ex. 30, p. 88, 92, 119) (T. 556-561, 1817-1819, 1844-1845, 1855-1858, 2001-2002)

151. The copy of the hospital chart that is on page 2 in Respondent's chart is not the same as the hospital chart at page 92. Respondent's record has the original typed date. It has the preoperative and postoperative diagnoses written in without the original dictation It is missing two words "manipulation and" which were added in the hospital chart on page 92 of Exhibit 30, but do not appear on page 2 of Exhibit 26. (Ex. 26, p. 2) (Ex. 30, p. 88, 92, 119) (T. 556-561, 1817-1819, 1844-1845, 1855-1858, 2001-2002)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT E

The Committee is now asked to determine whether the facts established support any of the charges regarding Patient E. In Allegation E.1 and E.2. Respondent is charged with a failure to take and record an appropriate patient history and appropriate physical examinations. The Committee finds the records for Patient E continued in the pattern of utterly substandard record keeping established by Respondent arising from his care and treatment of Patients A, B, C, and D. As in the previous cases, there was not a single word in Respondent's notes that gave any meaningful information about Patient E's medical history initially and

during the time between appointments. Likewise, there was virtually no evidence of any meaningful physical examination of this patient.

Therefore,
Allegation E. and E.1. are SUSTAINED
Allegation E. and E.2. are SUSTAINED

Allegations E.3. and E.4. WERE WITHDRAWN

In Factual Allegations 5, Respondent is charged with the failure to record any information regarding the removal of the patient's K wire. There is little to be said about this charge. The record contains no information regarding the removal of the wire.

Therefore,
Allegation E. and E.5. are SUSTAINED

In Factual Allegation 6, Respondent is charged with the failure to perform or order x-rays between his visit with the patient in the hospital on January 9, 1994 and her office visit on February 14. The State has established that there are neither films nor radiology reports to indicate x-rays were taken during this time.

Therefore,
Allegation E. and E.6. are SUSTAINED

In Factual Allegation E.7., Respondent is charged with a failure to provide adequate after care for this patient, particularly in the early stages of this fracture. Once again, the State has shown Respondent failed to provide after care for this patient that is even remotely consistent with accepted standards of medicine. In addition, Respondent made no mention of any follow up care or instructions provided to Patient E.

Therefore,
Allegation E. and E.7. are SUSTAINED

Factual Allegation 8 cites Respondent for failing to record whether a long arm or short arm cast was applied to this patient. The Committee finds that the records for this patient give enough information that one could discern which cast was applied. Ultimately, the Committee finds that the distinction does not amount to a significant difference.

Therefore,
Allegation E. and E.8. are NOT SUSTAINED

Factual Allegation 9. Was Withdrawn

Factual Allegation 10 charges Respondent did not maintain a sufficient record and x-ray films to accurately reflect the care and treatment provided to this patient. This charge is sustained in part. As repeatedly set forth in these conclusions, Respondent, at least within the universe of the charts provided, does not produce a record sufficient to inform a later reviewer of what was done and why. The charts for Patient E are no exception. However, Respondent did maintain x-ray films sufficient to inform others of the treatment provided to this patient.

Therefore,
Allegation E. and E.10. are SUSTAINED in part

FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT F

152. Respondent treated Patient F, a male, born on April 8, 1964. Patient F was treated at Respondent's office, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York. Patient F was treated for a dislocation of his finger. He was seen from January 28, 1993 to June 19, 1997. (Ex. 33, 34, 35, 36, 37, 91, T. 1008, 2003)

153. On October 20, 1993 Patient F sought treatment for what was diagnosed as a "dislocated PIP joint lt ring finger." Respondent recommended surgery.

154. Patient F had been treated by Respondent prior to this date for other problems but this was the first time that Patient F reported complaints leading to a diagnosis of dislocation.

155. Respondent did not provide care consistent with accepted standards of medicine at this visit because:

A. Respondent did not perform an appropriate physical examination. The closest notation suggesting an examination simply refers to the diagnosis of a dislocated PIP joint;

B. There is no patient history;

C. There is no description of the condition of the finger;

D. There is no record whether there was any discoloration of the skin;

E. There is no record of what, if any, motion could be performed by the patient;

F. There is no record of any attempt to check the level of sensation in the finger. (Ex. 34, p. 14) (Ex. 35, p. 6) (T. 612-614)

156. On October 26, 1993, Patient F underwent the recommended surgery performed by Respondent.

157. Respondent performed an exploration of the PIP joint of the left middle finger. The proximal interphalangeal joint capsule was opened. Upon visual examination it was determined that no changes had taken place. It was then realized that Respondent was performing surgery on the wrong finger.

158. Respondent then proceeded to operate on the PIP joint of the left ring finger. It was then determined that the ring finger was the correct site.

159. Surgeons practicing within accepted standards of medicine review any information on hand prior to starting surgery. It is the responsibility of the surgeon to be absolutely sure that the site of the surgery is correct.

160. In this case, the correct surgical site was identified prior to surgery in 5 places:

A. The left ring finger was identified in Respondent's chart on the initial visit of October 20th;

B. The short stay record which was prepared by a physician's assistant on October 22nd also refers to the fourth left finger/left ring finger/left fourth digit/left fourth ring finger;

C. The day surgery short stay admission assessment which was dated October 26th at 1:00 p.m. also indicates the fourth left finger

D. The pre anesthesia - ambulatory surgery form which was dated October 22nd also indicates the left ring finger;

E. The department of radiology pre-admission chest x-ray form which was dated October 22nd and dictated October 23rd also indicates the ring finger left hand (which is the correct finger).

161. All of these forms were prepared prior to the time Patient F entered the operating room on October 26th at 2:25 p.m.

162. At least those numbered (B), (C), (D), and (E) were available to Respondent in the operating room at the time of the surgery. (Ex. 34, p. 14) (Ex. 35, p. 6) (Ex. 36, p. 7, 11-12, 13, 18, 19) (T. 614-617, 634-636, 826-830)

163. The consent form was prepared by Respondent. This form indicated that the patient was consenting to obtain a procedure from Respondent for the left middle finger (the wrong finger). The form was signed by the patient and witnessed by a nurse.

164. Regardless of the following facts, Respondent is not exonerated from selecting the wrong finger. The surgeon is the person ultimately responsible for performing the surgery the patient requires:

A. The wrong finger was mentioned in the consent form;

B. The patient consented to having the procedure on the wrong finger in the consent form

C. A nurse witnessed the patient signing the consent form which had the wrong finger;

165. Minimum accepted standards of care require a surgeon to examine a patient, in the surgical facility on the date of the surgery prior to performing the surgery.

166. In a joint with a fracture dislocation, there is a deformity which is obvious upon visual observation of the patient.

167. Regardless of patient consent, minimum accepted standards of care require a surgeon to check his own notes and records to be certain he understands the precise pathology before him/her.

168. In this particular case, there were ample documents in Patient F's chart to dictate surgery on the correct digit. This file was available to Respondent in the operating room at the time of the surgery (Ex. 34, p. 14) (Ex. 35, p. 6) (Ex. 36, p. 5, 7, 11-12, 13, 19) (T. 614-620, 634-636, 826-830, 943-944)

169. In a letter to the Chairman of the Department of Surgery, dated November 10, 1993, Respondent admitted that on October 26, 1993, he obtained the wrong consent from Patient F and that the x-ray (of the correct site of the surgery) was displayed on the screen in the operating room. (Ex. 91) (T. 925, 931-933, 941, 976-977)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT F

At this point, the Committee turns its attention to the charges in order to determine if any of the facts established will support the allegations regarding Patient F. In Factual Allegation F.1., Respondent is cited for performing surgery on the wrong site. Respondent admits this charge but offers mitigating factors.

Respondent attempted to implicate other people and external forces for the error. In a letter to the Department Chairman, Respondent indicated that his back pain and a difficult day contributed to his failure

to identify the correct operative site. He also drew attention to the failure of the hospital administration to print the correct site on the operative schedule. In addition, he implicated the patient who he believed should have some accountability for signing a proper consent and verifying the correct site.

The fact that Respondent began surgery on the wrong body part is consistent with the pattern of sloppy and careless practice seen throughout the analysis of the charges in this matter. A majority of the Committee concluded that Respondent's error was particularly egregious because it subjected the patient to unnecessary risk and could have had catastrophic consequences. Finally, Respondent chose not to testify regarding Patient F. The Committee again applies the negative inference rule[3]. Based upon the facts presented regarding Patient F and the prior conclusions of the Committee, the Committee concludes Respondent did not testify about Patient F because if he testified truthfully, his testimony would not have been consistent with his defense and mitigating factors.

Therefore,
Allegation F. and F.1. are SUSTAINED

The Committee now considers Factual Allegations F.2 and F.4. Factual Allegation F.3 will be considered next. Factual Allegation F.2 again raises the issue of substandard physical examinations and the records for same. Factual Allegation F.4., again raises the issue of overall substandard records. Both charges are sustained. Respondent continued to show less than marginal evidence of anything approaching an appropriate physical examination or record. Again Respondent produces a patient record which is almost worthless in any quest to find out exactly what Respondent's treatment of this patient consisted of and why it was performed.

One additional point is noteworthy: Had Respondent, immediately prior to surgery, performed an examination of this patient according to accepted standards of care, this incident would have been prevented.

Therefore,
Allegation F. and F.2. are SUSTAINED
Allegation F. and F.4. are SUSTAINED

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[3] For a further explanation of the negative inference rule, see the discussion of Allegation A.4, page 15.

Factual Allegations F.3.a. and F.3.b. refer to the same sort of billing issues raised earlier. However, the Committee finds it was not supplied with sufficient evidence to sustain either of these charges.

Therefore,
Allegation F. and F.3.a. are NOT SUSTAINED
Allegation F. and F.3.b. are NOT SUSTAINED

FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT G

170. Respondent treated Patient G from September 15, 1988 to October 12, 1988 for repair of his right shoulder. Patient G is a male, born on February 18, 1966. Patient G was seen at the office of Respondent located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York. (Ex. 38, 39, 40, 1017)

171. Patient G's first visit with Respondent was on September 15, 1988. The patient record for this visit was not consistent with accepted standards of medicine:

A. The history that was taken on this date states that the patient dislocated his shoulder 15 times;

B. There is no statement regarding when the dislocations started;

C. There is no statement regarding how any of the dislocations occurred.

D. There was virtually no medical history other than a statement of the presenting problem;

E. The record of a physical examination (if any) consists of a note stating: "OE SKS right shoulder"

F. There are no further objective statements describing the physical examination or what was seen.;

G. There are no notes referring to a comprehensive examination of the upper extremities;

H. There is no description of the appearance of the shoulder;

I. There is no record stating whether there was any tenderness to palpation on or around the shoulder;

J. There is no record describing the kind of range of motion demonstrated by the patient;

K. There is no record whether an apprehension test was positive or negative;

L. There is no record of even a modest a neurologic examination;

M. There is no description of the reflexes of the patient. (Ex. 38, p. 9) (Ex. 39, p. 2) (Ex. 40) (T. 641-644, 1931-1935, 2048-2051, 2055-2057, 2063-2066, 2071-2074)

172. An entry on September15, 1988 reads, "For x-ray right shoulder"; Respondent billed for an x-ray of the right shoulder on that date. There are no further comments describing and interpreting the x-ray. (Ex. 38, p. 8, 9) (Ex. 39, p. 2) (T. 644-645, 670-671, 675-676)

173. Following the initial visit, Patient G was hospitalized from September 20 to September 23, 1988 for surgery to repair the recurrent dislocation of his right shoulder.(Ex. 38, p. 4, 6, 8) (Ex. 40, p. 16, 17, 20, 21, 26) (Ex. 78, p. 4, 27-28) (T. 645-650, 653)

174. Surgery was performed on September 21st. Respondent billed for in-hospital visits on September 21st (the date of the surgery), September 22nd and September 23rd. (Ex. 38, p. 4, 6, 8) (Ex. 40, p. 16, 17, 20, 21, 26) (Ex. 78, p. 4, 27-28) (T. 645-650, 653)

175. Respondent also billed for the follow-up visits in his office on October 6 and 12, 1988 which were still part of the postoperative period. (Ex. 38, p. 4, 6, 8) (Ex. 40, p. 16, 17, 20, 21, 26) (Ex. 78, p. 4, 27-28) (T. 645-650, 653)

176. Patient G received follow-up care from Respondent subsequent to his surgery. The first visits were on October 6 and 12, 1988. The physical examinations as described on both of those visits consist of "wound well healed" and "all wound healed." There is no evidence of any meaningful physical examination. Nor is there any evidence of even the most limited of a neurological examination. (Ex. 38, p. 5, 7) (Ex. 39, p. 3, 4) (T. 650-652)

177. The note of October 12,1988 reads in part: "Plan continue immobilization"[4]. There is no evidence Respondent had an overall plan for this patient. There is no plan for mobilization nor a time frame of when mobilization could begin. (Ex. 38, p. 5) (Ex. 39, p. 4) (T. 652-653)

178. Respondent's charting for this patient both in the hospital and in his office did not meet the minimum accepted standards of care:

A. The first visit of September 15, 1988 has no physical examination;

B. No statement of why the surgery was necessary and what kind of surgery would be done.

C. When Respondent recorded the entry "For x-ray right shoulder;" Respondent failed to note what the x-ray showed.

D. The hospital chart for the postoperative visits did not indicate what Respondent did or observed at those visits; *i.e.*, no physical exam, what the patient's status is, what day the patient is postoperatively. (Ex. 38, p. 9) (Ex. 39, p. 2) (Ex. 40, p. 20, 21) (T. 653-655, 657, 660-662)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT G

The Committee now addresses the issue of whether the findings of fact which were sustained, will support any of the charges alleged by the State. The Committee will consider Factual Allegations G.1., G.2., G.3. and G.5. now. Allegation G.4. will be considered later. Factual Allegations G.1., G.2., G.3. and G.5. each address an aspect of Respondent's demonstrated failure to take histories (G.1.), perform physical examinations (G.2.), develop or note a treatment plan (G.3), and his failure to maintain an appropriate patient record (G.5.).

In his care and treatment of Patient G, Respondent continued his pattern reflecting the absence of any meaningful patient history or physical examination. The Committee has stated that they find Respondent

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[4] The transcript says "mobilization." However the copy of the original Physician's notes refers to "immobilization." The copy of the original notes controls on this issue.

did not record even the most rudimentary history or physical examination for his patients because he did not actually perform them. The failure to inquire into a patient's history or perform a physical examination constitutes the practice of substandard medicine and could be very dangerous for the patient. Without a careful history and physical examination, Respondent cannot be aware of relevant factors which could effect the manner in which he addresses each patient's maladies.

As has been stated before, the failure to provide the patient and others who may read this patient's record, with a treatment plan leaves all concerned with the patient's care in the dark regarding what the treating physician intended to do and told the patient. The potential for patient harm is significant, particularly if Respondent is unable to continue the care of the patient. Successors are left to speculate as to what has been done and what was planned for the future.

Finally, absent the basic components of an acceptable patient record, Respondent has violated state law and regulations which require a physician to maintain a patient record sufficient to inform successor care givers and other reviewers with a clear understanding of the care rendered and the reasons for same. Had this patient or any other patient suffered further injury or a serious complication arising from Respondent's care, there would have been significant and potentially dangerous time wasted while the new treating medical staff tried to figure out the course of prior care.

Therefore,

Allegation G. and G.1. are SUSTAINED
Allegation G. and G.2. are SUSTAINED
Allegation G. and G.3. are SUSTAINED
Allegation G. and G.5. are SUSTAINED

In Factual Allegation G.4., Respondent is charged with over billing. Respondent charged for each hospital visit and each office visit. The State presented the theory that with each procedure performed, there are aftercare visits included in the payment for the procedure. Therefore, Respondent was paid twice for at least some of his aftercare.

This charge cannot be sustained. The State did not provide the Committee with the specific standards for billing for services rendered to this patient. The State established that most hospital procedures include a specific number of after care services. However, the State offered no evidence regarding the

amount of aftercare associated with the procedure performed on this patient. The State's expert testified that the amount of aftercare associated with each procedure varies. Furthermore, the allowances for the same procedure vary. Absent clear standards, the Committee cannot sustain this charge.

Therefore,
Allegation G and G.4. IS NOT SUSTAINED

FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT H

179. Respondent treated Patient H, for chronic osteomyelitis, from August 9, 1989 to January 14, 1991. Patient H is a male, born on June 9, 1955. Patient H was seen at the office of Respondent, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York,. (Dept's Ex. 41, 42, 43, 44, 45, 49)

180. Respondent first saw Patient H on August 9, 1989. Patient H complained of a painful swelling of the left knee after injuring it when he was working on August 7th. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

181. Osteomyelitis is bone infection; chronic osteomyelitis is bone infection that has existed for a significant time. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

182. Hemarthrosis is blood in the joint. There is no specific treatment for a hemarthrosis. Hemarthrosis is treated by keeping the patient under close scrutiny. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

183. When a physician aspirates a hemarthrosis, the question arises whether the drainage should be cultured. The answer to this question is dependent upon the previous history or mechanism of injury. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

184. Generally, if it is a traumatic injury to a knee, there could be blood in the knee. Furthermore, the drainage should be cultured to assess the existence of infection. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

185. The past history on this patient was quite complicated. About 20 years prior to his first visit with Respondent, Patient H had suffered an injury to both his legs. He had several surgeries and he developed bilateral osteomyelitis in both his legs. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

186. There is no history for this patient in the chart. (Ex. 41, p. 20, Ex 42, p. 3, Ex. 43, p. 2) (T. 688-693, 734-736, 793-799, 819-823)

187. Patient H had several office visits with Respondent between his first visit in August 1989 and April 1990. (Ex. 41, Ex. 42, Ex. 43) (T. 693-696, 749-751, 753-755)

188. In April 1990 Respondent performed his first surgery on Patient H. Prior to recommending surgery, Respondent had not tried less invasive modalities such as physical therapy, exercises, and anti-inflammatory medication. (Ex. 41, Ex. 42, Ex. 43) (T. 693-696, 749-751, 753-755)

189. Respondent noted at the office visit of August 28, 1989 that Patient H "has osteomyelitis in leg." No further history was provided. (Ex. 41, Ex 42, Ex. 43) (T. 693-701, 742-743, 749-751, 753-755, 776-777, 780-786, 799-803)

190. The note for physical examination indicated a sinus on the left leg. A sinus is a soft tissue tract that is usually open. A sinus can be coming from the bone. It could also merely be just in soft tissue. However, a sinus allows a conduit from inside the flesh to the outside. Respondent indicated that pus was draining from the sinus. (Ex. 41, Ex 42, Ex. 43) (T. 693-701, 742-743, 749-751, 753-755, 776-777, 780-786, 799-803)

191. The Treatment of Patient H's osteomyelitis between the visit of August 1989 and the hospitalization in April 1990 was not consistent with accepted standards of medicine:

A. There was no trial of non-surgical modalities;

B. There was no culture of the deeper tissue;

C. There had not been a trial of an oral antibiotic;

D. There had not been a combination of bone scan and gallium or indium scans to ascertain the extent of the involvement in the bone and confirm the existence of osteomyelitis;

E. There was no CT scan to define the extent of bony involvement;

F. There was no procedure to indicate the presence or absence of sequestrum; (Ex. 41, Ex 42, Ex. 43) (T. 693-701, 742-743, 749-751, 753-755, 776-777, 780-786, 799-803)

192. The office record kept by Respondent did not meet the minimum accepted standards of care:

A. At the initial visit, the history was incomplete;

B. There was no description of the type of injury;

C. There was no past medical or surgical history;

D. There were no interim histories noted from visit to visit;

E. Most of the notes for office visits do not mention physical examinations.

(Ex. 43, p. 2-10) (T. 707-710, 736, 740)

193. The office visit of June 27, 1990 was five months later than the previous visit of January 11, 1990. During those five months, Patient H had two hospitalizations and multiple surgical procedures. (Ex. 43, p. 2-10) (T. 707-710, 736, 740)

194. Respondent failed to note an interim history of what had transpired during that five month period. (Ex. 43, p. 2-10) (T. 707-710, 736, 740)

195. Patient H's next visit took place on December 13, 1990. There was no interim history about the previous two months. (Ex. 43, p. 2-10) (T. 707-710, 736, 740)

196. Respondent's notes for the April to June admission are on pages 19 to 43, and primarily consist of entries which read, "doing very well" and "doing much better". Exhibit 45 includes handwritten transcriptions of entries in Patient H's hospital charts for the two admissions of April 20 to June 14, 1990, and June 28 to August 23, 1990, including Respondent's entries. (Ex. 45, p. 19, 21, 26, 27, 28, 32, 43, 5, 7, 9, 10, 11, 12, 14, 15, 16, 17) (T. 710-722, 811-813)

197. Patient H had suffered a difficult course. He was repeatedly brought to the operating room for various procedures. He had suffered significant drainage and various fevers. (Ex. 45, p. 19, 21, 26, 27, 28, 32, 43, 5, 7, 9, 10, 11, 12, 14, 15, 16, 17) (T. 710-722, 811-813)

198. Respondent's notes do not at all document what was occurring to Patient H. They did not tell whether or not the patient had a dressing, who was taking care of the dressing, whether there was any drainage, or what had gone on for the day. (Ex. 45, p. 19, 21, 26, 27, 28, 32, 43, 5, 7, 9, 10, 11, 12, 14, 15, 16, 17) (T. 710-722, 811-813)

199. Respondent's notes for the June to August admission are on pages 3 to 16. The entirety of Respondent's notes consist, primarily, of entries which read "doing very well", "doing much better", and "doing great"." (Ex. 45, p. 19, 21, 26, 27, 28, 32, 43, 5, 7, 9, 10, 11, 12, 14, 15, 16, 17) (T. 710-722, 811-813)

200. The notes did not describe the wound in any way. (Ex. 45, p. 19, 21, 26, 27, 28, 32, 43, 5, 7, 9, 10, 11, 12, 14, 15, 16, 17) (T. 710-722, 811-813)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT H

The Committee now determines whether any of the facts they sustained will support a charge. In Factual Allegation 1., Respondent is alleged to have diagnosed a hemarthrosis, and aspirated it. However, Respondent is cited for his failure to culture the aspirate. There is no dispute that Respondent made the diagnosis, performed the aspiration, but did not have the product of the aspiration cultured. The State has proven by a preponderance of evidence that Respondent had a duty to culture the product of this aspiration but failed to do so.

Therefore,
ALLEGATIONS H. and H.1. are SUSTAINED

Factual Allegation H.2 has two distinct parts. The second part has 3 subdivisions:

a. Respondent did not provide **any** kind of treatment for either the draining chronic osteomylitis or the knee injury (emphasis supplied);

b. Respondent failed to perform:
   i. A bone and indium scan;
   ii. A bone biopsy;
   iii. An MRI or CT Scan;

The evidence clearly establishes that Respondent did provide some care. He treated the patient for osteomylitis. He aspirated the fluid and eventually had this patient in surgery. One can argue about the quality of the care rendered but it is clear some care was provided. As drafted, part i of the charge cannot be sustained.

The Committee finds that the second part of the charge, H.2,b.(i.), H.2,b.(ii.) and H.2.b.(iii) is sustained. Clearly, Respondent did not perform a bone and indium scan; a bone biopsy; nor an MRI or CT Scan. There exist neither films nor chart entries even suggesting Respondent performed these tests.

Therefore,
Allegation H. and H.2.a. IS NOT SUSTAINED
Allegations H. and H.2 b.(i.), H.2,b. (ii.) and H.2.b.(iii) are SUSTAINED

Allegation H.3., cites Respondent for failure to perform the surgical debridement according to accepted standards of medicine. There are three subdivisions to this charge:

A. Respondent attempted to cover the wound at the first debridement;
B. Respondent failed to ensure adequate bony debridement;
C. Respondent failed to ensure a clean bony bed on which to place soft tissue.

The Committee finds there was insufficient evidence to show that Respondent had acted as described in subdivisions A., B., C., The Committee did not receive sufficient evidence to establish the standard of care for the procedures cited. The Committee also did not receive sufficient evidence to support the failures cited in subdivisions ii and iii.

Therefore,
Allegation H. and H.3. are NOT SUSTAINED

Allegations H.4 and H.5 were withdrawn

In Factual Allegation H 6, Respondent is again charged with keeping inadequate records. As seen in each of the other cases presented in this proceeding, Respondent's were grossly inadequate.

Therefore,
Allegations H. and H.6. IS SUSTAINED

Factual Allegations I.1. through I.4 concern allegations of fraud. For the sake of continuity, Patients I and J will be considered next. Factual Allegations I.1. through I.4 will appear after Patient I and J.

FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT I

201. Respondent treated Patient I at his office, located at 421 Old Bridge Turnpike, East Brunswick, New Jersey, and at Raritan Bay Medical Center, Old Bridge Division, located at 1 Hospital Plaza, Old Bridge, New Jersey. Patient I is a male. His date of birth is December 23, 1949. Patient I was treated from approximately January 27, 1994 to April 12, 1994. He was seen for treatment arising from a fall. (Ex. 50, 51, 52, 53, 54, 1018)

202. On January 27, 1994, Patient I fell and broke his ankle. He was seen by Respondent. Respondent determined that Patient I needed surgery, and performed same. (Ex. 50, 51, 52, 53, 54, 1018)

203. Respondent said he would not accept payment from GHI, Patient I's insurer, because the reimbursement amount was too low. (Ex. 50, 51, 52, 53, 54, 1018)

204. Respondent treated Patient I at his office to remove the temporary cast and replace it with a permanent cast. Respondent performed a second operation in April 1994 to remove the pin from Patient I's ankle. This pin had been inserted at the prior surgery. (Ex. 50, 51, 52, 53, 54, 1018)

205. Respondent again refused to take Patient I's insurance, GHI, because their reimbursement was too low.(Ex. 50, 51, 52, 53, 54, 1018)

206. Patient I made two payments by check to Respondent. Each payment was in the amount of $1500. (Ex. 50, 51, 52, 53, 54, 1018)

207. Patient I also sought reimbursement from Worker's Compensation. Patient I asked Respondent to fill out the necessary forms but Respondent said he wouldn't accept any insurance. (Ex. 50, 51, 52, 53, 54, 1018)

208. Respondent brought an action against Patient I for payment of the balance due, $4650. Patient I agreed to pay the balance on two conditions: He would first be allowed to finish his hearing with Worker's Compensation; and Respondent would fill out the necessary forms. (Ex. 50, 51, 52, 53, 54, 1018)

209. Patient I was successful in his claim before the Worker's Compensation Board. (Ex. 50, 51, 52, 53, 54, 1018)

210. Respondent failed to fill out the necessary forms. Patient I also requested itemized bills, marked "paid" from Respondent as he needed to send them to Worker's Compensation. Respondent failed to provide Patient I with the itemized bill. (Ex. 50, 51, 52, 53, 54, 1018)

211. Patient I sent Respondent a certified letter requesting itemized bills and payment records. Patient I needed these so he could submit them to Worker's Compensation. Patient I received the Return Receipt. (Exhibit 51)

212. Respondent sent Patient I a statement. Patient I informed Respondent he could not get any reimbursement from Worker's Compensation unless he provided proof of actual payment: a paid receipt. (Exhibit 54).

213. Patient I enclosed what is Exhibit 54 in the envelope with the certified letter he sent to Respondent (Exhibit 51). Since Respondent refused to fill out the necessary forms for Worker's Compensation, Patient I had to see another physician in order to continue his Worker's Compensation case. (Ex. 51, Ex. 54) (T. 1015-1027, 1036, 1041-1044, 1046-1051, 1053-1058)

214. Patient I filed a complaint against Respondent with the New York State Health Department. Patient I made the previously described written requests to Respondent after an investigator from the State Health Department contacted him.

215. Patient I called Respondent to request the form and an itemized bill. Patient I's attorney had requested the forms and itemized bills from Respondent. The itemized bills that Patient I was requesting from Respondent would also show actual payments Patient I had already made to him. After Patient I sent the certified letter, he still did not receive the itemized bills and form that he was requesting, and neither did The Workers' Compensation Board. (T. 1028-1030, 1050-1053, 1059)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT I[5]

Factual Allegation J consists of two charges: Respondent failed to provide Patient I with receipts and bills he needed to submit to Worker's Compensation (J.1.) and Respondent was verbally abusive to Patient I (J.2). Patient I was a very convincing witness. He did not seem to have any hidden agenda. He simply wanted the supporting documents from Respondent which would allow him to receive his benefits.

Respondent did not reply appropriately to the patient, the patient's attorney nor even an investigator from the State Department of Health. This is consistent with Respondent's various demonstrations of contempt for patients and rules about documentation of medical care: Others may be required to keep full and accurate records, but not Respondent; Others may be required to perform examinations and collect histories, but not Respondent.

The Committee finds Patient I to be credible. His credibility is affirmed by his admission that Respondent was not abusive to him.

Therefore,
Allegations J. and J.1. are SUSTAINED
Allegation J. and J.2. are NOT SUSTAINED

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[5]Up through Patient H, the patient identification letter and the factual allegation letters were the same: For instance, the charges arising from the care and treatment of Patient H are referred to by the letter H. However, the charges arising from the care and treatment of the next Patient, Patient I, is considered under Allegations J.1 through J.4. The charges arising from the care and treatment of Patient J are considered under Allegations K.1. and K.2.

The discrepancy between the Patient being considered and the denomination of the charges identifying the patient and the allegations arises from the fact that Factual Allegation I refers to no patients at all. It refers to charges of fraud. Had the fraud charge been left to the end, this difficulty would not have arisen.

FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT J

216. Respondent treated Patient J, at his office, located at 410 Bard Avenue, Staten Island, New York, and at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York. Patient J is a male born on February 8, 1956. Respondent treated Patient J for left and right knee problems, from February 1, 1990 to January 3, 1996. (Ex. 55, 56, 90, 1019)

217. Patient J suffered from knee injuries which he received in his official duties as a police officer. As a result of these injuries, Patient J applied for Social Security Disability. (Ex. 55, 56, 90, 1019)

218. Patient J and his attorney requested that Respondent complete the necessary forms but Respondent failed to do so. (Ex. 55, 56, 90, 1019)

219. In late December 1995, Patient J had an appointment with Respondent. While he and his wife were in the examining room, Respondent stated he no longer wanted to treat Patient and he would not fill out any papers that Patient J needed to be filled out. (T. 834, 837-839, 845-849, 855-858, 864, 867-870, 875-876, 887-891, 894, 896-897, 900, 902-903)

220. A few days later, Patient J and his wife placed several calls to Respondent in an attempt to obtain the necessary forms for Patient J's Social Security Disability application. When Respondent returned Patient J's calls, Respondent told them that he would not fill out forms for Patient J nor give him anything. Respondent stated he did not want to have anything to do with Patient J. (T. 839-840, 877, 891-893, 897-898, 901-902, 907)

221. Prior to the visit of late December 1995, Patient J and his wife were satisfied with Respondent's care and treatment of Patient J, and there was no animosity between them. (T839, 854, 855, 859-861, 888-889, 892, 897, 903-904)

222. Respondent eventually provided Patient J with a report; Patient J paid Respondent for this report. Respondent also completed Workers' Compensation forms for Patient J. These were not the report/forms which Patient J needed in connection with his Social Security Disability application and requested from Respondent. (T. 836-837, 841, 849-851, 905)

223. Patient J is still disabled from the injury to his left knee. The refusal of Respondent to provide Patient J or his attorney with the necessary forms to apply for Social Security Disability, required Patient J to seek the services of another orthopaedist. This subsequent orthopaedist completed the necessary forms. Patient J's claim is currently on appeal. (T. 851-852, 857, 859, 863-864, 894, 904-905)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM THE CARE AND TREATMENT OF PATIENT J

The charges associated with the care and treatment of Patient J parallel those referring to Patient I. In Factual Allegation K.1., Respondent is charged with the failure to provide the forms necessary for Patient J to obtain reimbursement from Social Security Disability. Factual Allegation K.2. asserts Respondent was verbally abusive to Patient J and his wife.

The Committee finds Patient J was credible in his statements about his inability to convince Respondent to fill out the forms he needed. There was no reason for Patient J to fabricate his presentation. Furthermore, why would someone pay a subsequent orthopaedist to prepare the forms required by the disability board if Respondent had completed the forms?

With regard to the alleged verbal abuse, Patient J and his wife were contradictory. The descriptions of the last office visit and the phone calls were not consistent in the presentation of details.

Therefore,
Allegation K. and K.1. are SUSTAINED
Allegation K. and K.2. are NOT SUSTAINED

FINDINGS OF FACT
ARISING FROM AN APPLICATION
BY RESPONDENT TO
EMPIRE BLUE CROSS AND BLUE SHIELD MANAGED CARE NETWORKS

224. In a stipulation submitted in this proceeding on January 11, 2001, Respondent admitted that on July 5, 1981, he pled guilty to a class C misdemeanor. (Ex. 85)

225. On May 15, 1995 Respondent, made an application to Empire Blue Cross and Blue Shield Managed Care Networks (hereinafter "Empire"). In this application, Respondent answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?". (Ex. 58, p. 2, 5, 9)

226. On November 19, 1996 (signed again on July 20, 1997), Respondent filled out an Empire Re-Credentialing Application. In this application, Respondent answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense?". (Ex. 58, p. 14, 15, 16)

227. On January 5, 2000, Respondent, submitted an Empire Credentialing Attestation. In this document, Respondent answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?". (Ex. 58, p. 22, 23)

228. Each of the above documents were executed well after July 5, 1981 (the date of the conviction).

229. In the stipulation dated January 11, 2001, Respondent also admitted he had been involved in 9 malpractice actions between August 8, 1991 and March 20, 1995.

230. Respondent acknowledged service of 9 malpractice cases between August 8, 1991 and March 20, 1995. Respondent admitted he had knowledge that he was involved in those 9 cases from the date he was served with process until the conclusion of the litigation . (Ex. 86)

231. The plaintiffs' names[6] in those 9 malpractice cases were: Luongo, Adimando, Silvestri, Kovalsky, Meachum, D'Ambrosio, Dutton, Mitchell, and Adrian. (Ex. 86)

232. Between September 21, 1995 and June 21, 1996, Respondent had been involved in 3 additional malpractice actions.

233. In the stipulation dated January 11, 2001, Respondent admitted he was entirely familiar with the additional 3 malpractice cases during that time period. (Ex. 86)

234. The plaintiffs' names[7] in those 3 malpractice cases were: Pam, Ehlers, and McGregor. (Ex. 86)

235. On each of the applications submitted to Empire on May 15, 1995, November 19, 1996 (re-signed July 20, 1997), and January 5, 2000, the following questions were asked by Empire: "Are you presently involved in any malpractice suit?" and "Have you ever been involved in any malpractice suit?". Respondent answered "yes" to both questions each year that he submitted the application.

236. The applications required anyone who answered in the affirmative to provide details of the present and prior malpractice actions.

237. Respondent submitted a document entitled "SUMMARY OF MALPRACTICE" (Exhibit 58, page 53). This document is undated. It is signed by Respondent and is on his letterhead. Four malpractice actions were listed, and details about each suit were provided. (Ex. 58, p. 7, 15, 22, 53) (Ex. 86)

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[6]Actual names are used here because malpractice actions are public documents.

[7]Ibid.

238. The names[8] of the plaintiffs of the 4 malpractice actions which Respondent reported were: Schneider, Cochran, Flemming, and Stark. (Ex. 58, p. 53)

239. Since the SUMMARY OF MALPRACTICE is undated, it cannot be determined whether it was submitted to Empire together with Respondent's first application of May 15, 1995 or with his Re-Credentialing Application of November 19, 1996 (re-signed July 20, 1997) or with his Credentialing Attestation of January 5, 2000.

240. If Respondent submitted the SUMMARY OF MALPRACTICE in connection with his application of May 15, 1995, he failed to report 9 additional malpractice actions in which he was or had been involved. (T. 111, 114, 115).

241. If Respondent submitted the SUMMARY OF MALPRACTICE in connection with his Re-Credentialing Application of November 19, 1996 (re-signed July 20, 1997) or with his Credentialing Attestation of January 5, 2000, he failed to report 12 malpractice actions in which he was or had been involved. (Ex. 58, p. 7, 15, 22, 53) (Ex. 86)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS ARISING FROM AN APPLICATION TO EMPIRE BLUE CROSS AND BLUE SHIELD MANAGED CARE NETWORKS

The Committee next turns their attention to the allegations of fraud assessed against Respondent. These conclusions are based upon a split vote (2-1). The majority view of the evidence follows:

In order for the State to sustain its burden of proof, it must be shown, by a preponderance of the evidence that Respondent:

A.) In the practice of medicine, made a false representation by words, conduct or concealment of that which should have been disclosed accurately;

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[8]Ibid.

B.) Respondent knew the representation was false;

and

C.) Respondent intended to mislead through the false representation.

Respondent's knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences and the basis for the inference.

Referring to the specific charges before the Committee, there are three documents in question:

A. An initial application to participate in The Empire Blue Cross and Blue Shield Managed Care Networks ("Empire");
B. A Re-Credentialing Application to Empire;
C. An Attestation application to Empire.

These three documents were required by Empire so that Respondent could participate and continue his participation in the Empire medical insurance program. Respondent admitted, by stipulation, at the time he submitted the three documents, he had been involved in 13 to 16 malpractice actions. In the three applications in question, Respondent lists only 4 malpractice actions. The Committee finds that the number of cases Respondent failed to report is irrelevant. The point is whether he intentionally submitted any untruthful applications.

Since the applications referred to in the charges were filed so that Respondent could participate in a medical insurance program, the preparation of the applications was clearly an act within the practice of medicine. The stipulation by Respondent, received in this matter, establishes that he did not report 9 to 14[9] malpractice actions. The documents from Empire required him to list all 13 to 16 of the malpractice actions. Therefore, in the judgement of the majority of the Committee, the information Respondent provided was false.

Respondent demonstrated during his testimony, he is a highly educated and intelligent person. He is an experienced physician. Therefore, it is beyond debate that Respondent understood the simple instructions set forth in the questions in issue. Furthermore, the Committee finds Respondent was fully aware

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[9]The number of cases Respondent failed to report depends upon the date of the submission of the Summary of Malpractice. This date is unknown. However, the Committee finds that the number of cases Respondent failed to report is irrelevant. The gravamen of the charge is that he submitted an untruthful document in an application to a medical insurer.

of what was needed for the malpractice summary to be accurate. Respondent stipulated he was aware of the actual number of actions against him. Therefore, in the judgement of the majority of the Committee, the failure of Respondent to disclose each of the actions against him were those of a person who acted with the intent to deceive.

In further support of the inference regarding Respondent's intent, had Respondent merely submitted the malpractice summary in error, he would have had to commit the same error three times. A majority of the Committee does not believe there was any unintentional error committed by Respondent in his submissions. The Committee finds Respondent defrauded Empire so he could become and continue to be a participant in the program.

The intent of Respondent to defraud Empire may also be found by assessing the consequences of a truthful answer: Respondent knew that he was less likely to be admitted as a participant if he had reported all the 13 or 16 malpractice cases than if he reported only 4. In addition, the disposition of the cases he reported were far less damaging to his professional standing than the additional 9 or 12 that he did not report.

The Committee finds further basis for a finding of fraud upon the obvious fact that given the number of lawsuits Respondent was involved in, it was in Respondent's best interest to withhold the full truth. Respondent's whole purpose for the application and other documents in issue was pecuniary in nature. If Respondent had been refused participation, he would have had fewer patients and therefore, less income. The obvious financial cost to Respondent, had he submitted truthful answers, demonstrates a strong motivation to be less than truthful. In addition, the Committee sees no other potential explanation for the false entries other than an intent to deceive Empire for pecuniary interest.

Finally, the Committee invokes the negative inference rule: Where a Respondent chooses not to testify in an Administrative Law proceeding, the trier of fact may (but need not) infer the most negative conclusion that the established evidence supports[10]. Therefore, since Respondent refused to testify about the fraud allegations, the Committee infers that if Respondent had testified truthfully, his answers would have established Respondent intentionally and knowingly made false representations in order to defraud Empire.

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[10](See DeBonis v. Corgisiero, 155 A.D.2nd 299, 547 N.Y.S.2nd 276 and 279 citing Baxter v. Palmigiano 425 U.S. 308 (1976)

The State has established each of the elements necessary to find fraud based upon the actions of Respondent regarding the documents submitted to Empire. The State has also established by clear and convincing evidence, the specific allegations under Factual Allegations I.1, I.2. I.3. and I.4.

Therefore,

Allegations I. and I.1. are SUSTAINED
Allegations I. and I.2. are SUSTAINED
Allegations I. and I.3. are SUSTAINED
Allegations I. and I.4. are, by a split vote (2 - 1) SUSTAINED

CONCLUSIONS REGARDING SPECIFICATIONS

The Committee has sustained the majority of the Factual Allegations alleged in this proceeding. The Committee will now analyze the allegations which were sustained to see if any rise to the level of medical misconduct as set forth in Specifications One through Twenty-Eight.

THE FIRST SPECIFICATION NEGLIGENCE ON MORE THAN ONE OCCASION

The Committee now considers the various charges that have been sustained in order to determine whether the State has shown, by a preponderance of the evidence, that Respondent failed to demonstrate an appropriate level of care and diligence, expected of a practitioner in this State.

With regard to each of the patients considered in this proceeding, the Committee finds Respondent's patient records not only violate Education Law, subdivision 6530(32)[11] but rise to the level of negligence (subdivision 6530(3).

[11]This subdivision requires physicians to keep accurate records which reflect the care and treatment rendered to each patient.

In so finding, the Committee concludes Respondent's records are substantially below accepted standards. In fact, his patient records are virtually vacant. The difference between this finding and those under the Seventeenth through Twenty-Fourth Specifications [12] is the degree of the violation.

Where a physician fails to record some important events or information in a patient record, that practitioner has prepared substandard medical records and hence violated the Education Law, subdivision 6530(32). Here however, the records are so utterly useless that the Committee finds Respondent crossed the line from substandard records to virtually no records. The failure to provide any useful information that would help successor medical care providers is dangerous to the patient and reflects an entirely substandard level of care and diligence. In this State every physician has a duty to prepare records which would explain to another medical care provider what was done in the past and why. Respondent has ignored this duty.

In assessing Respondent's testimony regarding his patient records, a majority of the Committee noted a sense of arrogance and interpreted this arrogance to mean Respondent believed patient records are required for other physicians but not Respondent. Respondent knew what an appropriate patient record should contain but consciously decided to ignore this important area within the practice of medicine.

Moving now to the clinical care provided by Respondent, the Committee finds negligent practice in the treatment of patients A, B, D, E, F, G and H. Earlier in this decision, the Committee analyzed the findings of fact to determine which of the factual allegations had been proven by the State. That analysis appears in the sections above entitled conclusions with regard to factual allegations for each listed patient. It is based upon the previously stated conclusions that the Committee finds seven occasions of negligence.

With regard to Patient C, the Committee finds that while the State proved allegations C.1. through C.4. and C.7., the actions by Respondent did not rise to the level of negligence (other than with regard to his records). Allegations C.1, C.4, and C.7, which refer to his record keeping, were sustained and are part of the conclusions of negligence based upon extremely substandard patient records.

With regard to allegation C.3., the State established, by a preponderance of the evidence that Respondent inappropriately placed this patient under general anesthesia. However, the Committee is not convinced that this action rises to the level of negligence.

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[12] These specifications refer to violations of subdivision 6530(32) which requires physicians to keep accurate records which reflect the care and treatment rendered to each patient.

In allegation C.5., the State charged that the subsequent surgery performed on this patient was unnecessary. The Committee finds that the evidence shows the surgery was necessary. The question was: *When* should the subsequent surgery have been performed? The Committee finds the State did not establish the appropriate length of time between surgeries consistent with accepted standards of medicine. As drafted, this charge cannot be sustained and hence it cannot form the basis for sustaining a specification.

Finally, the State charged Respondent with planning for an unwarranted x-ray of the right elbow (C.6.). However, the evidence indicates that the x-ray may have been warranted. The State did not establish the objective criteria necessary to establish this particular x-ray was needed or not. Therefore, the Committee cannot determine whether it was warranted or not. As drafted, this charge cannot be sustained and hence it cannot form the basis for sustaining a specification.

Therefore,
Based upon the following Factual Allegations:
A.1., and A.5.;
B.1., B.2 and B.6;
C.1, C.3, C.4, and C.7;
D.1., D.2. and D.6.;
E.1., E.2., E.6, E.7.[13]and E.10;
F.1., F.2., and F.4.;
G.1., G.2. G.3 and G.5;
H.1., H.2b., H.2b(i)., H.2b(ii)., H.2b (iii)., and H.6.

THE FIRST SPECIFICATION IS SUSTAINED.

THE SECOND THROUGH NINTH SPECIFICATION
GROSS NEGLIGENCE

Gross negligence is defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The Committee has reviewed each of the acts of negligence established under the First Specification and found that only the Seventh Specification rises to the level of gross negligence. None of the remaining specifications individually nor all the acts combined, rise to the level of egregious conduct.

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[13]While Factual Allegation E.5. was sustained in that the Committee found Respondent had acted in the manner depicted in the charge, the Committee does not find that the conduct rises to the level of professional misconduct.

The Committee was split as to their response to the Seventh Specification. The conclusions of the majority follow:

The Seventh Specification arises from Factual Allegation F.1. In reference to this allegation, Respondent stipulated he operated on the wrong finger (the patient's left middle finger instead of the right middle finger). Wrong site surgery constitutes violations of some of the most basic and fundamental standards of medicine. In order to perform surgery on the wrong digit, a physician must demonstrate an egregious lack of care and diligence. To perform surgery on the wrong body part, the surgeon must ignore the x-rays, the patient record, and fail to perform the most limited physical examination.

Therefore,

THE SECOND SPECIFICATION IS NOT SUSTAINED;
THE THIRD SPECIFICATION IS NOT SUSTAINED
THE FOURTH SPECIFICATION IS NOT SUSTAINED;
THE FIFTH SPECIFICATION IS NOT SUSTAINED;
THE SIXTH SPECIFICATION IS NOT SUSTAINED
THE SEVENTH SPECIFICATION IS, BY A SPLIT VOTE, (2-1) SUSTAINED;
THE EIGHTH SPECIFICATION IS NOT SUSTAINED
THE NINTH SPECIFICATION IS NOT SUSTAINED;

THE TENTH SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Incompetence can arise where a practitioner demonstrates he or she does not have the knowledge necessary to appropriately provide a given course of care and treatment. It may also arise where a practitioner has the requisite training and knowledge for a course of treatment but acts as if he or she does not have the appropriate level of training and knowledge..

Employing the above definitions the Committee finds that Respondent did not demonstrate incompetence. The fact is, Respondent demonstrated he is a competent surgeon. He is also able to diagnose and treat patients within accepted standards. It can be said that since Respondent demonstrated he had appropriate levels of skill and training, his failure to practice according to generally accepted standards is more serious.

Therefore,

THE TENTH SPECIFICATION IS NOT SUSTAINED;

THE ELEVENTH SPECIFICATION
GROSS INCOMPETENCE

The Committee has not found any occasion of incompetence. Since ordinary incompetence is a lesser included offense in gross incompetence, the Committee cannot find gross incompetence.

Therefore,
THE ELEVENTH SPECIFICATION IS NOT SUSTAINED;

THE TWELFTH THROUGH SIXTEENTH SPECIFICATIONS
FRAUDULENT PRACTICE

The Committee has stated they did not find fraudulent practice in Factual Allegation D (Specification Thirteen), Factual Allegation F (Specification Fourteen) and Factual Allegation G (Specification 15). The primary reason the Committee did not find fraud in these charges is that the State never established the standards for what services, including aftercare, are part of the global fee for a procedure and what services can be billed separately. Since no standard was established, the Committee could not make a finding that Respondent submitted duplicate bills for services falling within the global fee plus aftercare.

The elements of proof necessary to sustain a finding of fraud have been stated in great detail under the discussion of the applications to Blue Cross and Blue Shield. They will not be repeated here.

In the charges which form the basis for the Twelfth Specification, the State has shown by a preponderance of the evidence that Respondent, in the conduct of his medical practice, presented bills for services which were not rendered or double billed for the same service. At the time Respondent rendered these bills, he knew the bills were false and Respondent intended to mislead the insurance carriers for monetary gain.

In so finding a majority of the Committee relies upon their previous conclusions Respondent was not a truthful witness and therefore fully capable of perpetrating this fraud. The subtlety of charging for the knee arthroplasty, a meniscectomy and a synovectomy at the same time indicates it is not a good faith error. Such a bill would require some thought and is evidence of dishonest intent. Respondent had a clear pecuniary interest in charging as much as possible for his services. As in the applications for participation in Blue Cross

and Blue Shield, Respondent has demonstrated an ability to provide false or misleading information when doing so will bring him additional income.

Therefore,

THE TWELFTH SPECIFICATION IS SUSTAINED;
THE THIRTEENTH SPECIFICATION IS NOT SUSTAINED;
THE FOURTEENTH SPECIFICATION IS NOT SUSTAINED;
THE FIFTEENTH SPECIFICATION IS NOT SUSTAINED;
THE SIXTEENTH SPECIFICATION IS SUSTAINED;

THE SEVENTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS FAILURE TO MAINTAIN RECORDS

The Committee has set forth their opinion regarding the utterly substandard records maintained by Respondent. As will be seen, some of the charges that form the basis for these specifications were not proven. However, there were more than enough examples for the Committee to sustain these specifications.

Therefore,
Based upon the following Factual Allegations:
A.5.;
B.1., B.2. and B.6;
C.1., C.4., and C.7;
D.1., D.2. and D.6.;
E.1., E.2., E.5., E.6., and E.7[14].;
F.2., and F.4.;
G.1., G.2., G.3 and G.5;
H.6.
THE SEVENTEENTH SPECIFICATION IS SUSTAINED;
THE EIGHTEENTH SPECIFICATION IS SUSTAINED;
THE NINETEENTH SPECIFICATION IS SUSTAINED;
THE TWENTIETH SPECIFICATION IS SUSTAINED;
THE TWENTY-FIRST SPECIFICATION IS SUSTAINED;
THE TWENTY SECOND SPECIFICATION IS SUSTAINED;
THE TWENTY-THIRD SPECIFICATION IS SUSTAINED;
THE TWENTY FOURTH SPECIFICATION IS SUSTAINED;

THE TWENTY-FIFTH THROUGH THE TWENTY-SIXTH SPECIFICATIONS FAILURE TO COMPLETE PATIENT REIMBURSEMENT FORMS

The Committee has found Respondent failed to provide Patient I and Patient J with forms necessary for the patients to obtain reimbursement.

Therefore,

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[14]Finding of fact E.10 was only sustained in part. The Committee will not include it in a Specification. The issue in E.10, substandard records, has been addressed repeatedly in the other charges.

THE TWENTY-FIFTH SPECIFICATION IS SUSTAINED;
THE TWENTY SIXTH SPECIFICATION IS SUSTAINED;

THE TWENTY-SEVENTH THROUGH THE TWENTY-EIGHTH SPECIFICATIONS WILLFULLY HARASSING, ABUSING AND INTIMIDATING A PATIENT

The Committee has found Respondent was not abusive to patient I and Patient J.

Therefore,

THE TWENTY-SEVENTH SPECIFICATION IS NOT SUSTAINED;
THE TWENTY EIGHTH SPECIFICATION IS NOT SUSTAINED;

SUMMARY
OF
DISPOSITION OF ALLEGATIONS

Allegations A. and A.1. **are SUSTAINED**

Allegation A. and A.2. **are NOT SUSTAINED**

Allegation A. and A.3. are **NOT SUSTAINED**

Allegations A and A.4. and A.4.a. **are SUSTAINED**

Allegation A.4. and A.4.b. **are NOT SUSTAINED**

Allegations A.4. and A.4.c. **are SUSTAINED**

Allegations A and A.5. **are SUSTAINED**

Allegations B. and B.1. **are SUSTAINED**

Allegations B. and B.2. **are SUSTAINED**

Allegation B. and B.3. **are NOT SUSTAINED**

Allegation B. and B.4. **are NOT SUSTAINED**

Allegation B. and B.5. **are NOT SUSTAINED**

Allegations B. and B.6. **are SUSTAINED**

Allegations C. and C.1 **are Sustained**

Allegation C.2. was withdrawn

Allegations C and C.3. by a 2 to 1 vote, **are SUSTAINED**

Allegations C and C.4. **are SUSTAINED**

Allegation C and C.5. **are NOT SUSTAINED**

Allegation C.5. A. was withdrawn

Allegation C. and C.6. **are NOT SUSTAINED**

Allegations C. and C.7. **are SUSTAINED**

Allegations D. and D.1. **are SUSTAINED**

Allegations D. and D.2. **are SUSTAINED**

Allegation D. and D.3 **are NOT SUSTAINED;**

Allegation D. and D.3.a. **are NOT SUSTAINED;**

Allegation D. and D.4. **are NOT SUSTAINED**

Allegation D. and D.5 **are NOT SUSTAINED;**

Allegations D. and D.5.a. **are SUSTAINED;**

Allegation D. and D.5.b. **are NOT SUSTAINED**

Allegations D. and D.6 **are SUSTAINED**

Allegations E. and E.1. **are Sustained**

Allegations E. and E.2. **are Sustained**

Allegations E.3. and E.4. WERE WITHDRAWN

Allegations E. and E.5. **are Sustained**

Allegations E. and E.6. **are Sustained**

Allegations E. and E.7. **are Sustained**

Allegation E. and E.8. **are Not Sustained**

Factual Allegation E.9. Was Withdrawn

Allegations E. and E.10. **are Sustained in part**

Allegations F. and F.1. **are SUSTAINED**

Allegations F. and F.2. **are SUSTAINED**

Allegation F. and F.3.a. **are NOT SUSTAINED**

Allegation F. and F3.b. **are NOT SUSTAINED**

Allegations F. and F.4. **are SUSTAINED**

Allegations G. and G.1. **are Sustained**

Allegations G. and G.2. **are Sustained**

Allegations G. and G.3. **are Sustained**

Allegation G and G.4. **are NOT SUSTAINED**

Allegations G. and G.5. **are Sustained**

Allegations H. and H.1. **are SUSTAINED**

Allegations H. and H.2.a. **are NOT SUSTAINED**

Allegations H. and H.2 b.(i.), H.2,b. (ii.) and H.2.b.(iii) **are SUSTAINED**

Allegations H. and H.3. **are NOT SUSTAINED**

Allegations H.4 and H.5 were withdrawn

Allegations H. and H.6. **Are SUSTAINED**

Allegations I. and I.1. **are SUSTAINED**

Allegations I. and I.2. **are SUSTAINED**

Allegations I. and I.3. **are SUSTAINED**

Allegations I. and I.4. **are,** by a split vote (2 - 1) **SUSTAINED**

Allegations J. and J.1. **are SUSTAINED**

Allegation J. and J.2. **are NOT SUSTAINED**

Allegations K. and K.1. **are SUSTAINED**

Allegation K. and K.2. **are NOT SUSTAINED**

SUMMARY
OF
DISPOSITION OF SPECIFICATIONS

THE FIRST SPECIFICATION IS SUSTAINED.

THE SECOND SPECIFICATION IS NOT SUSTAINED;

THE THIRD SPECIFICATION IS NOT SUSTAINED

THE FOURTH SPECIFICATION IS NOT SUSTAINED;

THE FIFTH SPECIFICATION IS NOT SUSTAINED;

THE SIXTH SPECIFICATION IS NOT SUSTAINED

THE SEVENTH SPECIFICATION IS, BY A SPLIT VOTE, (2-1) SUSTAINED;

THE EIGHTH SPECIFICATION IS NOT SUSTAINED

THE NINTH SPECIFICATION IS NOT SUSTAINED;

THE TENTH SPECIFICATION IS NOT SUSTAINED

THE ELEVENTH SPECIFICATION IS NOT SUSTAINED;

THE TWELFTH SPECIFICATION IS SUSTAINED;

THE THIRTEENTH SPECIFICATION IS NOT SUSTAINED;

THE FOURTEENTH SPECIFICATION IS NOT SUSTAINED;

THE FIFTEENTH SPECIFICATION IS NOT SUSTAINED;

THE SIXTEENTH SPECIFICATION IS SUSTAINED;

THE SEVENTEENTH SPECIFICATION IS SUSTAINED;

THE EIGHTEENTH SPECIFICATION IS SUSTAINED;

THE NINETEENTH SPECIFICATION IS SUSTAINED;

THE TWENTIETH SPECIFICATION IS SUSTAINED;

THE TWENTY-FIRST SPECIFICATION IS SUSTAINED;

THE TWENTY SECOND SPECIFICATION IS SUSTAINED;

THE TWENTY-THIRD SPECIFICATION IS SUSTAINED;

THE TWENTY FOURTH SPECIFICATION IS SUSTAINED

THE TWENTY-FIFTH SPECIFICATION IS SUSTAINED;

THE TWENTY SIXTH SPECIFICATION IS SUSTAINED;

THE TWENTY-SEVENTH SPECIFICATION IS NOT SUSTAINED;

THE TWENTY EIGHTH SPECIFICATION IS NOT SUSTAINED;

CONCLUSIONS REGARDING PENALTY

The Committee has found Respondent guilty of 14 Specifications of misconduct. In so doing, the Committee has found a disturbing pattern of sloppy care and extremely substandard records. The Committee believes Respondent has the basic skills expected of a orthopaedist in this state. However, a majority of the committee finds he exhibits a supercilious attitude such that he considers himself exempt him from common safety measures and record keeping. Patient F (wrong site surgery) is a prime example of this pattern: Had Respondent followed all the established protocols designed to make sure surgery is performed on the correct digit, Patient F would not have had to undergo a second surgery.

Perhaps of greater concern is Respondent's refusal to accept responsibility for his errors. As pointed out previously, with regard to Patient F, Respondent sought to implicate others and outside factors in explanation of the error: The members of the surgical team; the patient; and other members of the hospital staff were cited as bearing a portion of the responsibility for surgery he performed on the wrong finger. In his letter to the hospital administration, Respondent attributed the error to what can be summarized as a difficult day at the hospital. The first step to avoiding future errors is to admit the error that has been made and accept appropriate responsibility. Given Respondent's evident lack of insight, there is a significant danger Respondent may repeat his mishandling of this patient on a subsequent patient.

The substandard care rendered by Respondent is not limited to any specific area of medicine. Rather, the substandard care is global, covering virtually all aspects of his medical care. With the exception of his records (which were consistently abysmal), sometimes Respondent practiced within accepted standards. In another case, involving the same aspect of medicine, he demonstrates sub-marginal care. This inconsistency leads the Committee to conclude that Respondent is a sloppy practitioner who tends to cut corners. With regard to the matters for which Respondent did offer testimony, his testimony was evasive.

Finally, Respondent has been found guilty of two counts of fraudulent practice. Respondent defrauded a health insurance carrier by submitting bills twice for the same procedure. Respondent submitted charges for a hospital visit on a day when the patient was no longer in the hospital. Respondent also submitted false applications. Respondent, on the three occasions set forth above, lied.

This sort of behavior cannot be tolerated. Respondent has broken the special trust endowed upon physicians solely by virtue of their licensure. Respondent has also violated his fiduciary responsibilities to the

public. The people of this state have a right to expect physicians will not steal money from insurance carriers by submitting false bills. The people of this state have a right to expect a physician will not lie to insurance reimbursement programs in order to be granted membership. The people of this state have a right to expect all physicians to be trustworthy and honest. Finally, the people of this state have a right to expect their physicians to be direct and forthcoming, not evasive. Respondent has violated each of these rights, standards and obligations.

As set forth earlier, a majority of the Committee sees no hope of reform. According to Respondent, he has made no serious errors and has been entirely truthful in his practice. According to Respondent, his practice habits are entirely sufficient and violate no standards of medical practice. Indeed, Respondent, projects an air of superiority such that the established standards of medicine do not apply to him. According to Respondent, whatever criticism he has endured, has been caused substantially by the fault of others. It is impossible for a physician to reform when he denies his own shortcomings.

The final penalty was not unanimous. The majority found that given the magnitude of the deviations from accepted standards of medicine and Respondent's refusal to recognize his own faults, there can be only one remedy: revocation. The minority view was that Respondent should be subject to a suspension of his license, a civil penalty and probation plus re-education about record keeping.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

1. The following Factual allegations in the Statement of Charges (attached to this Decision and Order as Appendix One) **are Sustained;**

Allegations A. and A.1. A.4., A.4.a, A.4.c., and A.5.;
Allegations B. and B.1., B.2., and B.6.;
Allegations C. and C.1, C.3., C.4., and C.7.
Allegation D. and D.1., D.2., and D.6;
Allegation E. and E.1., E.2., E.5., E.6., E.7, E.10.
Allegation F. and F.1., F.2., F.4.
Allegation G. and G.1. G.2., G.3. G.5.;
Allegations H. and H.1., H.2 b.(i.), H.2,b.(ii.) H.2.b.(iii) and H.6.
Allegation I. and I.1. I.2. I.3. and I.4.
Allegation J. and J.1.;
Allegation K. and K.1.

Furthermore, it is hereby **ORDERED** that;

2. The Following Specifications of Misconduct contained within the Statement of Charges (Appendix One) are Sustained;

The First Specification
The Seventh Specification;
The Twelfth Specification;
The Sixteenth Specification;
The Seventeenth Specification;
The Eighteenth Specification;
The Nineteenth Specification;
The Twentieth Specification;
The Twenty-First Specification;
The Twenty Second Specification;
The Twenty-Third Specification;
The Twenty Fourth Specification
The Twenty-Fifth Specification;

The Twenty Sixth Specification;

Furthermore, it is hereby **ORDERED** that;

3. Respondent's license to practice medicine in the State of New York is **REVOKED**;

Furthermore, it is hereby **ORDERED** that;

4. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

DATED: Buffalo, New York

Dec. 18, **2002**

William K. Major Jr. MD.

WILLIAM K. MAJOR, JR., M.D., Chairperson
DAVID HARRIS, M.D.
REVEREND EDWARD J. HAYES

To:

Anne H. Gayle, Esq., Associate Counsel
Marcia Kaplan, Esq., Associate Counsel
Division of Legal Affairs
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001

Louis A. Piccone, Esq.
245 North Gannon Avenue
Staten Island, New York, 10314

Safwat A. Youssef, M.D.
410 Bard Avenue
Staten Island, New York

APPENDIX ONE

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

IN THE MATTER

OF

SAFWAT ATTIA YOUSSEF, M.D.

AMENDED STATEMENT OF CHARGES

Safwat Attia Youssef, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 3, 1981, by the issuance of license number 145667, by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a male, d.o.b. 2/17/30, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for at least osteoarthritis of the right and/or left knee, from approximately July 19, 1989 to October 17, 1991.

1. On or about June 7, 1991, Respondent inappropriately and unnecessarily performed arthroscopic surgery upon Patient A.
2. On or about June 21, 1991, Respondent failed to properly align Patient A's knee and/or failed to recognize and/or address this technical problem intraoperatively during a total knee replacement (TKR) which he performed upon Patient A which necessitated another procedure on or about June 26, 1991.
3. Respondent failed to date the x-rays taken of Patient A or have that done.
4. Respondent billed inappropriately for the procedures performed upon Patient A:

a. Respondent falsely billed for the procedures which he performed upon Patient A by billing separately for the total knee arthroplasty and the meniscectomy and the synovectomy.

b. Respondent billed for 11 inpatient post-operative visits which were all part of the after-care period.

c. On or about June 8, 1991, Respondent billed for an inpatient post-operative visit, a date on which Patient A was no longer in the hospital.

5. Respondent failed to maintain a record for Patient A which accurately reflects the care and treatment provided to Patient A.

B. Respondent treated Patient B, a then 51 year old female, at his office, located at 410 Bard Avenue, Staten Island, New York, for thumb pain and soft tissue swelling, from approximately February 4, 1991 to February 13, 1991.

1. Respondent failed to take an adequate history from Patient B or to note such history in the chart.

2. Respondent failed to perform an adequate physical examination upon Patient B or to note such examination in the chart.

3. Respondent failed to appropriately diagnose Patient B's condition.

4. Respondent inappropriately and incorrectly treated Patient B's acute condition with Allopurinol.

5. Respondent failed to follow up on findings from laboratory and other examinations which were performed upon Patient B or to note such follow up in the chart.

6. Respondent failed to maintain a record for Patient B which

ERROR B NOT WITHDRAWN 3/8/01

accurately reflects the care and treatment provided to Patient B.

C. Respondent treated Patient C, a female, d.o.b. 7/20/56, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for a left hip fracture-dislocation involving severe acetabulum fracture, and various other complaints, from approximately December 2, 1992 to September 6, 1994.

1. Respondent inappropriately failed to make and record a detailed pre-operative note about the patient's injuries and planned procedures.

2. Respondent ~~inappropriately failed to make and record accurate~~ operative notes.

3. Respondent inappropriately and unnecessarily used general anesthesia in the operating room for a procedure placing Patient C in femoral pin traction for a presumed loss of fixation.

4. Respondent failed to record chart notes which accurately reflect Patient C's condition as that condition was established by radiological and other studies.

5. Respondent unnecessarily performed a fourth operation upon Patient C to remove ectopic bone at the lateral acetabulum ~~when this problem could have been addressed at the total hip replacement (THR) procedure.~~

   a. ~~If a fourth operation was necessary, then~~ Respondent failed to appropriately defer that operation to a ~~later~~ time to allow maturation of the ectopic bone in order ~~to decrease~~ a risk of reoccurrence.

WITHDRAWN 3/6/01 JB

WITHDRAWN 3/6/01 JB

6. Respondent's office note of 5/24/93 inappropriately indicates a plan for right elbow x-rays.

7. Respondent failed to maintain a record for Patient C which accurately reflects the care and treatment provided to Patient C.

D. Respondent treated Patient D, a female, d.o.b. 11/29/53, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, and/or at Doctors Hospital of Staten Island, 1050 Targee Street, Staten Island, New York, for right shoulder pain and dislocation, from approximately May 25, 1988 to August 17, 1989.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient D or to note such history in the chart.

2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination upon Patient D or to note such examination in the chart.

3. On or about July 5, 1988, Respondent inappropriately performed surgery indicated for an acute problem when Patient D's problem was already chronic.

   a. Respondent's surgery of July 5, 1988 was poorly done resulting in reoccurrence of the deformity of the AC joint In September 1988 when she lifted her 16 pound child.

4. On or about January 20, 1989, Respondent performed surgery which was inappropriately indicated for a late reconstruction.

5. Throughout the course of treatment, Respondent billed inappropriately for the procedures performed upon Patient D:

a. Respondent failed to bill for a global surgical fee.

b. Respondent billed for each office and hospital visit and for dressing changes which were all part of the after-care period.

6. Respondent failed to maintain a record for Patient D which accurately reflects the care and treatment provided to Patient D.

E. Respondent treated Patient E, a female, d.o.b 12/22/38, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for left wrist fractures, and various other complaints, from approximately January 2, 1994 to May 13, 1994.

1. Repeatedly throughout the course of treatment, Respondent failed to take an adequate history from Patient E or to note such history in the chart.

2. Repeatedly throughout the course of treatment, Respondent failed to perform an adequate physical examination upon Patient E or to note such examination in the chart.

3. Respondent failed to timely split the cast and Webril on both sides to the skin or to use a well-molded sugar-tong splint.

4. In view of Patient E's complaint of paraesthesia and pain, Respondent failed to appropriately diagnose possible compartment syndrome or acute carpal tunnel syndrome and to bivalve the cast and cut the Webril down to the skin. If a subsequent open procedure was deemed necessary and a volar approach was chosen then Respondent inappropriately failed to perform a carpal tunnel release and open reduction internal fixation.

3/8/01 WITHDRAWN

5. Respondent failed to indicate in the chart when he had removed the K-wire.

6. Respondent failed to order or perform x-rays between the patient's treatment in the operating room on 1/9/94 and the office visit of 2/14/94, ~~or to follow her by x-ray to full healing~~ or to indicate such, ~~as well as the results of her occupational therapy treatment,~~ in the chart.

7. Respondent failed to pursue adequate follow-up of Patient E especially for the early stages of these fractures and/or failed to note his follow-up and/or his recommendations to the patient to follow-up in the chart.

8. Respondent failed to accurately record in his operative report for Patient E's surgery of 1/9/94 whether a long arm or short arm cast was applied ~~and whether she had a sugar tong splint.~~

9. Respondent failed to record chart notes which accurately reflect Patient E's condition as that condition was established by radiological and other studies.

10. Respondent failed to maintain a record and x-rays for Patient E which accurately reflects the care and treatment provided to Patient E.

F. Respondent treated Patient F, a male, d.o.b. 4/8/64, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for a dislocation of his finger, from approximately January 28, 1993 to June 19, 1997.

1. Respondent incorrectly and inappropriately performed surgery on Patient F's left middle finger.

2. Respondent failed to perform an adequate physical examination upon Patient F or to note such examination in the chart.

3. Respondent billed inappropriately for the procedures performed upon Patient F:

   a. Respondent failed to bill for a global surgical fee.

   b. Respondent billed for each office and hospital visit, and for dressing changes which were all part of the after-care period.

4. Respondent failed to maintain a record for Patient F which accurately reflects the care and treatment provided to Patient F.

G. Respondent treated Patient G, a male, d.o.b. 2/18/66, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for repair of his right shoulder, from approximately September 15, 1988 to October 12, 1988.

1. Respondent failed to take an adequate history from Patient G or to note such history in the chart.

2. Respondent failed to perform an adequate physical examination upon Patient G or to note such examination in the chart.

3. Respondent failed to provide a plan for mobilization or to note such plan in the chart.

4. Respondent billed inappropriately for the procedures performed upon Patient G by billing for each office and hospital visit which were all part of the after-care period.

5. Respondent failed to maintain a record for Patient G which accurately reflects the care and treatment provided to Patient G.

H. Respondent treated Patient H, a male, d.o.b. 6/9/55, at his office, located at

410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for chronic osteomyelitis, from approximately August 9, 1989 to January 14, 1991.

1. On August 9, 1989, when Respondent noted a hemarthrosis of Patient H's left knee, he aspirated it but failed to culture the drainage or send it for culture.
2. Prior to his first surgery of Patient H, Respondent failed to provide treatment of any kind for either the draining chronic osteomyelitis or the knee injury, or to obtain a bone and/or Indium scan, and/or a bone biopsy and/or an MRI and/or a CT scan to investigate the infection and/or presence of sequestrum.
3. Once surgical debridement was decided upon, Respondent inappropriately attempted to cover the wound at the first debridement; Respondent also failed to ensure adequate bony debridement and a clean bony bed on which to place soft tissue for coverage.
4. Respondent failed to adequately instruct Patient H on how to do dressing changes prior to his discharge on June 16, 1990 or to note such in the chart.
5. Respondent failed to prescribe or provide proper discharge antibiotics, and make the appropriate Infectious Disease follow-up for Patient H or to note such in the chart.
6. Respondent failed to maintain a record for Patient H which accurately reflects the care and treatment provided to Patient H.

1+5 WITHDRAWN 3/22/01 JB

I. With the intention of deceiving Empire Blue Cross and Blue Shield Managed Care Networks (hereinafter "Empire"):

1. Respondent, on or about May 15, 1995, in his physician application to Empire, knowingly and intentionally falsely answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?".

2. Respondent, on or about November 19, 1996 (re-signed July 20, 1997), on an Empire ReCredentialing Application, knowingly and intentionally falsely answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?".

3. Respondent, on or about January 5, 2000, on an Empire Credentialing Attestation, knowingly and intentionally falsely answered "no" to a question which read, "Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?".

4. Respondent, on or about May 15, 1995, or November 19, 1996, or July 20, 1997, or January 5, 2000, knowingly and intentionally falsely represented to Empire that he had been involved in only four malpractice actions.

J. Respondent treated Patient I, a male, d.o.b. 12/23/49, at his office, located at 421 Old Bridge Turnpike, East Brunswick, New Jersey, and/or at Raritan Bay Medical Center, Old Bridge Division, located at 1 Hospital Plaza, Old Bridge, New Jersey, for a fall, from approximately January 27, 1994 to April 12, 1994.

1. Respondent failed to provide Patient I with itemized bills for services rendered by Respondent and paid to Respondent by Patient I or to fill out forms which were required for reimbursement to Patient I in relation to his Workers'

Compensation claims.

2. Respondent was verbally abusive to Patient I.

K. Respondent treated Patient J, a male, d.o.b. 2/8/56, at his office, located at 410 Bard Avenue, Staten Island, New York, and/or at St. Vincent's Medical Center of Richmond, located at 355 Bard Avenue, Staten Island, New York, for left and right knee problems, from approximately February 1, 1990 to January 3, 1996.

WITHDRAWN JB 2/20/01

1. Respondent failed to ~~provide Patient J with copies of his medical records or to~~ fill out forms which were required for reimbursement to Patient J in relation to his Social Security Disability claims.

2. Respondent was verbally abusive to Patient J and Patient J's wife.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2001) 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:

1. Paragraphs A and A1-3 and/or 5, B and B1-6, C and C1-7, D and D1-4 and/or 6, E and E1-10, F and F1, 2 and/or 4, G and G1-3 and/or 5, H and H1-6.

SECOND THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2001) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

2. Paragraphs A and A1-3 and/or 5.
3. Paragraphs B and B1-6.
4. Paragraphs C and C1-7.
5. Paragraphs D and D1-4 and/or 6.
6. Paragraphs E and E1-10.
7. Paragraphs F and F1, 2 and/or 4.
8. Paragraphs G and G1-3 and/or 5.
9. Paragraphs H and H1-6.

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2001) 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:

10. Paragraphs A and A1-3 and/or 5, B and B1-6, C and C1-7, D and D1-4 and/or 6, E and E1-10, F and F1, 2 and/or 4, G and G1-3 and/or 5, H and H1-6.

ELEVENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2001) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

11. Paragraphs A and A1-3 and/or 5, B and B1-6, C and C1-7, D and D1-4 and/or 6, E and E1-10, F and F1, 2 and/or 4, G and G1-3 and/or 5, H and H1-6.

TWELFTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2001) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

12. Paragraphs A and A4a -c.
13. Paragraphs D and D5a and/or b.
14. Paragraphs F and F3a and/or b.
15. Paragraphs G and G4.
16. Paragraph I and I1-4.

SEVENTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §(32)(McKinney Supp. 2001) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

17. Paragraph A and A3 and/or 5.
18. Paragraph B and B1, 2, 5, and/or 6.
19. Paragraph C and C1, 2, 4, 6, and/or 7.
20. Paragraph D and D1, 2, and/or 6.
21. Paragraph E and E1, 2, and/or 5-10.
22. Paragraph F and F2 and/or 4.
23. Paragraph G and G1-3 and/or 5.
24. Paragraph H and H4-6.

TWENTY-FIFTH AND TWENTY-SIXTH SPECIFICATIONS

FAILURE TO COMPLETE FORMS REQUIRED FOR REIMBURSEMENT OF A PATIENT BY A THIRD PARTY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(43)(McKinney Supp. 2001) by failing to complete forms or reports required for the reimbursement of a patient by a third party, as alleged in the facts of:

25. Paragraph J and J1.

26. Paragraph K and K1.

TWENTY-SEVENTH AND TWENTY-EIGHTH SPECIFICATIONS

WILLFULLY HARASSING, ABUSING AND INTIMIDATING A PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(31)(McKinney Supp. 2001) by willfully harassing, abusing and intimidating Patients J and K, as alleged in the facts of:

27. Paragraph J and J2.

28. Paragraph K and K2.

DATED: January 9, 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct