THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY NY 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

Isidro M. Bulatao, Physician
7 Mohawk View Road
Latham, New York 12110-1735

July 23, 1993

Re: License No. 097438

Dear Dr. Bulatao:

Enclosed please find Commissioner's Order No. 13628. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service. . .

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

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR
cc: Barry A. Gold, Esq.
Thuillez, Ford, Gold & Connolly
90 State Street - Suite 1500
Albany, New York 12207

REPORT OF THE
REGENTS REVIEW COMMITTEE

ISIDRO MUNOZ BULATAO

CALENDAR NO. 13628

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

ISIDRO MUNOZ BULATAO **No. 13628**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

Between July 12, 1991 and April 10, 1992 a hearing was held in the instant matter on eight sessions before a hearing committee of the State Board for Professional Medical Conduct which subsequently rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "A". The statement of charges, as amended therein, and the "amendments to statement of charges" are annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded unanimously that respondent, Isidro Munoz Bulatao, was guilty of gross negligence (first through fifth specifications), gross incompetence (sixth through tenth specifications), negligence on more than one occasion (eleventh specification), and incompetence on more than one occasion (twelfth specification). The hearing committee recommended that

respondent's license to practice medicine be suspended for one year, respondent must organize a certain one year program of non-operational thoracic training, in the event of his failure to obtain hearing committee approval for this program, a suspension until the one year program is approved and completed, respondent will take and pass the recertification examination given by the American Board of Thoracic Surgery at the conclusion of the one year program, and respondent, when he resumes his practice, will perform surgery in only two certain hospitals.

The Commissioner of Health, by designee, recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted; the conclusions of the hearing committee be accepted, except (1) the general reference on page 38 of the hearing committee report should also include the reference to the record keeping charges as being not sustained and the allegations as to Patient D being not sustained and (2) the general reference on page 50 of the hearing committee report should be revised such that the report should refer to the hearing committee sustaining the first through third, fifth through eighth, tenth, eleventh, except as to D and D(1), and twelfth specifications except as to D and D(1); and the recommendation of the hearing committee be modified and respondent's license to practice medicine be suspended for three years, during such suspension period, respondent shall complete a certain one year program of non-operational thoracic surgery training, upon the completion of such program, the

suspension shall be stayed but, respondent's surgical practice for the remainder of the three year term shall be monitored by a board certified thoracic surgeon. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On December 22, 1992, respondent appeared in person and was represented by Barry A. Gold, Esq. E. Marta Sachey, Esq., presented oral argument on behalf of the Department of Health. Respondent's wife was present at respondent's request, for the oral argument.

Petitioner's written recommendation as to the penalty to be imposed, should respondent be found guilty, was the same as that of the Commissioner of Health.

Respondent's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was a suspension for two years, but that such suspension be stayed and he be placed on probation for two years, said terms of probation shall consist of: a supervising surgeon shall be present in the operating room and shall participate in each operation performed by respondent which involves entering a body cavity; that supervising surgeon shall also review the patient's record in order to determine that the patient has been cleared for surgery; the supervising surgeon shall preoperatively review the indications for all surgery that involves entering a body cavity, and shall approve the surgical plan; a pre-operative cardiology consultation for all

pacemaker replacement surgery; respondent shall be required to attend 100 hours of continuing medical education each year; respondent shall maintain legible medical records which accurately reflect his evaluation and treatment of each patient and respondent may continue to practice his profession as long as there is full compliance with every term of probation.

We have considered the record in this matter as transferred by the Department of Health, including respondent's memorandum and accompanying exhibits, a packet of letters in support of respondent, and petitioner's December 17, 1992 response.

Initially, we grant petitioner's application to correct allegation A of the statement of charges to the extent that the second sentence of said allegation be deemed corrected to read "Another physician" rather than respondent, implanted the pacemaker in 1984. This need for a correction was also pointed out by respondent.

Respondent challenges the findings and conclusions of the hearing committee. The report of the hearing committee indicated, on page 50, that the hearing committee sustained the first through twelfth specifications. Those specifications relate to charges of gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion. Such charges are each based upon various factual allegations regarding 5 patients, many of which allegations are repeated in different specifications. However, the hearing committee report does not

clearly and expressly state that respondent's guilt regarding the first through twelfth specifications is based upon every factual allegation sustained therein.

Respondent may not be found guilty to the full extent indicated by the hearing committee. The recommendation of the Commissioner of Health and the comments of petitioner show that the hearing committee sustained four different specifications which are not supported by its own findings of fact (fourth and ninth specifications as a whole and eleventh and twelfth specifications in part). Furthermore, although the hearing committee, on page 38 of its report, refers to respondent being guilty as to each charged definition of professional misconduct except fraud, the findings of fact also do not support any guilt being found as to unprofessional conduct based upon record-keeping.

The recommendation of the Commissioner of Health clarifies the above mistakes in the hearing committee's report. However, neither the hearing committee report nor the recommendation of the Commissioner of Health discusses the basis for finding respondent guilty as to each different definition of professional misconduct upon which respondent has been charged, or applies the elements of each definition of professional misconduct to the facts found. Respondent contended that these recommendations fail to distinguish between negligence and incompetence and between ordinary and gross misconduct.

We find respondent to be guilty, by a preponderance of the

evidence, of negligence on more than one occasion (eleventh specification) to the extent hereafter set forth. Such deviations from accepted standards in the practice of medicine were committed on three patients (A, B, and C). The record and the hearing committee report demonstrate a pattern, in these three cases, of respondent failing to act as a reasonably prudent physician. We do not accept the reference on page 51 of the hearing committee report to respondent's deficiencies being based on "surgical judgement".

We note that the guilt we find as to the five allegations sustained as to Patient A is two-fold. It relates to the inadequate follow-up care as charged in allegation A(1); and to the failure to properly evaluate, diagnose, and assess as charged in allegations A(2), A(5), and A(6) regarding the absence of an indication for the March 13, 1990 pacemaker replacement as charged in allegation A(3). With respect to Patient B, the conclusions we render are based solely on the record and not on the hearing committee's medical knowledge apart from the record. See, hearing committee report pages 43-44. In the case of Patient C, we do not accept the hearing committee's conclusions, on pages 44 and 45, regarding Dr. Ferraro's testimony inasmuch as Dr. Ferraro did not testify in this matter. See, hearing committee report pages 2-3. We have considered the entire record, including respondent's Exhibit M (Dr. Ferraro's November 14, 1990 letter) and Patient C's record, and find Dr. McCormack's opinion as to respondent's care and treatment of Patient C to be more credible than the opinion

evidence presented in respondent's case.

In our unanimous opinion, respondent is not guilty of the charges to the extent they relate to incompetence, gross incompetence, and gross negligence. The evidence was insufficient to establish, by a preponderance of the evidence, the elements of the first through tenth and twelfth specifications of the charges. Moreover, the hearing committee report and Health Commissioner recommendation, while showing respondent's commission of negligence on more than one occasion, do not sufficiently show, under all the circumstances, that respondent's conduct rose to the level of egregiousness* or was attributable to incompetence, as defined on page 37 of the hearing committee report.

We do not accept the recommended conclusion that respondent be found guilty regarding the allegations concerning Patient E. In our unanimous opinion, the charges as to Patient E are not supported by a preponderance of the evidence. We do not accord more weight to the opinion of petitioner's expert, Dr. Knight, who at the time of respondent's conduct in September 1981 was only a resident in general surgery and had not been the primary surgeon on a lung cancer case, than to the opinion of respondent's expert, Dr.

---

*The definition of gross negligence used by the hearing committee and Commissioner of Health (see, hearing committee report page 37) is not the definition previously followed by the courts for assessing the issue of gross negligence. Rho v. Ambach, 74 N.Y.2d 318 (1989); and Enu v. Sobol, 171 A.D.2d 302 (3rd Dept. 1991).

Arseneau. Cf. Stein v. Board of Regents of the University of the State of New York, 169 A.D.2d 857 (3rd Dept. 1991). After graduating from medical school in 1980, Dr. Knight was not licensed in New York State until 1982. In 1981, around seven years before he became board certified in thoracic surgery, Dr. Knight was not performing the type of surgery respondent performed on Patient E (pneumonectomy) and had never been the primary physician in charge of evaluating patients for pneumonectomies. Moreover, the hearing committee report does not discuss or demonstrate the basis for finding Dr. Knight to be more qualified than Dr. Arseneau.

We note that the hearing in this matter concluded more than 10 years after respondent treated Patient E.

We have also reviewed, in mitigation of penalty, the strong character evidence submitted in support of respondent. Both in testimony and in writing, respondent is considered by many of his peers to have an excellent reputation as a thoracic surgeon. He is a board certified thoracic surgeon. In addition, these professionals, from different practices and hospitals who have known respondent over a substantial period of time, find respondent to be compassionate, ethical, competent, professional, dependable, conscientious, and caring, and would utilize respondent's medical services on their family or themselves.

In agreement with respondent, the penalty we recommend is a two year suspension, execution of said suspension stayed, and probation for two years. The terms of probation we recommend

include, in the first year of probation, requirements for the direct supervision of respondent's practice of surgery, random review of respondent's office records, patient records, and hospital charts, and 100 hours of continuing medical education. In the second year of probation, the terms include the monitoring of respondent's practice and 100 hours of continuing medical education. This penalty is based on respondent being guilty of only the eleventh specification to the extent indicated herein. We have also considered the fact that two of the three patient cases we sustain as to negligence involve respondent's medical care occurring in or starting in 1984; and the third such case relates to respondent's medical care occurring in June 1988. Both petitioner and the hearing committee did not fault respondent for his surgical skills and abilities.

On the other hand, the penalties recommended by the hearing committee and Commissioner of Health, which do not state the specifications they are based upon or whether they are imposed cumulatively or concurrently, relate to their substantially different view as to the appropriate conclusions to be rendered regarding the specifications and allegations of charges.

We agree with petitioner that portions of the hearing committee's penalty recommendation is "not authorized by applicable law." In addition, the Commissioner of Health did not "believe that it is appropriate to demand that respondent be reboarded or resume his surgical practice at only two specific Albany area

hospitals." We do not accept the hearing committee's and Health Commissioner's different penalty recommendations, which both involve respondent's completion of a program of training during his actual suspension and, if the training program is not completed as indicated, there would be consequences to respondent's whole license for an indefinite period. The different conditional suspensions recommended by both the hearing committee and Commissioner of Health are not only unauthorized but confusing in their enforceability.

We unanimously recommend the following:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner as to those findings of fact be accepted, except finding of fact 75 not be accepted, finding of fact 49 be modified on line 6 of page 25 such that the reference to "Patient B" be deemed to read "Patient C", and finding of fact 51 be modified on page 26 line 1 such that the word "effecting" be deemed to read "affecting";
2. The conclusions of the hearing committee and the recommendation of the Health Commissioner as to those conclusions be modified;
3. Respondent be found guilty, by a preponderance of the evidence, of the eleventh specification of negligence on more than one occasion to the extent indicated in this Regents Review Committee report involving respondent not

adequately periodically assessing the magnet rate of Patient A's pacemaker (allegation A(1)); not properly evaluating the pacemaker for battery integrity, replacing the pacemaker, which was not indicated, failing to diagnose Patient A's underlying rhythm of atrial fibrilation, and not properly assessing atrial capture (allegations A(2), A(3), A(5), and A(6)); performing the contraindicated procedure of partially mobilizing a segment of Patient B's esophagus with its adherent periesophageal modes (allegation B(1)); and performing a radical resection of Patient C's tumor without having a definite diagnosis (allegation C(1)); and not guilty of the remaining allegations and specifications; and

4. The recommendation of the hearing committee and the recommendation of the Health Commissioner as to the recommendation of the hearing committee not be accepted and respondent's license to practice medicine in the State of New York be suspended for two years upon the eleventh specification of the charges of which respondent has been found guilty, as aforesaid, execution of said suspension be stayed, and respondent be placed on probation for a period of two years under the terms annexed hereto, made a part hereof, and marked as Exhibit D".

ISIDRO MUNOZ BULATAO (13628)

Respectfully submitted,

CARL T. HAYDEN

ROBERT E. DONNELLY

JOHN T. McKENNAN

Chairperson

Dated: 1/7/72

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

IN THE MATTER	:	REPORT
OF	:	OF THE
ISIDRO MUNOZ BULATAO, M.D.	:	HEARING COMMITTEE

TO: MARK R. CHASSIN, M.D., COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

WILLIAM A. STEWART, M.D. (Chair), MICHAEL R. GOLDING, M.D. and SISTER MARY THERESA MURPHY, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. MAUREEN J.M. ELY, ESQ. served as the Administrative Officer.

After consideration of the entire record, the Hearing Committee submits this Report.

SUMMARY OF PROCEEDINGS

Date of Notice of Hearing Statement of Charges:	June 11, 1991
Answer to Statement of Charges:	None

Pre-Hearing Conference:	*July 8, 1991*
Hearings Held:	*July 12, 1991* *October 2, 1991* *October 3, 1991* *December 5, 1991* *December 6, 1991* *February 27, 1992* *February 28, 1992* *April 10, 1992*
Location of Hearings:	*Empire State Plaza* *Albany, New York*
Adjournments:	*February 5 and 6, 1992* *(Respondent unable to attend hearings due to grave illness of his sister in the Phillipines. Documentation received.)* *November 15, 1991* *(Adjourned because it would not be a full-day of hearing and more economical use of time to hear witness on next scheduled date.)*
Received Petitioner's Proposed Findings of Fact:	*May 22, 1992*
Received Respondent's Proposed Findings of Fact:	*May 21, 1992*
Deliberations Held:	*June 8, 1992*
State Board for Professional Medical Conduct appeared by:	*E. Marta Sachey, Esq.* *Associate Counsel*
Respondent, Isidro Bulatao, appeared by:	*Barry A. Gold, Esq.*
Witnesses for State Board for Professional Medical Conduct:	*James W. Catlett* *Barry S. Lindenberg, M.D.* *Patricia McCormack, M.D.* *Peter A. Knight, M.D.*

Witnesses for Isidro Bulatao:	*Eric D. Cohen, M.D.* *Murray J. Miller, M.D.* *William V. Jacobson, M.D.* *James C. Arseneau, M.D.* *James E. Graber, M.D.* *John T. Phelan, Jr., M.D.*
Amendment of Statement of Charges:	*Addition of paragraph 4(a) in Allegation A* *Addition of reference to paragraph 4(a) in Thirteenth Specification* *Allegation B(1) changed "from" to "with"* *Allegation C(1) deleted "including a partial pericardiectomy and a partial pleurectomy"* *Allegation E(1) deleted "until September 21, 1981, when Respondent ordered an emergency echocardiogram, which was not"*

STATEMENT OF CASE

The Statement of Charges alleges that Isidro Bulatao, M.D. practiced medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraudulently, and failed to maintain adequate records in that he replaced a pacemaker without indication (Patient A) and performed surgery without indication (Patients B

through E). The allegations arise from the treatment of five patients seen between 1981 and 1990. The allegations are set forth with more particularity in the Amended Statement of Charges which is attached hereto as Appendix I.

FINDINGS OF FACT

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

1. Isidro Munoz Bulatao, M.D., hereinafter referred to as Respondent, was authorized to engage in the practice of medicine in New York State on September 20, 1966 by the issuance of license number 097438 by the New York State Education Department. (Statement of Charges, Exhibit 1).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period from January 1, 1991 through December 31, 1992. (Statement of Charges, Exhibit 2).

3. Respondent is a Board certified thoracic surgeon, trained in thoracic surgery at Albany Medical Center Hospital. (T. 1177; Ex. H). Respondent performs most of his surgery at Albany Memorial Hospital and St. Peter's Hospital. (T. 1188).

Patient A

4. Respondent provided medical care to Patient A at various times from 1984 through April 17, 1990 at his office and at the Leonard Hospital, Troy, New York. (Exs. 5 and 6).

5. In 1984, the patient, then eighty-seven years old, had an Intermedics Avius Model 263-01 Pacemaker inserted. (Ex. 7, pp. 3, 5).

6. Respondent, from approximately December 11, 1984 through October 11, 1988, provided pacemaker follow-up care to Patient A at his office. (Ex. 6, pp. 12-28).

7. On March 13, 1990 at the Leonard Hospital, Respondent removed the Intermedics Pacemaker and implanted a Pacesetter AFP II Model 283 Pacemaker in Patient A, then aged ninety-three. (Ex. 5, p. 96).

8. The pacemaker which was implanted in Patient A in 1984 by Dr. Posada is a DVI or A-V sequential pulse generator. The free running rate of this pacemaker does not change with battery depletion. Assessment of battery depletion is made by measuring the rate of the pacemaker when a magnet is applied. At the beginning of service, the magnet rate of the pacemaker is approximately ninety beats per minute. That magnet rate drops gradually as the battery becomes depleted to eighty-three beats per minute, which is considered end of life. (T. 93-94).

9. Proper follow-up care of the Intermedics Pacemaker originally implanted in Patient A should have included periodic assessment of the pacemaker's magnet rate. Such monitoring is important because early assessment and documentation of the magnet rate provide a baseline standard to compare with subsequent magnet

rate testing. (T. 95-97, 110).

10. During the first three years, the pacemaker's magnet rate should be determined at least every six months and, thereafter, every three months. (T. 97). There are multiple sources for the standards regarding the frequency with which patients should be seen for pacemaker follow-up. Every pacemaker comes with a manual containing the manufacturer's recommendations and it would be acceptable practice to follow those recommendations. (T. 98-100; Exs. 8A, 8B, pp. 23-24). The Medicare Program also has certain standards for frequency of patient follow-up. (T. 152). There are certain standards regarding what should be done at the time the patient is seen. (T. 200-201). Proper pacemaker follow-up would include determining the pacemaker's magnet rate. (T. 165).

11. Respondent provided pacemaker follow-up care to Patient A for approximately four years. He saw her every three months for the first two visits and, thereafter, every four months. (T. 95; Ex. 6). The frequency with which Respondent saw

the patient was "very acceptable." (T. 160, 203). However, Respondent did not periodically assess the pacemaker's magnet rate. (T. 203).

12. During the four years Respondent provided pacemaker follow-up care to the patient he checked the pacemaker magnet rate two times, June 25, 1985 and October 11, 1988. At no time did Respondent record the magnet rate and the June 25, 1985 rhythm strip is not in the patient's records. Further, no baseline magnet rate was documented. (T. 845, 862; Ex. 6).

13. The Intermedics Avius Model 263-01 pacemaker has an estimated life of between five to eight and one-half years. Respondent's reason for not determining the magnet rate of Patient A's pacemaker more frequently was the eight and one-half year life estimated by the manufacturer (T. 867).

14. On March 13, 1990, while at Leonard Hospital, Respondent saw Patient A's daughter who asked him to check on Patient A. Respondent looked at Patient A's EKG tracings and determined that an analysis of the patient's pacemaker was

warranted. Respondent contacted a pacemaker company representative with whom Respondent had worked for 15 years and requested an analysis of the pacemaker. (T. 874-879). Later that same day, Respondent replaced Patient A's pacemaker (Ex. 5, p. 96). Respondent did not evaluate the pacemaker company representative's analysis of the pacemaker (documentation).

15. Respondent's stated reason for replacing Patient A's pacemaker was pacemaker battery depletion. (Ex. 5, p. 96). Respondent further documented that the battery depletion was determined by the pacemaker company representative. (Ex. 5, pp. 15-16: "...on the present hospitalization a pacemaker analysis performed by...of the pacemaker company revealed pacemaker battery depletion" [consultation record, dictated 3-13-90]; Ex. 5, p. 26: "patient had pacemaker analysis performed by pacer company representative... Findings that of pacer battery depletion" [note, 3-13-90]. Respondent relied solely on the purported communication from the pacemaker company representative to him that there was battery depletion.

16. Respondent did not evaluate the pacemaker for battery integrity before he replaced the pacemaker due to battery depletion. There was no documentation or evidence that the pacemaker's magnet rate was assessed, which is the means to determine battery integrity. There was no documentation of a comparison of a current magnet rate with a prior rate. There was no documentation that the battery had reached its end of life parameters. There was no indication of how the battery was tested. [T. 118-119].

17. Respondent replaced Patient A's pacemaker with a Pacesetter DDD Pacer. (Ex. 5, p. 96). The original pacemaker was a DVI that stimulated both heart chambers, sensed in the ventricle and inhibited when it sensed. The replacement pacemaker was a DDD that paced and sensed both chambers and triggered, depending on the particular heart rhythm sensed. (T. 121).

18. Indications for the replacement of a pacemaker are battery depletion, component failure, or upgrade for various reasons, including changing from a single to a dual chamber pacer

if a patient is suffering from side effects of a single chamber pacemaker. None of these indications was present in Patient A's case. (T. 121-122).

19. The pulse generator that was removed was found by the manufacturer to be working properly and not to have reached its elective replacement indication. (Ex. 7, p. 5). Patient A, at the time of the pacemaker replacement, was ninety-three years old, ill, and had a DNR order. (T. 123, 127-128). Patient A had a "very poor outlook from even the time of admission" to the hospital. (Ex. 5, p. 5 [discharge summary]). Patient A's original pacemaker was functioning properly. (T. 191, 127-128). The pacemaker was responding normally to Patient A's underlying heart rhythm of atrial fibrillation. Once Patient A's natural rhythm of atrial fibrillation was recognized, an appropriate intervention would have been to reprogram her original pacemaker to a VVI mode. (T. 123-127, 128, 191-192, 705; Ex. 5, pp. 56, 57).

20. It would have been statistically rare for

Patient A's atrial fibrillation to have been due to her pacemaker. If Patient A's atrial fibrillation had been due to her pacemaker, that would not have been a reason to replace the pacemaker. Respondent never documented this as a reason for replacing the pacer in records made contemporaneous with the replacement. (Ex. 5, p. 96). In fact, several weeks after replacing the pacemaker, Respondent reprogrammed the new pacemaker in view of Patient A's underlying rhythm of atrial fibrillation. (Ex. 5, p. 39). Patient A was left with a new pacemaker that functioned very much like the one that was removed. (T. 142, 812, 823-824).

21. Respondent failed to diagnose Patient A's underlying rhythm of atrial fibrillation at the time Respondent replaced the patient's pacemaker. There was no documentation in the records made contemporaneous with Respondent's replacement of the pacemaker that he recognized that heart rhythm. (T. 133, 134).

22. Patient A had an underlying heart rhythm of atrial fibrillation. The March 11, 1990 EKG shows that rhythm. (T. 125-

126; Ex. 5, p. 57). The strip marked "old pacemaker out" shows irregular rhythm and no P-waves. (T. 134; Ex. 5, p. 25).

23. Respondent did not recognize Patient A's atrial fibrillation at the time he replaced her pacemaker. Respondent reported in his operative report a given atrial threshold. He reported a P-wave measurement. (T. 135-136, 204; Ex. 5, p. 96). He chose a replacement pacemaker left programmed in a DDD mode which was not indicated and contraindicated in a patient with atrial fibrillation. (T. 129-130, 136-137).

24. The above factors contradict and bring into question the veracity of the entry in the "Permanent Record" Respondent dictated on June 11, 1990 that Respondent recognized atrial fibrillation on March 13, 1990. (T. 137; Ex. 6, p. 2 [Respondent's office records]).

25. Failing to recognize the presence of atrial fibrillation in Patient A, Respondent implanted an inappropriate pacemaker left programmed in a contraindicated mode. (T. 129-130, 136-137).

26. Respondent did not properly assess atrial capture at the time he replaced Patient A's pacemaker. Atrial capture, the ability of a pacemaker to stimulate and cause electrical contraction in the atrium, cannot be assessed in a patient whose underlying rhythm is atrial fibrillation. In such a patient there is no atrial capture. In Patient A's case, there is a description of the minimal amount of energy necessary to cause capture but in a patient with atrial fibrillation the determination is without meaning. (T. 139-141; Ex. 5, p. 26).

27. When it was recognized that Patient A was in atrial fibrillation her new pacemaker was programmed from the DDD to the DDI mode. Patient A was left with a new pacemaker which functioned basically the same way her old one had. Although the new pacer sensed in the atrim and her old one did not, due to the patient's condition of atrial fibrillation that atrial sensing had no significance. (T. 141; Ex. 5, p. 39).

Patient B

28. Respondent provided medical care to Patient B at various times from May 18, 1988 through June 26, 1988 at the Albany Medical Hospital in Albany, New York. (Ex. 12).

29. Patient B, sixty-six years old, was admitted to the hospital for the first time on May 18, 1988. She had a three-week history of dysphagia, a weight loss of thirty pounds, and a cough of six months duration which produced phlegm and was occasionally streaked with blood. (T. 244, 269; Dept. Ex. 12, p. 5).

30. Preadmission x-rays showed blockage in the right lower lobe. (T. 246; Exs. 15, pp. 9-10, 16a). A barium swallow revealed an eight centimeter mass obstructing the middle third of the esophagus. (T. 247; Exs. 16c, 16d, 16e). A lateral view showed the esophagus being pushed posteriorly towards the vertebral bodies with a very narrow lumen and normal mucosal folds, indicating there was an extrinsic rather than intrinsic tumor of the esophagus. (T. 247-248; Ex. 16d). A preadmission CT scan revealed the esophagus becoming smaller as one followed it down to the carina, a very large mass compressing the esophagus to the left side, the beginning of the collapsed lower lobe, and an enlarged adrenal gland. (T. 251; Ex. 15, p. 5, Exs. 16f, 16g [5-16-88 CT scan]). From these preadmission studies, the most likely diagnosis was a primary bronchogenic carcinoma with metastasis to the mediastinum, compression of the esophagus, and a probable metastasis to an adrenal gland. (T. 252-253).

31. Patient B underwent an esophagoscopy and flexible bronchoscopy performed by Respondent. Respondent's findings

included fixation of the lateral wall of the middle third of the esophagus with the sensation of an extrinsic mass. The overlying mucosa was slightly congested but otherwise smooth. (T. 253, 299, 300-301, T. (2/27/92) 899, 900; Ex. 12, pp. 32-33).

32. Biopsies of the esophagus and carina were normal. Brushings from the right lower lobe were reported as suspicious for malignancy and washings reported as doubtful for malignancy. (T. 254; Ex. 12, pp. 5-6, 141). Needle biopsies were both negative. (T. 254; Ex. 12, pp. 6, 12).

33. A mediastinoscopy with mediastinal lymph node biopsies was performed. The frozen section diagnosis was positive for lung cancer metastatic to the mediastinal nodes. (T. 254; Ex. 12, pp. 6, 46, 145-146).

34. Patient B was discharged to be followed by an oncological consult. During this first admission the care provided to the patient was "exemplary." (T. 254-255, 270).

35. Patient B was readmitted because the preliminary diagnosis of lung cancer on the frozen section was not confirmed

on the permanent section. (T. 255; Ex. 12, p. 151).

36. Respondent performed an exploratory thoracotomy on Patient B on June 7 mainly for diagnostic purposes. (T. 256, 257).

37. Respondent, during the exploratory thoracotomy, partially mobilized a segment of Patient B's esophagus with its adherent periesophageal nodes. (Ex. 12, pp. 416-418). Respondent could not see the wall of the esophagus as it was involved with tumor. (T. 2/27/92 936). At the mobilization, Respondent got as far as the aorta and could feel it against the back of his fingers. (T. 2/27/92 931). Respondent's manipulation was between the esophagus with the mass of nodes and the underlying tissue. (T. 2/27/92 920), T. 279). Respondent freed up three inches of the esophagus longitudinally and one to one and one-half inches around posteriorly and probably a little anteriorly. (T. 2/27/92 914, 921-922). The mobilization was sufficient to improve the patient's ability to swallow immediately postoperatively. (T. 2/27/92 930-931).

38. Respondent's procedure, as understood by Petitioner's expert, Dr. McCormack, consisted of incising the mediastinal pleura overlying the middle third of the esophagus from the level of the azygous vein down. Respondent then mobilized the esophagus with its mass of nodes by getting behind both the mass of nodes and the esophagus and freeing this up from the surrounding tissue bed. (T. 257-258, 279). Dr. McCormack's diagram of the procedure is basically consistent with Respondent's diagram. Dr. McCormack's diagram does show some obliteration of the vertebral bodies and Respondent's does not. However, with regard to other points, the diagrams are essentially the same. (Exs. B, B1). Dr. McCormack's diagram is consistent with preadmission radiology studies which show the esophagus being pushed posteriorly towards the vertebral bodies. (T. 247-248; Ex. 16d).

39. In his esophagoscopy findings, Respondent discovered the fixation of the esophagus in the area he subsequently mobilized. He also described the mucosa as slightly

congested. These findings indicate that there is direct invasion of the wall of the esophagus by tumor. The congestion described means that there has been invasion of the tissue by tumor directly under the lumen. While the nodes could have caused this congestion, they would not have caused the fixation Respondent described. Further, lymph nodes usually do not cause fixation; fixation usually means there is invasion. (T. 259-260, 293-294, 302; Ex. 12, pp. 32-33 [report of esophagoscopy]). Any manipulation of Patient B's tumor, which was invading the esophageal wall, presented the danger of fracturing the tumor, thereby, disrupting the lumen and interrupting the blood supply and causing perforation of the esophagus. With the tumor the size of Patient B's, even freeing the portion of the esophagus which was facing Respondent could compromise the blood supply.

40. Even with no freeing up or dissection of the esophagus circumferentially, the mobilization was not appropriate; the tumor mass already involved fifty-percent of the esophageal wall. To free up even a little more posteriorly would encompass

two-thirds to three-fourths of the esophageal lumen. (T. 260, 262, 266, 290, 294-296).

41. Patient B, in fact, suffered a perforation of her esophagus on the fifth postoperative day. An emergency esophagram confirmed the perforation of the esophagus in the area of the known tumor and known surgical intervention. The timing of the perforation is consistent with the likelihood that the perforation was a result of compromise of the blood supply from Respondent's mobilization of the esophagus. Interruption of the blood supply in this area usually results in necrosis and tissue breakdown within five to ten days postoperatively. The patient had a DNR status and died on the eighteenth postoperative day. (T. 262-264, 291; Ex. 12, pp. 159, 162, 163-168, 398). Respondent characterized the perforation, in the middle third of the esophagus, as "spontaneous" in the discharge summary. (Ex. 12, p. 195). This characterization is questionable given the manipulation of the tumor site and incision of the pleura in the area. (T. 263).

Patient C

42. Respondent, on approximately June 26, 1984 and at various times through January 26, 1988, provided medical care to Patient C at the Leonard Hospital in Troy, New York.

43. In early June 1984, Patient C, forty-four years old, was first admitted to the hospital for evaluation. She had a low grade fever, progressive weight loss, and anterior chest pain. She was discharged for an outpatient CT after having normal reports from chest x-rays, a barium enema, and upper GI series. (T. 336; Ex. 18, pp. 4-8).

44. Patient C was readmitted with a known diagnosis of an anterior mediastinal mass diagnosed on chest x-ray and CT scan for diagnostic biopsy of the mass by a mediastinoscopy. (T. 33; Ex. 18, pp. 48-49).

45. The June 27 pathology report from an "adequate" biopsy (Ex. 18, p. 101-102) taken at the mediastinoscopy was not definite and the case was referred to New York State for evaluation. However, the pathologist reported differential

diagnoses of nodular sclerosing Hodgkin's disease or fibrosing mediastinitis. (T. 337-338; Ex. 18, pp. 101-102). Nodular sclerosing Hodgkin's disease is one type of malignant lymphoma. Fibrosing mediastinitis is a benign disease characterized by scarring of mediastinum tissue. (T. 338).

46. On June 29, Respondent performed a mediastinotomy on Patient C, removed a portion of the mediastinal tumor for frozen section, and performed an incomplete resection of the tumor. (T. 339; Ex. 18, pp. 116-117). The day before this surgery, Respondent made the determination to resect Patient C's tumor. Respondent in a June 28 note wrote: "Mediastinal lesion definitely tumoral in nature w/exact dx still unknown... Plan: resection of tumor via sternal split." (Ex. 18, p. 60).

47.The pathologist's frozen section diagnosis from the biopsy Respondent obtained in surgery on June 29 was not definite. The pathologist wrote "F.S. Dx - Pending permanent section." However, the pathologist also wrote that the specimen was suggestive of Hodgkin's disease, nodular, sclerosis type. (Ex.

18, pp. 128-129). A pathologist's characterization of a specimen as "suggesting" a diagnosis usually means the pathologist favors the diagnosis but is unwilling to make a definite statement as to the type of tumor. (T. 340).

48. Patient C's tumor was definitely diagnosed as nodular sclerosing Hodgkin's disease in a pathology report dated July 9, 1984 from another hospital. (Ex. 18, p. 119).

49. The treatment modality for Hodgkin's disease is and since the early 1970's has been chemotherapy, not surgical excision (T. 341-342, 345, 1219-1220, 1244). In 1984, the only role for surgery in the treatment of Hodgkin's disease was to obtain tissue for diagnosis. T. 1227). Respondent undertook the radical resection of the tumor before a diagnosis was confirmed. It was imperative to ascertain the diagnosis of the tumor before proceeding with treatment. Such a diagnosis is a pathologic one, not a clinical one. It is not unusual to encounter some difficulty in ascertaining the precise diagnosis of a tumor such as Patient C had. Pathologists usually do not commit themselves

on frozen sections and those are not usually relied upon. T. 345-347, 350, 354-355, 363, 367-368). Statistics regarding the incidence of lymphoma and Hodgkin's disease would not provide an acceptable basis to proceed with surgery without a diagnosis. (T. 362). Even if the diagnosis turned out to be thymoma, necessitating another surgery for Patient B, that would not be an appropriate reason to proceed without a diagnosis. (T. 364).

50. Respondent's rationale for undertaking the surgery without having a definite diagnosis was that he thought as his first consideration that the tumor was a thymoma, which is treated with surgical resection. (T. 1035, 1061). Nowhere in either pathology report is thymoma considered as a possible diagnosis. Respondent conceded that there is no difference in the clinical manifestation of thymoma and Hodgkin's disease (T. 1062) and that before the surgery he knew there was a differential diagnosis which included Hodgkin's disease. (T. 1066).

51. In addition to the risks posed by the radical resection performed, the surgery also had the potential for

effecting the patient's later treatment options. The patient developed osteomyelitis in her sternotomy wound. The existence of the operative wound, in conjunction with the effects of her disease and chemotherapy treatment, contributed to her inability to have a bone marrow transplant when she developed recurrent tumor. (T. 345, 359-360, 1070-1071; Ex. 18, pp. 236, 268-269, Ex. 22, pp. 2-4).

Patient D

52. Respondent provided medical care to Patient D at various times from March 25, 1985 through August 20, 1988 at the Leonard Hospital in Troy, New York. (Exs. 25, 26).

53. Patient D was admitted to the hospital with an abnormal chest x-ray showing a mass in the left perihilar region. Prior history was significant for hypertensive heart disease and emphysema. Biopsy of the mass was positive for carcinoma but a metastatic work-up was negative. The patient had smoked three packs of cigarettes daily for forty years but had quit fifteen years before. (T. 388-389; Ex. 25, pp. 7-9). Preadmission EKG

showed left ventricular hypertrophy. (T. 389; Ex. 27, p. 77). Respondent knew the patient had chronic obstructive pulmonary disease. (T. 1106; Ex. 25, p. 10).

54. Patient D's history and status on admission was that of a patient with a diagnosis of lung cancer, emphysema, as reflected in the impression of the attending medical physician and examination showing increased AP diameter. The patient had hypertensive cardiomyopathy with left ventricular hypertrophy as seen on the preadmission EKG. (T. 390-391).

55. The preadmission chest x-rays of March 23 show increase in the AP chest diameter and darkening in the upper lobes which are indicative of chronic obstructive pulmonary disease. (T. 391-392; Exs. 28A, 28B). Comparison of the March 23 x-rays with those of January 28, two months earlier, show the mass in the left lung to be about the same size. (T. 454-456; Exs. 28A, 28B; Exs. Panel 1A, 1B).

56. Pulmonary function studies revealed a FEV, of .71 liters, with no improvement after broncodilation, which was 39% of

predicted. The FVC was 1.22 liters, 51% of predicted. The interpretation of the study was "...severe obstructive airways disease. An additional restrictive problem cannot be ruled out." (T. 431, 433; Exs. 25, p. 8, 26, p. 2).

57. Respondent's clinical evaluation of Patient D's pulmonary functions was better than Patient D's PFT status. (T. 1116, 1119).

58. Respondent, on March 26, operated on Patient D and removed the upper lobe of the left lung and performed a wedge resection of the left lower lobe to attempt a cure. (T. 397-398, 402, 1090-1091, 1114-1115; Ex. 25, p. 214-215).

59. Evaluation of a patient's suitability for lung resection involves different factors but of paramount importance is the patient's pulmonary function after surgery.

60. Patient D had a problematic postoperative course. She was weaned from mechanical ventilation slowly and she needed a number of interventions to improve her status, including multiple bronchoscopies to manage the build-up of secretions in the

remaining portion of her left lung. (T. 403-404; Ex. 25, pp. 257-272). Patient D was discharged from the hospital approximately six weeks after the surgery but readmitted the following day with respiratory problems. She was placed back on a ventilator and weaned again over a two week period. Patient D died ultimately of respiratory failure on September 16. (T. 404; Ex. 25, pp. 475-476, 709).

61. Patient D's mass was central and a lobectomy was the smallest operation that would ensure removal of the tumor. The tumor was located near the hilum, "deep seated towards the hilum" (T. 1110), "towards the center." (T. 1110).

62. The most Patient D could have tolerated, from a surgical point of view, was a very limited resection of the mass itself and a very small margin of normal tissue to be sure the tumor was removed but sparing the bulk of the functioning lung tissue. What Patient D in fact had was removal of approximately 850 cubic centimeters of lung tissue instead of approximately 15 cubic centimeters that would have been removed with a limited

resection of only the tumor. (T. 408-410, 447-449). Respondent's description of the tumor in his operative report indicates that the mass would have been removable by a wedge resection. (T. 471-472; Ex. 25, p. 215). Patient D's prognosis without surgical intervention or radiation was only a few years. However, her prognosis with the kind of surgery that was performed was very poor. The sequence of events that unfolded after the surgery was very likely to occur based on Patient D's preoperative status. (T. 412-413, 414-418, 465).

63. Removal of the upper lobe and the wedge resection were indicated procedures for Patient D. (T. 1090-1091, 1114-1115).

Patient E

64. Respondent provided medical care to Patient E at various times from approximately September 17, 1981 through September 22, 1981 at the Cohoes Memorial Hospital in Cohoes, New York.

65. Respondent had seen Patient E on referral the day

before the patient's hospital admission. The patient was a fifty-three year old, heavy smoker (1 1/2 to 2 packs per day). His symptoms had started six to seven weeks before. He had pains in his anterior chest radiating under his ears. He had a cough, which produced some phlegm but no blood and pains in his chest. Chest x-rays showed a right hilar density with a loss of volume in the right middle lobe. Respondent's impression was a tumor of the right lung, rule out bronchogenic cancer. The patient was to be admitted to the hospital. (T. 480; Ex. 31, p. 3 [Respondent's office records]).

66. Patient E was admitted to the hospital. His admission EKG showed atrial fibrillation which resulted in an uncontrolled ventricular response rate of approximately 160. (T. 484; Ex. 30, p. 45). Patient E's pulse rate was at least 100 throughout the hospital course. (T. 487; Ex. 30, pp. 57, 66). A consultation record requested on the first day of Patient E's admission noted that physical examination at the time of admission showed "a pulsus paradoxicus." (Ex. 30, p. 10).

67. Patient E underwent diagnostic work-up. Respondent performed a bronchoscopy. Findings on bronchoscopy included some blunting of the main carina but an apparently intact mucosa and an almost complete obstruction of the orifice of the right upper lobe bronchus with an endobronchial lesion. (T. 481-482; Ex. 30, pp. 7, 21). The blunting of the carina, which is usually fairly sharp, was an indication there might be a mass or enlarged lymph nodes in the subcarinal area. (T. 482). The bronchoscopy biopsy was reported as cancer, "neoplastic epithelial cells in mucin and blood clot." (T. 482; Ex. 30, p. 22).

68. Pulmonary function studies, undated, revealed a FEV1 of .7 liters which is 26% of predicted. (T. 483; Ex. 30, p. 56).

69. Admission chest x-rays were reported as showing "a mass density within the right middle lobe with accompanying atelectasis highly suggestive of a central bronchogenic carcinoma" and an enlarged heart. (Ex. 30, p. 42 [radiology report]. The x-rays themselves showed a central and large mass in the right lung.

consistent with lung cancer and the heart moderately enlarged. (T. 484; Exs. 32A, 32B [x-rays]).

70. Pericardial effusion is fluid around the heart within the pericardial sac. Unaddressed, the fluid has the potential to impede the flow of blood into the heart. If the fluid accumulates to a sufficient degree it can be life threatening since it limits the ability of the heart to fill with blood. Fluid accumulation can result in cardiac tamponade, a critical situation which can lead to cardiac arrest. (T. 485-486, 488).

71. Patient E was diagnosed on September 21 as having marked pericardial effusion by means of an emergency echocardiogram ordered by Respondent. Respondent ordered the echocardiogram at the suggestion of the cardiology consult Respondent had requested that same day. That consultant's impression was cardiac tamponade secondary to probable malignant effusion. (T. 514, 1140; Ex. 30, pp. 8, 11, 54-55).

72. There was a likelihood that Patient E had

pericardial effusion on his very first day of admission. (T. 486, 519-520).

73. Patient E was admitted with a presumptive diagnosis of lung cancer. (T. 486). X-rays on the date of admission showed an enlarged heart and Respondent viewed those x-rays on the date they were taken. (T. 486, 1159). An admission EKG revealed atrial fibrillation. In a patient with lung cancer, especially a central hilar mass, atrial fibrillation, and an enlarged heart, pericardial involvement is likely. (T. 486, 519-520).

74. Respondent, after performing an emergency pericardiocentesis and creating a pericardial window, removed Patient E's right lung. (T. 489-492; Ex. 30, pp. 26-27). The patient died of cardiac arrest the day following the surgery. (Ex. 30, p. 4).

75. Respondent's removal of Patient E's right lung was not in keeping with accepted standards of medical care. The surgery was not indicated and contraindicated both in view of the Stage III nature of the patient's disease and the physiologic

consequences of the procedure. The patient had lung cancer metastatic to the pericardium, State III, which is not amenable to surgical care. Pneumonectomy is not viewed as a palliative procedure. (T. 497-499, 510, 513).

76. Respondent's stated purpose for the pneumonectomy was "...consolidation of the right upper lobe and right middle lobe which would eventually become infected and most likely an abscess formation." (T. 1162-1163; Ex. 30, p. 26). Respondent knew the bloody pericardial effusion he evacuated was in all likelihood malignant (T. 1195), that the patient had Stage III-B disease (T. 1149, 1179), and that he could not achieve a cure by the surgery (T. 1163). Finally, Respondent also knew that if Patient E's lung became infected, antibiotic treatment would have been an option. (T. 1165).

77. Respondent performed the pneumonectomy he had entertained preoperatively (T. 1140-1141, 1186). Respondent's surgical approach was of a right thoracotomy to drain the pericardium when the left chest is usually used. (T. 1185).

Patient E's life expectancy was less than a year and there was no intervention which could extend that. (T. 449-500). Patient E died the day following the surgery. (Ex. 30, p. 4).

CONCLUSIONS

Respondent is charged with professional misconduct within the meaning of Sections 6509(2) and (9) of the Education Law. During the course of its deliberation on these charges, the Hearing Committee consulted a memorandum dated September 19, 1988 prepared by Peter J. Millock, General Counsel for the Department of Health. This document, entitled "Definitions of Professional Medical Conduct under the New York Education Law" set forth suggested definitions for incompetence, gross incompetence, negligence, gross negligence and fraudulent practice. The administrative officer amplified the definition of fraudulent practice to conform to case law, in that "a knowing, intentional or deliberate act" is required for fraud pursuant to Section 6509(2) of the Education Law (Brestin v. Commissioner of

Education, 116 AD 2nd 359, 359 [3rd Dept. 1986]).

A summary of the definitions used, in pertinent part follows:

> *"Gross negligence is...a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, a disregard of the consequences which may ensue from such failure and an indifference to the rights of others'...;*
>
> *"Gross incompetence involves a total and flagrant lack of necessary knowledge or ability to practice";*
>
> *"Negligence is a failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances";*
>
> *"Incompetence is a lack of knowledge to practice medicine";*
>
> *"Fraudulent practice of medicine is an intentional misinterpretation or concealment expressed or inferred from certain acts" and requires scienter which mat be inferred.*

The Administrative Officer defined the locality rule, a concept arising from medical malpractice law but an issue raised by Respondent, as requiring that a physician conform to "accepted community standards of practice" and "use whatever superior knowledge, skill and intelligence he has" in the treatment of his patients (Toth v. Community Hospital, 22 NY2d 255, 262). The Administrative Officer also cited Rho v. Ambach, 144 AD2d 774 [3rd

Dept. 1988] which states that "the 'locality rule' does not insulate from guilt doctors who, like petitioner, a Board-certified forensic pathologist, possess superior knowledge and skills that exceed local standards, and provided the wherewithal [e.g. equipment, personnel, funding] to use these attributes as available [Riley v. Wieman, 137 AD2d 309, 315]).

Using these definitions as a framework for its deliberations, the Hearing Committee found that by a preponderance of the evidence all of the charges were sustained except the charge of fraudulent practice. The Hearing Committee did not find any evidence of intent on Respondent's part to misinterpret or conceal his treatment of Patients A through E. The rationale for these conclusions follows.

CONCLUSIONS

Patient A

The Hearing Committee found that James Catlett, the pacemaker representative called as a witness by Petitioner, was not a credible witness and his testimony was not used as a basis for any findings. The Hearing Committee found Mr. Catlett's memory during his first appearance as a witness on July 12, 1991 was highly selective. At that time, Mr. Catlett could not recall raising the issue of the battery depletion of Patient A's pacemaker, could not reconstruct the telephone conversation he had with Respondent regarding Patient A's pacemaker and did not recall if Respondent asked him what the pacemaker's magnet rate was. When Mr. Catlett appeared before the Hearing Committee again on December 5, 1991, his memory had improved. Mr. Catlett testified that he did not tell Respondent that Patient A's pacemaker battery was depleted (T. 539), did recollect his conversation with Respondent following his "interrogation" (T. 544) of Patient A's pacemaker (T. 556-559), and recalled that Respondent did not

inquire about the pacemaker's magnet rate (T. 556).

In addition, Mr. Catlett contradicted himself while testifying. When asked if he had a present recollection of whether he had tested Patient A's battery, Mr. Catlett answered,

> *"I didn't recall nor do I believe that I tested the battery." (T.537).*

Later, when asked if he had tested Patient A's battery, Mr. Catlett replied,

> *"No, I did not test the patient's battery." (T. 543).*

No matter what Mr. Catlett did or did not report to Respondent, the Hearing Committee believed that a reasonably prudent physician should have evaluated a pacemaker representative's interpretation before removing the pacemaker. The Hearing Committee concluded that it is the physician's responsibility to assess the pacemaker for battery integrity before subjecting the patient to surgery. The Hearing Committee believed that Respondent should have ascertained the magnet rate of Patient A's pacemaker before replacing her pacemaker.

It was very unlikely that the atrial fibrillation Patient A was in at the time Respondent replaced Patient A's pacemaker was due to her pacemaker. Patient A's replacement pacemaker was a Pacesetter DDD pacer which paced and sensed both chambers and triggered depending on the heart rhythm sensed. This type of pacemaker was appropriate for a younger patient who needed an atrial kick. Patient A was ninety-three years old at the time of the replacement and had a DNR order. The Pacesetter DDD pacer was more complex than needed and implanting a pacemaker that would drive the atrium in a patient with atrial fibrillation was inappropriate.

Respondent did fail to diagnose Patient A's atrial fibrillation. Although Respondent saw an "irregular rhythm" (Ex. 5, p. 15), it was left to the cardiologist to diagnose this as atrial fibrillation. Respondent, however, did not recognize Patient A's atrial fibrillation at the time of the pacemaker replacement. Respondent later recognized Patient A's atrial fibrillation but by that time the replacement pacemaker had been

programmed in a DDD mode, a mode contraindicated for a patient with atrial fibrillation.

Because the Hearing Committee did not find James Catlett a credible witness, they made no findings based on his testimony. Therefore, the allegations in paragraphs A.4 and A.4a were not sustained.

The Hearing Committee found Dr. Lindenberg more credible as an expert witness than either Doctors Cohen or Miller. The Hearing Committee found that the credentials of Doctors Lindenberg and Cohen were superior to those of Dr. Miller but that Dr. Cohen spoke in generalities, did not answer with directness, and made an argument for AV sequential pacing in the elderly that is not generally accepted practice. Doctor Cohen admitted that he had not reviewed the entire record and acknowledged that it was important to know the magnet rate of a pacemaker from the beginning of the pacemaker's service. Dr. Miller's testimony was essentially theoretical and he admitted that he had not read Respondent's operative record for the pacemaker replacement

surgery. Dr. Miller also agreed that there was no evidence that a magnet rate had been determined before pacemaker replacement.

Patient B

The Hearing Committee concluded that Respondent's workup of Patient B was appropriate. Respondent stated that mobilization of the esophagus with its adherent periesophageal nodes would compromise Patient B's blood supply. The Hearing Committee found that if Respondent performed the mobilization, it made the tumor ischemic since it was impossible to separate the tumor from Patient B's blood supply. The Hearing Committee found it contraindicated for Respondent to have incised the pleura. The pleura is very decompressable tissue and by incising it, Respondent took the risk of interfering with Patient B's blood supply.

The Hearing Committee had the opportunity to question Respondent and from their questions determined that the procedure was not a minimal dissection. Respondent stated that he could feel Patient B's aorta during the exploratory thoracotomy. From

its knowledge that the aorta goes down the left side of the hemothorax, the Hearing Committee concluded that if Respondent saw the aorta, it was not a minimal dissection.

The Hearing Committee's conclusion was that even a minimal dissection would have been too much and that any manipulation of Patient B's tumor was contraindicated given the risk of compromising Patient B's blood supply.

Patient C

The Hearing Committee concluded that a reasonably prudent physician should have waited for the permanent section results before resecting Patient C's tumor given the notorious unreliability of frozen sections for glandular tissue, particularly Hodgkins or lymphoma. The Hearing Committee also concluded that Patient C's tumor should have been staged pre-operatively and was not.

In evaluating the testimony of the expert witnesses regarding the treatment of Patient C, the Hearing Committee found Dr. Ferraro's testimony extensively qualified and undercut by the

unproven assumption that Patient C had a thymoma. Dr. Arseneau stated that further surgery was reasonable but in context he was endorsing further diagnostic surgery, not the therapeutic surgery Respondent performed. The Hearing Committee agreed with Dr. Arseneau when he advocated a biopsy of the tumor to obtain more tissue but found both Doctors Arseneau and Ferraro testified favorably in regard to Respondent's treatment of Patient C based on the unproven assumption that Patient C had a thymoma. When asked by Dr. Golding of the Hearing Committee what the place was for surgery in the treatment of Hodgkin's disease in 1984, Dr. Arseneau replied, "To obtain tissue." (T. 1226-1227). The Hearing Committee also found Dr. Arseneau avoided answering questions directly. When asked by Dr. Stewart, Chairman of the Hearing Committee, why Respondent could not have waited until a diagnosis was made following an adequate biopsy, before deciding whether or not to proceed to surgery Dr. Arseneau said,

> "Well, it's hard to be psychic and know what could occur, but I would say that there is a substantial chance that that could be detrimental to the patient, yes." (T. 1232).

The Hearing Committee concluded that while diagnostic surgery was indicated for Patient C, the therapeutic surgery that was performed by Respondent was not and that Respondent should have waited for the tissue sample diagnoses before making a decision regarding surgery.

Patient D

Patient D's tumor was located near the hilum ("deep seated towards the hilum" [T. 1110], "towards the center" [T. 1110]). The Hearing Committee recognized that this location made the tumor difficult to reach and ruled out any possibility of a more minimal procedure.

In questioning Respondent, Doctor Golding, Hearing Committee member, got Dr. Bulatao's concurrence with the statement that if one looked at the plane film alone it would appear that "this mass was located in a position where it could be taken out and in just a simple wedge which is the most sparing of pulmonary tissue." Dr. Golding went on to point out that the lateral x-ray and CAT-scan report showed that "the mass was central and there

was no way to do that, certainly no way safely, and the lobectomy was the smallest operation that would do the job." Dr. Bulatao agreed. (T. 1112-1113).

The Hearing Committee concluded that it was not necessary to order repeat pulmonary functions tests. Respondent's clinical evaluation of Patient D's pulmonary function overrode the test results. Respondent was able to ascertain that Patient D could walk and climb stairs and leave her house for shopping. While Patient D had borderline pulmonary function, she was clinically better than her pulmonary function tests indicated.

The Hearing Committee concluded that removal of Patient D's upper lobe of her left lung and wedge resection of her lower left lobe were indicated. Respondent's surgical treatment was reasonable even though Patient D died six months after the operation. The Hearing Committee subscribed to the opinion that there are no absolutely certain criteria in evaluating a patient's suitability for lung resection but recognized that Respondent's clinical evaluation of Patient D's pulmonary function made her a

more suitable candidate for the surgery performed than her pulmonary function tests indicated. In addition, the operation was discussed at length with Patient D and her family before the decision was made to perform the surgery.

Patient E

The Hearing Committee concluded that the determinative issue regarding Respondent's care of Patient E was failure to order an echocardiogram in a timely manner. If Patient E's pericardium had been tapped in a timely manner, there would have been no reason to perform the pneumonectomy. The Hearing Committee disagreed with Respondent's contention that since Patient E was already in the hands of an internist and a cardiologist, he, as surgeon, was not primarily responsible for diagnosing and treating Patient E's pericardial effusion. Even though an internist and a cardiologist were involved in Patient E's care, it was Respondent who elected to go forward with the surgical procedure. The Hearing Committee concluded that a reasonably prudent physician does not anesthetize a patient first

and then perform a tap. A reasonably prudent physician will do a tap first and then anesthetize the patient. The Hearing Committee found that Respondent was the key person responsible for diagnosing and treating Patient E's pericardial effusion. Dr. Arseneau's opinion was that without a reason to suspect pericardial tamponade, reasonable care did not require the ordering of an echocardiogram. The Hearing Committee discounted this opinion because pericardial effusion was seen on Patient E's admission chest x-ray. The Hearing Committee also relied on Dr. Marrus' handwritten consultation note on Patient E's hospital chart despite Respondent's attempts to cast doubt on its validity because it had been written in a different color ink.

The Hearing Committee concluded that Respondent's removal of Patient E's right lung was not indicated. The fact that ten out of ten nodes were positive on the resection was in itself an indication that the pneumonectomy should never have been done.

FACTUAL ALLEGATIONS

Patient A

A(1)	--	Sustained
A(2)	--	Sustained
A(3)	--	Sustained
A(4)	--	Not Sustained
A(4)(a)	--	Not Sustained
A(5)	--	Sustained
A(6)	--	Sustained

Patient B

B(1)	--	Sustained

Patient C

C(1)	--	Sustained

Patient D

D(1)	--	Not Sustained

Patient E

E(1)	--	Sustained
E(2)	--	Sustained

SPECIFICATIONS

The Hearing Committee finds the first through twelfth specifications sustained. The Hearing Committee finds that the thirteenth and fourteenth specifications are not sustained.

RECOMMENDATION

The Hearing Committee found that Dr. Bulatao appeared to have adequate surgical skills since none of the cases involved technical problems. The deficiencies noted were matters of surgical judgement, paticularly indications for surgical intervention. Based on this, the Hearing Committee recommends the following penalty.

1. Suspension from practice for one year.
2. Respondent must organize a one-year program of non-operational thoracic training aimed at acquiring didactic knowledge and knowledge of indications, subject to approval by this Hearing Committee.
3. Failure to obtain the approval of the Hearing Committee for this program will result in Respondent's license being suspended until the one-year program is approved and completed.
4. Respondent will take and pass the recertification examination given by the American Board of Thoracic Surgery at the conclusion of the one-year program.

5. Respondent will perform surgery in only two hospitals when he resumes practice:

-- St. Peter's Hospital, Albany, New York; and
-- Albany Memorial Hospital, Albany, New York.

DATED: Syracuse, New York

July 8, 1992

William A Stewart M.D.

WILLIAM A. STEWART, M.D.
Chairman

MICHAEL R. GOLDING, M.D.
SISTER MARY THERESA MURPHY

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ISIDRO MUNOZ BULATAO, M.D.	:	CHARGES

----------X

ISIDRO MUNOZ BULATAO, M.D., the Respondent, was authorized to practice medicine in New York State on September 20, 1966 by the issuance of license number 097438 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 7 Mohawk View Road, Latham, New York 12110-1735.

FACTUAL ALLEGATIONS

A. Respondent, on or about November, 1984 and at various times through April 17, 1990, provided medical care to Patient A [patients are identified in the Appendix] at his office and at the Leonard Hospital, 74 New Turnpike Road, Troy, New York [hereinafter "Leonard Hospital"]. Respondent, in approximately November, 1984, implanted an Intermedics Avius Model 263-01 pacemaker in Patient A. Respondent, from on or about December

11, 1984 through on or about October 11, 1988, provided pacemaker follow-up care to Patient A. Respondent, on March 13, 1990, removed the Intermedics pacemaker and implanted a Pacesetter AFP II Model 283 pacemaker in Patient A, then age ninety-three.

1. Respondent failed to provide adequate pacemaker follow-up care to Patient A during the time subsequent to implantation of the Intermedics pacemaker in November, 1984 and through October 11, 1988, in that Respondent did not periodically assess the magnet rate of the pacemaker.

2. Respondent, in on or about March, 1990, failed to properly evaluate the Intermedics pacemaker for its battery integrity prior to his replacing the pacemaker due to "battery depletion".

3. Respondent, on March 13, 1990, replaced the Intermedics pacemaker, which was not indicated.

4. Respondent recorded in medical records pertaining to Patient A that a pacemaker company representative had performed an analysis of the Intermedics pacemaker, and/or had found pacemaker battery depletion, and/or had communicated such information to Respondent when, in fact, no such analysis was performed, no such finding was made, and no such information was communicated to Respondent.

5. Respondent, on March 13, 1990, at the time he replaced the Intermedics pacemaker, failed to diagnose Patient A's condition of atrial fibrillation.

6. Respondent, on March 13, 1990, at the time he replaced the Intermedics pacemaker, failed to properly assess atrial capture.

B. Respondent, on or about May 18, 1988 and at various times through approximately June 26, 1988, provided medical care to Patient B at Albany Memorial Hospital, 600 Northern Boulevard, Albany, New York. Patient B had bronchogenic cancer which had spread extensively. She had difficulty in swallowing which had begun several months prior to her June 6, 1988 Hospital admission.

amended 4/3/92 ME

1. Respondent, on June 7, 1988, partially with mobilized a segment of Patient B's esophagus ~~from~~ its adherent periesophageal nodes to enlarge the esophageal opening, which was not indicated and/or contraindicated.

C. Respondent, on or about June 26, 1984 and at various times through approximately January 26, 1988, provided medical care to Patient C at Leonard Hospital. Patient C had a mediastinal tumor which was diagnosed definitively, on or about July 9, 1984, as Hodgkin's disease, nodular sclerosis type. On June 26, 1984, a differential diagnosis of nodular sclerosing Hodgkin's disease or fibrosing mediastinitis was made from a frozen section obtained through a mediastinoscopy. On June 29, 1984, a suggested diagnosis of Hodgkin's disease was made from a frozen section obtained through a median sternotomy performed by Respondent.

1. Respondent, on June 29, 1984, without having a final pathologic diagnosis of Patient C's tumor and with a differential diagnosis which

included Hodgkin's disease, performed an incomplete resection of the mediastinal tumor, [including a partial pericardiectomy and a partial pleurectomy] on Patient C, which was not indicated and/or contraindicated. amended 2/28/92

D. Respondent, on or about March 25, 1985 and at various times through August 20, 1985, provided medical care to Patient D at Leonard Hospital. Patient D had lung cancer. Upon admission to the Hospital and/or prior to surgery performed by Respondent on March 26, 1985, Patient D had a history of chronic obstructive pulmonary disease and had severely impaired pulmonary function.

1. Respondent, on March 26, 1985, removed the upper lobe of Patient D's left lung [lobectomy] and performed a wedge resection of the left lower lobe, which were not indicated and/or contraindicated.

E. Respondent, on or about September 17, 1981 and at various times through September 22, 1981, provided medical care to Patient E at Cohoes Memorial Hospital, Cohoes, New York. Patient E had lung cancer. Upon admission to the Hospital and prior to surgery performed by Respondent on September 21, 1981, Patient E had shortness of breath and severely impaired pulmonary function.

1. Respondent failed to obtain an echocardiogram for Patient E to assess

pericardial effusion [until September 21, 1981, when Respondent ordered an emergency echocardiogram, which was not] in a timely manner. amended 10/3/91 ME

2. Respondent, on September 21, 1981, removed Patient E's right lung [pneumonectomy], which was not indicated and/or contraindicated.

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with practicing the profession of medicine with gross negligence under N.Y. Educ. Law §6509 (2) (McKinney 1985) in that Petitioner charges the following:

1. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.5, and/or A and A.6.
2. The facts in paragraphs B and B.1.
3. The facts in paragraphs C and C.1.
4. The facts in paragraphs D and D.1.
5. The facts in paragraphs E and E.1 and/or E and E.2.

SIXTH THROUGH TENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE ON A PARTICULAR OCCASION

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law §6509 (2) (McKinney 1985) in that Petitioner charges the following:

6. The facts in paragraphs A and A.1, A and A.2., A and A.3, A and A.5, and/or A and A.6.

7. The facts in paragraphs B and B.1.

8. The facts in paragraphs C and C.1.

9. The facts in paragraphs D and D.1.

10. The facts in paragraphs E and E.1 and/or E and E.2.

ELEVENTH SPECIFICATION

PRACTICING WITH NEGLIEGENCE
ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6509 (2) (McKinney 1985) in that Petitioner charges that Respondent has committed two or more of the following:

11. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.5, A and A.6, B and B.1, C and C.1, D and D.1, E and E.1, and/or E and E.2.

TWELTH SPECIFICATION

PRACTICING WITH INCOMPETENCE
ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6509 (2) (McKinney 1985) in that Petitioner charges that Respondent has committed two or more of the following.

12. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.5, A and A.6, B and B.1, C and C.1, D and D.1, E and E.1, and/or E and E.2.

THIRTEENTH SPECIFICATION

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession of medicine fraudulently under N.Y. Educ. Law §6509 (2) (McKinney 1985) in that Petitioner charges the following:

13. The facts in paragraphs A and A.4.

FOURTEENTH SPECIFICATION

FAILING TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with committing unprofessional conduct under N.Y. Educ. Law §6509 (9) (McKinney 1985) in that Respondent failed to maintain a record which accurately reflects the evaluation and treatment of the patient within the meaning of 8 NYCRR §29.2(a)(3)(1987), in that Petitioner charges the following:

14. The facts in paragraphs A and A.4.

DATED: Albany, New York
June 3, 1991

Peter D. Van Buren

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

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

----------X

IN THE MATTER : AMENDMENTS

OF : TO STATEMENT

ISIDRO MUNOZ BULATAO, M.D. : OF CHARGES

----------X

The Statement of Charges is amended as follows:

[Statement of Charges, Page 2, addition of paragraph 4a]

4a. Respondent made the recordings, described in paragraph 4, above, in medical records pertaining to Patient A, knowing that the pacemaker company representative had not performed an analysis of the Intermedics pacemaker and/or had not found pacemaker battery depletion and/or had not communicated to Respondent that such analysis was performed and/or that pacemaker battery depletion was found.

[Statement of Charges, Page 7, Thirteenth Specification, addition of reference to paragraph 4a.]

13. The facts in paragraphs A and A.4 and A.4a.

Petitioner's Exhibit
1 - marked Rec'd 7/12/91
7/12/91 MET ME

EXHIBIT "D"

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

IN THE MATTER :

OF :

ISIDRO MUNOZ BULATAO, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on July 12, 1991, October 2, 1991, October 3, 1991, December 5, 1991, December 6, 1991, February 27, 1992, February 28, 1992 and April 10, 1992. Respondent, Isidro Munoz Bulatao, M.D., appeared by Barry A. Gold, Esq. The evidence in support of the charges against the Respondent was presented by E. Marta Sachey, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Conclusions of the Committee should be accepted in full except that (1) the general reference on page 38 of the Report of the Hearing Committee to the charges not sustained should also include the charges relating to Patient D and the charges relating to record keeping and (2) the general reference on page 50 of the Report of the Hearing Committee to the specifications sustained should be revised to read: "The Hearing Committee sustains the First through Third, Fifth through Eighth, Tenth, Eleventh, except as to D. and D.1.,

EXHIBIT "C"

and Twelfth Specifications, except as to D. and D.1.

C. The recommendations of the Committee should be modified. In my view, Respondent did not have adequate surgical skills because surgical skills encompass not just the technical capacity to perform surgery but also include the judgment as to when surgery is indicated, a judgment clearly lacked by the Respondent. I recommend that Respondent's license to practice medicine be suspended for three years. During such suspension period, Respondent shall complete a one year program of non-operational thoracic surgery training aimed at acquiring didactic knowledge and knowledge of indications for surgery. The program shall be approved in advance by the Office of Professional Medical Conduct (OPMC). Upon the completion of such a program, the suspension of Respondent's license shall be stayed but Respondent's surgical practice for the remainder of the three year term shall be monitored by a board certified thoracic surgeon approved in advance by OPMC. I do not believe that it is appropriate to demand that Respondent be reboarded or resume his surgical practice at only two specific Albany area hospitals although he should be encouraged to work at larger facilities where interaction with peers and peer review is generally more intense.

D. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation as described above.

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

DATED: Albany, New York
September 2, 1992

MARK R. CHASSIN, M.D., COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

BY: _____

LLOYD F. NOVICK
NEW YORK STATE DEPARTMENT OF HEALTH

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

ISIDRO MUNOZ BULATAO

CALENDAR NO. 13628

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall be in compliance with the standards of conduct prescribed by the law governing respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has

advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training in non-operational thoracic surgery aimed at acquiring didactic knowledge and knowledge of indications for surgery, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said course to consist of 100 hours of continuing medical education in each of the two years of probation, for a total of 200 hours of continuing medical education and to be satisfactorily completed during each year of the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct;

3. During the first year of the period of probation, when the respondent performs any surgical procedures, it is to be in a supervised setting, under the direct supervision of a physician board certified in general surgery or thoracic surgery, said supervising physician to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, the cost of supervision to be at the respondent's expense, and the supervisor shall be present in the operating room, shall participate in each operation performed by respondent, shall assure that all necessary consultations, including the need for pacemaker replacement, are obtained by respondent pre-operatively, shall review the patient's record in order to determine that the patient has been cleared for surgery and shall regularly review the medical records of patients treated by respondent, shall obtain any other necessary information, and shall perform all tasks and responsibilities appropriate for the supervisor of respondent. Said supervisor shall submit a report, once every three months, regarding the above mentioned direct supervision of respondent's practice to the Director of the Office of Professional Medical Conduct and shall also immediately report to the Director of the Office of Professional Medical Conduct any changes in respondent's level of performance, any incidents, problems, errors or lapses related to his medical practice or treatment of patients, and any failures by respondent to comply with each condition described herein;

4. During the first year of the period of probation, respondent shall be subject to random selections and review by an employee of and selected by the Office of Professional Medical Conduct of the New York State Health Department of respondent's patient records, office records, and hospital charts to review respondent's professional performance, and respondent shall also be required to make such records available to said employee at any time requested;

5. During the second year of the period of probation, respondent shall have respondent's practice monitored, at respondent's expense, as follows:

   a. That said monitoring shall be by a physician selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct;

   b. That respondent shall be subject to random selections and reviews by said monitor of respondent's patient records, office records, and hospital charts in regard to respondent's practice, and respondent shall also be required to make such records available to said monitor at any time requested by said monitor; and

   c. That said monitor shall submit a report, once every four months, regarding the above-mentioned monitoring of respondent's practice to the Director of the Office of Professional Medical Conduct and shall also immediately report to the Director of the Office of Professional Medical Conduct any changes in respondent's level of performance, any incidents, problems, errors or lapses related to his medical practice or treatment of patients, and any failure by respondent to comply with each condition described herein;

6. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

VOTE AND ORDER

ISIDRO MUNOZ BULATAO

CALENDAR NO. 13628

The University of the State of New York

IN THE MATTER

OF

ISIDRO MUNOZ BULATAO
(Physician)

DUPLICATE
ORIGINAL
VOTE AND ORDER
NO. 13628

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 13628, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (July 23, 1993): That, in the matter of ISIDRO MUNOZ BULATAO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner as to those findings of fact be accepted, except finding of fact 75 not be accepted, finding of fact 49 be modified on line 6 of page 25 such that the reference to "Patient B" be deemed to read "Patient C", and finding of fact 51 be modified on page 26 line 1 such that the word "effecting" be deemed to read "affecting";
2. The conclusions of the hearing committee and the recommendation of the Health Commissioner as to those conclusions be modified;
3. Respondent is guilty, by a preponderance of the evidence, of the eleventh specification of negligence on more than one occasion to the extent indicated in the Regents Review Committee report involving respondent not adequately periodically assessing the magnet rate of

Patient A's pacemaker (allegation A(1)); not properly evaluating the pacemaker for battery integrity, replacing the pacemaker, which was not indicated, failing to diagnose Patient A's underlying rhythm of atrial fibrilation, and not properly assessing atrial capture (allegations A(2), A(3), A(5), and A(6)); performing the contraindicated procedure of partially mobilizing a segment of Patient B's esophagus with its adherent periesophageal modes (allegation B(1)); and performing a radical resection of Patient C's tumor without having a definite diagnosis (allegation C(1)); and not guilty of the remaining allegations and specifications; and

4. The recommendation of the hearing committee and the recommendation of the Health Commissioner as to the recommendation of the hearing committee not be accepted and respondent's license to practice medicine in the State of New York be suspended for two years upon the eleventh specification of the charges of which respondent has been found guilty, as aforesaid, execution of said suspension be stayed, and respondent be placed on probation for a period of two years under the terms prescribed by the Regents Review Committee;

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

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

ISIDRO MUNOZ BULATAO (13628)

IN WITNESS WHEREOF, I, Henry A. Fernandez, Deputy Commissioner, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand, at the City of Albany, this 23rd day of July, 1993.

HENRY A. FERNANDEZ
DEPUTY COMMISSIONER