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

IN THE MATTER

OF

JOHN RAGUE MANGIARDI, M.D.

MODIFICATION ORDER

BPMC No. #06-162

Upon the proposed Application for a Modification Order of JOHN RAGUE MANGIARDI, M.D. (Respondent), which is made a part of this Modification Order, it is agreed to and

ORDERED, that the attached Application, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Modification Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Modification Order, either by first class to Respondent at the address in the attached Application or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 12-22-2008

Redacted Signature

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER

OF

JOHN RAGUE MANGIARDI, M.D.

APPLICATION FOR MODIFICATION ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF)

JOHN RAGUE MANGIARDI, M.D., (Respondent) being duly sworn, deposes and says:

That on or about December 1, 1978, I was licensed to practice as a physician in the State of New York, and issued License Number 136921 by the New York State Education Department.

My current address is Redacted Address , and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I am currently subject to a BPMC Order, BPMC # 06-162, which became effective on July 21, 2006. (A copy of this order is attached to this Application as Attachment I, and is henceforth referred to as "Original Order.") I am aware that a current OPMC investigation is open and not concluded. In the interest of resolving the pending investigation, and having no intention of returning to the practice of medicine in New York, I hereby apply to the State Board for Professional Medical Conduct for an order (henceforth "Modification Order") modifying the Original Order, and substituting a surrender of license for the sanction imposed upon me in the Original Order and currently in effect; i.e., a three year suspension of license, with the final two years of the suspension stayed, and two years of probation during the period of stayed suspension, with practice monitoring during the period of probation. I understand that this Modification Order shall modify only the penalty

imposed in the Original Order, and subject me to the requirements of the terms set forth in Attachment II ("Guidelines for Closing a Medical Practice"), and that it shall not otherwise disturb the terms and findings of the Original Order, BPMC # 06-162. While I have no present intention of returning to the practice of medicine in New York, I understand that, for the purposes of any future petition for restoration pursuant to N.Y. Educ. Law § 6511 that I may bring, the effective date of my license surrender shall be the effective date of this Modification Order.

I ask the Board to accept this Modification Order and my surrender of license, and I agree to be bound by, and to comply with, all of the terms of the order for which I apply.

I understand and stipulate that this Modification Order shall be in satisfaction of all matters currently under investigation by any office of the Office of Professional Medical Conduct, or any future matters that OPMC may become aware of concerning me, if, and only if, I never reapply for a license to practice medicine in New York State; if I ever submit an application for relicensure, I understand and agree that all such matters shall immediately be reopened for investigation. I further agree that my surrender of license pursuant to this Order shall have the effect of a limitation on issuance of further license, as set forth in N.Y. Pub. Health Law §230-a(6).

I make this Application of my own free will and accord and not under duress, compulsion or restraint, and seek the anticipated benefit of the requested modification. In consideration of the value to me of the acceptance by the Board of this Application, I knowingly waive my right to contest the Original Order or the Modification Order for which I apply, whether administratively or judicially, and ask that the Board grant this Application.

DATE: 12/12/08

Redacted Signature

JOHN RAGUE MANGIARDI, M.D.
RESPONDENT

The undersigned agree to the attached Application of Respondent and to the proposed penalty based on its terms and conditions.

DATE: _____ _____

, ESQ.
Attorney for Respondent

DATE: Dec. 16, 2008 Redacted Signature

MARCIA E. KAPLAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 12/19/08 Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

ATTACHMENT I

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

July 14, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leslie Eisenberg, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Wilfred T. Friedman, Esq.
Friedman & Mahdavian, P.C.
The Bar Building
36 West 44th Street
New York, New York 10036

John Rague Mangiardi, M.D.

Redacted Address

RE: In the Matter of John Rague Mangiardi, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-162) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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

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

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

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Sincerely,

Redacted Signature

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

IN THE MATTER

OF

JOHN RAGUE MANGIARDI, M.D.

DETERMINATION

AND

ORDER

BPMC #06-162

COPY

A Notice of Hearing, dated August 18, 2005, and a Statement of Charges, dated August 18, 2005, attached and annexed hereto as Exhibit A, were duly served upon the Respondent, **JOHN RAGUE MANGIARDI, M.D.** **JERRY WAISMAN, M.D.**, Chairperson, **JAY ROSENBLUM, M.D.** and **LOIS JORDAN**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee ("the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **FREDERICK ZIMMER, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The **NEW YORK STATE DEPARTMENT OF HEALTH** ("the Department" or "the Petitioner") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **LESLIE EISENBERG, ESQ.**, of Counsel. Respondent appeared by **FRIEDMAN AND MAHDAVIAN, P.C., WILFRED T. FRIEDMAN, ESQ.**, of counsel.

Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Answer Filed	September 1, 2005
Pre-Hearing Conference	September 12, 2005
Witnesses for Petitioner	Daniel Drew Galyon, M.D., Marie C. Lee, M.D., Kristin Byrne, M.D., Elizabeth McCaffrey, R.N.
Witnesses for Respondent	John Rague Mangiardi, M.D., Arnold Komisar, M.D., Axel Wadewitz, R.P.A., Mark Norman Hadley, M.D., I. Michael Leitman, M.D.
Hearing Dates	September 23, November 28 and December 6, 2005 and January 13, 17, 24, and 27, February 28 and March 8, 2006
Deliberation Date(s)	April 21, June 12 and 19, 2006[1]

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the Petitioner, New York State Department of Health, Office of Professional Medical Conduct, pursuant to §230 of the P.H.L. Respondent, John Rague Mangiardi, M.D., is charged with three specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). Specifically, Respondent is charged with one specification of practicing the profession of medicine with gross negligence on a particular occasion, one specification of practicing the profession of medicine with negligence on more than

[1] The deliberations were regarded as the final hearing dates.

one occasion and one specification of failing to maintain a record for each patient which accurately reflected the care and treatment of the patient.

These charges concern, among other things, numerous allegations that Respondent was negligent with regard to Patient A's care, particularly with regard to his post operative management of her care following surgery to remove a tumor. The allegations also address Respondent's care of Patient B.

Respondent, in his Answer, denied the allegations and specifications contained in the Statement of Charges.

The parties agreed to waive the statutory deadlines requiring completion of the hearing within 120 days from the first hearing date of September 23, 2005 (T. 380).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Committee in arriving at a particular finding.

Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Committee hereby makes the following Findings of Fact:

1. **JOHN RAGUE MANGIARDI, M.D.** ("Respondent") was authorized to practice medicine in New York State on December 1, 1978 by the issuance of license number 136921 by the New York State Education Department (Pet's Ex. 2).
2. Respondent first saw Patient A, a 70 year old woman, on July 2, 2002 at his office. Patient A

was complaining of numbness in her hands (Resp's Ex. D; Mangiardi, T. 924-925).

3. An MRI had been performed upon Patient A which revealed that she had a meningioma just behind the body of C-1, anterior to the cervical medullary junction (Resp's Ex. D; Mangiardi, T. 925-926).

4. Upon further evaluation, including a consultation with a neurologist, Dr. Dickoff, it was determined that Patient A had a cervical spinal tumor. Dr. Dickoff's evaluation, dated July 2, 2002, was made part of Respondent's office record for Patient A. At a July 16, 2002 meeting, Respondent discussed with Patient A and her family the possibility of performing at least a partial trans-oral resection of the tumor to allow for decompression at the cervical-medullary junction. It was decided that Patient A would be reevaluated in September 2002. This discussion was documented in Respondent's office record for Patient A (Resp's Ex. D; Galyon, T. 832-837; Mangiardi, T. 927-936).

5. A reasonably prudent neurosurgeon, or his/her qualified agent, must perform a thorough history in order to appropriately assess a patient. A thorough history involves questioning the patient, and analyzing and documenting all aspects of his/her complaints. A focused history is helpful with regard to pathology and in locating the area of the lesion. A neurosurgeon should ascertain whether the tumor is progressing quickly or slowly. A complete and thorough history should be documented in the patient's record (Galyon, T. 131-135, 143-146).

6. In order to appropriately evaluate a patient, a reasonably prudent neurosurgeon, or his/her qualified agent, must perform a complete physical examination. A complete neurological examination includes a mental status examination to ascertain brain function, an examination of the cranial nerve functions, and of motor functions to ascertain muscle strength. If the patient's complaints deal with the upper spinal cord, the exam can be focused on the upper motor neuron.

The neurosurgeon must also perform a sensory exam focusing on reflexes, and should test the patient's balance and perform a cerebellar test. A complete and thorough physical examination should be documented in the patient's record and should include a plan. It is especially important to document the initial examination in complex cases so that there is a baseline for future reference (Galyon, T. 136-144, 433; Mangiardi, T. 1548-1549).

7. The history, physical examination and neurological examination recorded in Respondent's office record for Patient A, which included Dr. Dickoff's evaluation, met acceptable medical standards. Respondent assessed Patient A as normal as a result of her neurological examination (Galyon, T. 147-153, 832-837; Resp's Ex. D, see pg. 2 in particular and pgs. 39-42).
8. Respondent discussed the risks and benefits of the trans-oral procedure with Patient A, on July 16, 2002, and later on other occasions (Mangiardi, T. 935-943).
9. The standard of care does not require documentation of discussion with a patient of the specific risks and benefits of a procedure as well as the alternatives to the procedure. It is sufficient for a physician to record that he met with the patient and her family to discuss a proposed procedure without documenting the details of that discussion (Hadley, T. 1254-1259).
10. Respondent met with Patient A again on October 2, 2002, at which time Respondent scheduled Patient A for a trans-oral resection of the C1 area of the meningioma in November 2002. The surgery was to occur after Patient A took a cruise to Hawaii (Resp's Ex. D; Mangiardi, T. 937-938, 1474-1475).
11. Patient A was admitted to Lenox Hill Hospital, on November 13, 2002. (Pet's Ex. 3).
12. At Lenox Hill Hospital in November 2002, the history and physical examination were customarily not written by an attending physician but by an authorized agent such as a resident, physician's assistant, fellow or medical student. The history and physical examination were

then signed by the attending physician, if he/she concurred with it, with the same effect as though the attending physician had written it (Mangiardi, T. 954).

13. A medical history and physical examination of Patient A were recorded in the Lenox Hill Hospital medical record by a third year medical student who signed the note. The history and physical examination were reviewed and approved by Respondent as indicated by his sign at the end of the note (Mangiardi, T. 953-955; Pet's Ex. 3, pgs. 27-29).

14. The history and physical examination recorded in Patient A's hospital medical record met acceptable standards. The history and physical examination recorded in the record by the third year medical student and countersigned by Respondent, were adequate for an elective procedure performed on a known patient such as Patient A which was performed for a known problem. No additional documentation concerning the history and physical was needed (Galyon, T. 147-151, 218-219; Hadley, T. 1250-1256).

15. With regard to the performance of a neurological examination, Patient A's hospital record only contains a note by the third year medical student which states "neuro: CN (cranial nerves) 2-12 intact" (Pet's Ex. 3, pg. 28).

16. The pre-operative neurological examination recorded in Patient A's hospital record was incomplete and failed to meet acceptable medical standards. The recorded pre-operative neurological examination lacked a baseline analysis and an evaluation of cranial nerves, motor, sensory, reflex function and ability with gait and station. Dr. Dickoff's July 2, 2002 evaluation was not made part of the hospital record and was, in any event, performed approximately four months prior to Patient A's hospital admission (Pet's Ex. 3; Galyon, T. 219-220, 814, 838-840; Hadley, T. 1330-1331, 1334).

17. The bony anatomy in the upper cervical spine includes the base of the skull, which consists of

two occipital condyles that interface with a bone called the atlas or C1 which is the first cervical vertebrae. The atlas is a ring that interfaces with the skull above and with the axis or C2 below. This anatomy is referred to as the atlantoaxial joint which allows for rotation or turning of the head. Pivoting rotation can occur because C2 contains a bone shaped like a peg, called the odontoid or dens, that sticks up into C1. The odontoid keeps C1 from going forwards or backwards on C2 (Pet's Ex. 13a and 13b; Galyon, T. 41-49; Mangiardi, T. 968-969).

18. The spinal canal at the C1-C2 region can be viewed in thirds: one third is the dens, another third is the spinal cord and the last third is the space around the cord, for spinal fluid. There is enough room around the cord to allow for some movement. Once alignment is altered and the space diminishes, the spinal cord becomes impinged; that is when there is a problem (Galyon, T. 65-68).

19. In terms of the nerve anatomy, the brain sends signals down the spinal cord to the arms and legs and receives signals coming up from the spinal cord. The spinal cord also signals the chest and lung muscles to open and close to assist in breathing. A small nerve, the phrenic nerve, which branches off the spinal cord below C1-C2, controls the diaphragm. Therefore, a nerve injury at the upper cervical junction is particularly critical because this region controls the patient's breathing apparatus as well as his/her arms and legs (Galyon, T. 63-65).

20. The concept of stability refers to normal and abnormal amounts of movement or motion. Instability in the upper cervical spine is uncommon. Gross instability in this region occurs most often from trauma where there is an injury to the supporting structures of the bone, ligaments or muscle, that results in abnormal motion and produces irritation or injury to neural tissue (Galyon, T. 69-79).

21. Trans-oral means through the oral cavity. A trans-oral tumor resection refers to a surgical

resection of a tumor by going through the mouth to access the upper cervical cavity at C1-C2 (Galyon, T. 97).

22. On November 14, 2002, a trans-oral resection of Patient A's tumor was performed by Respondent (Pet's Ex. 3).

23. A consent to perform a trans-oral resection of the tumor was signed by Patient A and made part of her hospital record (Pet's Ex. 3, pgs. 17 et seq.).

24. There was no need for Respondent to document the specifics of the procedure in the consent particularly vis-à-vis his reasons for perfoming a trans-oral procedure as opposed to a procedure using a far lateral approach (Hadley, T. 1254-1259).

25. Based upon Patient A's pathology, her age and the absence of destabilizing ligamentous diseases such as rheumatoid disease, Paget's disease or Downs Syndrome, she did not have features pre-operatively which would be predictive of post–operative instability. The likelihood of instability with regard to Patient A who was confined to bed, was low. There was no need for Respondent to document pre-operatively whether stabilization was required (Hadley, T. 1216-1220, 1251-1254).

26. Post-operatively, Respondent did not order that Patient A be placed in a collar or in a temporary rigid fixation device such as a stryker frame or a halo (Pet's Ex. 3; Mangiardi, T. 1413-1415).

27. A collar does not provide much restriction and is problematic in an ICU or monitored setting due to the collar's tendency to shift and to restrict both the patient's breathing and observation of the patient's hygiene (Hadley, T. 1218-1221).

28. A reasonably prudent neurosurgeon would not have found it necessary to put Patient A in a halo or collar, as her chances of developing instability were low (Hadley, T. 1220).

29. Stryker frames are generally not used and would have been contraindicated in Patient A's case

(Hadley, T. 1221).

30. Respondent trained in neurosurgery at New York University for approximately 6 and ½ years. He completed his training in 1983 and has been practicing since then. Respondent has performed approximately 70 trans-oral procedures (Mangiardi, T. 922-924).

31. An experienced neurosurgeon would not normally need to develop or document a post-operative plan to deal with destabilizing motion (Hadley, T. 1225-1227).

32. On November 16th, 2002, at approximately 6:00 p.m., Dr. Sajewicz, an intern, responded to a call from a nurse and came to check Patient A's lumbar drain which Dr. Sajewicz determined was working properly. Patient A was complaining of bilateral hand weakness. Dr. Sajewicz reported these findings to Respondent (Pet's Ex. 3, pg. 98; Galyon, T. 252-255).

33. The night nurse documented a neurological examination, at approximately 8:00 p.m., which indicated a number of problems that could have been caused by something at Patient A's operative site. For instance, Patient A had vertical nystagmus, a phenomena where the eyes move in a repetitive oscillation. Vertical nystagmus is rare and is associated with abnormality of the cervical medullary junction between the skull and neck. As a result, the nurse notified Dr. Marie Catherine Lee who was the resident on call (Pet's Ex. 3, pg. 99; Galyon, T. 256-263; Lee, T. 533- 539).

34. At approximately 11:15 PM, Dr. Lee, a second-year surgical resident, arrived to see Patient A and performed a thorough examination of Patient A. Dr. Lee determined that Patient A was hemodynamically stable but that she had developed paralysis of the right upper extremity and had generalized weakness (Pet's Ex. 3, pg. 103; Lee, T. 530-539).

35. Patient A related that, at some point during the day, she had moved herself or was moved by someone. She experienced a sharp pain that ran from her head down to her feet and began to

feel the sensation of pins and needles and a headache. From that point on, she became progressively weaker (Lee, T. 536; Pet's Ex. 3, pg. 103).

36. Dr. Lee called Respondent, informed him of Patient A's status, i.e., that she had right upper extremity paralysis and generalized weakness, and that she had ordered a brain CT scan. Respondent agreed with the ordering of the CT scan and asked that Dr. Lee call him after the scan (Pet's Ex. 3, pg. 103; Lee, T. 541-542).

37. Because of her concerns about Patient A's cervical stability, Dr. Lee took Patient A on her bed to radiology. Along with other hospital personnel, Dr. Lee took Patient A to the scan area and met Dr. Kristin Byrne, the radiology resident on call that night (Lee, T. 542-544; Byrne, T. 879).

38. After she observed spinal cord compression on the first image, Dr. Byrne instructed the technician to include cuts lower down into the operative site at the cervical spine (Lee, T. 546; Byrne, T.881).

39. Dr. Lee called Respondent immediately and told him that the scan looked abnormal. Dr. Lee stated that she did not feel competent to interpret the scan appropriately and asked Respondent to talk to Dr. Byrne. Dr. Byrne told Respondent that there was spinal cord compression and it was abnormal. Respondent told Dr. Byrne that it was supposed to be that way. Dr. Byrne told Respondent that he should see the scan and Patient A (Lee, T. 546, 556, 564-567; Byrne, T. 881-882).

40. Dr. Lee got back on the phone with Respondent and stated that she was very concerned about Patient A. Dr. Lee asked if he was going to come in to see the patient. Respondent told Dr. Lee that he would see Patient A in the morning and instructed Dr. Lee to place her in a soft collar and to call him if there was any change in Patient A's condition (Lee, T. 547).

41. At approximately 11:45 PM, Dr. Lee returned Patient A to her room. Dr. Lee wrote in the

hospital record that the preliminary results of the CT scan were discussed with Respondent and that Respondent was to see Patient A and the scan the next morning (Pet's Ex. 3, pg. 103; Lee, T. 547-548).

42. Dr. Byrne documented her preliminary findings on a note filed with the films. The following morning, Dr. Jahre, a neuro-radiologist, read the scan and the preliminary findings. Dr. Jahre's radiology report which was made part of Patient A's chart, indicated that the test was taken on November 17th and was signed on November 18th. The report states that Dr. Lee and Respondent were immediately notified of the findings upon the completion of the examination. The report also indicates the specific findings of the scan: marked displacement of C1 and C2 with marked compromise of the spinal canal and marked compression of the spinal cord and an increase in subarachnoid air (Pet's Ex. 3, pg. 241; Pet's Ex. 8A-J; Galyon, T. 265-270, 465, 477-478; Byrne, T. 886-888, 894, 897).

43. The CT scan from the evening of November 16, 2002, clearly demonstrates a change in alignment of the base of the skull and the body of C2. C1, along with the base of the skull, is moved forward in relation to C2. There is marked subluxation and severe compromise of the spinal cord (Pet's Ex. 3, 8 and 13A; Resp's Ex. L and M; Galyon, T. 265-276, 280-285; Byrne, T. 884-885, 888).

44. Patient A's deterioration in neurological status and symptoms of headache and weakness on the right side, are consistent with the findings of cervical compression made as a result of the November 16, 2002 CT scan. These exam findings were the first clinical signs of instability. Respondent failed to examine Patient A in a timely fashion because faced with the information reported to him by Dr. Sajewicz and Dr. Lee about Patient A's condition and the preliminary results from the CT scan, and in the absence of a neurosurgical resident or neuro-radiologist

who could have interpreted the results in his stead, Respondent should have examined Patient A himself and reviewed the scan immediately (Galyon, T. 307-312, 465; Hadley, T. 1310-1311, 1316-1318).

45. There were no neurosurgical residents on call to care for surgical patients. There were only surgical residents and physician assistants. In the event of an emergency, the protocol was that the surgical resident would contact the attending physician. There was no routine for scans to be read by the attending neuroradiologist on call following the review by the radiology resident (Lee, T. 532, 577, 589-591; Byrne, T. 876, 886, , 894).

46. Elizabeth McCaffrey was the nurse assigned to care for Patient A, on 8:00 am, on November 17, 2002. When she came on duty, she received the report from the evening nurse and was made aware of Patient A's condition (McCaffrey , Tr. 602-604).

47. Respondent did not see Patient A until the late morning of November 17, 2002. Respondent went to the head of her bed, and, in an attempt to achieve a more normal alignment, either moved Patient A's head or allowed her head to go forward, and she immediately stopped breathing. Patient A was intubated and taken to the operating room (Galyon, T. 323-325; McCaffrey, T. 607-611, 628; Mangiardi, T. 1003-1005, 1403-1405; Pet's Ex. 3, pg. 46, 102).

48. Respondent's actions exposed Patient A to the risk of further impingement upon her spinal canal and the crushing of her spinal cord (Galyon, T. 515).

49. Patient A had a spinal cord injury which caused a significant neurological event whereby she stopped breathing, required intubation and became quadriplegic (Pet's Ex. 3, pg. 113; Galyon, T. 331-333, 515-516; Hadley, T.1231).

50. Respondent told Patient A's son words to the effect of "I can't believe I just did that. I did this with my own hands". (McCafrey, T. 612; Mangiardi, T. 1007).

51. Respondent's attempt to re-align Patient A's upper cervical spine was inappropriate. First, Respondent should have gained control of Patient A's upper cervical spine by immobilizing Patient A before attempting to restore a more normal orientation. Respondent should, then, have stabilized Patient A, so that she remained flat with her head in traction. Then, Respondent should have attempted to reduce her bony anatomy toward a normal position, by pulling her head upwards, relative to her neck, not in extension. Respondent then should have attempted to re-align C1 as it relates to C2. Respondent should have taken these measures while monitoring Patient A by utilizing x-ray guidance. Instead, Respondent allowed Patient A's head to move without any x-ray guidance, without reducing the subluxation, without traction or any safety measures. Respondent's efforts to re-align Patient A's upper cervical spine were not safe and not adequate (Resp. Ex B; Galyon, T. 315-326, 333-334; 418; 788-790; Mangiardi, T. 1398-1399).

52. Respondent failed to attempt to re-align and stabilize Patient A's upper cervical spine in a timely fashion. Respondent should have attempted to correct the problem, without doing any further harm (Galyon, T. 316-334; Resp's Ex. B, Pgs. 7-8).

53. On November 17, 2002, Respondent performed a second surgery on Patient A. In this procedure, Respondent attempted to re-align her cervical spine and perform a fusion of Patient A's upper cervical spine. Respondent's attempt to surgically stabilize Patient A's upper cervical spine involved fixation screws placed into either side of C1 and C2 and the application of bone paste material to act as a graft (Pet's Ex. 3, pg. 113; Galyon, T. 328-330).

54. Respondent failed to stabilize Patient A's upper cervical spine adequately. He utilized screws as part of the stabilization procedure that were one inch long and were to be the foundation of

support for the head and skull on C1 and C2. When these screws did not affix well, Respondent had to replace them with larger screws, to capture a different part of bone. The fact that he had to replace the screws with rescue screws indicates that Patient A's bone quality was not good. In addition, he only placed screws into C1 and C2. The amount of instability and the degree of spinal cord compromise present in Patient A, required a longer construct of support than that employed by Respondent. Stabilization at C1 and C2 can meet the standard of care. However, in this instance, Respondent should have gone further down to C3 or C4, to make sure that Patient A's upper cervical spine remained stable (Pet's Ex. 3, g. 113; Resp's Ex. B; Galyon, T. 328-330, 335-341, 719-725; Hadley, T. 1234-1235; Mangiardi, T. 1013).

55. Patient A was moved to the ICU and an intensivist assumed charge of her care, although Respondent remained responsible for resolving surgical issues (Mangiardi, T. 1013-1014, 1523).

56. Post-operatively, Patient A developed meningitis. By November 23rd, Patient A had a fever and was not blinking to questions or commands, indicative of an infection inside her central nervous system. Patient A, also, had decreased mental status which is indicative of a reaction of blood vessels in the brain resulting in a stroke. This is a strong indicator of bacterial meningitis. Patient A was on a medication, Decadron, that could have masked signs of meningitis (Pet's Ex 3, pgs. 7, 11, 280-281; Galyon, T. 357-362, 372-373, 767-769).

57. On November 25, 2002, an infectious disease consultation was obtained. The consultation note stated that cultures were drawn on Patient A's cerebral spinal fluid, on November 17, 2002, which were negative. Patient A was on antibiotics at that time. Subsequently, cultures of fluid from Patient A's lumbar drain proved positive (Pet's Ex. 3, pg. 225).

58. Patient A expired on December 19, 2002 (Pet's Ex. 3, pg. 222).

PATIENT B

59. Patient B, a 66 year old male with a history of colon cancer, developed an excruciating headache, vomited and then collapsed at his home on June 21, 2003. Patient B presented to the emergency room at Lenox Hill Hospital where a CT scan was done. Respondent performed a surgical procedure involving placement of a ventricular drain which entered Patient B's skull through a right frontal burr-hole (Pet's Ex. 4; Galyon, T. 386-387).

60. Patient B's surgery was performed by Respondent on an emergency basis to reverse a possible hydrocephalus (Mangiardi, T. 1463).

61. Respondent documented notes concerning Patient B, on June 22, 2003 (Pet's Ex. 4, pgs. 19 and 65).

62. Respondent documented discussions between himself and Patient B's family, of Patient B's care, as indicated by progress notes of June 22, 25 and June 26, 2003 (Pet's Ex. 4, pgs. 65, 87, 90).

63. Patient B died on June 26, 2003 (Pet's Ex. 4).

PRIOR DISCIPLINE

64. Consent Order BPMC No. 03-314 was issued by the Department after Respondent entered into a Consent Agreement and Order which he signed on April 10, 2003. In that Consent Agreement, Respondent did not contest the First (and only) Specification of a Statement of Charges, dated November 13, 2003, which alleged that he failed to maintain a record for Individuals A through H which accurately reflected their care and treatment because, during the period of 1994 through 2000, he had failed to maintain appropriate records for prescriptions of Percocet and other controlled substances which he issued in the names of these individuals. A censure and

reprimand was imposed upon Respondent's license (ALJ's Ex. 2).

WITNESSES

In its deliberations, the Committee initially considered the credibility of the expert witnesses presented by the parties. Daniel Gaylon, M.D., testified as an expert witness for the Department. Mark Hadley, M.D. testified as an expert witness for Respondent. The Committee found both expert witnesses credible yet problematic.

Dr. Galyon was generally regarded as very honest and forthright. He acknowledged when Respondent had performed appropriately, and was willing to change his mind about aspects of Respondent's care of Patient A when warranted by the facts. However, two members of the Committee felt that Dr. Galyon was testifying as an advocate for the Department's position. More significantly, the Committee questioned Dr. Galyon's expertise as a witness in this proceeding.

While one Committee member found Dr. Galyon generally persuasive as a State's advocate, two members regarded Dr. Galyon as lacking expertise in the procedure performed upon Patient A. They were not impressed by Dr. Galyon's need to extensively research the medical literature and consult with colleagues in order to form an opinion about Respondent's care of Patient A. While they recognized that the trans-oral procedure in question is rarely performed for sub-dural tumors and that it was difficult for the Department to find a physician who has performed such a procedure, it was nevertheless, felt that Dr. Galyon's lack of independent expertise concerning the procedure undermined his credibility and rendered his testimony not authoritative.

The Committee believed Dr. Galyon committed a major error when he discussed Respondent's case with Dr. Kornel whom he assumed had reviewed this case on behalf of the hospital but who had actually independently reviewed this case on behalf of Respondent (T. 842-860). The Committee, also, questioned Dr. Galyon's difficulties in measuring the space between

Patient A's C1 facet joints in order to demonstrate the splaying which he testified had occurred and which was visually apparent to him from the films of Patient A (T. 794-812).

The Committee, also, found Dr. Hadley's testimony problematic. While Dr. Hadley was regarded as successful and prominent within his field, the Committee believed Dr. Hadley was facile, and that he hedged his testimony when asked what he would do in his personal practice, as opposed to what he had previously testified was the standard of care regarding Respondent's actions. The Committee noted instances where Dr. Hadley testified that Respondent had met a minimum standard of care and not what he would accept under similar circumstances. Furthermore, Dr. Hadley, in contrast to Dr. Galyon, was unfamiliar with details of the case and had not thoroughly reviewed Patient A's chart.

Neither expert testified in a persuasive manner on all of the major points in this case. Consequently, the Committee accepted portions of each expert's testimony. Ultimately, the expert testimony was regarded by the Committee as less critical than the testimony of the fact witnesses, Drs. Lee and Dr. Byrne. Respondent's failure to immediately take appropriate action when he was contacted by them on the evening of November 16, 2002 was regarded as the critical issue in this case.

The Department presented three fact witnesses, Elizabeth McCaffrey, R.N., Kristin Byrne, M.D. and Marie C. Lee, M.D. who testified with regard to the events of November 16 and 17, 2002. Ms. McCaffrey was regarded as credible notwithstanding that she had some difficulties recollecting the events in question. The Committee members noted that Drs. Lee and Byrne had been subpoenaed by the Department and regarded them as reluctant but measured and credible witnesses. Their testimony was weighed heavily in regard to the critical events after Patient A's first operation.

With regard to Respondent's witnesses, the Committee concluded that Dr. Komisar was credible and honest, although disagreeable and not happy about having to testify. He did not testify with regard to the critical aspects of Patient A's care. Mr. Wadewitz, through his testimony, supported Respondent but was thought to be credible. Dr. Leitman, who testified as to the role of an intensivist at Lenox Hill Hospital, was regarded as a credible and straightforward witness who clarified the protocols in the critical care unit.

The Respondent, Dr. Mangiardi, was viewed as credible to a limited extent. However, aspects of his testimony were internally inconsistent and self serving. Respondent's testimony was contradicted by both Patient A's medical record and by the testimony of other witnesses. For example, the Committee viewed that Respondent's testimony, as to the events of the morning of November 17, 2002, was internally inconsistent as to whether he removed the pillows from behind Patient A's head or whether he asked the nurse to remove the pillows when he visited Patient A. Nurse McCaffrey mentioned nothing about pillows being removed and Respondent's operative report, likewise, mentions nothing about the removal of pillows. The Committee questioned whether the actions described by Respondent in his testimony with regard to removing the pillows and holding Patient A's head were even physically possible if Respondent had performed these alone. The Committee believed that Respondent, through his testimony, was attempting to justify his actions, and that his testimony conflicted with the statement which he acknowledged making to Patient A's family to the effect that "I did this with my own hands" (T. 1007).

Additionally, the Committee believed that Respondent was evasive in taking responsibility for the post operative events that led to Patient A's deterioration. Specifically, they had concerns about the events leading up to and including the morning of November 17. Respondent testified that he knew nothing of the subluxation until he looked at Patient A's CT scan himself on the

morning of November 17, 2002. This account conflicted with the testimony of Drs. Lee and Byrne and was ultimately not believed by the Committee. Respondent's testimony that he ordered the CT scan (T. 994-995), also, conflicted with Dr. Lee's testimony that she had ordered the CT scan.

GENERAL CONCLUSIONS

Respondent is charged with three specifications alleging professional misconduct within the meaning of Education Law §6530. Specifically, Respondent was charged with one specification of practicing medicine with gross negligence, one specification of practicing medicine with negligence on more than one occasion, and one specification of failing to maintain a record for each patient which accurately reflected his care and treatment of the patient.

Education Law §6530 sets forth numerous forms of conduct that constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Committee consulted a memorandum prepared by the former General Counsel for the Department of Health. This memorandum, which is entitled "Definitions of Professional Misconduct Under the New York State Education Law", sets forth suggested definitions for, among other things, negligence and gross negligence. The following definitions, taken from this memorandum, were utilized by the Committee:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances, Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88, 606 N.Y.S. 2d 381 (3d Dept. 1993). It involves a deviation from acceptable medical standards in the treatment of patients. Injury, damages and proximate cause are not essential elements in a medical disciplinary proceeding (Id.). The Court of Appeals has interpreted "occasion" to mean "an event of some duration, occurring at a particular time and place, and not simply ..... a discrete act of negligence which can occur in an instant" Rho v. Ambach, 74

N.Y.2d 318, 322 , 546 N.Y.S. 2d 1005 (1989) ("Rho"). While several acts of negligence occurring during a single autopsy do not constitute professional misconduct (Rho), an act of negligence regarding a single patient repeated on a subsequent occasion, does constitute misconduct, Orosco v. Sobol, 162 A.D. 2d 834, 557 N.Y.S. 2d 738 (3d Dept. 1990).

Gross negligence may consist of "a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." (Rho, supra at 322). Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion (Rho, supra at 322). No single formula has been articulated to differentiate between simple negligence and errors that are viewed as gross. While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad", articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent significant or serious deviations from acceptable medical standards that present the risk of potentially grave consequences to the patient, Post v. State of New York Department of Health, 245 A.D. 2d 985, 986, 667 N.Y.S. 2d 94 (3d Dept. 1997). There is no need to prove that a physician was conscious of impending dangerous consequences of his or her conduct, Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752, 634 N.Y.S. 2d 856 (3d Dept. 1995).

In determining whether Respondent committed record keeping violations which rose to the level of negligence, the Committee was instructed that in order to constitute negligence, the record keeping violation must be such that it would potentially effect the future care of the patient. In other words, in order for the record keeping violation to constitute negligence, the inaccurate portion of the record needed to be inaccurate in a manner such that subsequent treating care givers could potentially rely on the problematic portion of the record to the patient's detriment.

PATIENT A

FACTUAL ALLEGATION A

Factual Allegation A alleges that Respondent first saw Patient A, a 70 year old woman complaining of numbness in her hands, in July of 2002. An MRI revealed a benign tumor at the upper portion of the neck. Patient A's symptoms did not improve. On November 14, 2002, Respondent performed a trans-oral resection of the tumor at Lenox Hill Hospital in New York.

The Committee sustains Factual Allegation A based upon confirming information contained in Respondent's office record for Patient A, Patient A's hospital record and Respondent's testimony (see Findings of Fact# 1-22).

FACTUAL ALLEGATION A.1

Factual Allegation A.1 alleges that Respondent failed to perform and/or document in the hospital record, a thorough history and physical examination of Patient A. The Committee does not sustain Factual Allegation A.1. A history and physical examination were documented in the hospital record by a third year medical student which note was countersigned by Respondent, as indicated by his sign at the end of the note. The testimony presented by Respondent's expert indicated that the history and physical examination were adequate. The testimony presented by the Department's expert failed to contradict the testimony of Respondent's expert with regard to the adequacy of the history and, indeed, supported that the note of the physical examination was adequate. The Committee, therefore, concluded that Respondent's note was at least minimally acceptable.

FACTUAL ALLEGATION A.2

Factual Allegation A.2 alleges that Respondent failed to perform and/or document in the hospital record, a complete pre-operative neurological examination of Patient A. The Committee sustains this allegation.

The Committee observes that although Patient A was initially evaluated by Dr. Dickoff in July 2002, that report was not made a part of the hospital record. In any event, that examination had been conducted four months prior to the hospital admission. There was no documented complete neurological examination in the interval.

The hospital record only contains a cursory note by a third year medical student indicating "neuro: CN (cranial nerves) 2-12 intact". Furthermore, there is no baseline for Patient A contained in the hospital chart. Respondent stated that Patient A's symptoms progressed over time prior to her admission. Yet, there is no documentation of such progression. The Committee believed that Respondent should have performed a new neurological examination and obtained a new MRI.

Even Respondent's own expert, Dr. Hadley, testified that the neurological examination was incomplete. He stated that he would have directed his own residents to document a more thorough neurological examination including an assessment of cranial nerves, motor, sensory, reflex function and ability with gait and station (T. 1330-1334).

The Committee sustains this allegation as simple rather than gross negligence. The failure to document a complete neurological examination did not meet the standard of care, and potentially impacted Patient A's future care and treatment due to its lack of a baseline of the progress of Patient A's symptoms which a subsequent treating health care professional may have referred to. However, because the failure to adequately document the neurological examination would not have likely

impacted upon the decision to operate on Patient A, the Committee concluded that this deviation did not immediately impact Patient A's care and, therefore, did not rise to the level of gross negligence.

The Committee, also, sustained this allegation as a failure to maintain a record accurately reflecting Patient A's care and treatment. The cursory neurological examination which was documented in the hospital record, i.e., "N, 2-12 intact" was incomplete and therefore, could not have accurately reflected the examination of Patient A.

FACTUAL ALLEGATION A.3

Factual Allegation A.3 alleges that Respondent failed to assess and/or document whether stabilization was required. The Committee does not sustain Factual Allegation A.3. It accepted Dr. Hadley's testimony that where there was no instability preoperatively, and where instability was not anticipated, a prudent neurosurgeon, trained in trans-oral procedures, would not make a list of possible complications and anticipated countermeasures because he/she would have been trained at handling post operative instability. The Committee concluded that Respondent was aware of routine stabilization procedures, did not need to document these, and that there was no need for additional documentation regarding stabilization.

FACTUAL ALLEGATION A.4

Factual Allegation A.4 alleges that Respondent failed to appropriately stabilize Patient A's upper cervical spine. The Committee does not sustain Factual Allegation A.4. While Respondent did not stabilize Patient A's upper cervical spine in the period immediately following surgery, the Committee accepted Dr. Hadley's testimony that, during this period, there was no need for Respondent to stabilize Patient A who was lying on her back in bed and who had a low chance of

becoming unstable. The Committee, also, accepted Dr. Hadley's testimony that the measures which the Department's expert, Dr. Galyon, suggested to stabilize Patient A's spine such as a cervical collar, halo or stryker frame were not necessary, and that, in fact, the use of a strkyer frame would have been inappropriate. Dr. Galyon testified that the use of a collar would have been a judgment call on the part of the neurosurgeon (T. 683-684).

FACTUAL ALLEGATION A.5

Factual Allegation A.5 alleges that Respondent failed to adequately monitor Patient A's upper cervical stability. The Committee sustained Factual Allegation A.5 and concluded that Respondent did not follow up in a timely manner to the calls which he received from Dr. Lee on the night of November 16, 2002. In the first call which occurred around 10:30 p.m., Dr. Lee reported to Respondent that Patient A had paralysis of the upper right extremity and generalized weakness. Respondent agreed with Dr. Lee's decision to order a brain CT scan and that Dr. Lee would call Respondent with the results. Respondent was contacted by Dr. Lee and the radiologist, Dr. Byrne, sometime before 11:45 p.m. The Committee found Dr. Byrne credible in her testimony that she told Respondent that the brain scan was abnormal in that it showed spinal cord compression and that he should see the scan[2]. The Committee did not believe Respondent's account that he was not told that the spinal cord was being impinged upon (T. 996). However, even assuming that Respondent's account is accurate, the Committee concluded that when he received these late night calls from the resident physicians, he should have recognized that given the complexities of Patient A's surgery, it was urgent for him to come to the hospital and personally assess the situation.

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[2] While the final interpretation of the CT scan, performed by Dr. Jahre, indicates that the CT scan was performed on November 17, 2002, the Committee concluded, on the basis of the record, that the CT scan was actually performed on November 16th, as testified to by Dr. Byrne and Dr. Lee. Because the CT scan was performed shortly before midnight, the final report erroneously noted that the scan was performed on November 17th. The Committee believed that the CT scan was interpreted by Dr. Jahre on November 17th.

Dr. Lee testified that there were no neurosurgical residents who could have assessed Patient A in Respondent's absence. It is unclear from the testimony of Drs. Byrne and Lee to what extent a neuroradiologist was available. However, Dr. Byrne who had neuroradiologic training, testified that Dr. Jahre, an attending neuroradiologist, did not review the scan till the following morning. Respondent did not testify that there was anyone else available who could have adequately assessed Patient A and, in fact, testified that had he been aware that the spinal cord was being impinged upon, he would gone to see Patient A earlier (T.996).

Rather than coming in immediately to see Patient A, Respondent told Dr. Lee that he would come in the next morning to see the patient. The Committee concluded that Respondent should have gone to the hospital immediately to assess Patient A and examine the brain scan.

The Committee sustained Allegation A.5 as gross negligence based upon what they considered Respondent's failure to monitor Patient A by following up in a timely manner once her condition began to deteriorate. The Committee concluded that the potential risks to Patient A accruing from Respondent's failure to monitor were particularly grave, as evidenced by her subsequent change in status. His failure to monitor was particularly serious in light of his failure to adequately follow up on the telephone calls from Drs. Lee and Byrne who were resident physicians at the time.

FACTUAL ALLEGATION A.6

Factual Allegation A.6 alleges that Respondent failed to develop and /or document a post-operative plan to protect against destabilizing motion. The Committee does not sustain Allegation A.6. The Committee accepted Dr. Hadley's testimony that during the period immediately following surgery, there was no need for Respondent to stabilize Patient A who was lying on her back in bed and who had a low chance of becoming unstable, and that there was no need to write out a plan. As

Dr. Hadley testified, "Write out a plan? No... So I don't go through an elaborate list. I have this check off in my mind about what if instability occurs, what would I do next, sure. Because we have managed those patients and those problems many times. No, I don't write it out. I don't put it in the medical record..... we don't make a list of all the contingencies. We have to be able to deal with them. And anyone trained to do trans-oral work is also trained at handling post-operative instability." (T. 1226-1227). The Committee concluded that it was not the standard of care to develop or document a plan to protect against destabilizing motion.

FACTUAL ALLEGATION A.7

Factual Allegation A.7 alleges that, on November 16, 2002, Patient A began complaining of a headache and weakness and numbness in her hands. A subsequent CT scan revealed cervical compression.

Factual Allegation A.7(a) alleges that Respondent failed to examine the patient and review the CT scan in a timely fashion.

Factual Allegation A.7(b) alleges that Respondent failed to attempt to realign the upper cervical spine in a timely fashion.

The Committee sustains Factual Allegations A.7, A.7(a) and A.7(b).

Factual Allegations A.7 is sustained to the extent that the record indicates that Patient A's condition changed on November 16, 2002 in that she began to feel pins and needles and a headache and developed bilateral hand weakness. A CT scan was performed which indicated cervical compression.

As discussed with regard to Allegation A.5, the Committee concluded that Respondent did not follow up in a timely manner to the calls which he received from Dr. Lee, on the night of November 16, 2002, regarding the change in Patient A's condition. During the first call which

occurred around 10:30 p.m., Dr. Lee reported to Respondent that Patient A had paralysis of the upper right extremity and generalized weakness. He agreed with Dr. Lee's decision to order a brain CT scan and that Dr. Lee would call Respondent with the results. Respondent was contacted by Dr. Lee and the radiologist, Dr. Byrne, sometime before 11:45 p.m., and was told that the brain scan was abnormal in that it showed spinal cord compression. Rather than coming in immediately to see Patient A, Respondent told Dr. Lee that he would come in the next morning to see the patient. The Committee concluded that Respondent should have gone to the hospital immediately to assess Patient A and examine the brain scan.

The Committee also believed that Respondent had warning prior to Dr. Lee's initial call that Patient A's condition was changing. For example, Dr. Sajewicz reported to Respondent that Patient A was complaining of hand weakness at approximately 6:00 P.M. on November 16, 2006.

The Committee sustains Allegations A.7(a) and (b) as gross negligence. Once Respondent was warned that the CT scan demonstrated cervical compression, it was incumbent upon Respondent to immediately review the CT scan and attempt remedial measures to realign Patient A's upper cervical spine. The Committee concluded that Respondent's failures in this regard were egregious and subjected Patient A to grave risk, as evidenced by the subsequent change in her status. The failure to review the CT scan in a timely fashion was particularly serious given that Respondent was notified of the results of the CT scan by Drs. Lee and Byrne who were only residents at the time.

FACTUAL ALLEGATION A.8

Factual Allegation A.8 alleges that Respondent saw Patient A, on November 17, 2002, and attempted to manually realign the upper cervical spine. Patient A became quadriplegia, was

intubated and taken to the operating room. Respondent performed a surgical procedure which included an attempt to realign the neck and, a stabilizing procedure by attaching bone screws to C1 and C2.

Factual Allegation A.8 is sustained as true. The Committee concluded that Respondent attempted to realign Patient A's cervical spine by either moving her head or allowing it to go forward. Patient A, then, became quadriplegic and was intubated. The record indicates that, on November 17, 2002, Respondent performed a second surgery on Patient A during which he attempted to re-align Patient A's upper cervical spine and fuse the upper cervical spine. Respondent's attempt to surgically stabilize Patient A's upper cervical spine involved fixation screws placed into either side of C1 and C2, and a bone paste material to act as a graft.

Factual Allegation A.8(a) alleges that Respondent attempted to realign Patient A's upper cervical spine inappropriately.

The Committee sustains allegation A.8(a) because Respondent's attempt to realign Patient A's cervical spine was inappropriate. The Committee had serious questions concerning the credibility of Respondent's account of what happened when he first saw Patient A on November 17th. Respondent testified that when he walked into the room, Patient A's head was propped up on pillow(s), with her head rotated dramatically to the left. He also claimed that he examined her and that she was quite weak. In addition, Respondent asserted that Patient A's legs and arms extended once he removed the pillows, as though she were in shock following his attempt at cervical realignment (T.1000-1006).

By contrast, Nurse McCaffrey did not see Respondent remove pillows from under Patient A's head nor did she remove any pillows from Patient A's head upon being instructed to do so by Respondent. Significantly, Respondent did not include any mention of pillows in his operative

report which presumably would have been written close in time to the event. In fact, his operative report stated that "we attempted to hyper-extend her neck and rotate her to the right". Nurse McCaffrey did not see Respondent examine Patient A. Nor did she see the involuntary movement described by Respondent involving the outward extension of Patient A's arms and legs (Pet's Ex. 3, pg. 113; McCaffrey, T. 610-612;Mangiardi, T. 1000-1006, 1403-1404, 1504-1506).

Regardless of whether Respondent manually "manipulated" or manually "repositioned" Patient A's head, or asked the nurse for assistance in removing the pillow(s) or removed the pillow(s) himself, Respondent created a situation whereby Patient A's head was allowed to move in such a way that she suffered a serious spinal cord injury. Giving every benefit of doubt to Respondent as to what actually transpired, Respondent's attempt to realign Patient A's cervical spine was still inappropriate. It is likely that based on the anatomy of the upper cervical spine, the effect of Respondent's allowing Patient A's head to move was such that the back arch of C1 dug into her spinal cord even more and further compromised the spinal cord, making a bad situation worse.

Dr. Hadley testified that he felt Respondent's actions met the standard of care, and that he, too, would have taken the pillow(s) out, but he, also, stated unequivocally that he is not in favor of manual manipulation. He does not do it and does not allow his best friend, a chiropractor, to do it to him (T. 1230-1232). In fact, Dr. Hadley described a case of an 80 year old patient with a tumor at C2 in the dens who developed an acute subluxation after trans-oral surgery. Three days after surgery, while still in the ICU, this patient developed severe neck pain, numbness and tingling in his hands and, was unable to lift one leg. Contrary to Respondent's actions, Dr. Hadley immediately instructed his resident to limit this patient's movement and ordered a cervical spine CT scan which demonstrated a subluxation of C1-C2. Dr. Hadley personally viewed the scan and then placed this

patient in a halo ring. In a controlled setting, Dr. Hadley realigned this patient's cervical spine.

The Committee believed that once her condition had changed, Patient A should have been kept immobile or in a halo and not have been moved without the benefit of images taken via fluoroscopy. Respondent's actions on the morning of November 17th, exposed Patient A to grave risk, as testified to by Dr. Galyon. He said, "... putting the patient in extension actually made a bad situation worse by further impinging into the canal and crushing the spinal cord". (T. 515).

The Committee sustains Factual Allegation A.8(a) as gross negligence, as alleged in the First Specification. The Committee concluded that Respondent's action exposed Patient A to grave risk and that she ultimately became quadriplegic. The allegation is, therefore, sustained as gross negligence.

Factual Allegation A.8(b) alleges that Respondent's effort to stabilize Patient A's cervical spine was inadequate. The Committee sustains allegation A.8(b) as simple negligence.

Two members of the Committee concluded that under the circumstances of this case, Respondent, during Patient A's second surgery, should have taken the extra precaution of extending her spinal fixation down to C3 and C4. While neither expert testified that such extended fixation was necessarily required by the standard of care, the Committee noted that both experts felt that there were situations where extra fixation might be necessary. While Dr. Hadley testified that the standard of care in this case did not require fixation lower down, he did testify that there can be reason to affix lower down to C4 and that he sometimes does so. The two Committee members concluded that given the softness of Patient A's bone and the failure of the initial screws to fix into the bone, Respondent should have gone down to C3 and C4 to achieve maximum fixation. It was observed that the conduct of the second surgery reflected a lack of consideration and of a plan by Respondent.

A third Committee member noted the dire circumstances and did not view the interoperative procedure unfavorably.

FACTUAL ALLEGATION A.9

Factual Allegation A.9 alleges that post-operatively, Patient A developed meningitis, a known risk associated with surgery involving exposure of the spinal cord covering. Patient A expired on December 19, 2002.

Factual Allegation A.9(a) alleges that Respondent failed to appropriately monitor Patient A for meningitis.

Factual Allegation A.9(b) alleges that Respondent failed to obtain an infectious disease consultation in a timely fashion.

The Committee declines to sustain allegations A.9(a) and (b). Much testimony was given concerning the "leapfrog" initiative in intensive care units whereby an intensivist assumes the care of the patient and the degree to which the intensivist in the ICU assumed such responsibility for Patient A's care. Regardless of whether the "leapfrog" initiative was in effect or not, the Committee concluded that the intensivist and other physicians in the ICU were following Patient A, that they were aware of her infection and of her fever which were usual events after intra-dural surgery. The Committee notes that Patient A was quadrapalegic and non-responsive which would have made it more difficult to recognize changes in her condition. Under all of these circumstances, the Committee could not fault Respondent's monitoring of Patient A following the second surgery.

With regard to Factual Allegation A.9(b), Patient A had been placed on antibiotics and cultures were taken. An infectious disease consultation was obtained in a timely manner, on November 25, 2002, and the Committee did not feel that a consultation would have been previously

indicated.

FACTUAL ALLEGATION A.10

Factual Allegation A.10 alleges that Respondent failed to maintain adequate records to reflect the care and treatment rendered to Patient A. The Department cited eight instances in which Respondent's record keeping was deficient.

It appeared at first blush that a number of the A.10 allegations were repetitive of the earlier allegations which charged Respondent with deficient record keeping. After closely reviewing the allegations, the Administrative Law Judge instructed the Committee that the earlier allegations referred specifically to the hospital record whereas the broader A.10 allegations referred largely to Respondent's office records.

The Committee ultimately declined to sustain any of the Factual Allegations contained in allegation A.10. Although, the Committee had reservations concerning Respondent's record keeping, it noted that with respect to the A.10 allegations, either both experts felt that the records met minimally acceptable medical standards or that the Department offered no testimony in support of the allegation in question.

Factual Allegations A.10(a) and A.10(b) allege that Respondent failed to document an adequate history and failed to document an adequate physical examination. The Committee did not sustain Allegation A.1(a) and A.1(b). The Department's expert, Dr. Galyon, testified that he had "to pass" on whether there was a major lapse in terms of standards regarding Patient A's medical history and that although problematic, the documentation of the physical examination in Respondent's record for Patient A was "barely" adequate (T. 147-151; Resp's Ex. D).

Factual Allegation A.10(c) alleged that Respondent failed to document an adequate neurological examination. Dr. Galyon testified that Respondent had checked off "normal" for

various categories on his worksheet (Resp's Ex. D, pg. 2). Dr. Galyon testified that although sparse on details, "normal is normal" (T. 153). Furthermore, Dr. Galyon testified that the neurological examination performed by Dr. Dickoff was adequate and documented in Respondent's office record (T.834).

Factual Allegation A.10(d) alleged that Respondent failed to document his treatment plan and/or thought processes for managing this lesion. The Committee noted no testimony which would substantiate this allegation and located at least some documentation of Respondent's treatment plan or thought processes in his July 16, 2002 note. In that note, Respondent spoke of performing a trans-oral resection of the tumor at least partially to allow for decompression of the cervicomedullary junction subject to Patient A's being reevaluted in September (Resp's Ex. D, pg. 8). The allegation was, therefore, not sustained by the Committee.

Factual Allegation A.10(e) alleged that Respondent failed to document discussions with the patient regarding the potential risks and benefits of the selected procedure as well as alternatives. The Committee did not sustain this allegation. It accepted the testimony of Respondent's expert, Dr. Hadley, that the standard of care would not require documentation of discussions concerning the risks and benefits of a procedure as well as alternatives. The Committee agreed that this degree of detail would not be required to be documented, and noted the discussions with Patient A's family described in Respondent's office record concerning the possibility of performing a trans-oral resection of the tumor (Resp's Ex. D, pg. 8). Dr. Hadley's testimony was persuasive insofar as he testified that it is sufficient for a doctor to document that he met with a patient's family to discuss a proposed procedure without documenting the details of that discussion.

Factual Allegation A.10(f) alleged that Respondent failed to adequately document the specifics of this particular procedure in the consent form in the record. Factual Allegation A.10(g)

alleged that Respondent failed to document reasons for selecting this particular surgical procedure in his operative notes. Factual Allegation A.10(h) alleged that Respondent failed to document any rationale for not stabilizing Patient A's cervical spine post-operatively.

The Committee did not sustain these allegations. In each instance, the Committee concluded that these were not the type of details that would be documented in either the consent or the medical record. A consent, signed by Patient A, to undergo a trans-oral tumor resection was documented in Patient A's hospital record (Pet's Ex. 3, pg. 17, et seq.). The Committee concluded, based on Dr. Hadley's testimony, that there was no need to document the specifics of the procedure in the consent. In terms of Respondent's alleged failure to document the reasons why he was intending to do a trans-oral procedure, as opposed to a far lateral approach in Patient A's operative notes, the Committee accepted Dr. Hadley's testimony that such detail would neither have assisted Patient A or subsequent treating physicians or caregivers. With regard to Respondent's alleged failure to document any rationale for not stabilizing Patient A's cervical spine post-operatively, the Committee reiterates its reasoning with respect to allegations A.3, A.4 and A.6 above. It accepted Dr. Hadley's testimony that in a situation such as here where there is no instability preoperatively, and where instability is not anticipated, the prudent neurosurgeon who is trained in trans-oral procedures, does not need to make a list of possible complications and anticipated countermeasures because he/she is already trained at handling post operative instability and presumably would know what to do if it occurred. The Committee concluded that Respondent was aware of routine stabilization procedures, did not need to document these, and that there was no need for additional documentation regarding stabilization.

PATIENT B

FACTUAL ALLEGATION B

Factual Allegation B alleges that Patient B, a 66 year old man with a history of colon cancer, presented to Lenox Hill Hospital emergency room after collapsing at home on June 21, 2003. A CT scan was ordered which revealed an abnormality within the cerebellum. After a substantial neurological change, Respondent, who was on call that night, operated on Patient B on June 22, 2003. Patient B expired on June 26, 2003. The Committee sustains Factual Allegation B based upon the information contained in Petitioner's Exhibit 4.

FACTUAL ALLEGATIONS B.1(a) and B.1(b)

Factual Allegation B.1(a) alleges that Respondent failed to maintain adequate records to reflect the care and treatment rendered to Patient B including but not limited to his failure to document his analysis regarding Patient B's care. Factual Allegation B.1(a) is not sustained.

The Committee concluded that Respondent's notes concerning Patient B were not detailed in the manner that would normally be expected. However, the Committee believed that, in this instance, the lack of detail did not rise to the level of a record keeping violation given the emergent circumstances under which Patient B presented. In any event, the Committee believed there was little Respondent could have done to assist Patient B. As Dr. Galyon testified, "I don't think anything the respondent did would have mattered one bit with the care of this patient." (T. 388).

Factual Allegation B.1(b) alleges that he failed to document discussions with family members regarding choices made in treating Patient B. The Committee does not sustain this allegation. Respondent documented that he discussed Patient B's care with the patient's family. These discussions are evidenced by the entries in Patient B's record on pages 65, 87 and 90. They indicate that Respondent would discuss or had discussed Patient B's care with his family. The first entry was a pre-operative note, on June 22, and the second and third entries were post-operative

notes, on June 25 and 26. As noted in the discussion of Patient A, the Committee did not believe the conversations which Respondent had with Patient B's family needed to be described in detail in the medical record.

SPECIFICATIONS

FIRST SPECIFICATION

GROSS NEGLIGENCE

The First Specification which alleges that Respondent practiced the profession of medicine with gross negligence is sustained, on the basis of Factual Allegations A and A.5, A7, A.7(a), A.7(b), A.8 and A.8(a). The rationale upon which the Committee based its conclusions with regard to gross negligence is found in the discussions concerning these allegations

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

The Second Specification is sustained. This specification alleges that Respondent practiced medicine with negligence on more than one occasion. The Committee viewed the deviation described in allegation A.2 as occurring on a separate occasion from the deviations described in allegations A.5, A.7 and A.8. Specifically, the failure to perform and/or document a complete pre-operative neurological examination in the hospital record, took place prior to surgery, whereas the events described in A.5, A.7 and A.8, occurred post-operatively. Consequently, the Committee concluded that Respondent committed negligence on more than one occasion, as alleged in the Second Specification.

THIRD SPECIFICATION

FAILING TO MAINTAIN A RECORD REFLECTING THE EVALUATION AND TREATMENT OF A PATIENT

The Third Specification is sustained based on the discussions above concerning sustained Factual Allegation A.2.

DETERMINATION AS TO PENALTY

The Committee unanimously concludes that Respondent's license to practice medicine should be suspended for three years with the final two years of the suspension being stayed. The Committee concludes that Respondent should be monitored by a practice monitor during the last two years of the suspension which will be stayed.

The Committee's determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L §230-a, including:

> (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license to a specified area or type of practice; (4) Revocation of the license; (5) Annulment of the license or registration; (6) Limitations on registration or the issuance of any further license; (7) The imposition of monetary penalties; (8) A course of education or training; (9) Performance of public service, and (10) Probation.

Once the Committee concluded its deliberations with regard to Respondent's innocence or guilt concerning the various specifications, and had determined that Respondent was guilty of at least one of the specifications, the Committee turned its consideration to the issue of penalty. At that point, the Administrative Law Judge provided the Committee with Consent Order BPMC No. 03-314 which was issued by the Department after Respondent had entered into a Consent Agreement and Order, signed by him on April 10, 2003. In that Consent Agreement, Respondent did not contest the First (and only) Specification of a Statement of Charges, dated November 13, 2003. Specifically, Respondent did not contest that he had failed to maintain a record for Individuals A through H which accurately reflected their care and treatment because, during the period of 1994 through 2000, he had failed to maintain appropriate records for prescriptions of

Percocet and other controlled substances which he issued in the names of these individuals. A censure and reprimand was imposed upon Respondent's license as a result of the prior disciplinary action. The Committee considered the prior discipline in reaching its determination with regard to an appropriate penalty in the instant case.

The Committee initially considered that Respondent clearly has long experience in a specialized area of medicine, neuro-surgery. He has skills which can benefit the community. Given the expertise he has developed over the years in this specialized area of medicine, it would not make sense to revoke Respondent's license. At the other extreme, it would be meaningless to impose a censure and reprimand since Respondent has already been censured and reprimanded in a prior proceeding. The Committee was disturbed by and found it significant that Respondent had been previously disciplined for record keeping deficiencies involving controlled substances. They noted that the instant case involved a record keeping violation, as well, and that while allegation B.1(a) was not sustained, the record for Patient B was problematic. Based on Respondent's level of expertise, retraining was not considered an appropriate option nor was probation alone considered to be a practical penalty.

Two Committee members were troubled by Respondent's demeanor at the proceeding. They felt that he did not take the proceeding seriously and did not regard the allegations with the concern which they deserved. They felt that Respondent did not approach the proceeding or the forum with the gravity or respect that the situation warranted, particularly in light of his prior discipline. Respondent's air of informality reflected upon his credibility and affected their assessment of the appropriate penalty. One Committee member did not regard Respondent's demeanor as unusual or as an issue affecting the case.

Despite Respondent's obvious experience and skills, the Committee concluded that

Respondent simply did not take matters seriously when he was notified in the evening of November 16, 2002 that a CT scan revealed cervical compression and that Patient A was exhibiting weakness and tingling in her hands. Respondent's failure to immediately return to the hospital to deal with this situation was critical to the Committee. Furthermore, given Patient A's dire situation, the Committee could not understand Respondent's explanation that he was involved in emergency surgery on another patient (T.997-1000). The Committee believed that other arrangements should have been made to resolve any conflicts in patient care and that it was unacceptable, even assuming that there was another emergent situation, to simply have Patient A await Respondent's arrival. The Committee ultimately did not believe Respondent's account of the events of the evening of November 16, 2002 when compared to the testimony of Drs. Byrne and Lee and was troubled by what they concluded was a lack of credibility on his part. The Committee also questioned Respondent's credibility regarding the events of the morning of November 17th when Patient A became quadriplegic following Respondent's attempt to realign her spine and noted the inconsistencies in his own accounts of the incident as well as the inconsistencies with Nurse McCaffrey's account.

The Committee finally determined that the only response to the seriousness of Respondent's actions, and to deter this type of event from repeating itself, was to impose a suspension upon Respondent. Respondent clearly has the skill and knowledge to practice medicine safely, provided that he approaches his practice with the appropriate gravitas. The Committee's hope and expectation is that he will take this penalty to heart, and that he may return to the practice of medicine and benefit the larger community.

ORDER

IT IS HEREBY ORDERED THAT:

1. The **FIRST** through **THIRD SPECIFICATIONS** are hereby **SUSTAINED;**
2. The license to practice medicine of **RESPONDENT, JOHN RAGUE MANGIARDI, M.D.** is hereby **SUSPENDED FOR A PERIOD OF THREE YEARS WITH THE LAST TWO YEARS OF SAID SUSPENSION BEING STAYED** contingent upon **RESPONDENT'S** compliance with the **TERMS OF PROBATION** which are annexed and attached hereto as **EXHIBIT B**; and
3. This **DETERMINATION AND ORDER** shall be effective upon service on **JOHN RAGUE MANGIARDI, M.D.,** pursuant to Public Health Law § 230(10)(h).

DATED: New York, New York
July 12 **, 2006**

Redacted Signature

JERRY WAISMAN, M.D.
Chairperson
JAY ROSENBLUM, M.D.
LOIS JORDAN

TO: Leslie Eisenberg, Esq.
Bureau of Professional Medical Conduct
Division of Legal Affairs
New York State Department of Health
90 Church Street- 4th floor
New York, New York 10007

Wilfred T. Friedman, Esq.
Friedman and Mahdavian, P.C.
The Bar Building
36 West 44th Street
New York, New York 10036

John Rague Mangiardi, M.D.

Redacted Address

EXHIBIT A

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

IN THE MATTER OF JOHN RAGUE MANGIARDI, M.D.	STATEMENT OF CHARGES

John Rague Mangiardi, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 1, 1978, by the issuance of license number 136921 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent first saw Patient A, a 70 year old woman complaining of numbness in her hands, in July 2002. An MRI revealed a benign tumor at the upper portion of the neck. Patient A's symptoms did not improve. On November 14, 2002, Respondent performed a trans-oral resection of the tumor at Lenox Hill Hospital in New York. (The identity of the patients is contained in the attached appendix)

1. Respondent failed to perform and/or document in the hospital record, a thorough history and physical examination of Patient A.
2. Respondent failed to perform and/or document in the hospital record, a complete pre-operative neurological examination of Patient A.
3. Respondent failed to assess and/or document whether stabilization was required.
4. Respondent failed to appropriately stabilize Patient A's upper cervical spine.
5. Respondent failed to adequately monitor Patient A's upper cervical stability.

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6. Respondent failed to develop and/or document a post-operative plan to protect against destabilizing motion.

7. On November 16, 2002, Patient A began complaining of a headache and weakness and numbness in her hands. A CT scan revealed cervical compression.

   a. Respondent failed to examine the patient and review the CT scan in a timely fashion.

   b. Respondent failed to attempt to realign the upper cervical spine in a timely fashion.

8. Respondent saw Patient A on November 17, 2002. Respondent attempted to manually realign the upper cervical spine. Patient A became quadriplegia, was intubated and taken to the operating room. Respondent performed a surgical procedure which included an attempt to realign the neck and, a stabilizing procedure by attaching bone screws to C1 and C2.

   a. Respondent attempted to realign Patient A's upper cervical spine inappropriately.

   b. Respondent's effort to stabilize Patient A's cervical spine was inadequate.

9. Post-operatively, Patient A developed meningitis, a known risk associated with surgery involving exposure of the spinal cord covering. Patient A expired on December 19, 2002.

   a. Respondent failed to appropriately monitor Patient A for meningitis.

   b. Respondent failed to obtain an infectious disease consultation in a timely fashion.

10. Respondent failed to maintain adequate records to reflect the care and treatment rendered to Patient A including but not limited to the following:

a. Respondent failed to document an adequate history.

b. Respondent failed to document an adequate physical examination.

c. Respondent failed to document an adequate neurological examination.

d. Respondent failed to document his treatment plan and/or thought processes for managing this lesion.

e. Respondent failed to document discussions with the patient regarding the potential risks and benefits of the selected procedure as well as alternatives.

f. Respondent failed to adequately document specifics of this particular procedure in the consent form in record.

g. Respondent failed to document reasons for selecting this particular surgical procedure in his operative notes.

h. Respondent failed to document any rationale for not stabilizing Patient A's cervical spine post-operatively.

B. Patient B, a 66 year old man with a history of colon cancer, presented to Lenox Hill Hospital emergency room after collapsing at home on June 21, 2003. A CT scan was ordered which revealed an abnormality within the cerebellum. After a substantial neurological change, Respondent, who was on call that night, operated on Patient B on June 22, 2003. Patient B expired on June 26, 2003.

1. Respondent failed to maintain adequate records to reflect the care and treatment rendered to Patient B including but not limited to the following:

   a. Respondent failed to document his analysis regarding Patient B's care.

   b. Respondent failed to document discussions with family members regarding choices made in treating Patient B.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

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

1. Paragraph A and its subparagraphs.

SECOND SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

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

2. Paragraph A and its subparagraphs.

THIRD SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

3. Paragraphs A and its subparagraphs and/or Paragraphs B and its subparagraphs.

DATED: August 18, 2005
New York, New York

Redacted Signature

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT B

Standard Terms of Probation

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

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

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

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law Section 171(27); State Finance Law Section 18; CPLR Section 5001; Executive Law Section 32].

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

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

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

8. Within thirty (30) days of the effective date of the Order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty and familiar with the care of hospital patients ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least quarterly and shall examine a selection (no less than 10) of records maintained by Respondent, including in and out patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

   b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

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

ATTACHMENT II

GUIDELINES FOR CLOSING A MEDICAL PRACTICE

1. Respondent shall immediately cease the practice of medicine in compliance with the terms of the Modification Order. Respondent shall not represent himself as eligible to practice medicine and shall refrain from providing an opinion as to professional practice or its application.

2. Within 15 days of the Modification Order's effective date, Respondent shall notify all patients that Respondent has ceased the practice of medicine, and shall refer all patients to another licensed practicing physician for their continued care, as appropriate.

3. Within 30 days of the Modification Order's effective date, Respondent shall deliver Respondent's original license to practice medicine in New York State and current biennial registration to the Office of Professional Medical Conduct (OPMC) at 433 River Street, Suite 303, Troy, N.Y. 12180-2299.

4. Respondent shall arrange for the transfer and maintenance of all patient medical records. Within 30 days of the Modification Order's effective date, Respondent shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate contact person, acceptable to the Director of OPMC, who shall have access to these records. Original records shall be retained for patients for at least 6 years after the last date of service, and, for minors, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall ensure that all patient information is kept confidential and is available only to authorized persons. When a patient or authorized representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be provided promptly or sent to the patient at reasonable cost (not to exceed 75 cents per page.) Radiographic, sonographic and like materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of inability to pay.

5. Within 15 days of the Modification Order's effective date, if Respondent holds a Drug Enforcement Agency (DEA) certificate, Respondent shall advise the DEA in writing of the licensure action and shall surrender his DEA controlled substance certificate, privileges, and any used DEA #222 U.S. Official Order Forms Schedules 1 and 2, to the DEA.

6. Within 15 days of the Modification Order's effective date, Respondent shall return any unused New York State official prescription forms to the Bureau of Narcotic Enforcement of the New York State Department of Health. Respondent shall have all prescription pads bearing Respondent's name destroyed. If no other licensee is providing services at Respondent's practice location, Respondent shall dispose of all medications.

7. Within 15 days of the Modification Order's effective date, Respondent shall remove from the public domain any representation that Respondent is eligible to practice medicine, including all related signs, advertisements, professional listings whether in telephone directories or otherwise, professional stationery or billings. Respondent shall not share, occupy or use office space in which another licensee provides health care services.

8. Respondent shall not charge, receive or share any fee or distribution of dividends for professional services rendered (by himself or others) while barred from practicing medicine. Respondent may receive compensation for the reasonable value of services lawfully rendered, and disbursements incurred on a patient's behalf, prior to the Modification Order's effective date.

9. If Respondent is a shareholder in any professional service corporation organized to engage in the practice of medicine and Respondent's license is revoked, surrendered or suspended for 6 months or more pursuant to this Modification Order, Respondent shall, within 90 days of the Order's effective date, divest all financial interest in the professional services corporation, in accordance with New York Business Corporation Law. If Respondent is the sole shareholder in a professional services corporation, the corporation must be dissolved or sold within 90 days of the Modification Order's effective date.

10. Failure to comply with the above directives may result in civil or criminal penalties. Practicing medicine when a medical license has been suspended, revoked or annulled is a Class E Felony, punishable by imprisonment for up to 4 years, under N.Y. Educ. Law § 6512. Professional misconduct may result in penalties including revocation of the suspended license and/or fines of up to $10,000 for each specification of misconduct, under N.Y. Pub. Health Law § 230-a.