Public

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

IN THE MATTER OF BRAD J. JACOBS, M.D.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: BRAD J. JACOBS, M.D.
55 East 86th Street - Suite IB
N.Y., N.Y. 10028

The undersigned, Richard F. Daines, M.D., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by BRAD J. JACOBS, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

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

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401 . The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on June 28, 2007, at 10:00 a.m., at the offices of the New York State Health Department, 90 Church Street, 4th floor, N.Y. N.Y. 10007, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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

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

DATED: New York, New York
June 18, 2007

Richard F. Daines, M.D.
Commissioner of Health
New York State Health Department

Inquiries should be directed to:

Dianne Abeloff
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
90 Church Street - 4th fl.
N.Y., N.Y. 10007
212-417-4450

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department no less than two days prior to the date of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____ Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

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

IN THE MATTER OF BRAD J. JACOBS, M.D.	STATEMENT OF CHARGES

BRAD J. JACOBS, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 26,1988, by the issuance of license number 175524 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about April 21, 2001, Patient A (the identity of the patients appears in the attached Appendix) went to Respondent's office, for liposuction of her hips and lower extremities and medial thigh lift.

Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to follow appropriate sterile technique in the immediate post-operative care of Patient A;
4. Failed to provide timely post-operative examination of Patient A;
5. Failed to timely diagnose and treat the wound infection and abscess;
6. Failed to examine Patient A daily while she was hospitalized for treatment of her wound infection;
7. Violated the Patient A's privacy, when against her wishes,

he undressed her wounds in front of his girlfriend, an individual not involved in Patient A's medical care;

8. Failed to maintain a record which accurately reflected his care and treatment of Patient A.

B. On or about July 25, 2005, Patient B consulted with Respondent about a breast lift and repair of an umbilical hernia; Respondent persuaded Patient B that she needed breast augmentation as well. On or about August 19,2005, Respondent performed mastopexy, breast augmentation, repair of an umbilical hernia, and touch up liposuction to flanks.

Respondent's care and treatment of Patient B deviated from accepted standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to provide timely post-operative examination of Patient B;
4. Failed to comply with Patient B's direction concerning brassiere cup size;
5. Inappropriately implanted breast implants that were too large for the pocket;
6. Inappropriately discharged the patient from his office at 5:30 a.m. on the day of surgery without examining her and left the country for two weeks;
7. Failed to remove implants in a timely fashion after wound dehisced and failed to heal;
8. Failed to maintain a record which accurately reflected his care and treatment of Patient B.

C. On or about July 16, 2002, Patient C went to Respondent's office for bilateral capsulectomy, exchange of implants and a mastopexy. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to comply with Patient C's direction concerning brassiere cup size;
4. Inappropriately implanted implants that were too large for the pockets;
5. Failed to provide timely post-operative examination of Patient C;
6. Failed to maintain a record which accurately reflected his care and treatment of Patient C.

D. On or about August 20, 2004, Patient D went to Respondent's office for rhinoplasty and breast augmentation. On October 18, 2005 she went to Respondent for bilateral exchange of breast implants and on December 15, 2005, Respondent performed a release of scar contracture bilateral areola. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to comply with Patient D's direction concerning brassiere cup size;
4. Inappropriately implanted implants that were too large for

the pockets.

5. Failed to document indications for the October 18 and December 15, 2005 surgeries;
6. Failed to maintain a record which accurately reflected his care and treatment of Patient D.

E. On or about June 7, 2002, Patient E went to Respondent for a rhinoplasty. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Removed an inappropriately large amount of cartilage from the left side of Patient E's nose.
4. Failed to maintain a record which accurately reflected his care and treatment of Patient E.

F. On or about April 9, 2004, Patient F consulted with Respondent about a breast lift , rhinoplasty and liposuction. He persuaded her to have breast augmentation; mastopexy; liposuction of the abdomen, flanks, hips, thighs, knees and arms; upper eyelid blepharoplasty; open rhinoplasty and fat transfer to her lips, which he performed on April 29, 2004. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to comply with Patient F's direction concerning brassiere cup size;

4. Inappropriately implanted implants that were too large for the pockets;
5. Inappropriately discharged Patient F from his office at or about 1:30 a.m. on the day of surgery;
6. Failed to maintain a record which accurately reflected his care and treatment of Patient F.

G. On or about April 29, 2003, Patient G went to Respondent's office for mastopexy with implant exchange and UAL to her abdomen. Respondent's care deviated from accepted medical standards, in that, Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to comply with Patient G's direction concerning brassiere cup size;
4. Inappropriately implanted implants that were too large for the pockets.
5. Failed to maintain a record which accurately reflected his care and treatment of Patient G.

H. On or about April 13, 2004, Patient H consulted with Respondent about mastopexy. Respondent persuaded Patient H that she needed breast augmentation as well as mastopexy. On or about June 4, 2004, Respondent performed mastopexy, breast augmentation and removal of lipoma. Respondent's care and treatment of Patient H deviated from accepted standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. Failed to provide timely post-operative examination of Patient in light of findings of immediate post-operative breast ischemia;
4. Inappropriately implanted breast implants that were too large for the pocket;
5. Inappropriately inserted different size implants to correct breast asymmetry during a combined mastopexy and breast augmentation procedure;
6. Failed to timely perform a culture and sensitivity test of the wound;
7. Inappropriately prescribed long term antibiotic therapy without culture and sensitivity guidance;
8. Failed to timely remove implants after the wound dehisced and failed to heal;
9. Failed to maintain a record which accurately reflected his care and treatment of Patient H.

I. On or about January 6, 2003, Patient I went to Respondent's office for exchange of breast implants. On or about June 18, 2004, Respondent performed a rhinoplasty. On or about July 30, 2004, Respondent performed a revision of nasal surgery, bilateral capsulotomy and exchange of breast implants. Respondent arranged for Patient I, who lived in Los Angeles, California, to stay in his apartment, 435 E. 86th Street, N.Y., N.Y. Respondent's care deviated from accepted medical standards, in that Respondent:

1. Failed to obtain an adequate history;
2. Failed to perform an adequate physical examination;
3. During the original rhinoplasty surgery, Respondent removed an inappropriately large amount of nasal cartilage from Patient I's nose causing deformity and functional airway obstruction;
4. Failed to fully and accurately describe the post-operative complications in the healing of Patient I's nose;
5. Failed to refer Patient I to a plastic surgeon in Los Angeles to follow her nasal wound dehiscence;
6. Respondent prematurely and inappropriately performed nasal revision surgery worsening the deformity;
7. On various occasions while Patient I was staying in Respondent's apartment, he provided her with crystal methamphetamine, which on some of the occasions they both smoked. On one occasion while Patient I recuperated in his apartment, Respondent engaged in sexual intercourse with Patient I;
8. Failed to maintain a record which accurately reflected his care and treatment of Patient I.

J. On or about January 12, 2001, Patient J went to Respondent's office, for breast augmentation. On or about May 7,2002, she went to Respondent's office for abdominal liposuction.

Respondent's care and treatment of Patient J deviated from accepted standards, in that Respondent:

1. Failed to obtain an adequate history;

2. Failed to perform an adequate physical examination;
3. Removed an inappropriately large amount of fatty tissue from the patient's abdomen;
4. Inappropriately performed liposuction causing several areas of skin necrosis;
5. Failed to perform adequate post-operative care for the patient;
6. Failed to maintain a record which accurately reflected his care and treatment of Patient J.

SPECIFICATION OF CHARGES

ONE THROUGH TENTH 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;
2. Paragraph B and its subparagraphs;
3. Paragraph C and its subparagraphs;
4. Paragraph D and its subparagraphs;
5. Paragraph E and its subparagraphs;
6. Paragraph F and its subparagraphs;
7. Paragraph G and its subparagraphs;
8. Paragraph H and its subparagraphs;
9. Paragraph I and its subparagraphs;

10. Paragraph J and its subparagraphs;

ELEVENTH 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:

11. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs; Paragraph H and its subparagraphs; Paragraph I and its subparagraphs; and/or Paragraph J and its subparagraphs.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

12. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph

D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs;
Paragraph G and its subparagraphs; Paragraph H and its subparagraphs; Paragraph I and its subparagraphs; and/or Paragraph J and its subparagraphs.

THIRTEENTH THROUGH SEVENTEENTH SPECIFICATION

PERFORMING SERVICES NOT AUTHORIZED BY PATIENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(26) by performing professional services which have not been duly authorized by the patient, as alleged in the facts of:

13. Paragraph B and B (4);
14. Paragraph C and C (3);
15. Paragraph D and D (3);
16. Paragraph F and F (3);
17. Paragraph G and G (3);

EIGHTEENTH THROUGH NINETEENTH SPECIFICATIONS

MORAL UNFITNESS

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

18. Paragraph A and A(7);
19. Paragraph I and I (7);

TWENTIETH THROUGH TWENTY-NINTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

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

20. Paragraph A and A (8);
21. Paragraph B and B (8);
22. Paragraph C and C (6);
23. Paragraph D and D (6);
24. Paragraph E and E (4);
25. Paragraph F and F (6);
26. Paragraph G and G (5);
27. Paragraph H and H (9);
28. Paragraph I and I (8);
29. Paragraph J and J (6).

DATE: June 18, 2007
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct