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NEW YORK
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HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 11, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert Cattani, M.D.
450 Slosson Avenue
Staten Island, New York 10314

Michael J. Morris, Esq.
Costello, Shea & Gaffney, LLP
44 Wall Street
New York, New York 10005

Dianne Abeloff, Esq.
NYS Department of Health
Division of Legal Affairs
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Robert Cattani, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-186) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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
James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

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

COPY

IN THE MATTER

OF

ROBERT CATTANI, M.D.

DETERMINATION

AND

ORDER

BPMC 12-186

A Notice of Hearing and Statement of Charges were served on attorneys for **ROBERT CATTANI, M.D.**, Respondent, on November 2, 2011. Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on December 5 and December 19, 2011, continuing on January 18, February 27, April 10, June 11, and August 6, 2012. All hearings were held at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **Steven M. Lapidus, M.D. CHAIR, James R. Dickson, M.D., and Deborah Whitfield, M.A., Ph.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **David A. Lenihan, Esq.**, Administrative Law Judge, served as the Administrative Officer. The Petitioner appeared by **James E. Dering, Esq.**, General Counsel, by **Dianne Abeloff, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent appeared with several counsel and, for a time, *pro se*. The last attorney to represent the Respondent was **Michael J. Morris, Esq.**, of the firm of **Costello, Shea, and Gaffney, LLP** of New York City. Evidence was received, witnesses were sworn or affirmed, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice Of Hearing and Statement of Charges:	November 2, 2011
Answer Filed:	November 23, 2011
Pre-Hearing Conference:	November 22, 2011
Hearing Dates:	December 5, 2011 December 19, 2011 January 18, 2012 February 27, 2012 April 10, 2012 June 11, 2012 August 6, 2012
Commissioner's Order of Summary Suspension	December 6, 2011
Witnesses for Petitioner:	Barry Zide, M.D. Patient "A" Mr. Israel Steinberg Rabbi Isaac Leider Mr. Marc Weiss Patient "B" Patient "C" Patient "D"
Witnesses for Respondent:	Robert Cattani, M.D. Semen Avshalumov, M.D. Faiz Hasham, M.D. Richard Dolsky, M.D.
Deliberations Date:	August 6, 2012

STATEMENT OF THE CASE AND BACKGROUND

Petitioner charged Respondent, a physician practicing cosmetic surgery, with twelve (12) specifications of professional misconduct. The first through fifth specifications charged Respondent with committing professional misconduct as defined in N.Y. Educ. Law §6530 (4) by by practicing the profession of medicine with gross negligence on a particular occasion for each of the five named patients.

In the sixth specification, Respondent was 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 for each of the five named patients. In the seventh specification, Respondent was 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 with regard to each of the five named patients. In the eighth through the twelfth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for patients A, B, C, and D which accurately reflects the care and treatment of the patient in question.

It should be noted that the Respondent had retained several attorneys over the course of these proceedings and that he had dismissed and then rehired Attorney Morris to continue and finish the case. At the first day of hearing, the Panel reviewed the

admitted evidence and heard the State's expert, Dr. Barry Zide, and determined that there was an imminent threat to the health and safety of the people of New York should the Respondent be allowed to continue in practice. The panel went into executive session and determined, unanimously, that a recommendation should be given to the Commissioner to suspend the Respondent's license to practice medicine immediately.

The Department's attorney conveyed the wishes of the panel to the Commissioner and on December 6, 2011, the Commissioner, on the above recommendation and upon review of the Statement of Charges, determined that the continued practice of medicine by the Respondent would constitute an imminent danger to the health of the people of the State of New York and Ordered the Respondent to cease his practice of medicine immediately pending the determination of this matter.

At the next hearing day, December 19, the Respondent made a statement to the panel (T. 176 - 181) and abruptly walked out of the hearing. The ALJ directed the attorney for the Respondent at the time, Mr. Raymond Belair[1], to go after the Respondent and advise him of the consequences of such a move. Mr. Belair returned to the hearing room and stated that he had been fired. (T. 193) The hearing then proceeded in the Respondent's absence and the case for the State was heard and then completed on January 18, with the Respondent not present. In the following weeks, Mr. Michael J. Morris, Esq. was retained by the Respondent and Mr. Morris made an application to reopen the hearing and be allowed to present a case for the Respondent to the panel.

[1] Of the firm, Belair and Evans, 61 Broadway, NY, NY 10005

The panel considered this request and, taking into account the Respondent's several decades of medical practice and his record of military service to our Country during the Vietnam War, acceded to the request of Mr. Morris with the understanding that any objection to the timeliness of the proceedings was thereby waived. It should be noted that the panel also gave the Respondent added consideration later on by granting the further request of Mr. Morris to have an additional day of summation and argument after the parties had concluded the case and had submitted their written summations and recommendations. Again, this latitude was afforded the Respondent in view of his years of practice and service to our country in the Air Force in time of war.

A copy of the Notice of Hearing and Statement of Charges, dated November 2, 2011, is attached to this Determination and Order as Appendix I.

A copy of the Commissioner's Summary Order of Suspension, dated December 6, 2011, is attached to this Determination and Order as Appendix 2.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to transcript page numbers or Exhibits, denoted by the prefixes "T." or "Ex." These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous.

1. Respondent was authorized to practice medicine in New York State on or about July 1, 1968 by the issuance of license number 101545 by the New York State Education Department.

2 On or about August 5, 2010, Patient A, a 20 year old male, went to Respondent's office for evaluation for an abdominoplasty. On or about August 17, 2010, Respondent performed, in his office, liposuction of the trunk and extremities, excision of gynecomastia and lower abdominoplasty on Patient A. (T. 262; Dept Ex.2)

3. By or about 4:35 p.m. (approximately 3 hours post operatively) Patient A's blood pressure dropped significantly. He became hypotensive and tachycardic. Throughout the post-surgical course, Patient A was anxious, nauseous, dizzy, and syncopal and had vomited. (T.269-271, 912; Dept Ex.2, pp. 58, 59, 59A)

4. Patient A, while in recovery, realized something went wrong during surgery. He felt nauseous, faint and was scared for his health and safety. He wanted to go to the hospital, but every time he asked Respondent to transfer him, Respondent would just push him back down on the table and discuss transfer to a hotel on Staten Island. Patient A was scared of Respondent. He found him very threatening. (T. 269-272, 282, 283)

5. Respondent told Patient A that he did not need to go to the hospital, but that he should not travel back to his home in Monsey, New York. Respondent told the patient that Monsey was too far away and that he should go instead to a hotel on Staten Island. Patient A asked if a paramedic could stay with him. Respondent said no; he told Patient A that he would be available by phone. (T. 278)

6. Patient A saw that the sheets on his bed were all bloody and when his hands were by his side they would get all bloody. The bloody sheets, blankets and bandages were changed several times. (T. 275, 276, 291)

7. Patient A remained in the operating room. He never was stable enough to be transferred to the recovery room. (T.269, 294, 327, 328)

8. Patient A called his friend, Rabbi Isaac Leider, and asked him to send help to transfer him out of Respondent's office and to a hospital. (T. 241,272, 273)

9. Rabbi Leider called Marc Weiss of Hatzolah of Staten Island, an ambulance service, to go to Respondent's office and see what was happening to Patient A. (T. 241, 319)

10. Marc Weiss arrived at Respondent's office around 6:00 p.m. He saw Patient A's pallor and knew something must be wrong. Respondent prevented him from entering the operating room. Respondent did not allow Mr. Weiss to examine the patient or even speak privately with the patient. Respondent only allowed Mr. Weiss to speak to the patient from the doorway. Patient A told Marc Weiss that he was fine and would stay with Respondent. Patient A replied that way because he was scared of Respondent. (T. 320, 276-280, 330)

11. Marc Weiss left Respondent's office and called Rabbi Leider to report that Patient A looked very pale but he wanted to remain in the office. Rabbi Leider was not convinced that Patient A was safe. He and Israel Steinberg from Kiryas Joel Hatzolah Ambulance Corps drove down from Monsey, New York to see Patient A. Marc Weiss said he would return to Respondent's office to meet them upon their arrival there. (T.199-200)

12. Despite Patient A's continuing decline, Respondent did not transfer the patient to the hospital instead he asked the anesthesiologist to return to the office. The anesthesiologist, Dr. Faiz Hasham, administered ½ cc of ephedrine at or about 6:30 p.m. The ephedrine

caused the blood pressure to artificially rise for about an hour at which point the pressure started to fall again. The ephedrine failed to address the underlying problem of bleeding which caused the blood pressure to fall. (Dept Ex. 2; T. 68)

13. The Ambulance Corps from the Hatzolah of Staten Island withdrew and the Ambulance Corps from Klryas Joel Hatzolah arrived at or about 8:00p.m. When Israel Steinberg saw Patient A he was pale, almost dead. (T.203, 208-211, 214)

14. Patient A and Rabbl Leider saw blood everywhere in the operating room and Israel Steinberg eventually discarded the patient's blood soaked pajamas. (T.215-216, 244,247,307)

15. The CT scan of the abdomen performed later at Staten Island University Hospital showed no internal bleeding supporting the conclusion that the blood came out externally, in other words, Patient A bled extensively in Respondent's operating room. (Dept Ex. 3 p. 121)

16. By the time Rabbi Leider and Israel Steinberg arrived Patient A was disoriented and his mentation was clearly affected. He recognized Isaac but was confused and kept fainting. (T. 245, 259)

17. After much cajoling by the EMTs and a syncopal episode which caused Patient A to fall back on the table with a thud, Respondent finally agreed to allow the patient to be transferred to Staten Island University Hospital. (T. 203, 208-211, 214, 324)

18. Even with 6 liters of Ringer's Lactate infused throughout the post-operative time from 1:15 p.m. through 10:20 p.m., Patient A never urinated. (Dept Ex. 2)

19. Respondent never inserted a Foley catheter, nor did he administer any medication to encourage urination. (Dept Ex. 2)

20. Respondent did not even mention a Foley catheter to Patient A until the second crew of emergency medical technicians came to the office. (T. 281, 282; Dept Ex. 2)

21. By the time Patient A reached Staten Island University Hospital he was in renal failure and needed three units of blood. (Dept Ex. 3A)

22. Patient A was not a candidate for abdominoplasty; he was only 20 years old, his skin was still elastic. Respondent's history and physical failed to document weight loss which would have caused Patient A's skin to hang. The record also failed to document if there was indeed a weight loss and, if so, how much. The record also failed to indicate the length of time of the weight loss or if diet and exercise were discussed with the patient. Again, since the patient was so young the skin was elastic, there was no need to excise the skin. (Dept Ex. 2; T. 29-33, 924-928)

23. Patient A's post-surgical dropping blood pressure was indicative of bleeding. (Dept Ex. 2; T. 46)

24. If the patient is bleeding, the surgeon can give the patient a fluid bolus or medication to see if the blood pressure goes up **and** stays up. The patient must be monitored appropriately which means a Foley catheter must be inserted. It is incumbent upon the doctor to monitor the intake and outflow of the fluids. The physician must ascertain whether a patient's kidneys are working. If a patient does not urinate after receiving fluids, there is a problem which the physician must address, which the Respondent did not do in this case. (T. 46-49,81,82)

25. The insertion of a Foley catheter is the physician's decision, not the patient's. The physician bears the responsibility to determine the care that is necessary to maintain patient's safety, not the patient. (T. 51,52)

26. The clinical symptoms of dropping blood pressure must also be monitored, (i.e., whether the patient is light-headed, dizzy, nauseated, agitated, and anxious). (T. 49)

27. Patient A was in hypovolemic shock. Even Dr. Dolsky, Respondent's own expert, agreed that Patient A had all the components of hypovolemic shock. (T. 1020)

28. When patient's post-operative blood pressure falls, the surgeon must assume that the cause is bleeding and must examine the patient to determine the cause of the bleeding. Leaving the medical management of the post-surgical patient to a medical assistant who does not have medical training falls below accepted medical conduct. This record was silent as to any post-operative examination by Respondent. If Respondent actually examined Patient A, he failed to note it in the medical record and he failed to treat this patient appropriately. (T. 57, 59, 60,67; Dept Ex. 2)

29. Hypotension, syncope, and bleeding are emergent conditions. These conditions can result in kidney failure, and/or lack of profusion of peripheral digits and systems. Respondent failed to act on this emergent condition. Respondent's failure to monitor the patient and address the underlying bleeding problem exposed the patient to considerable risk. This failure deviated from accepted medical practice. (T.63, 64, 68-70)

30. Patient A experienced all of the signs and symptoms of acute renal failure and should have been transferred to the hospital. He had no urine output and did show signs of confusion, nausea and lethargy. In addition, he was vomiting. (Dept Ex. 2; T. 1019, 1020)

31. Respondent should have allowed Patient A to be transferred when the first ambulance came to the office. Transferring the patient to a hotel as Respondent wanted would have been a medical disaster.(T. 77,78)

32. The way to deal with hypovolemic shock is through fluid replacement. If this approach fails, as it did with Patient A, then blood replacement should follow. Dr.Dolsky agrees that Patient A should have been transferred to the hospital. (T. 1022 – 1024)

33. Respondent's notes in the adverse outcome report to the Center for Office Based Surgery indicated that Patient A's post-surgical problems were caused by his abuse of Percocet. Percocet does not cause hypotension; it cannot explain the cause of Patient A's post-surgical problems, especially since, according to the testimony of Patient A, he did not take any Percocet on the day of surgery or anytime near the day of surgery. (T. 79-80, 267; Dept Ex. 2)

34. Patient A was forthcoming about his drug use. He said that he took Percocet for non - medical purposes. There was no pattern. He could have a gone a year without it or he could of taken have taken some two days in a row. He testified that he had taken some Percocet the week prior to surgery, but he was clear that he had not taken any the day before surgery. (T. 266-267, 284)

35. Upon arrival to the hospital, Patient A was found to be anemic, hypovolemic with marked ecchymosis extending across the abdomen basically to the proximal thighs above the knees, with profuse oozing from his multiple wound sites. There were also multiple ecchymotic marks over the chest, back, abdomen, and proximal thighs and large amounts of blood were found in the urinalysis. All of these clinical findings indicate that there was untreated post–operative bleeding. (Dept Ex.1 3A, p. 31, 117)

36. Upon arrival to the hospital at 22:15, which was around an hour after the second dose of ephedrine, Patient A's blood pressure was 136/77. An hour later it was 118/81. His

blood pressure started to climb about three hours later after treatment was started. (Dept Ex. 3A, p.10, 29A, Dept Ex. 2, p. 58)

37. Patient A's condition while at Respondent's office did not improve with the administration of fluids (6 liters of Ringer's Lactate); his acute anemia secondary to blood loss and renal injury was resolved only after the transfusion of 3 units of packed red blood cells. After nine days in the hospital, Patient A was finally stable enough to return to his home. (Dept Ex.3A, p. 31)

38. The purpose of a physician's medical records is to **accurately** record the physician's treatment of the patient and the patient's medical condition. Records are necessary for the physician to recall the details of his treatment, but they are especially necessary for subsequent treating physicians to be able to understand the patient's condition and the prior treatment afforded this patient. (T. 83, 84)

39. Respondent's record for Patient A was not accurate. The following are some of the most striking inaccuracies: failure to record significant post-operative bleeding, or even any bleeding; in the Adverse Outcome Report to the Center for Office Based Surgery Dr. Cattani reported that the vital signs were stable, when the blood pressure recorded by his medical assistant reflected consistently plummeting blood pressure; Dr. Cattani also reported in that same document that he wanted to transfer the patient to a hotel. He was silent about transferring the patient to the hospital until around 10:00 p.m. when he wrote that he summoned the patient's private ambulance; exaggerated the information about Patient A's recreational drug use; Dr. Cattani failed to record weight loss in the history and physical; failed to document second dose of Ephedrine that must have been given at or

about 9:05p.m.when the patient's blood pressure began to elevate. This second dose was referenced in the EMS report. (Dept Ex. 2, 3A, p. 29A; T. 907)

PATIENT B

40. Patient B went to Respondent for an abdominoplasty (tummy tuck) which was performed in June of 2006. (Dept Ex. 4)

41. Patient B suffered post-abdominoplasty complications which required treatment by Respondent. The post-operative complications that Patient B suffered were loss of skin in the inferior part of the flaps that were elevated for the abdominoplasty. (Dept Ex. 4, photo. P.135)

42. This complication is difficult to manage because the skin is very tight and there is a loss of fat in the area of the tissue that is lost; consequently, the skin is extremely thin and lies directly on top of the abdominal wall. The skin sitting right on top of the muscle fascia is very thin. The skin is extremely susceptible to perforation in the midline. (T. 98-100)

43. On or about March 20, 2007, Respondent, while performing a liposuction of the abdomen and revision of the post-operative scar of the abdomen, perforated the abdominal wall. Respondent made the incision for the scar revision in the same thin area of abdominal wall which was severely compromised during the complications from the earlier procedure. He made the incision right where the umbilicus would have been, right where the skin adhered to the abdominal wall. There was no fat in that location; the incision was in the worst possible location. Respondent should have made his incision as far from the scar as possible. (T. 111,112,114,115; Dept Ex. 4, photo p. 135)

44. Several days after the revision surgery, Patient B's abdomen became extremely painful and itchy. He took off the abdominal binding. Upon taking off the binding, Patient B saw feces pouring out of his abdomen. (T. 369)

45. After cleaning himself, he immediately called Respondent and told him about the feces. Respondent told him to rest and go to his office the next day. (T.367- 371)

46. As Respondent directed, Patient B went to Respondent's Staten Island office on Monday afternoon. Respondent after briefly examining Patient B again did not recommend that Patient B go to the emergency room, but instead sent Patient B, via a friend's car, to Patient B's primary treating physician in New Jersey. Patient B's primary treating physician immediately transferred Patient B to St. Michael's Hospital. (T.372, 373)

47. Respondent's failure to either immediately send Patient B to the hospital or meet him in his office deviated from accepted medical conduct. Fecal matter exuding from an incision is a life threatening problem which requires immediate medical attention. (T.122,123)

48. The patient's life was saved by Respondent's mistake of locating the incision in the incorrect area, the place closest to the intra-abdominal contents. The feces came out of Patient B's body rather than going into the peritoneal cavity. (T. 122,123, 126-128, 130)

49. Respondent's records failed to accurately reflect the condition of the patient and/or the treatment that he rendered. The following are some of the inaccuracies: Respondent claimed that the patient was not in pain on the day that he called to report the explosion of feces from the incision, when Patient B was in excruciating pain. Respondent also recorded that he offered to see the patient the day of the feces incident. The patient denied that he was offered an opportunity to see Respondent. He would have jumped at the

opportunity if it had been offered. When Respondent finally saw Patient B, again he recorded that the patient felt fine, when he was in a great deal of pain. Respondent accused Dr. Almodovar of not cooperating with Respondent, when it was just the opposite. The physicians at St. Michaels tried to communicate with Respondent but he refused. (T.367-371; Dept Ex. 4, p. 13,14)

50. Respondent admits that he caused the fistula and has taken full responsibility for it. (T. 1181)

51. Patient B was very credible. He has no motivation to testify to anything but the truth. The malpractice suit in this matter has already settled in Patient B's favor.

PATIENT C

52. On or about July 5, 2005, Patient C went to Respondent for a face lift and a four lid blepharoplasty. (eyelid lift) This surgery was performed on July 26, 2005. Prior to surgery Patient C had good vision in both eyes. (Dept Ex. 7; T. 358)

53. Prior to performing a blepharoplasty every physician must know that a retrobulbar hematoma may develop. A retrobulbar hematoma, bleeding which places pressure on the optic nerve, is a medical emergency which must be repaired quickly or the nerve can die and blindness would ensue. A physician needs to make a prompt clinical diagnosis by looking into the eyes; if one eye is significantly different than the other, or the patient cannot see out of each eye, the physician must release the pressure on the nerve through a canthotomy.(T. 133, 140-143, 166; Dept Ex. 7)

54. Every physician who performs a blepharoplasty MUST be able to recognize a retrobulbar hematoma, the bleeding which places pressure on the optic nerve, and must know how to perform a canthotomy to release the pressure. Once the physician goes through the orbital septum, a necessary part of a blepharoplasty, it is always possible to have bleeding.(T. 143, 166)

55. Patient C was released from the recovery room 70 minutes after surgery. Her discharge was premature. Patient C needed to remain in the recovery room for at least two hours. Two hours is the period of time that has been found necessary to determine if the eye is free of swelling. But in this case, most importantly, Respondent did not even examine Patient C's eye prior to discharge. He never determined that she could see out of each eye. (Dept Ex. 7; T. 144, 348)

56. Patient C's eyes were swollen after surgery. She followed the instructions, placed cold compresses on her eyes and slept in a semi-reclining position. Respondent testified that Patient C violated his discharge instructions. She did not call his office to report the swelling before she returned on the afternoon of post-operative day #1. Respondent's discharge instructions said that she should call for sudden swelling. Patient C's eyes were swollen immediately after surgery forward, there was no sudden swelling. In addition, Patient C was told by Respondent to expect swelling after the surgery. Patient C did not violate the discharge instructions. (T. 336, 338, 559,557, 573)

57. Patient C returned to the office on July 27, 2005, the day after surgery. Her right eye was swollen shut. Patient C could not see out of her right eye. The left eye was swollen, but could open. Respondent tried to open her right eye. She said that it hurt. Respondent

gave up trying to open the right eye. He looked in her left eye, but never the right eye.(T. 337, 339; Dept Ex. 7)

58. Respondent's testimony about his examination on post-operative day #1 is contradictory. First he testified that: "I will tell you that she had edema and ecchymosis, and that to fully evaluate her ocular motion and her ability to see, **I had to pry open both eyes. Both.**" (emphasis added) (T. 617, line 9)

Attorney Abeloff's question: "You had to?" (line 10)

Respondent's answer: "Open with my hands to make sure we had full exposure of the globe to see if it was moving or not." (line 13)

Attorney Abeloff's question: "So it's your testimony here that you used your hands, your fingers to pry open each of her eyes?"

Respondent's answer: "No. I didn't say that. I **didn't say pry open.**" (emphasis added) (T. 617-618, line 18)

59. By late Thursday, Patient C could only open her right eye to a mere slit; however, she could not see anything. On Friday she also could barely open her eye. When she arrived at the Respondent's office Friday afternoon her right eye was still quite swollen and she could barely see in the lower fields of the right eye. Respondent still did not try to release the pressure on the nerve, nor did he transfer her to a hospital. He sent her to Dr. Gerstenfeld, an ophthalmologist, and met her at his office. He still did not realize the cause of Patient C's vision catastrophe. (T. 148, 156, 160, 161, 341, 343, 447; Dept Ex. 7,8)

60. Patient C could only see downward and not straight forward because the eye was bulging too much. (T. 154)

61. Dr. Gerstenfeld found that Patient C's right eye had an obvious large APD (Afferent Pupillary Defect) indicating retrobulbar optic neuropathy related to trauma from blood leaking posteriorly. The trauma was the blepharoplasty. APD results from retrobulbar hemorrhage. Dr. Gerstenfeld sent Patient C to The New York Eye and Ear Infirmary (NYEE). (Dept Ex. 8, 9)

62. An MRI was performed four days post-surgery. The impression was optic neuritis. An MRI cannot rule out a retrobulbar hematoma because there are no isolated areas of bleeding. It is bleeding from multiple tiny vessels. This would be very difficult to see on an MRI four days after surgery. Patient C's post–operative condition is also called optic neuritis, or inflammation of the optic nerve which is loss of blood supply. Often optic neuritis is caused by retrobulbar hematoma. (T. 159, 163, 164,167,168; Dept Ex. 9)

63. Patient C is an extremely credible witness. She has no motivation to lie. She has already won her lawsuit. Even Respondent testified that she was a very nice, responsible person. (T. 514,515, 582)

64. Dr. Zide, the Department's expert witness, has an expertise in orbital plastic surgery. He has authored two complete textbooks as well as numerous articles. The textbooks are entitled: Surgical Anatomy of the Orbit (1986) and Surgical Anatomy Around the Orbit (2005). (Dept Ex. 14)

65. The testimony of Dr. Avshalumov's, Respondent's witness and the anesthesiologist involved in the Patient C case, did not support Respondent's position that Patient C was able to see when she left the office. Dr. Avshalumov testified that at the time he left Respondent's office the patient's eyes were not open. She spoke to him with her eyes closed; in fact her eyes were covered. (T. 705,709, 711)

66. Respondent's record for Patient C does not accurately reflect the patient's condition or the care and treatment rendered to this patient. The main inaccuracies are: Respondent recorded that he examined the patient post-operatively, he did not; on post-operative day #1, the Respondent recorded that the patient was seeing well out of both eyes. This statement was completely false. On post-operative day #1 Patient C could not even open her right eye, Respondent never successfully opened her eye, obviously, she could not see. Respondent also recorded "no lack of mobility of the globe and no evidence of any ptosis." Those are such unexpected complications that a physician would only comment upon them if there were actually problems encountered. (T.337,339,148,150-152; Dept Ex. 7, p. 34)

67. Another problem with the medical record in this case is that an individual reviewing the record cannot determine the nature and extent of the surgery that Respondent actually performed. (T. 136, 638)

PATIENT D

68. Patient D had breast augmentation performed by Respondent in 2000. Patient D felt that her implants had shifted and she wanted new implants. Respondent agreed to perform another breast augmentation procedure on March 2, 2010, which he did. (Dept Ex. 10)

69. Patient D is a controlled Type 1 diabetic. She had no problems with healing after her first breast augmentation. (T. 380, 381)

70. From the time Patient D returned home after surgery on March 2nd, she noticed that her left breast was red and inflamed. The left breast was causing excruciating pain. (T. 381)

71. Patient D called Respondent's office the next day. She spoke with the Receptionist, Donna. Donna said that Respondent was unavailable. After hearing about the problems about one breast healing more quickly than the other; Donna told Patient D it was probably nothing to worry about (T. 382, line 14) and to continue with antibiotics and pain medication. Despite asking Donna to have Respondent call Patient D, Respondent never called Patient D. (T. 383, line 17)

72. Patient D continued to call Respondent's office. He never returned the calls. Patient D was so upset and uncomfortable, her mother made calls to Respondent's office.(T. 383, 384)

73. A surgeon must personally examine the patient within the first few days after surgery or at a minimum have a registered nurse with appropriate experience evaluate the patient. Examination of a patient by only an untrained medical assistant fell far below the standard of care. Respondent did not personally evaluate Patient D. This care fell below accepted medical standards. (T. 384, 385, 417, 420, 421, 436)

74. It is also mandatory for the surgeon to examine a patient who complains that one breast is more painful, hotter than the other. This unilateral side complaint in a bilateral procedure is a medical emergency. (T. 419)

75. Patient D called repeatedly complaining of pain, heat, redness, and inflammation in the left breast. Patient D's mother was so concerned about her daughter's discomfort that she too repeatedly called Respondent's office to report the pain, redness, sensitivity of the left breast. Her calls also went unanswered. (T. 381-398)

76. Redness, sensitivity and pain are all signs of potential complications of infection. The surgeon must evaluate those complaints promptly. Although Patient D did not have a

fever, this lack of fever did not negate an infection. Pursuant to the direction of Respondent's office staff, Patient D had been on Levaquin for about a month. (T. 415,420, 428, 429, Dept Ex. 12)

77. On post-operative day six, Respondent's note indicated that the patient is doing well; however, he found ecchymosis and swelling. The patient returned in three days. The note on March 11th stated that the patient had no complaints, return in two weeks. The next note is four days (March 15th) later with no explanation why the patient who lives at least one and a half hours away returned. He merely stated "the patient continues to do well with normal healing." (Dept Ex. 10)

78. One week later on March 23, Patient D returned to the office. NOW there is induration of the left breast significant enough to require exploration and drainage on that date. Also a culture of the abscess was taken. The culture could not be tested due to expiration of the culture medium. (Dept Ex. 10)

79. After the March 23rd procedure the pain was worse. Patient D was unable to speak with Respondent. She spoke with Donna, the Receptionist, and Denise, the Medical Assistant. (T. 390)

80. Three days after the drainage procedure, (March 26), Patient D returned to the office and despite the fact that she was healing well, Respondent took another culture. (Dept Ex. 10)

81. Patient D returned to Respondent's office just one week later, on April 1. Patient D was in such terrible pain her boyfriend took her to Respondent's Manhattan office. NOW, Respondent notes swelling, tenderness, erythema of the left breast. According to Respondent's testimony and his record, he was suddenly quite concerned that if the

implants were not immediately removed they would necrotize in the patient's breasts, but again there were no signs of any infection. (Dept Ex. 10, T. 392)

82. On April 2nd, 2010, Respondent removed the implants from Patient D's breasts and placed Jackson-Pratt drains in the breast to allow for continued drainage of the fluid. He did note that there was thickening of the capsule on the left side far in excess of a normal post-operative course. (Dept Ex. 10)

83. Patient D was in such excruciating pain after this last procedure, her mother took her to a physician at NYU, Dr. Guth, on April 6th. Dr. Guth found that the left breast had significant volume loss and collapse of the central portion of the breast with residual skin infection. He removed the drains and referred Patient D to Dr. Hazen, a plastic surgeon. (Dept Ex. 11)

84. Patient D has had a series of procedures by Dr. Hazen to correct the deformities caused by the bad infection. (Dept Ex. 12, page 4)

85. Respondent's record for Patient D does not accurately reflect the patient's condition or the care and treatment rendered to that patient. The main inaccuracies are: Respondent recorded that he personally examined her post-operatively on March 8, when he did not. He also recorded that there was no indication of an abnormal post-operative course; however, Patient D and her mother had repeatedly called concemed about the excruciating pain in Patient D's left breast. He again claimed to have examined her on March 11, 2010 and the breast was healing well, no symptom or signs of infection and no complaints. Patient D called regularly in pain. She made her complaints well known. Respondent chose to ignore them. He also ignored the clinical signs of infection, swelling, redness, heat. All of which were reported by Patient D. Despite this alleged absence of infection,

his staff continued to prescribe antiblotics and pain kllers. Throughout this record, Respondent maintained the incorrect statements about the lack of evidence of infection; however, he did culture the wound (using an out of date medlum). If he had not suspected infection, he would not have cultured the wound. He even blamed the patient for causing erythema; he reported that the erythema was due to the tape she was putting on her breast. Respondent and/or his office staff failed to record the numerous telephone calls made to Respondent by Patient D and her mother.(T.381-398; 399- 407; Dept Ex. 10 p. 10-16, 38, Dept Ex. 12)

86. These inaccurate records deviated from accepted medlcal standards. The accepted standard is to author a truthful report of the actions taken by the physician and the patient's physical response to these actions. If a patient had an infection, the record should report the patient's response to the infection and actions taken by the physician to allow a subsequent treating physician to pick up and take over the care of that patient. Reliance on these records would have hindered and at best misinformed subsequent providers about the patient's conditions while under Respondent's care. (T. 423)

87. Respondent's care of Patient D deviated from accepted medical standards. Respondent failed to timely diagnose and treat Patient D's infection of her breast; he inappropriately delegated the care of Patient D to an unqualified assistant. Respondent's failure to respond in a timely fashion to the complaints of Patient D also deviated from accepted standards. (T. 424, 426)

CONCLUSIONS OF LAW

Pursuant to the Findings of Fact as set forth above, the Hearing Committee unanimously concludes that the Factual Allegations and Specifications as set forth in the Statement of Charges, are resolved as follows:

1. The First, Second, Third, Fourth, Sixth, Seventh, Eighth, Ninth, Tenth, and Eleventh Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

2. The Fifth and Twelfth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**

These specifications of professional misconduct are listed in New York Education Law §6530. This statute sets forth numerous forms of conduct, which constitute professional misconduct, but does not provide definitions of the various types of misconduct. The definitions utilized herein are set forth in a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," dated January 9, 1996, sets forth suggested definitions for gross negligence, negligence, gross incompetence, and incompetence.

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

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health,

245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). 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 v. Ambach, 74 N.Y, 2d 318, 322 (1991). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

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

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

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the above conclusions of law pursuant to the factual findings listed above. All of the above conclusions resulted from a unanimous vote of the Hearing Committee.

DISCUSSION

The Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the seven (7) Hearing days, the Department's Proposed Findings of Fact, Conclusions of Law, and Sanction as well as the Respondent's Summation and attached Exhibits, dated July 6, 2012. During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

1. The Committee's determination is limited to the Allegations and Charges set forth in the Statement of Charges. (Appendix I)

2. The burden of proof in this proceeding rests on the Department. The Department must establish by a fair preponderance of the evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegations presented are more likely than not to have occurred (more likely true than not true). The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim.

3. The specifications of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence. The Hearing Committee understands that the Department must establish each and every element of the charges by a preponderance of the evidence and, as to the veracity of the opposing witnesses, it is for the Hearing Committee to pass on the credibility of the witnesses and to base its inference on what it accepts as the truth.

4. Where a witness's credibility is at issue, the Committee may properly credit one portion of the witness' testimony and, at the same time, reject another. The Hearing Committee understands that, as the trier of fact, they may accept so much of a witness' testimony as is deemed true and disregard what they find and determine to be false. In the alternative, the Hearing Committee may determine that if the testimony of a witness on a material issue is willfully false and given with an intention to deceive, then the Hearing Committee may disregard all of the witness' testimony.

5. The Hearing Committee followed ordinary English usage and vernacular for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony

presented, the Hearing Committee evaluated all the witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. The Hearing Committee considered whether the testimony presented by each witness was supported or contradicted by other independent objective evidence.

At the beginning of its deliberations, the panel considered the request of Respondent's Attorney, Mr. Morris, to make a recommendation to the Commissioner to lift the Summary Suspension which had been in effect since December 6, 2011. The panel reviewed the testimony and the documentation submitted by Mr. Morris and concluded that the evidence presented after the reopening of the case did not warrant a change in their initial recommendation for suspension. The panel was unanimous in concluding that the Summary Suspension should not be lifted.

The panel based its conclusion on the following points that were proven by a clear preponderance of the evidence.

1. The failure of the Respondent to recognize and treat hypovolemic shock in the post-operative treatment of Patient A.

2. The failure to observe and report a perforated viscus while performing the liposuction on Patient B.

3. The failure to observe the intraorbital hemorrhage during and after the blepharoplasty for Patient C, resulting in permanent vision loss.

4. The blatant lack of compliance with basic surgery practice and the simple requirement of follow-up in a timely fashion for Patient D.

For these reasons, the panel determined the Summary Suspension should remain in

effect.

The panel then went on with its deliberations to determine a final penalty to be imposed. The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony. The Department presented an expert witness, Dr. Zide, whom the panel found credible and persuasive. This expert witness of the Department, presented a cogent and persuasive scientific case that, in the estimation of the panel, clearly established, by a preponderance of the evidence, that Respondent, was negligent and a threat to the health and safety of the people of New York.

It should be noted that the panel found that there was insufficient evidence to support the allegations concerning Patient E, who did not testify. Accordingly, the panel did not sustain the factual allegations or specifications which dealt with Patient E, specifically, specifications five and twelve.

In evaluating the testimony of the expert witnesses, the panel gave greater credence to the testimony of Doctor Zide than that of Doctor Richard Dolsky, the Respondent's expert witness. The panel found that Doctor Zide's credentials were outstanding and that he was the author of relevant medical textbooks. It was clear that Doctor Zide had reviewed more evidence and had more expertise than Doctor Dolsky. The panel found Doctor Dolsky to be less credible and less persuasive that Doctor Zide. The panel found that Dr. Dolsky was not forthcoming. When questioned about Patient C, he evaded the questions and stated that he was not an ophthalmologist and was unfamiliar with optic neuritis.

The other witnesses presented by the Department were found to be credible and persuasive. It is noted that the credibility of these witnesses could have been challenged

by the Respondent had he not chosen to absent himself from the hearing and thereby deny himself the opportunity to cross examine them. As it stands, the Respondent walked out of the hearing and cannot now complain about testimony he did not contest. The panel, for its part, weighed and evaluated the testimony of Department's witnesses and found them credible.

The Hearing Committee did not believe the testimony of Dr. Cattani and found it to be false and self-serving. The panel found that Dr. Cattani had every reason to testify inaccurately and to author inaccurate records, and the panel determined, unanimously, that that is exactly what he did. Thus, the panel did not believe Dr. Cattani.

As for the other witnesses, Rabbi Leider's testimony was found credible and consistent with the testimony of the various emergency medical technicians from the staff of Ambulance Corps from both the Hatzolah of Staten Island and the Hatzolah from Kiryas Joel of Monsey, New York, who testified. Rabbi Leider had no reason to lie and it appears that he became involved to help a friend in medical trouble. The various EMTs from Staten Island and Kiryas Joel who testified did not know the Respondent and had only the safety and welfare of the patient as a concern. Their testimony was believable and persuasive.

The panel did not find the testimony of Dr. Hasham, the anesthesiologist who treated Patient A, to be credible or persuasive. Dr. Hasham's treatment was itself questionable as he left a patient in significant distress. Dr. Hasham left a patient who had been tachycardic, hypotensive, nauseous and dizzy. In addition, this patient had not urinated for several hours. Accordingly, the panel found Dr. Hasham's testimony to be self-serving and unreliable.

In sum, the Department's witnesses were found to be credible and persuasive and the panel found that they established the Department's case by a clear preponderance of the evidence.

VOTE OF THE HEARING COMMITTEE

FIRST through FOURTH SPECIFICATIONS

VOTE: SUSTAINED (3-0)

The first four specifications in this case charged Respondent 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 for each of the named patients.

In its deliberations the panel reviewed the record and testimony as it pertained to each of the named patients and determined, unanimously, that the allegations of gross negligence, with regard to patients A,B, C, and D as set forth in paragraphs A through D of the Statement of Charges were sustained. As defined above, Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. It is noted that the allegations of gross negligence concerning Patient E were not sustained as this patient did not testify.

As for Patient A, the panel noted, in particular, that the record clearly establishes that a substantial blood loss was evidenced by the bloody sheets in the operating room

as can be seen in Department's Exhibit 3, page 121. The failure of the Respondent to address this significant blood loss was gross negligence. The panel also noted that when this patient finally reached Staten Island University Hospital, three units of blood were required. (See Department's Exhibit 3 A) The panel concluded that the evidence in the matter of Patient A shows not only gross negligence but also extremely poor judgment to even consider liposuction for this person. Patient A was not a candidate for abdominoplasty as he was only 20 years old and his skin was still elastic. Respondent's history and physical failed to document weight loss which would have caused Patient A's skin to hang. The record also failed to document if there was indeed a weight loss and, if so, how much it was. The record also failed to indicate the length of time of the weight loss or if diet and exercise were discussed with the patient. Again, since the patient was so young the skin was elastic, there was no need to excise the skin and the decision to do so showed poor judgment. Another indication of the Respondent's poor judgment was the idea that this patient should go to a hotel rather than a hospital. Had this patient taken the Respondent's advice and gone to a hotel, there would, in all likelihood, have been a medical catastrophe.

As for the specification about Patient B, the panel was unanimous in concluding that Gross Negligence was clearly established by the Department's evidence. In addition to the proven negligence, the panel found that very poor judgment was shown in the treatment of this patient. The record shows that the Respondent made the incision for the scar revision in the same thin area of abdominal wall which was severely compromised during the complications from an earlier procedure. Doctor Cattani made his incision right where the umbilicus would have been, right where the skin adhered to the abdominal

wall. There was no fat in that location; the incision was in the worst possible location. Respondent should have made his incision as far from the scar as possible.

The panel found that these surgical decisions show poor judgment and the panel notes that continued medical education or course work cannot remedy this defect of poor judgment for this Respondent.

In addition, the testimony at the hearing established that the Respondent did not see this patient immediately on being informed that feces were discharging from the patient's abdomen. The Respondent should have seen this patient immediately or sent him to the hospital. It was grossly negligent to wait till the following day to refer this patient on to a private doctor as the Respondent did.

As for Patient C, the panel was unanimous in concluding that Gross Negligence was clearly established by the Department's evidence. In addition to the proven negligence, the panel found that very poor judgment was shown in the care and treatment of this patient. The panel noted that prior to performing a blepharoplasty every physician must know that a retrobulbar hematoma may develop. The record and expert testimony in this case established that a retrobulbar hematoma is a medical emergency which must be repaired quickly or the nerve can die and blindness will ensue.

The Respondent failed to respond to this situation and the panel unanimously concluded that this failure was gross negligence noting that a physician needs to make a prompt clinical diagnosis by looking at and examining the eyes; if one eye is significantly different than the other, or the patient cannot see out of each eye, the physician must release the pressure on the nerve through a canthotomy. This examination was not done in this case and patient lost vision in her right eye as a result.

As for Patient D, the panel was unanimous in concluding that Gross Negligence was clearly established by the Department's evidence. The record shows that Doctor Cattani ignored the signs of infection and did not return the patient's phone calls made in pain and distress. In addition to this negligence, the panel found that very poor judgment was shown in the treatment of this patient by delegating the patient's treatment to unqualified staff and ignoring critical questions raised by the patient's phone calls.

FIFTH SPECIFICATION

VOTE: NOT SUSTAINED (3-0)

This specification dealt with the treatment afforded Patient E in this case and charged Respondent 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 for this patient.

Patient E did not testify and thus the panel could not sustain the charges about negligence in the care and treatment of this patient.

SIXTH SPECIFICATION

VOTE: SUSTAINED (3-0)

In the sixth specification, Respondent was 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 for each of the five named patients.

In its deliberations the panel unanimously sustained this specification and noted that the testimony and record clearly show proof of Negligence on more than one occasion for Patients A, B, C. and D. The panel did not sustain this specification for Patient E as this patient did not testify.

As seen above, Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances. Examples of such negligence can be seen in the following proven facts with regard to the treatment of patients A through D:

Patient A: Failure to respond to the blood loss and lack of urination.

Patient B: The decision to make the incision for the scar revision in the same thin area of the abdominal wall which was severely compromised during complications from an earlier procedure, and the failure to respond immediately to feces pouring out of the patient's abdomen.

Patient C: Failure to respond to the retrobulbar hematoma and to examine the patient's eyes post-operatively.

Patient D: Failure to examine the patient after complaints of one breast being more painful than the other. Permitting untrained medical assistants to examine and give medical advice to the patient.

It is noted that the above are but a few examples of the many instances of negligence proven by the Department in this case.

.SEVENTH SPECIFICATION

VOTE: SUSTAINED (3-0)

In the seventh specification, Respondent was 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 with regard to each of the five named patients.

In its deliberations the panel unanimously sustained this specification with clear proof found of Incompetence on more than one occasion for patients A, B, C, and D.

As seen above, Incompetence is defined as a lack of the skill or knowledge necessary to practice the profession.

The panel did not sustain this specification for Patient E as this patient did not testify. As for the other patients, the panel found that incompetence was established in several instances, such as the following:

As for Patient A, his post-surgical dropping blood pressure was indicative of bleeding and if the patient is bleeding, the surgeon can give the patient a fluid bolus or medication to see if the blood pressure goes up **and** stays up. The patient must be monitored appropriately which means a Foley catheter must be inserted. It is incumbent upon the doctor to measure the intake and out flow of the fluids. The physician must ascertain whether a patient's kidneys are working. If a patient does not urinate after receiving fluids, there is a problem which the physician must address, which the Respondent did not do in this case. The failure to insert a Foley catheter was evidence of incompetence in this case.

As for Patient B, Incompetence was proven by the Department when the evidence established that the Respondent, while performing a liposuction of the abdomen and revision of the post-operative scar of the abdomen, perforated the abdominal wall. Respondent made the incision for the scar revision in the same thin area of abdominal wall which was severely compromised during the complications from the earlier procedure. Doctor Cattani made the incision right where the umbilicus would have been, right where the skin adhered to the abdominal wall. There was no fat in that location; the incision was in the worst possible location. Respondent should have made his incision as far from the scar as possible and the failure to do so showed incompetence.

As for Patient C. the panel noted, in particular, that the chart for Patient C shows that she was released from the recovery room only 70 minutes after surgery. The panel noted the testimony of the Department's expert was that at least two hours was required to see that the eye is free of swelling. This requirement was not followed and this was found by the panel to be evidence of incompetence.

As for Patient D, the testimony at the hearing clearly established that from the time she returned home after surgery she noticed that her left breast was red and inflamed and was causing excruciating pain. This patient called Respondent's office the next day and Doctor Cattani did not respond. It was the receptionist, Donna, who responded to the patient and told her it was probably nothing to worry about and to continue with antibiotics and pain medication. The delegation of care in this case to untrained office staff was evidence of the Respondent's incompetence, to say the least. A surgeon must personally examine the patient within the first few days after surgery or at a minimum have

a registered nurse with appropriate experience evaluate the patient. Examination of a patient by only an untrained medical assistant fell far below the standard of care.

EIGHTH THROUGH ELEVENTH SPECIFICATIONS

VOTE: SUSTAINED (3-0)

The Respondent was charged with professional misconduct as defined in N.Y. Educ. Law § 6530(32) for failing to maintain records for his patients which accurately reflect the care and treatment of his patients. Specifications eight through eleven dealt with the care of patients A, B, C, and D.

The panel, unanimously sustained these specifications for these patients, noting that the records appeared fabricated and prepared after the fact, presumably for litigation. The panel found it hard to believe that these were accurate patient records maintained in a regular, on-going, medical practice. As medical records, the documentation for these patients was not credible and, in several instances was contradicted by the testimony of the patients themselves, who the panel found highly credible and persuasive.

The panel noted that the record for Patient A reported and recorded by the Respondent indicated a stable blood pressure while the blood pressure recorded by the medical assistant in the same document reflected a consistently plummeting blood pressure.

As for Patient B, the panel noted that the records of the Respondent are contradicted by the testimony of the patient. The Record for Patient B, Exhibit 4, page 13, indicates that the patient felt comfortable and that the Respondent could see him right

away if he wished. The patient testified to a very different scenario from that documented in the record. Patient B testified that he called the Respondent on Sunday and was told to come to the office on Monday and when he arrived he was told to come back the following day. The panel found Patient B to be highly credible and the Respondent completely lacking in credibility. (See T. 372)

The Respondent's record for Patient C is similarly inaccurate and false. The record for Patient C, Exhibit 7, page 34, indicates that, one day after the operation, the patient was seeing well out of both eyes. This record was directly contradicted by the testimony of this patient who stated that her right eye could not be opened on the day in question. The patient testified that she could not see out of this eye at all. (T. 339-340)

As for Patient D, the panel found similar glaring inaccuracies and false statements. The record indicates that the Respondent saw Patient D on March 8. The record for Patient D was directly contradicted by the patient's testimony indicating numerous phone calls made to the Respondent's office complaining of severe pain which were not answered. The panel found the testimony of Patient D to be credible and the medical records kept by the Respondent to be false and inaccurate. (See T. 381-398 and Exhibit 10, page 10)

At the hearing, one of the panel members questioned Patient D about the records in this case and asked the patient directly about the record dated March 11:

The record says: "Seen and examined by Dr. Cattani. Healing well. No symptoms or signs of infection. No complaints." (T. 400)

The patient was asked if this is what transpired and she said no. The patient record goes on to indicate that there was an office visit on March 15 and this was flatly

contradicted by the patient's testimony. (T. 403) The questioning of Patient D by the panel (T. 400 to 408) establishes the fact that the Respondent fabricated the record for his own purposes and the record was not at all reflective of the actual treatment of his patient. The panel found that this record falls below the standard for accuracy and honest reporting that is essential for a medical record and was quite concerned that conversations reported in this record never took place. (See T. 408 line 24)

TWELFTH SPECIFICATION

VOTE: NOT SUSTAINED (3-0)

This specification dealt with the medical records for Patient E. Patient E did not testify and thus the panel could not sustain the charges about the accuracy and reliability of the records for this patient.

HEARING COMMITTEE DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, after due deliberation, unanimously determined that all but the fifth and twelfth charges and specifications raised against Respondent were sustained. Patient E did not testify and the panel felt that the documentary record alone did not suffice to sustain the charges pertaining to Patient E.

However, all the other charges and specifications were sustained by a clear

preponderance of the evidence. It was by virtue of his medical license that Respondent gained the trust of the patients in this case. It was their confidence in Respondent's position as their doctor that led them to place their trust in him. The Committee has a responsibility to protect the patients of the State. The issue before this Committee is to choose a penalty that offers the best protection to the patient public of the State. The Committee finds that the Respondent has committed sufficiently egregious misconduct that is worthy of the revocation of his medical license.

In its deliberations, one panel member initially entertained the possibility of leaving the Respondent with some small vestige of his practice, such as hair restoration. However, after much discussion, it was decided that even that minor area would leave the people of New York vulnerable and at substantial risk to their health and safety should they be treated by the Respondent. The panel recognized that, even with minor procedures, emergencies can arise at any time, and the panel did not trust the judgment of the Respondent to deal with an emergency. Accordingly, the panel concluded, unanimously, that the appropriate penalty should be revocation.

The Committee concluded that the only way to ensure the safety of the public is to revoke Respondent's medical license. Any other penalty would risk a recurrence of this behavior. The public should not bear that risk.

The panel noted that all the injuries documented in this case were preventable and they show serious flaws in judgment and insight which no manner of re-training could remedy. The Committee has a responsibility to protect the patients of the State. The issue before this Committee is to choose a penalty that offers the best protection to the people of the State. The Committee finds that the Respondent has committed sufficiently egregious

misconduct that is worthy of the revocation of his medical license.

In reaching this conclusion, the Committee considered the full range of penalties available in a case such as this. As to the penalty, the Hearing Committee determined, unanimously, that the people of New York State would be protected only by a revocation of the Respondent's license.

ORDER

IT IS HEREBY ORDERED THAT:

1. The first, second, third, fourth, sixth, seventh, eighth, ninth, tenth, and eleventh Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**
2. The fifth and twelfth Specifications of professional misconduct, as set forth in the Statement of Charges, are **NOT SUSTAINED;**
3. The Respondent's license to practice medicine is hereby **REVOKED;**
4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Carmel, New York

September, 10, 2012

REDACTED

Steven M. Lapidus, M.D. CHAIR

James R. Dickson, M.D.

Deborah Whitfield, M.A., Ph.D.

TO:

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APPENDIX I

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

IN THE MATTER

OF

ROBERT CATTANI, M.D.

NOTICE
OF
HEARING

TO: ROBERT CATTANI, M.D.
450 Slosson Avenue
Staten Island, NY 10314

PLEASE TAKE NOTICE:

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 December 5, 2011, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th floor, New York, New York 10007, and at such other adjourned dates, times and places as the committee may direct.

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. You shall appear in person at the hearing and may be represented by counsel who shall be an attorney admitted to practice in New York state. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here_____

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone 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. JAMES HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (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. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. 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. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

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 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 OUT 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
November 2 ,2011

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street -4th floor
New York, New York 10007
212-417-4431

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

ROBERT CATTANI, M.D.

STATEMENT

OF

CHARGES

ROBERT CATTANI, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1968, by the issuance of license number 101545 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From or on or about August 5, 2010, through on or about August 17, 2010, Respondent treated Patient A. (The identity of the patients appears in the Appendix.) On or about August 17, 2010, Respondent performed, in his office, liposuction of the trunk and extremities, excision of gynecomastia and lower abdominoplasty on Patient A. Approximately 3 hours after surgery, Patient A became hypotensive and tachycardic. Patient A was eventually transferred to Staten Island University Hospital in impending renal failure, with a progressively dropping hematocrit and a severe leukocytosis. Respondent's care and treatment of Patient A deviated from accepted medical standards, in that he:

1. Performed an abdominoplasty which was not medically indicated for this patient;
2. Failed to recognize and appropriately treat life threatening blood loss under the abdominal skin flap;
3. Failed to transfer the patient to the hospital in a timely manner;

4. Prevented EMS from assisting a patient in need of emergency care;

5. Failed to accurately record the condition of the patient in the records and/or the care and treatment rendered.

B. From in or about September 8, 2006, to in or about March 26, 2007, Respondent treated Patient B. On or about September 20, 2006, Respondent performed an abdominoplasty. On or about March 20, 2007, Respondent performed liposuction of the abdomen and revision of the post-operative scar of the abdomen. Respondent's care and treatment of Patient B deviated from accepted medical standards, in that he:

1. Failed to recognize and timely treat a fecal fistula due to iatrogenic perforation created during the March 20th liposuction;

2. Failed to accurately record the condition of the patient in the patient's chart and/or the care and treatment rendered.

C. In or about July 2005, Respondent treated Patient C. On or about July 26, 2005, Respondent performed a blepharoplasty and face lift on Patient C. After the procedure, Patient C permanently lost the sight in her right eye. Respondent's care and treatment of Patient C deviated from accepted medical standards, in that he:

1. Prematurely discharged Patient C home from his recovery room;

2. Failed to recognize and appropriately treat Patient C's emergent compartment syndrome/retrobulbar hematoma;

3. Failed to possess the necessary knowledge and skill to immediately decompress the occipital orbit when performing a

procedure which incises the orbital septum;

4. Failed to accurately record the condition of the patient in the patient's chart and/or the care and treatment rendered.

D. From in or about February 15, 2010, to in or about April 2, 2010, Respondent treated Patient D. On or about March 2, 2010, Respondent removed the patient's existing breast implants and implanted new, 750 cc implants. Patient B developed an infection and Respondent removed the new implants on April 2, 2010. Respondent's care and treatment of Patient D deviated from accepted medical standards in that he:

1. Failed to provide timely post-operative examination of Patient D after the March 2nd procedure;
2. Failed to timely diagnose and appropriately treat the wound infection and abscess;
3. Failed to accurately record the condition of the patient in the patient's chart and/or the care and treatment rendered.

E. From in or about October 15, 2005, through in or about March 26, 2007, Respondent treated Patient E. On or about November 16, 2005, Respondent removed the patient's existing breast implants and replaced them with new, larger implants. Respondent's care and treatment deviated from accepted medical standards in that he:

1. Performed breast augmentation, a procedure that was not indicated, and failed to perform a mastopexy, the procedure that was indicated.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH 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.

SIXTH 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:

6. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; and/or Paragraph E and its subparagraphs.

SEVENTH 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:

7. Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; and/or Paragraph E and its subparagraphs.

EIGHTH THROUGH TWELFTH 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:

8. Paragraph A and A (5);
9. Paragraph B and B (2);
10. Paragraph C and C (4);
11. Paragraph D and D (3).

DATE: November 2, 2011
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

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

IN THE MATTER
OF
ROBERT CATTANI, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: ROBERT CATTANI, M.D.
450 Slosson Avenue
Staten Island, NY 10314

The undersigned, Nirav R. Shah, M.D., M.P.H., 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 ROBERT CATTANI, 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 ROBERT CATTANI, 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, already in progress, will continue 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, at the offices of the New York State Health Department, 90 Church Street, 4th Floor, New York, NY 10007, at such adjourned dates, times and places as the committee may direct.

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. DAVID LENIHAN, ADMINISTRATIVE OFFICER, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below. 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: Albany, New York
December 6 ,2011

REDACTED

Nirav R. Shah, M.D., M.P.H.
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 Floor
New York, NY 10007

These charges are only allegations which may be contested by the licensee in an administrative hearing.

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

IN THE MATTER

OF

ROBERT CATTANI, M.D.

STATEMENT

OF

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procedure which incises the orbital septum;

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1. Failed to provide timely post-operative examination of Patient D after the March 2nd procedure;
2. Failed to timely diagnose and appropriately treat the wound infection and abscess;
3. Failed to accurately record the condition of the patient in the patient's chart and/or the care and treatment rendered.

E. From in or about October 15, 2005, through in or about March 28, 2007, Respondent treated Patient E. On or about November 16, 2005, Respondent removed the patient's existing breast implants and replaced them with new, larger implants. Respondent's care and treatment deviated from accepted medical standards in that he:

1. Performed breast augmentation, a procedure that was not indicated, and failed to perform a mastopexy, the procedure that was indicated.

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9. Paragraph B and B (2);
10. Paragraph C and C (4);
11. Paragraph D and D (3).

DATE: November 2, 2011
New York, New York

[redacted]

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct