THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

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

December 7, 1990

David G. Amamoo, Physician
P.O. Box 10001
Kingston, N.Y. 12401

Re: License No. 140906

Dear Dr. Amamoo:

Enclosed please find Commissioner's Order No. 11224. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:
Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: Philip C. Pinsky, Esq.
Pinsky & Skadalis
State Tower Building
Suite 1020
Syracuse, N.Y. 10202

REPORT OF THE
REGENTS REVIEW COMMITTEE

DAVID G. AMAMOO

CALENDAR NO. 11224

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

DAVID G. AMAMOO **No. 11224**

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

REPORT OF THE REGENTS REVIEW COMMITTEE

DAVID G. AMAMOO, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on 12 separate dates from March 9, 1989 to January 30, 1990 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of

the fifth specification of the charges based on incompetence on more than one occasion to the extent indicated in its report, and the sixth specification of the charges, and not guilty of the remaining charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for two years, that the suspension be stayed pending the Office of Professional Medical Conduct monitoring respondent's surgical practice over the stayed period, and that respondent be fined $5,000.

On July 12, 1990 the Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the recommendation of the hearing committee be modified as indicated in his July 12, 1990 recommendation. A copy of the July 12, 1990 recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On September 4, 1990 the Commissioner of Health issued a revised recommendation in which he recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted, and that the recommendation of the hearing committee be modified as indicated in his September 4, 1990 revised recommendation. A copy of the September 4, 1990 revised recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "D".

On September 17, 1990 respondent appeared before us in person and was represented by an attorney, Philip C. Pinsky, Esq., who presented oral argument on respondent's behalf. Kevin P. Donovan, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's September 4, 1990 revised recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was:

> "$5,000 fine. Three year license suspension stayed, provided that Respondent adhere to standard probationary terms during the three years. In addition, Respondent may not perform surgery until he has completed 6 months of retraining approved by OPMC, except for surgery required solely for the purposes of retraining. For 30 months after the retraining is completed, Respondent may only perform surgery when such surgery has been approved in advance by a monitoring surgeon approved by OPMC."

Respondent's recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was:

> "As set forth in our brief, any sanction for the record-keeping specification should be <u>minimal</u>. <u>No</u> retraining or prior approval of surgery is necessary or appropriate."

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's undated brief with attached documents; petitioner's September 12, 1990 letter; respondent's September 13, 1990 letter; the September 18, 1990 letter forwarded to the parties on our behalf; petitioner's September 27, 1990 letter with attached reply brief;

respondent's October 9, 1990 letter with attached reply brief; and the October 12, 1990 letter forwarded to the parties on our behalf. We ruled to reject any submissions other than those authorized by our September 18, 1990 letter, we closed the record on October 10, 1990, and we further ruled to give the appropriate weight due all documents received prior to our closing of the record.

Petitioner objected, in petitioner's September 12, 1990 letter, to respondent's inclusion of certain documents in respondent's undated brief. We overrule petitioner's objection and accept into the record the documents submitted by respondent. We note that the rationale of this ruling also applies to respondent's October 9, 1990 brief.

Respondent objected, in respondent's September 13, 1990 letter, to the inclusion in the record of the September 4, 1990 revised recommendation of the Commissioner of Health. We overrule respondent's objection and accept into the record the revised recommendation of the Commissioner of Health.

The record was left open until October 10, 1990 for each party to respond to the submissions of the other. Both parties availed themselves of this opportunity to respond. Therefore, respondent has suffered no prejudice from the inclusion in the record of the September 4, 1990 revised recommendation of the Commissioner of Health. This revised recommendation was merely a clarification of his earlier July 12, 1990 recommendation and constituted no

material change that could prejudice respondent. Similarly, we find no prejudice to petitioner from respondent's inclusion of character reference items with respondent's briefs, as such items will be given appropriate weight by this Committee.

With respect to the measure of discipline to be imposed, we agree with part of the hearing committee's recommendation and part of the Commissioner of Health's revised recommendation. The hearing committee appropriately recommends a two year suspension, stayed, with monitoring of respondent's surgical practice. The Commissioner of Health appropriately recommends a course of retraining in surgery. The measure of discipline we hereafter recommend is a hybrid of the aspects we deem to be appropriate in the hearing committee's and revised Commissioner of Health's recommendation. However, we do not see the need for any fine in this case. Neither the hearing committee nor the Commissioner of Health expressed any reason for recommending a $5,000 fine. In our unanimous opinion, the record in this case does not demonstrate any reason for the imposition of such a fine. Therefore, we reject the imposition of any fine.

With respect to respondent's practice of surgery, the monitoring of respondent's surgical practice suggested by the hearing committee, which we also recommend, is sufficient to address the basic problem herein of respondent's making too hasty determinations to perform surgery.

We agree with the hearing committee's findings and conclusions and find that they are appropriately based on the evidence in the record and that they reflect a proper evaluation of respondent's actions.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 56 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
3. Respondent be found guilty, by a preponderance of the evidence, of the fifth specification of the charges based on incompetence on more than one occasion to the extent indicated in the hearing committee report, and the sixth specification of the charges, and not guilty of the remaining charges; and
4. Respondent's license to practice as a physician in the State of New York be suspended for two years upon each specification of the charges of which we recommend respondent be found guilty, said suspensions to run concurrently, that execution of said suspensions be

stayed, and respondent be placed on probation for two years under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "E", said probation terms to include monitoring of respondent's practice of surgery, a course of training in medical record-keeping, and a course of training in surgery.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: 10/15/90

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
DAVID G. AMAMOO, M.D.	:	CHARGES

----------X

DAVID G. AMAMOO, M.D., the Respondent, was authorized to practice medicine in New York State on December 21, 1979 by the issuance of license number 140906 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 31, 1986 through December 31, 1988 from P.O. Box 10001, Kingston, New York 12401.

FACTUAL ALLEGATIONS

A. With respect to Patient A admitted to the Kingston Hospital, Kingston, New York, from approximately September 23 to October 3, 1984, with a chief complaint of right lower quadrant pain, upon whom the Respondent performed an emergency laparotomy on or about September 25, 1984, the Respondent:

1. Diagnosed a small bowel obstruction without justification;
2. Performed an emergency laparotomy unnecessarily.

EXHIBIT "I"

B. With respect to Patient B admitted to the Kingston Hospital from approximately March 5 to March 19, 1985, with a diagnosis of acute abdominal pain, upon whom the Respondent performed an exploratory laparotomy, lysis of adhesions, and common bile duct exploration on or about March 11, 1985, the Respondent performed surgery unnecessarily.

C. With respect to Patient C admitted to the Kingston Hospital from approximately November 27, 1986 to January 5, 1987, for evaluation of nausea, abdominal pain and vomiting, upon whom the Respondent performed a colon resection on or about November 29, 1986, and a colostomy and enterostomy on or about December 6, 1986, the Respondent:

1. Failed to adequately investigate Patient C's condition;
2. Performed colon resection without adequate indication;
3. Performed colon resection without adequate bowel preparation.

D. With respect to Patient D admitted to the Kingston Hospital from approximately December 28, 1984 to February 2, 1985, complaining of pain in the left leg, upon whom the Respondent performed a bi-lateral thromboembolectomy on or about January 8, 1985, the Respondent:

1. Performed a bilateral angiogram unnecessarily;
2. Failed to adequately investigate a false aneurysm of the right thigh;

3. Performed surgical exploration of the left leg, without adequate indications, despite the fact that Patient D had just suffered severe hemorrhage and shock.

SPECIFICATION OF CHARGES

SPECIFICATIONS ONE THROUGH FOUR

GROSS NEGLIGENCE AND/OR GROSS INCOMPETENCE

The Respondent is charged with professional misconduct by reason of practicing the medical profession with gross negligence and/or gross incompetence under N.Y. Educ. Law §6509(2) (McKinney 1985), in that, the Petitioner alleges:

1. The facts contained in Paragraph A.
2. The facts contained in Paragraph B.
3. The facts contained in Paragraph C.
4. The facts contained in Paragraph D.

SPECIFICATION FIVE

NEGLIGENCE AND/OR INCOMPETENCE

ON MORE THAN ONE OCCASION

The Respondent is charged with professional misconduct by reason of practicing the medical profession with negligence and/or incompetence on more than one occasion under N.Y. Educ. Law §6509(2) (McKinney 1985), in that, the Petitioner alleges:

5. The facts contained in two or more of the following paragraphs A and A(1), A(2), B, C and C(1), C(2), C(3), D and D(1), D(2), and/or D(3).

SPECIFICATION SIX

INADEQUATE RECORD KEEPING

The Respondent is charged with professional misconduct by reason of committing unprofessional conduct as defined by the Board of Regents within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985), in that he failed to keep records which accurately reflected the condition and treatment of Patients C and D, in violation of N.Y. Admin. Code tit. 8, §29.2(a)(3) (1987).

DATED: Albany, New York
February 1, 1989

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

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

IN THE MATTER	:	REPORT OF
OF	:	THE HEARING
DAVID G. AMAMOO, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Rev. Edward J. Hayes, Chairman, Joseph E. Geary, M.D. and Robert A. Menotti, M.D. designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Tyrone T. Butler, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Service of Notice of Hearing and Statement of Charges:	February 2, 1989
Prehearing conference(s):	March 9, 1989
	March 10, 1989
	May 19, 1989
	October 25, 1989
	December 12, 1989
	January 30, 1990

EXHIBIT "B"

Hearing Dates:	March 9, 1989
	March 10, 1989
	May 19, 1989
	June 14, 1989
	July 26, 1989
	August 2, 1989
	September 13, 1989
	October 4, 1989
	October 25, 1989
	November 28, 1989
	December 12, 1989
	January 30, 1990
Statement of Charges Amended:	May 19, 1989
Deliberations were held on:	March 2, 1990
	March 21, 1989
Place of hearing:	Corning Tower Building Empire State Plaza Albany, New York
	Court of Claims Justice Building Empire State Plaza Albany, New York
	Syracuse Motor Inn Hancock International Airport North Syracuse, New York
	Concourse Meeting Room Empire State Plaza Albany, New York

Department of Health appeared by:	Peter J. Millock, Esq., General Counsel by: Ralph J. Bavaro, Esq. & David A. Dietrich, Esq. Office of Professional Medical Conduct Corning Tower Building Empire State Plaza Albany, New York 12237
Respondent appeared by:	Pinsky and Skandalis 1020 State Tower Building Syracuse, New York 13203 by: Philip C. Pinsky, Esq. & Roy D. Pinsky, Esq.
Witnesses for Department of Health:	Harold F. Welch, M.D. Richard A. Konys, M.D. David Ryon, M.D.
Witnesses for Respondent:	Richard D. Eberle, M.D. Patient A Fran Berke, R.N. Thomas A. Koshy, M.D. Thomas F. Minehan, M.D. Michael Steckman, M.D. Kurken Kirk, M.D. David G. Amamoo, M.D. (Respondent)

Petitioner (Department) filed Proposed Findings of Fact, Conclusions of Law: February 23, 1990

Respondent filed Proposed Findings of Fact, Conclusions of Law: February 23, 1990

On February 2, 1989, the Respondent was served with the Notice of Hearing and Statement of Charges. The Department of Health and the Respondent presented their entire cases and the record was closed on January 30, 1990. On March 2, 1990 and March 21, 1990 the Hearing Committee held deliberations.

SUMMARY OF CHARGES

In the Statement of Charges (Dept's. Ex. 1 - copy attached), the Respondent, Dr. David G. Amarco, M.D. was charged with professional misconduct pursuant to Education Law §6509. The specific charges were: practicing the profession with gross negligence and/or gross incompetence [Education Law §6509(2) (McKinney 1985)] (First through Fourth specification), practicing the profession with negligence on more than one occasion [Education Law §6509(2) (McKinney 1985)] (Fifth specification), and inadequate record keeping [Education Law §6509(9) (McKinney 1985)] (Sixth specification).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Pre-hearing transcripts were not made available to the Hearing Committee at the time of deliberations.

1. Dr. David G. Amamoo, M.D., Respondent, was authorized to practice medicine in New York State on December 21, 1979, by the issuance of license number 140906, by the New York State Education Department. (Ex. 1)

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 31, 1986 through December 31, 1988, from P.O. Box 10001, Kingston, New York 12401. (Ex. 1)

FINDINGS OF FACT - PATIENT A

3. Patient A, a fifty year old female, was admitted to Kingston Hospital, Kingston, New York, at approximately 2:00 p.m. on September 23, 1984. She was treated by the Respondent and underwent an exploratory laparotomy on September 25, 1984. (Ex. 2)

4. Upon admission the chief complaint, as referred to in the patient's history, was a "persistent right lower Quadrant pain", and in an admission note was "repeated right lower quadrant pain and syncopy". Patient A was admitted in "no apparent distress". She reported that her pain increased with standing and bearing down and that she had no vomiting. (Ex. 2 - pgs. 3, 6, 7, 17, 65)

5. Patient A's history included phlebitis in both legs, several benign tumors removed, episodes of tachycardia with syncope, hypertension, treatment for "anxiety states", and a total hysterectomy 17 years ago. (Ex. 2 - pgs. 3, 17, 78)

6. The Respondent's physical examination of Patient A on September 23, 1984, revealed soft abdomen with positive rebound tenderness in right lower quadrant, good bowel sounds, no evidence of toxicity or herniations. The Respondent's admission note states: impression - small bowel obstruction; Plan - repair as indicated. (Ex. 2 - pgs. 4, 7)

7. Patient A had experienced pain in her right lower quadrant since 1975, subsequent to her hysterectomy at the Albany Medical Center. (T. 855)

8. Patient A had a good appetite for dinner on September 23, 1984. In his initial physician's order, the Respondent ordered a "general diet". Patient A was out of bed most of the evening. Patient A had no complaints of distress on the evening of September 23, except for tenderness in the right axilla upon palpation and discomfort in the right groin when stretching her legs out, in bed. (Ex. 2 - pgs. 27, 65)

9. At approximately 11:00 a.m. on September 24, 1984, the Respondent wrote in his progress notes that Patient A had pain in the right groin the previous night, good bowel sounds and no evidence of toxicity. The Respondent's impression was again small bowel obstruction and his plan and order was for exploratory laparotomy and repair as indicated. Patient A's appetite on September 24, 1984, was good. (Ex. 2 - pgs. 3, 4, 17, 27, 65)

10. A medical consultant's evaluation on September 24, 1984, found Patient A medically stable for surgery. Patient A was also found to be in no acute distress, afebrile, abdomen soft, positive bowel sounds, pain in right lower quadrant with referral to right groin and back. The consultant's impression was as follows: "(1) Abdominal discomfort, etiology adhesions vs. intermittent obstruction. (2) Other diagnoses by history include anxiety with gastritis. (3) Diabatic tendency on diabetic diet. (4) History of elevated sed rate. (5) Status post multiple abdominal surgeries. (6) Fibrocystic disease.". The consultant recommended a rheumotoid factor, ANA and sed rate. (Ex. 2 - pg. 17)

11. Patient A had undergone diagnostic testing as an inpatient at Child's Hospital in 1982. The Kingston Hospital chart showed a history of the hysterectomy. Respondent did not have the patient's Child's Hospital chart when he treated Patient A but he did have a summary thereof from Child's Hospital read to him by the patient's personal physician. Patient A also explained to Respondent what had happened at Child's Hospital. (T. 869, 1529, Ex. 2 - pg. 78, Ex. H)

12. Respondent ordered several diagnostic radiological examinations during 1983 and during the first eight months of 1984. These examinations were performed as an out-patient and were not contained in the Kingston Hospital Chart. (T. 1530-1531, Ex. 2, Ex. B-G)

13. During the present hospitalization, no abdominal X-ray film was taken of Patient A. A flat plate and upright abdominal X-ray taken previously, on August 2, 1984, was read as: "there is normal distribution of bowel gas". (Ex. 2, Ex. B)

14. After reading the flat plate X-ray to be negative, Respondent let time pass to rule out a viral process. When the abdominal pain did not abate, Respondent told Patient A that more tests were needed, namely a CAT scan of the abdomen, upper GI series, gall bladder series, barium enemas and small bowel series. Patient A refused all of these tests, telling the Respondent that she had gone through them at Child's Hospital where they did not find anything. (T. 1532-1533)

15. The chart from Child's hospital that had been read to Respondent referred to all of the aforementioned tests and reported that they were all found negative. Respondent therefore agreed not to repeat such tests preceding his hospitalization of Patient A in September, 1984. (T. 869, 1529, 1533)

16. Respondent decided approximately two to three days prior to the September, 1984, hospital admission to perform the exploratory laparotomy. (T. 875, 1536)

17. There were no radiological examinations prior to or during the September 23, 1984 admission demonstrating an intestinal obstruction. (T. 796, 799, 813, 817, Exs. B-G)

18. On September 25, 1984, the Respondent performed an exploratory laparotomy upon Patient A. (Ex. 2 - pg.2)

19. The operative report does not describe an intestinal obstruction. The Respondent found loops of the small bowel entrapped retroperitoneally next to the ureter of the right side. The Respondent did not observe any distension of the bowl or any gangrene. (T. 1564-1565, 1574, 1594-1596, Ex. 2 - pgs. 2, 22)

CONCLUSIONS - PATIENT A

The Committee finds that the Respondent should have made an attempt to pursue the diagnoses despite the patient's reluctance to undergo further testing. The Respondent's expert witness, Dr. Eberle, testified that the failure to perform further testing such as: a barium enema and an upper GI series with a small bowel follow through was a deviation from the standard of a reasonably prudent physician. (T. 819, 835-837)

The Committee found that the testimony of Dr. Welch regarding the care and treatment of Patient A was credible. He testified that the diagnosis was unsubstantiated and that the operation was unnecessary. We find that his opinion is further substantiated by the medical records in evidence and our findings of fact.

The record indicates that Patient A received a series of tests at Child's Hospital (ex. H), in January of 1982. The Respondent alleges that he used these test results in diagnosing this patient. However, the Committee finds that these tests were irrelevant in the September, 1984 admission because of the elapsed time period.

An examination of Exhibits B through G are likewise irrelevant as Exhibits C and D are X-rays taken relevant to an auto accident, in which Patient A was involved, and Exhibits B, E, F and G do not substantiate the diagnosis of intestinal obstruction.

It was not reasonable and prudent of the Respondent to proceed with the laparotomy without performing the necessary diagnostic testing simply because of the patient's reluctance to undergo the needed procedures.

We therefore conclude that in diagnosing a small bowel obstruction and performing a laparotomy on Patient A, on September 25, 1984, during her admission to Kingston Hospital, from September 23, 1984 to October 3, 1984, the Respondent acted incompetently. However, we do not find that in this instance that he acted with gross negligence, gross incompetence or negligence.

FINDINGS OF FACT - PATIENT B

20. Patient B, a thirty-eight year old female, was admitted to Kingston Hospital from March 5, 1985 to March 19, 1985, was treated by the Respondent and underwent surgery on March 11, 1985. The Respondent performed an exploratory laparotomy, lysis of adhesions and common bile duct exploration. (Ex. 3)

21. Patient B presented to the Kingston Hospital Emergency Room at approximately 5:30 p.m. complaining of severe abdominal pain and vomiting. She was admitted to Kingston Hospital at approximately 6:20 p.m. (Ex. 3 - pgs. 3-6, 10, 70)

22. Patient B had been discharged from Benedictine Hospital, Kingston, New York, earlier in the day on March 5, 1985, where she had been hospitalized since February 27, 1985, due to severe abdominal pain and vomiting. Patient B had also been hospitalized at Benedictine Hospital from January 9, 1985 to January 11, 1985 and seen in the Emergency Room at Benedictine Hospital on January 3, 1985 and January 6, 1985, for abdominal pain. (Ex. 3 - pgs. 4, 6, 10, Ex. 4 - pgs. 1-10, 12, 18)

23. Patient B had a long history of institutional confinement due to retardation and psychiatric problems. (Ex. 3 - pgs. 23, 24)

24. Patient B's examination by Dr. Michael Steckman on March 6, 1985 revealed, among other things, soft abdomen, bowel sounds present, no distension and negative rectal examination. (Ex. 3 - pgs. 7, 22)

25. Patient B had previously been seen by Dr. Steckman for the first time in September of 1983, complaining of severe abdominal pain. Her previous medical history was: status post cholecystectomy four years ago, status post appendectomy and status post hysterectomy. (Ex. K - pg. 2, Ex. L - pg. 2)

26. Dr. Steckman admitted Patient B to Benedictine Hospital on January 9, 1985 with severe abdominal pain and diarrhea. He noted in his physical examination report that Patient B had been worked-up extensively, in the past, but has not had a good cholangiogram. He noted that " we must strongly

consider and endoscopic retrograde cholangiopancreatogram (ERCP), to rule out common bile duct disease once and for all". Patient B refused to undergo the ERCP during that hospitalization and she was discharged. (Ex. L - pgs. 2, 4, 8)

27. Dr. Steckman again admitted Patient B to Benedictine Hospital on February 27, 1985 with severe abdominal pain and vomiting. The admission history stated: "...The patient has continued to complain of severe symptoms and she is now admitted to finally have an ERCP; and if the study is abnormal, a laparotomy is being contemplated". (Ex. K - pg. 2)

28. Dr. Steckman performed the ERCP on February 27, 1985. His report on the ERCP, dated February 27, 1985, stated that the "common bile duct was mildly dilated approximately 12 mm. in the extra-hepatic portion." He reached the following impression and conclusion:

> "IMPRESSION: 3) Dilated extra-hepatic portion of the common bile duct which may represent a normal variant status post cholecystectomy but biliary dyskinesia on an intermittent basis or mild distal common bile duct stricture cannot be ruled out completely.
>
> On the basis of this study, if operative intervention seems indicated, for example to lyse adhesions which may be causing this patient's pain, I would opt that a surgical sphincterotomy be performed simultaneously since the common bile duct is dilated on this examination."

Dr. Steckman also reported: "At the distal common bile duct, there is a narrowing which corresponds to the intramural duodenal portion of the common bile duct and I do not feel this represents a stricture." (Ex. 4 - pg. 19, Ex. K - pgs. 24, 34-35)

29. The Respondent saw Patient B at Benedictine Hospital on February 27, 1985, following the ERCP. His entry in the Benedictine Hospital chart shows that he then suspected a common bile duct stricture and that he planned an exploratory laparotomy and repair as indicated. (T. 1636-1638, Ex. K - pgs. 5-6)

30. The discharge from Benedictine Hospital planned for March 3, 1985, was postponed by Dr. Steckman after the patient had about of vomiting and complained of abdominal pain. She was discharged by Dr. Steckman two days later on March 5, 1985. Patient B presented herself at the Kingston Hospital Emergency Room on the evening of March 5, 1985, with a complaint of severe right upper quadrant pain. On admitting Patient B, to Kingston Hospital, the Respondent wrote in the chart that he planned "conservative management, investigation and repair if indicated." (Ex. 3 - pg. 7, Ex. K - pg. 12)

31. Patient B was examined at Kingston Hospital by Dr. Steckman, who wrote a consultation report dated March 6, 1985. The impression and recommendations of Dr. Steckman at that time were:

> "IMPRESSION: Recurrent abdominal pain syndrome. Although the patient has a somewhat dilated common bile duct, free flow of contrast out of the duct was demonstrated on the ERCP. There may be intermittent biliary spasm not appreciated on the endoscopic retrograde study. The patient certainly has a supraputorial component to her pain which makes evaluation extremely difficult.
>
> Recommendations: I believe the patient should be observed in the hospital for progression of her abdominal symptoms. I would strongly recommend a psychiatric consultation before any further intervention is entertained. We shall review her previous studies, and further recommendations can be made as we observe the patient and following psychiatric consultation."

(Ex. 3 - pgs. 21-22)

32. On Thursday, March 7, 1985, at approximately 11:00 a.m., the Respondent planned an exploratory laparotomy for Patient B for the following Monday, March 11, 1985. The surgery was planned prior to the psychiatric consultation which was performed later in the day on March 7, 1985. (T. 192, 193, Ex. 3 - pgs. 23, 24)

33. The Respondent wrote a pre-op note in the hospital chart on March 10, 1985, as follows:

> "This is a very complex case."
>
> "The patient had had multiple abdominal surgeries, namely one cholecystectomy, appendectomy, abdominal hysterectomy. Since the cholecystectomy, has repeated right upper quadrant crampy pains. Extensive investigations have all failed to reveal any cause for the pain. a recent ERCP done about fourteen days ago at Benedictine Hospital was normal except dilated common bile duct. Subsequently the patient developed an episode of acute pancreatitis. On the day of dismissal from Benedictine Hospital, the patient was apparently well. Several hours later that same day, the patient was admitted to the Kingston ER with acute abdomen. Initial diagnosis was possible acute pancreatitis which [was] treated conservatively. All tests have been normal except alkaline phosphatase. Suspicious of ampullar obstruction. The patient has been seen in consultation by Dr. Hermele to rule out any psych problem. The patient continued to complain of severe epigastric pain, crampy. This is quite tender to deep palpation. No evidence of sepsis. Serum and urine amylase levels within normal limits. The patient has been advised that it is quite possible she may still have her pain if no organic pathologies found at surgery.

Impression, repeated right upper quadrant and epigastric pain. Suspect ampullary obstruction.
Plan, exploratory laparotomy, sphincterotomy and repair as indicated. Procedure and risk explained to the patient."

(T. 1662-1663, Ex. 3 - pgs. 13-15)

34. On the morning of March 11, 1985, the Respondent performed an exploratory laparotomy, lysis of adhesions, common bile duct exploration and an operative cholangiogram on Patient B. The common duct was found to be slightly dilated. It was opened and Bakes dilators up to #7 were passed easily into the duodenum. The duct was found to be empty. (Ex. 3 - pgs. 26, 28)

CONCLUSIONS - PATIENT B

The Committee concludes that the tests and the results thereof being negative, with some controversy surrounding the size of the common bile duct, there were no indications that surgery was necessary. Continued observation would have been the reasonable and prudent course of treatment in light of the medical and psychiatric consultant's recommendations. We concur with the findings of Doctors Steckman and Hermele that Patient B had a psychiatric condition that should have been positively addressed before surgery was instituted.

Dr. Welch, whose testimony the committee found credible, testified that he found no real justification for operating on this patient (T. 156). He further stated that:

> "I think it was unwarranted. I think that in the absence of physical findings, the fact that she had a very good ERCP which delineated the fact that there was no obstruction; she had no clinical signs of biliary obstruction; she was known to have repeated somatic complaints, and I find that there was no real justification for operating on this woman,..."

The Committee therefore finds that the Respondent acted incompetently in performing unnecessary surgery, on Patient B, on March 11, 1985. However, we do not find that his actions reached the degree of gross incompetence, gross negligence or negligence.

The Committee is particularly disturbed by the Respondent's testimony that he was hoping that the psychiatrist would relieve him of the "agony" of performing this surgery (T. 167). The Committee finds that this is not the way that a reasonable and prudent surgeon should make his decision or accept his responsibility regarding whether to operate or not.

FINDINGS OF FACT - PATIENT C

35. Patient C, a sixty-three year old mentally retarded male, was admitted to Kingston Hospital at approximately 4:00 p.m. on November 27, 1986, was treated by the Respondent, underwent surgery on November 29 and December 6, 1986 and was discharged on January 5, 1987. (Ex. 5 - pg. 1)

36. Patient C had been transferred to Kingston Hospital, on November 27, from the Ellenville Community Hospital, Ellenville, New York, where he had been hospitalized since November 24, 1986, because there was no longer surgical coverage available. (Ex. 5 - pg. 6, Ex. 6 - pgs. 3 , 4)

37. Patient C presented to the Emergency Room at Ellenville Community Hospital at approximately 2:35 a.m. on November 24, 1986, complaining of abdominal pain, vomiting and two episodes of syncope since 6:00 p.m. on November 23, 1986. Physical examination revealed: abdomen slightly distended, soft, non-tender, no mass palpable, positive bowel sounds. Patient C was slightly dehydrated and had an elevated BUN. Patient C was admitted to Ellenville Community Hospital to rule out intestinal obstruction. Additional history learned subsequently was that Patient C had ingested and vomited three plastic sandwich bags. (T. 507-508, Ex. 6 - pgs. 10, 11, 30)

38. Abdominal radiology at Ellenville Community Hospital on November 24 and 25, 1986, including two flat and two upright abdominal X-rays and a barium enema, revealed no intestinal obstruction. The radiologist's "Impression" following the barium enema was that a small bowel follow-up be performed. (T. 508-511, 613-615, Ex. 6 - pgs. 36-38, Ex. 12A)

39. Upon transfer from Ellenville Community Hospital to Kingston Hospital at approximately 4:00 - 5:00 p.m. on November 27, Patient C had had no vomiting during his stay at Ellenville. He had had no nausea for several days, was afebrile, his vital signs and laboratory results were normal. The Ellenville discharge diagnosis included "...small bowel obstruction...". (T. 511-512, Ex. 5 - pg. 6, Ex. 6 - pgs. 2, 3, 22, 28, 32-34)

40. Patient C's physical condition upon presenting to the Respondent at approximately 5:00 to 5:30 p.m. on November 27, 1986 was as follows: Vital signs normal, afebrile, well hydrated, abdomen distended, moderate tenderness and no bowel sounds. This examination was conducted by the Respondent at Kingston Hospital's Emergency Room. (T. 513-515, 1776-1777, Ex. 5 - pgs. 7, 9, 142)

41. On November 27, 1986, flat and upright abdominal X-rays showed no signs of intestinal obstruction as interpreted in a formal dictated and transcribed report prepared by Dr. David Ryon, the radiologist assigned. The Respondent never read Dr. Ryon's report prior to the surgery. (T. 515, 522, 1817, 2102-2105, 2107, 2122, 2120-2121, Ex. 5 - pg. 102, Ex. 11A, Ex. 11B)

42. On the morning of November 28, 1986, Patient C had a bowel movement. His clinical condition on the evening of November 27 and the morning of November 28, 1986, was stable and normal. On November 28, at approximately 1:00 p.m. the Respondent's pre-operative note "Impression" was:

"1.) Rehydrate and

2.) Exploratory laparotomy and repair as indicated".

(T. 1192, 1850, Ex. 5 - pg. 13)

43. On November 28, the Respondent had already given his pre-operative orders. Patient C was taken to surgery as an emergency on November 29, 1986. (Ex. 5 - pgs. 37, 54)

44. Respondent's progress note concerning his physical examination of November 28, 1986 at 10:00 a.m. showed "increased distention"[sic] and "now mid-abdominal pain". Respondent testified that his note reflected the patient's complaint of pain that morning and that this was something new as compared to the moderate tenderness found upon palpation the previous evening. (T. 1790-1792, Ex. 5 - pg. 12)

45. On November 28, 1986 at 1:00 p.m., the Respondent wrote a pre-operative note in the chart which stated that "barium enema reveals normal but redundant large bowel, especially the sigmoid colon, with moderately dilated small bowel. No bowel sounds." The handwritten pre-op impression was small bowel obstruction that is not responding to conservative treatment. (T. 1787, Ex. 5 - pg. 13)

46. The Respondent's Operative Report states that the Respondent resected a sigmoid volvulus. The radiography of November 24 and November 27, do not reveal a volvulus. The Pathology Report reflects that a 59 centimeter segment of redundant colon was excised. There was no significant pathology. (Ex. 5 - pgs. 37, 38)

47. On the morning of November 29, 1986, the Respondent performed surgery on Patient C. Anesthesia commenced at 9:10 a.m. Patient C's bowel was unprepared. The Respondent testified that he performed a colon resection without adequate bowel preparation. (T. 1893, Ex. 5 - pg. 37)

48. The Respondent's Operative Report for the November 29, 1986 surgery was dictated on January 16, 1987. The Respondent testified, in regard to the operative note as follows:
"By Dr Geary:
Q: Okay. Let me just simply ask this now: In the context of the charges of inadequate record keeping, do you believe that this operative note is a reflection of inadequate record keeping?
Judge Butler:
Could you refer to which note you are talking about?
Dr. Geary:
The operative note dictated two months after the case on page 37.
Judge Butler:
Of Exhibit 5?
Dr. Geary:
Of Exhibit 5.
Judge Butler:
That is 37...
A: Yes. It is not completely accurate.
Q: So, the answer to that is, yes?
A: Yes..."
(T. 1899-1900, Ex. 5 - pg. 37)

49. The Respondent's Operative Report for the December 6, 1986 surgery, was dictated on January 16, 1987, it does not include a description of operative findings, techniques employed, reasons for procedures performed or the presence or absence of contamination. The Respondent's "Post Operative Diagnosis" and Operation and Findings", in said operative report, do not conform to the narrative description. (Ex. 5 - pgs. 45)

CONCLUSIONS - PATIENT C

The Committee finds that the Respondent failed to adequately investigate Patient C's condition before performing surgery on November 29, 1986.

The Respondent departed from a standard of reasonable care when he failed to secure and read the X-ray report prepared by Dr. David Ryon, the assigned radiologist. This report showed no evidence of intestinal obstruction. Instead, the Respondent conferred informally with Dr. Thomas Koshy, who offered an interpretation of Sigmoid Volvulus. The Respondent did not agree with this analysis. However, even in spite of this disagreement, he did not seek out the official radiological report. The Committee found that Dr. Ryon's analysis of the X-rays were very compelling when compared with the analysis offered by Dr. Koshy. The Committee found Dr. Ryon to be a credible and competent witness and ascribes the greater weight to his interpretation of the X-rays.

Dr. Thomas Minehan, the Respondent's expert, testified that proceeding to surgery without further testing, with a significant degree of tenderness, would be reasonable. Therefore, following this line of reasoning, if Patient C exhibited moderate tenderness in the mid-abdomen on November 27, 1986, with a suspected diagnosis of small bowel obstruction, surgery should have been performed at that time. However, the Respondent delayed surgery until November 29, 1986. During this period he should have performed: repeat X-ray studies i.e: serial X-rays of the abdomen (plain film and upright), upper GI series. (T. 1194) In addition, he could have decompressed the small bowel by passage of a long tube. (T. 1195)

The Committee concludes, therefore, that the Respondent acted incompetently in his pre-operative investigation of Patient C's condition before surgery on November 29, 1986.

In his testimony before this Committee the Respondent admitted to the fact that he did not do an adequate bowel preparation of Patient C prior to surgery. (FF #47) Therefore, the Committee finds that the Respondent acted incompetently when he performed a colon resection without adequate bowel preparation.

Although, the radiological and pathological tests do not confirm a diagnosis of Sigmoid Volvulus and the operative report was dictated on January 16, 1987, approximately six weeks later, the Committee agrees that we must accept the operating surgeon's interpretation of the findings and subsequent bowel resection as presented by the Respondent. Therefore, we cannot substantiate that the Respondent performed a colon resection without adequate indication.

The Committee concludes that in this instance, the dictation of the operative report approximately six weeks after the actual operation was a deviation from the standard of a reasonable and prudent physician.

FINDINGS OF FACT - PATIENT D

50. Patient D, a fifty-nine year old female, was admitted to Kingston Hospital from December 28, 1984 to February 2, 1985, and was treated by the Respondent. (Ex. 7)

51. Patient D presented to Kingston Hospital Emergency Room complaining of numbness in the left leg/foot. She had also presented to two other hospitals within several days prior to her admission to Kingston Hospital. (Ex. 7 - pgs. 2-5, 20)

52. On December 30, 1984, the Respondent ordered a bilateral angiogram to be performed on Patient D. (T. 1404, 1934)

53. Patient D had an acute bleeding from the angiogram site. The Respondent's investigation of the condition of the angiogram site, between the performance of the angiogram on December 31, 1984 and the acute bleeding episode that occurred on January 8, 1985, was adequate. (T. 884, 1960, Ex. 7 - pgs. 13, 37, 187)

54. At 1:45 p.m. on January 8, 1985, the medical records document that Patient D was pale, cold and diaphoretic. At 3:00 p.m., Patient D's blood pressure was recorded as 60/40. At 3:20 p.m. the Respondent indicated in the progress notes that Patient D suddenly started to bleed from the arterial puncture site. (Ex. 7 - pgs. 13, 21, 117, 187)

55. The Respondent performed bilateral thromboembolectomy on Patient D on January 8, 1985. (T. 1403, Ex. 7)

56. The operative note was dictated on March 8. 1985. (Ex. 7 - pg. 23)

CONCLUSIONS - PATIENT D

The Committee finds that although the Respondent ordered an angiogram for Patient D on December 30, 1984, the record does not substantiate the allegation that the angiogram was unnecessary.

The Committee finds that the record does not substantiate that the Respondent failed to adequately investigate a false aneurysm of Patient D's right thigh. The record indicates that this was not an "aneurysm" but an "acute bleed" from the angiogram site.

The Committee finds that when the Respondent performed surgical exploration of Patient D's left leg he did so without adequate indication. (T. 1965) Although the left leg appeared eschemic during surgery (Ex. 7), the Respondent should have repaired the right femoral artery and stopped. (T. 397-398) Patient D was in shock at the time of the operation and the Respondent's concern should have been to not prolong the operation and sustain added blood loss.

The Committee therefore concludes that The Respondent acted incompetently when he performed surgical exploration of Patient D's left leg without adequate indication.

GENERAL CONCLUSIONS

The Committee concludes that the Respondent did not act with gross negligence and/or gross incompetence in his care and treatment of Patients A through D. Specifications one through four are not sustained.

The Committee concludes that the Respondent acted with incompetence, but not negligence, on more than one occasion in his treatment of Patients A through D. Specification five is sustained.

The Committee concludes that the Respondent failed to keep records that adequately reflected the condition and treatment of Patients C and D. The charge of Inadequate Record Keeping, Specification six, is therefore sustained.

RECOMMENDATIONS

The Committee recommends that the Respondent, Dr. David G. Amamoo be suspended from the practice of medicine for a period of two years. The Committee further recommends that the suspension period be stayed pending OPMC monitoring of the physician's surgical practice over the stayed period. In addition, the Committee recommends that the Respondent be fined $5,000, (five thousand dollars), effective upon final determination of this matter and service upon the Respondent or his Counsel.

DATED: Albany, N.Y.
April 4, 1990

Respectfully submitted

Rev. Edward J. Hayes
Chairman
Dr. Joseph E. Geary, M.D.
Dr. Robert A. Menotti, M.D.

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

IN THE MATTER :

OF :

DAVID G. AMAMOO, M.D. :

COMMISSIONER'S RECOMMENDATION

----------X

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

A hearing in the above-entitled proceeding was held on March 9, 1989, March 10, 1989, May 19, 1989, June 14, 1989, July 26, 1989, August 2, 1989, September 13, 1989, October 4, 1989, October 25, 1989, November 28, 1989, December 12, 1989 and January 30, 1990. Respondent, David G. Amamoo, M.D., appeared by Philip c. Pinsky, Esq. and Roy D. Pinsky, Esq. The evidence in support of the charges against the Respondent was presented by Ralph J. Bavaro, Esq. and David A. Dietrich, Esq.

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

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

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

B. The Recommendation of the Committee should be modified as follows: The Committee recommends that the Respondent be fined $5,000. I agree. The Committee recommends that the Respondent be suspended from practice for one year and that suspension be stayed "pending OPMC monitoring of the physician's surgical practice." I believe the

pattern of incompetence found by the Committee warrants greater protection to Respondent's patients. The Committee found four separate incidents of incompetence. In three cases, surgery was unnecessary. In all four cases, Respondent failed to perform standard pre-operative tests. The thrust of a conclusion of incompetence is that Respondent "didn't know any better." Before Respondent is permitted to perform surgery on others, he should be required to acquire the knowledge he now lacks. Therefore, I recommend that Respondent's license be suspended for three years and such suspension be stayed subject to standard monitoring by OPMC and the following further conditions: Respondent may not perform any surgery until he has completed six months of retraining approved by OPMC except that Respondent may perform surgery during that six month retraining solely for the purpose of such retraining. When the six month retraining is completed and for the remainder of the three year suspension, Respondent may only perform surgery when such surgery has been approved in advance by a monitoring surgeon approved by OPMC; and

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

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

DATED: Albany, New York
July 12, 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

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

IN THE MATTER	:	REVISED
OF	:	COMMISSIONER'S
DAVID G. AMAMOO, M.D.	:	RECOMMENDATION

----------X

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

A hearing in the above-entitled proceeding was held on March 9, 1989, March 10, 1989, May 19, 1989, June 14, 1989, July 26, 1989, August 2, 1989, September 13, 1989, October 4, 1989, October 25, 1989, November 28, 1989, December 12, 1989 and January 30, 1990. Respondent, David G. Amamoo, M.D., appeared by Philip C. Pinsky, Esq. and Roy D. Pinsky, Esq. The evidence in support of the charges against the Respondent was presented by Ralph J. Bavaro, Esq. and David A. Dietrich, Esq. I executed a Commissioner's Recommendation on July 12, 1990. By letter, dated July 31, 1990, David Dietrich requested clarification of my recommendation.

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

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

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

B. The Recommendation of the Committee should be modified as follows: The Committee recommends that the Respondent be fined $5,000. I agree. The Committee recommends that the Respondent be suspended from practice for one year and that suspension be stayed "pending OPMC monitoring of the physician's surgical practice." I believe the pattern of incompetence found by the Committee warrants greater protection to Respondent's patients. The Committee found four separate incidents of incompetence. In three cases, surgery was unnecessary. In all four cases, Respondent failed to perform standard pre-operative tests. The thrust of a conclusion of incompetence is that Respondent "didn't know any better." Before Respondent is permitted to perform surgery on others, he should be required to acquire the knowledge he now lacks. Therefore, I recommend that Respondent's license be suspended for three years and such suspension be stayed provided that Respondent, during such three year period, adhere to the standard probationary conditions. In addition, Respondent may not perform any surgery until he has completed six months of retraining approved by OPMC except that Respondent may perform surgery during that six month retraining solely for the purpose of such retraining. For 30 months after the six month retraining is completed, Respondent may only perform surgery when such surgery has been approved in advance by a monitoring surgeon approved by OPMC; and

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

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

DATED: Albany, New York
September 4 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

EXHIBIT "E"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

DAVID G. AMAMOO

CALENDAR NO. 11224

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

   a. That respondent, during the period of probation, shall act in all ways in a manner befitting respondent's professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by respondent's profession;

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

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

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of

Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That, during the period of probation, respondent shall have respondent's practice of surgery monitored, at respondent's expense, as follows:

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

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

   c. That said monitor shall submit a report, once every four months, regarding the above-mentioned monitoring of respondent's practice of surgery to the Director of the Office of Professional Medical Conduct;

3. That respondent shall, at respondent's expense, enroll in and diligently pursue a course of training in medical record-keeping, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said course to consist of six months and to be satisfactorily completed during the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct, within 10 days of such completion;

4. That respondent shall, at respondent's expense, enroll in and

diligently pursue a course of training in surgery, said course of training to be selected by respondent and previously approved, in writing, by the Director of the Office of Professional Medical Conduct, said course to consist of six months and to be satisfactorily completed during the period of probation, such completion to be verified in writing and said verification to be submitted to the Director of the Office of Professional Medical Conduct, within 10 days of such completion;

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

ORDER OF THE COMMISSIONER OF EDUCATION OF THE STATE OF NEW YORK

DAVID G. AMAMOO

CALENDAR NO. 11224

The University of the State of New York

IN THE MATTER

OF

DAVID G. AMAMOO
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11224

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11224, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (November 16, 1990): That, in the matter of DAVID G. AMAMOO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 56 findings of fact and conclusions as to the question of respondent's guilt be accepted, and the Commissioner of Health's recommendation as to those findings of fact and conclusions be accepted;
2. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;
3. Respondent is guilty, by a preponderance of the evidence, of the fifth specification of the charges based on incompetence on more than one occasion to the extent indicated in the hearing committee report, and the sixth specification of the charges, and not guilty of the remaining charges; and
4. Respondent's license to practice as a physician in the State of New York be suspended for two years upon eachh

specification of the charges of which respondent was found guilty, said suspensions to run concurrently, that execution of said suspensions be stayed, and respondent be placed on probation for two years under the terms prescribed by the Regents Review Committee which include monitoring of respondent's practice of surgery, a course of training in medical record-keeping, and a course of training in surgery;

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

and it is

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

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

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 21st day of November, 1990.

Thomas Sobol

Commissioner of Education