NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 28, 2016

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Percy Aspi Erachshaw, M.D.
418 Stanhope Street
Brooklyn, New York 11237

Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road – Suite 311
White Plains, New York 10605

Claudia Morales Bloch, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, New York 10801

RE: In the Matter of Percy Aspi Erachshaw, D.O.

Dear Parties:

Enclosed please find the Determination and Order (No. 16-098) 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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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:cah
Enclosure

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

COPY

IN THE MATTER

OF

PERCY ASPI ERACHSHAW, D.O.

DETERMINATION

AND

ORDER

BPMC-16-098

A Notice of Hearing and Statement of Charges, dated August 6, 2014, was served on attorneys for **PERCY ASPI ERACHSHAW, D.O.**, "Respondent." There was no objection as to jurisdiction. (T. 5) Hearings were held pursuant to N.Y. Public Health Law §230 and New York State Admin. Proc. Act §§ 301-307 and 401 on September 9 and 10, October 13, 2014 (with Judge Terepka) and October 30, 2014, November 19 and 20, 2014, December 3, 4 and 12, 2014, January 7, 2015 (with Judge Gayle), May 14, 2015, June 4 and 24, 2015, September 10, 2015 and October 29, 2015.

All hearings were held at the Offices of the New York State Department of Health, 90 Church Street, New York, New York ("the Petitioner"). **William M. Bisordi, M.D., Chair, Iffath Abbasi Hoskins, 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, and **Claudia Morales Bloch, Esq.**, Associate Counsel, New York State Department of Health, of Counsel. The Respondent

appeared by **Anthony Z. Scher, Esq.**, of the firm of **Wood & Scher** of White Plains, New York.

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:	August 6, 2014
Answer Filed:	August 13, 2014
Pre-Hearing Conference:	August 13, 2014
Hearing Dates:	September 9, 2014 September 10, 2014 October 13, 2014 (with Judge Terepka) October, 30, 2014 (with Judge Lepicier) November 19, 2014 November 20, 2014 December 3, 2014 December 4, 2014 December 12, 2014 January 7, 2015 (with Judge Gayle) May 14, 2015 June 4, 2015 June 24, 2015 September 11, 2015 October 29, 2015
Deliberation Date:	January 15, 2016
Witnesses for Petitioner:	Christine Scaminaci Ashraf Toma, M.D.

	Mark Nuqui, D.O. Biagio Pacifico, D.O. Gerard Baltasar, D.O. Thomas Gouge, M.D. Steven Pulitzer, M.D. Akella Chendrashekar, M.D.
Witnesses for Respondent:	Percy Aspi Erachshaw, D.O. David Mayer, M.D. Addagada Rao, M.D.
Deliberations Date:	January 15, 2016

STATEMENT OF THE CASE AND BACKGROUND

Petitioner charged Respondent, a physician practicing surgery, with eighteen (18) 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 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 tenth specifications Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently.

In the eleventh through thirteenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by conduct in the practice of medicine which evidences moral unfitness to practice medicine.

In the fourteenth through eighteenth 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, D, and E which accurately reflects the care and treatment of the patient in question.

A copy of the Notice of Hearing and Statement of Charges is attached hereto as Appendix 1.

EVALUATION OF TESTIMONY

The expert witnesses in this case were Doctor Thomas Gouge for the Department and Doctor David Mayer for Respondent. The panel considered and evaluated the testimony of each but gave greater credence to the testimony of Dr. Mayer. On several occasions Doctor Gouge did not appear to give objective and credible testimony, oftentimes agreeing with the State's assertions based on poor understanding of the medicine involved. This damaged his credibility.

The most compelling aspect of the Department's case was the testimony about Patient A and the colonoscopy that went bad. Patient A's colon had been perforated during

a colonoscopy and Respondent was charged with failing to terminate the operation in a timely manner. The evidence shows that the colon had been perforated and EMS was called and the Patient was transported to Jamaica Hospital.

Doctor Gouge maintained that Respondent should have been aware of this situation from the outset. The panel did not accept this testimony and relied, instead, on the testimony of Respondent's expert, noting the perforation was only 1.5 centimeters and would, in all likelihood, have been missed by a competent surgeon. The panel was concerned that Doctor Gouge had not performed a colonoscopy in many, many years and was not up-to-date with current practice. Doctor Gouge stated that most perforations are diagnosed during the procedure but that is not true as most perforations are discovered after the procedure is terminated.

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 except where otherwise noted.

1. Respondent was authorized to practice medicine in New York State on or about August 20, 2001 by the issuance of license number 222537 by the New York State Education Department.

PATIENT A

2 Respondent undertook the care and treatment of Patient A at his Brooklyn, New York, office located at 418 Stanhope Street from on or about September 14, 2012 through September 17, 2013. (T. 1664-1665)

3. Patient A's chief complaints were chronic constipation, pain and rectal bleeding. (T. 1656, 1674)

4. Respondent performed an anal manometry on Patient A on September 14, 2012 without an assessment or evaluation of the patient before doing the anal rectal manometry. (T. 1656) On September 17, 2013, Respondent performed a colonoscopy on Patient A and perforated her colon at the recto-sigmoid juncture and insufflated her colon. (T. 143-144 and Exhibit 3)

5. Patient A required a colonoscopy and Respondent recommended a colonoscopy and the patient either refused or simply did not show up for a procedure that had been scheduled. (T. 1537)

6. Eight months prior to the September 17, 2013 procedure, Respondent had advised the patient to have the colonoscopy. (T. 1755)

7. Patient A had developed a painful anal fissure and Respondent treated her with topical nitroglycerin and anal dilations. This treatment worked as the fissure was healed by the time the colonoscopy was performed. (T. 1754)

8. The Respondent did not know there was a perforation and, therefore, he could not terminate the procedure based on the perforation. (T. 1560)

9. During the colonoscopy, Respondent advanced the scope all the way to the cecum when the anesthesiologist, Dr. Toma, stated he was having a problem ventilating the patient and asked Respondent to stop the procedure, which Respondent did, immediately. (T. 1561)

10. Respondent's record for Patient A's colonoscopy does not have an exam date, does not have a notation for the "Scopes used" and has no date of signature nor is it electronically signed by Respondent. (Ex, 19 and T. 1592)

11. Respondent acknowledged that signing the operative record does close the document, disallowing reentry into the system. (T. 1592)

12. Respondent testified that the circulating nurse inputs the patient's name and date of service and "all that stuff." The report for Patient A is the only one without that information. The record for Patient A is neither electronically signed nor dated. (T. 1592-1594, 1604-1609)

PATIENT B

13. Respondent undertook the care and treatment of Patient B at Wyckoff Heights Medical Center, 374 Stockholm Street, Brooklyn, New York from on or about May 3, 2009 through November 7, 2010. (T. 211-222)

14. On June 23, 2009, Respondent performed a primary repair of umbilical hernia on Patient B under general anesthesia, without determining whether the hernia was reducible, which was important because of the patient's comorbidities. (T. 213-215)

15. On December 22, 2009, Respondent performed a second surgery under general anesthesia, to wit a "Repair of Recurrent Umbilical Hernia with Mesh." (Exhibit 7a, p. 175 and T. 273)

16. On November 2, 2010, Respondent performed a Minilaparotomy with removal of mesh and primary repair of recurrent umbilical hernia, under general anesthesia. (Exhibit 9, p.1, T. 334-336)

17. On November 5, 2010, Patient B was brought back to Wyckoff Heights Medical Center in grave condition and another surgeon performed an exploratory laparotomy, subtotal colectomy, multiple small bowel resections, primary small bowel anastomosis and end-ileostomy. (Exhibit 7, p. 522)

18. Patient B expired on November 7, 2010. (Exhibit 7, pp. 731, 993-994)

19. Respondent's medical record for Patient B shows a history of vascular disease, Peripheral Vascular Disease, Hepatitis C, liver failure, Diabetes, Hypertension, Obesity, Asthma, and Alcohol abuse. This history was not taken on the first visit, but was only taken after the surgery. (Ex. 6, p. 1, T. 1216-1217)

20. Respondent's medical history for Patient B shows a weight of 235 lbs. but no height is noted, an essential fact in evaluating obesity. (T. 211)

21. Respondent's medical history for Patient B, failed to obtain a history of the patient's comorbiditles. Respondent testified that he found out about this patient's Hepatitis C and liver failure only after he had performed two surgical procedures. (T. 1216)

PATIENT C

22. On or about September 2, 2010 through April 12, 2012, Respondent undertook the care and treatment of Patient C at Wyckoff Heights Medical Center. (T. 396-398 and Ex.11, pp. 11-12)

23. On January 11, 2011, Respondent performed an exploratory laparotomy with sigmoid resection and appendectomy. (T. 416-418)

24. On December 27, 2011, Respondent Admitted Patient C to Wyckoff Heights Medical Center for a planned colon resection for "recurrent diverticulitis." (T. 781-782)

25. On December 27, 2011, Respondent performed an exploratory laparotomy, lysis of adhesions and sigmoidoscopy and did not resect the colon. (T. 783)

26. Respondent had no motive to exaggerate the extent of the adhesions, as there would be no greater reimbursement for documenting extensive adhesions versus a minimal amount of adhesions. (T. 2047)

27. Respondent did follow Patient C preoperatively (along with Dr. Benedicto) and postoperatively. (T. 2035)

28. Patient C had two episodes of well documented severe abdominal pain during his hospital stay and it was clear that the patient's diverticulitis necessitated a bowel resection. (T. 2036 – 2037)

29. The plan for the surgery on December 27, 2011 was to do a laparotomy, lysis of adhesions, and a possible bowel resection. (T. 957 and Ex. 12, pp, 175-176)

30. Whenever an exploratory laparotomy is done in situations where the bowel is involved, it is routine to get a consent from the patient for a possible bowel resection. (T. 958)

31. In regard to the December 27, 2011 surgery, this patient had a prior colonoscopy that ruled out a stricture and a repeat colonoscopy would not show adhesions. The information from the prior colonoscopy was sufficient for Respondent to proceed to surgery. (T. 914)

32. In regard to the December 27, 2011 surgery, there was a sufficient lysis of adhesions to warrant the prophylactic placing of a drain. Under the circumstances, it was clear that there was more than a minimal lysis of adhesions. (T. 2047)

33. In regard to the December 27, 2011 surgery, Respondent used the anethesic time by mistake, and he wrongly estimated the time spent lysing adhesions. This was simply an error and not fraud sufficient to support a charge of fraudulent medical practice. (Ex. 11, p. 1788)

34. In regard to the December 27, 2011 surgery, it would be impossible to perform an extensive lysing of adhesions without running the bowel. "Running the bowel" means examining the entire bowel to rule out abnormalities. This procedure excludes the possibility of injury or perforation of the bowel. The full lysing of adhesions necessarily included a running of the bowel. (T. 2045)

35. With the minor exception of the time spent lysing adhesions during the December 27, 2011 surgery, Respondent's medical record for Patient C was adequate and reflected the care and treatment of the patient. (T. 2050)

PATIENT D

36. Respondent undertook the care and treatment of Patient D at Wyckoff Heights Medical Center from on about April 6, 2005 to April 17, 2007. (Ex. 13, pp. 11, 12 and T. 486-487)

37. On May 20, 2005, Respondent performed a laparoscopic cholecystectomy on Patient D. (Exit 14, p. 247 and T. 518-520)

38. Within 24 hours after surgery, Patient D had a markedly sharp elevation in total bilirubin and hepatocellular enzymes and an ERCP with stenting was performed under general anesthesia. (T. 1348-1353)

39. Respondent discharged Patient D on May 24, 2005, despite the fact that the bilirubin and hepatocellular enzymes were still elevated. (T. 511-513)

40. There are standard approaches to dissecting the anatomy out to delineate the cystic duct and the cystic artery which the Respondent did not follow. (T. 492-494)

41. Respondent failed to use any of the appropriate and standard techniques to identify the anatomy, and, in particular, the cystic duct. He did not isolate the structures in a way that would allow a positive identification based on their anatomic relationship. If he had done this, the end result would not have been injury to the ductal system which the Panel felt was iatrogenic and not the result of Mirizzi Syndrome as the Respondent contended (T. 531 – 533)

42. Patient D's bilirubin was elevated postoperatively, but Respondent addressed this issue and requested an "ERCP." This is an acronym for an endoscopic retrograde

cholangiopancreatogram, a test that checks the tubes (ducts) that drain the liver and gallbladder. (T. 1367 and Ex. 14, p. 31)

43. Respondent addressed the drainage of the bile ducts by attempting two ERCPs with attempted stenting. (T. 2084)

44. The drainage of the bile ducts by attempting two ERCPs with attempted stenting did not work so the Respondent performed a hepatic jejunostomy, the surgical joining of the hepatic duct and the jejunum. (T. 2084)

45. The Respondent treated Patient D's jaundice in a timely manner. The Respondent got an ERCP the next day and then another ERCP about a week later and then re-operated in a timely fashion. (T. 2084 – 2085)

46. The discharge of Patient D was proper as the hospital chart demonstrates that Patient D had stable vital signs and was afebrile. (T. 1373)

47. The Gastroenterologist stated that Patient D was afebrile and that the bilirubin was coming down and that the patient should be followed as an outpatient. (Ex 14, p. 44)

PATIENT E

48. Respondent undertook the care and treatment of Patient E from March 19, 2009 through April 28, 2009. (T. 1432-1434)

49. Respondent diagnosed the patient's right upper quadrant pain as due to cholecystitis and scheduled the patient for a laparoscopic cholecystectomy on April 14, 2009 at Wyckoff Heights Hospital. (T. 544-546, 557-559 and Ex.15, pp. 16-24)

50. Respondent failed to perform and/or note a complete, appropriate and directed physical examination of the patient. He planned to perform a laparoscopic cholecystectomy on Patient E without medical indication or justification. His plan to do a cholecystectomy was based on an erroneous ultrasound report. (T. 1427-1428, 1513 – 1515)

51. A vertical midline incision is almost never utilized to remove a gallbladder. (T. 1434 – 1435)

52. Respondent explained to Patient E that the cause of her pain was from gallstones or it could be from adhesions. (T. 1446)

53. The operative plan was laparoscopy, laparoscopic cholecystectomy, and lysis of adhesions. (T. 1447, Ex. 15, pp. 16 – 17)

54. Therefore, the surgery was not stopped when the gallbladder could not be located because it was not being performed solely to remove the gallbladder – it was also being performed for lysis of adhesions. (T. 1447)

CONCLUSIONS OF LAW

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

Factual Allegation A

1. **NOT SUSTAINED**
2. **NOT SUSTAINED**

3. **NOT SUSTAINED**

4. **NOT SUSTAINED**

5. **NOT SUSTAINED**

6. **NOT SUSTAINED**

7. **NOT SUSTAINED**

8. **NOT SUSTAINED**

9. **NOT SUSTAINED**

Factual Allegation B

1. a. **SUSTAINED**

   b. **NOT SUSTAINED**

   c. **NOT SUSTAINED**

   d. **NOT SUSTAINED**

   e. **NOT SUSTAINED**

   f. i. **NOT SUSTAINED**

      ii. **NOT SUSTAINED**

      iii. **NOT SUSTAINED**

      iv. **NOT SUSTAINED**

2. a. **NOT SUSTAINED**

   b. **NOT SUSTIANED**

   c. **NOT SUSTAINED**

   d. **NOT SUSTAINED**

3. a. **NOT SUSTAINED**

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

4, a. **NOT SUSTAINED**

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

e. **NOT SUSTAINED**

f. **NOT SUSTAINED**

g. i. **NOT SUSTAINED**

ii. **NOT SUSTAINED**

iii. **NOT SUSTAINED**

5. a. **NOT SUSTAINED**

b. **NOT SUSTAINED** - The panel found no need to treat from the evidence presented.

c. **NOT SUSTAINED** - The panel found insufficient evidence to warrant hospitalization.

d. **NOT SUSTAINED**

6. a. **NOT SUSTAINED** - The panel found the patient was not febrile, pre-operatively.

b. **NOT SUSTAINED** - The panel found the patient was not febrile, post-operatively.

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

7. **NOT SUSTAINED**

8. **NOT SUSTAINED**

9. a. **NOT SUSTAINED** - The panel noted that Respondent was out of town at the time of this incident.

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

e. **NOT SUSTAINED**

10. **NOT SUSTAINED**

11. **NOT SUSTAINED**

Factual Allegation C

1. a. **NOT SUSTAINED** - The panel determined that none of the allegations on this patient should be sustained.

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

2. a. **NOT SUSTAINED**

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

e. **NOT SUSTAINED**

f. **NOT SUSTAINED**

3. a. **NOT SUSTAINED**

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. i. **NOT SUSTAINED**

ii. **NOT SUSTAINED**

iii. **NOT SUSTAINED**

iv. **NOT SUSTAINED**

4. **NOT SUSTAINED**

Factual Allegation D

1. a. **SUSTAINED** - The panel noted that Respondent failed to properly identify the ductal system.

b.

i. **SUSTAINED**

ii. **SUSTAINED** - The panel noted that the Respondent should have converted to open procedure.

c. **SUSTAINED** - The panel noted that the Respondent caused injury to the ductal system and failed to recognize the injury.

2. a. **NOT SUSTAINED**

b. **NOT SUSTAINED**

c. **NOT SUSTAINED**

d. **NOT SUSTAINED**

e. **NOT SUSTAINED**

3. **NOT SUSTAINED -** The panel noted that time was needed and the delay was not inappropriate.

4. **NOT SUSTAINED -** The panel found that the record keeping charge was not sustained by the evidence.

Factual Allegation E

1. **SUSTAINED –** Because the patient did not have a gall bladder, a fact that would been discovered with an adequate, complete and thorough medical history.

2. **NOT SUSTAINED**

3. **NOT SUSTAINED**

4. **NOT SUSTAINED**

5. **NOT SUSTAINED**

6. **NOT SUSTAINED**

7. This allegation was withdrawn by the Department on October 30, 2014.

8. **NOT SUSTAINED**

SPECIFICATIONS OF CHARGES AND VOTE OF THE HEARING COMMITTEE

FIRST THROUGH FIFTH SPECIFICATIONS

These specifications 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 five named patients.

VOTE:

Specification: 1 - NOT SUSTAINED 3-0

Specification: 2 - SUSTAINED - 3-0

Specification: 3 - NOT SUSTAINED 3-0

Specification: 4 – SUSTAINED 3-0

Specification: 5 – 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.

Specification: 6 – 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.

Specification: 7 - NOT SUSTAINED (3-0)

In the eighth through the tenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently.

Specification: 8 – NOT SUSTAINED (3-0)

Specification: 9 – NOT SUSTAINED (3-0)

Specification: 10 – NOT SUSTAINED (3-0)

In the eleventh through thirteenth specifications, Respondent was charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by conduct in the practice of medicine which evidences moral unfitness to practice medicine.

Specification: 11 – NOT SUSTAINED (3-0)

Specification: 12 – NOT SUSTAINED (3-0)

Specification: 13 – NOT SUSTAINED (3-0)

In the fourteenth through eighteenth 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, D and E which accurately reflects the care and treatment of the patient in question.

Specification: 14 – NOT SUSTAINED (3-0)

Specification: 15 – NOT SUSTAINED (3-0)

Specification: 16 – N0T SUSTAINED (3-0)

Specification: 17 – NOT SUSTAINED (3-0)

Specification: 18 – NOT SUSTAINED (3-0)

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 except as noted.

DISCUSSION

The Hearing Committee carefully reviewed the Exhibits admitted into evidence, the transcripts of the fifteen (15) Hearing days, the Department's Proposed Findings of Fact, Conclusions of Law, and Proposed Sanction, dated December 23, 2015, as well as the Respondent's Summation and Post –Hearing Memorandum of Law to the Hearing Committee dated December 22, 2015. 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.

In evaluating the testimony of the expert witnesses, the panel gave greater credence to the testimony of Doctor Mayer. The majority of the factual allegations were not, in the panel's opinion, established by the Department by a preponderance of the credible evidence. Nevertheless, the panel was deeply concerned by what they saw about the Respondent's practice set forth in those allegations that were proven by a preponderance of the credible evidence. They noted a sometimes careless surgeon whose practice at times presented a clear danger to his patients.

The panel found Respondent's treatment of Patient D to be incompetent. Not only did the Respondent perform the wrong surgery on this patient, but he also failed to follow appropriate and standard techniques to identify the anatomy. When the Respondent found a distorted anatomy there are standard approaches that he should have followed. (See T. 531-533) Respondent did not follow any of these courses.

The specific techniques that Respondent could have followed to identify the anatomy and specifically the cystic duct include exclusion – taking all the tissue out of the triangle of Calot so that only one tube is visualized coming out of the gallbladder. Another technique would have been to elevate the bottom of the gallbladder off the liver so that Respondent could identify any structures going up into the bile duct. Finally, Respondent could have dissected the cystic duct out from the infundibulum of the gallbladder to its junction with the

common hepatic duct, because that relationship is what defines the cystic duct. Respondent followed none of these approaches and that, the Hearing Committee found, was evidence of his incompetence.

In addition, the case of Patient E showed a sloppy and careless preparation for surgery. The Respondent proceeded to surgery for the removal of a gall bladder that had been taken out many years before .This is a fact that should have been ascertained by a proper medical history. While the other factual allegations for Patient E were not sustained by a preponderance of the evidence, the fact remains that a proper medical history could have obviated significant pain and suffering for this patient.

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 Suspension of his medical license. The Committee concludes that the Respondent's conduct in this matter warrants a Suspension as the only appropriate penalty under the circumstances of this case. In reaching this conclusion, the Committee considered the full range of penalties available in a case such as this.

The incompetence exhibited by Respondent's treatment of Patient D and E and the general carelessness exhibited in his practice moved the Hearing Committee to require Respondent, after the completion of his Suspension, to undergo competency examination pursuant to PHL § 230(7)(c). Should the examination find the Respondent competent to return to practice, the Suspension will end.

However, should the examination find that the Respondent is not competent to return to practice, the Suspension shall continue under such terms and conditions that the OPMC Director will specify.

The Department's attorney had asked for a revocation of the Respondent's license to practice medicine. The Hearing Committee disagreed and found that the proven factual allegations for all the patients did not add up to such a harsh penalty. A judgement of revocation in the estimation of the panel, would be excessive. The Hearing Committee were not at all pleased with what the evidence presented about the Respondent established and determined, unanimously, after much discussion, that a Suspension would be an appropriate penalty.

The Panel noted that there were far too many allegations presented without a coherent discussion of the evidence. Also, it was felt that many of the allegations demonstrated a stunning lack of basic, accepted medical knowledge. The Panel determined, unanimously, after much discussion, that a Suspension would be an appropriate penalty.

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 the license of the Respondent to practice medicine should be **SUSPENDED** for a period of at least six months. At the completion of this Suspension, the Respondent is directed to undergo a competency examination pursuant to PHL § 230(7)(c). Should the examination find the

Respondent competent to return to practice, the Suspension will end.

However, should the examination find that the Respondent is not competent to return to practice, the Suspension shall continue under such terms and conditions that the OPMC Director will specify.

ORDER

IT IS HEREBY ORDERED THAT:

1. The second, fourth, fifth, and sixth Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED;**

2. All the other 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 **SUSPENDED** for a period of at least six months. At the completion of this Suspension, the Respondent is directed to undergo a competency examination pursuant to PHL § 230(7)(c). Should the examination find the Respondent competent to return to practice, the Suspension will end.

However, should the examination find that the Respondent is not competent to return to practice, the Suspension shall continue, indefinitely, under such terms and conditions that the OPMC Director will specify.

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: Larchmont, New York

March 18, 2016

[redacted]

William M. Bisordi, M.D. CHAIR

Iffath Abbasi Hoskins, M.D.,

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

TO:

Percy Aspi Erachshaw, M.D.
418 Stanhope Street
Brooklyn, NY 11237

Anthony Z. Scher, Esq.
Attorney for Respondent
800 Westchester Avenue - Suite N-641
Rye Brook, New York 10573

Claudia Morales Bloch, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, New York 10801

APPENDIX I

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

IN THE MATTER OF PERCY ASPI ERACHSHAW, D.O.	NOTICE OF HEARING

TO: PERCY ASPI ERACHSGAW, D.O.
418 Stanhope Street
Brooklyn, NY 11237

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 September 9 and 10, 2014, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street,4th floor, N.Y., N.Y. 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

EXHIBIT
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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 [redacted]

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, Riverview Center,150 Broadway - Suite 510, Albany, NY 12204-2719, ATTENTION: HON. JAMES HORAN, 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.

DATE 3/6/14
New York, New York

[redacted]
ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be directed to:
Claudia Bloch, Associate Counsel
Dianne Abeloff, Associate Counsel
Bureau of Professional Medical Conduct

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

IN THE MATTER

OF

PERCY ASPI ERACHSHAW, D.O.

STATEMENT

OF

CHARGES

PERCY ASPI ERACHSHAW, D.O., the Respondent, was authorized to practice medicine in New York State on or about August 20, 2001, by the issuance of license number 222537 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A, (the identity of all patients herein charged is set forth in Appendix "A") at his office(s), located at 145 St. Nicholas Avenue, Brooklyn, NY and 418 Stanhope Street, Brooklyn, NY (hereinafter referred to as "his offices") and the Queens Surgi Center, from on or about September 14, 2012 through on or about September 17, 2013. Patient A's chief complaints were chronic constipation; pain and rectal bleeding. Respondent's first encounter with Patient A was on September 14, 2012, when he performed an anal manometry on her. On or about September 17, 2013, Respondent performed a colonoscopy on Patient A at the Queens Surgi Center. During the course of the procedure, Respondent perforated the colon at the recto-sigmoid juncture and insufflated the colon, abdomen and chest, causing extensive subcutaneous emphysema. EMS was called and Patient A was transferred to Jamaica Hospital where she underwent an exploratory laparoscopy to treat a one and a half centimeter perforation at the recto-sigmoid juncture; bilateral pneumothoraces, pneumoperitoneum and pneumomediastinum; and a deserosalized right colon.

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

1. Failed to meet with and examine Patient A prior to ordering and performing an anal manometry on September 14, 2012;
2. Failed to perform a colonoscopy on Patient A in a timely manner;
3. Performed anorectal dilatations on June 21, July 9 and August 30, 2013 without medical indication and justification;
4. From on or about September 14, 2012 to on or about September 17, 2013, failed to evaluate the results of tests and/or procedures, and failed to coordinate the care of Patient A based upon the tests;
5. Failed to terminate the September 17, 2013 colonoscopy when he realized that the patient's preparation was inadequate and/or he had trouble with visualization of the colon;
6. Failed to timely terminate the colonoscopy once he perforated the patient's colon at the rectosigmoid junction;
7. Failed to maintain a medical record for Patient A in accordance with accepted medical standards and which accurately reflected his care and treatment of the patient;
8. Knowingly and willfully, with intent to deceive, created a false medical record for Patient A;
9. Knowingly and willfully, with intent to deceive, gave incomplete and/or misleading information to the Emergency Medical Techs and to the physician(s) in the Jamaica Hospital Emergency Department, to wit: in reporting that Patient A's condition related to intubation by the anesthesiologist and by failing to report a possible colon perforation.

B. Respondent undertook the care and treatment of Patient B both at his office(s) and at Wyckoff Heights Medical Center, 374 Stockholm St., Brooklyn, NY (hereinafter referred to as "Wyckoff") from on or about May 8, 2009 through on or about November 7, 2010. On or about June 23, 2009, Respondent performed a primary repair of umbilical hernia on Patient B under general anesthesia. On or

about December 22, 2009, Respondent performed a second surgery under general anesthesia, to wit a "Repair of Recurrent Umbilical Hernia with Mesh." On or about November 2, 2010, Respondent performed a Minilaparotomy with removal of mesh and primary repair of recurrent umbilical hernia, under general anesthesia. On or about November 5, 2010, Patient B was brought to Wyckoff, via ambulance, in grave condition. Approximately 13 hours later, Patient B was brought to the operating room where another surgeon perform an exploratory laparotomy, subtotal colectomy, multiple small bowel resections, primary small bowel anastomosis and end-ileostomy. Patient B expired on November 7, 2010. Respondent's care and treatment of Patient B deviated from accepted standards of care in that:

1. Throughout his care and treatment of the patient, Respondent failed to:
   a. Obtain and/or note an adequate, complete and accurate medical history and/or history of current complaint(s) and/or condition(s) from Patient B;
   b. Perform and/or note an adequate, complete and appropriate physical examination of Patient B;
   c. Obtain and/or note a medication history for the patient and to consider and note current medications;
   d. Note medications prescribed by him;
   e. During each of Patient B's four (4) admissions to Wyckoff, failed to see and/or examine the patient while in the hospital and/or appropriately follow the patient in the hospital postoperatively;
   f. Inappropriately and without accepted medical indication and justification prescribed and/or maintained Patient B on various medications, to wit:
      i. Lasix
      ii. Darvocet
      iii. Xanax
      iv. Tylenol #3, which was, additionally, contraindicated;
2. Regarding the primary repair of umbilical hernia performed on June 23, 2009, Respondent:

a. Failed to order and/or obtain complete and appropriate pre-operative testing and/or imaging studies on Patient B;

b. Failed to formulate an appropriate treatment plan for Patient B;

c. Inappropriately elected to perform the umbilical hernia repair which was contraindicated;

d. Inappropriately elected to perform the surgery under general anesthesia which was contraindicated;

3. Subsequent to June 23, 2009, Patient B presented at Respondent's offices with an abdominal wall cellulitis, umbilical abscess, suture granuloma and recurrent hernia. Respondent failed to adequately and appropriately follow the patient postoperatively and to treat these conditions in that, Respondent:

a. Failed to appropriately treat Patient B with antibiotics;

b. Failed to timely and appropriately remove the suture granuloma;

c. Failed to adequately and appropriately care for Patient B's continuing infection and open wound;

d. Inappropriately, and without medical indication and justification, performed work-up and preparation for varicose vein surgery on Patient B;

4. Regarding December 22, 2009 "Repair of Recurrent Umbilical Hernia with Mesh," Respondent:

a. Failed to perform and/or obtain a complete and appropriate pre-operative work up;

b. Failed to have and/or consider an appropriate treatment plan prior to performing surgery;

c. Failed to appropriately treat the patient with antibiotics;

d. Inappropriately elected to perform the surgery on Patient B in that the surgery was contraindicated;

e. Inappropriately proceeded with surgery despite the fact that Patient B was febrile pre-operatively;

f. Failed to appropriately treat the patient's wound infection before performing surgery;

g. Post-operatively, on December 22, 2009 and continuing through December 23, 2009, Patient B developed a fever, increasing to 102.8. Respondent:

i. Inappropriately treated Patient B with Tylenol which was contraindicated;

ii. Failed to appropriately and adequately treat the patient's infection;

iii. Inappropriately discharged the patient on December 23, 2009;

5. From on or about December 23, 2009 through on or about November 1, 2010, Patient B continued to present to Respondent's offices with an infected, open umbilical wound which was actively draining purulent discharge. Further, Patient B appeared jaundice and suffered, inter alia, with pancreatitis and worsening liver failure. Respondent:

a. Failed to appropriately evaluate the patient;

b. Failed to treat and/or appropriately treat the patient's active infection, including, failing to provide appropriate antibiotic treatment;

c. Failed to hospitalize the patient to appropriately treat the infection;

d. Failed to timely remove the Kugel Mesh;

6. Regarding the November 2, 2010 Minilaparotomy with removal of mesh and primary repair of recurrent umbilical hernia, Patient B was febrile before the surgery and remained febrile post-operatively. Pre-operative and post-operative laboratory results reported significant abnormalities. Respondent:

a. Failed to medically optimize the patient pre-operatively;

b. Failed to adequately and appropriately treat the patient's infection and fever post-operatively;

c. Inappropriately ordered Tylenol, which was contraindicated, in response to the patient's fever;

d. Inappropriately discharged the patient on November 3, 2010;

7. Respondent failed to follow the patient in his offices after discharging the patient on November 3, 2010;

8. On or about November 4, 2010, Respondent inappropriately, without medical indication and justification, and without seeing the patient, prescribed Ambien

to the patient and instructed the patient to take Darvocet which had previously been prescribed;

9. Regarding Patient B's last admission to Wyckoff of November 5, 2010, where the patient was admitted to Respondent's care, at on or about 5:20am, Respondent:
   a. Failed to see the patient and to examine the patient, even though Respondent was present and available;
   b. Failed to timely operate on the patient and/or to direct prompt surgical preparation of the patient;
   c. At or about 11:06pm on November 5, 2010, knowingly and willfully, with intent to deceive, instructed the surgical resident under his control, and to whom Respondent had been giving orders, to change Respondent's name as the admitting physician on the hospital medical record, to the name of the other surgeon who performed the aforementioned surgery, as set forth in paragraph 8, supra;
   d. Additionally, knowingly and willfully, with intent to deceive, further instructed the same resident to alter the hospital medical record by changing and/or attempting to change any and all orders made by Respondent to the name of the other surgeon who performed the aforementioned surgery, and by instructing the resident to include a note in the medical record that Patient B had "erroneously" been admitted to Respondent's service;
   e. Subsequent to the patient's death, and on or about November 9, 2010, knowingly and willfully, and with intent to deceive, instructed the surgical resident who assisted on the aforementioned surgery, to dictate a second operative report;
10. Throughout his care and treatment of the patient, Respondent knowingly and willfully created an office record and hospital medical record for Patient B which did not accurately reflect the care and treatment rendered to the patient;

11. Failed to maintain a medical record for Patient B in accordance with accepted medical standards and which accurately reflected his care and treatment of the patient.

C. Respondent undertook the care and treatment of Patient C, both at his office(s) and Wyckoff from on or about September 2, 2010 through on or about April 12, 2012. During this period of time, Patient C was hospitalized on numerous occasions and on January 11, 2011, Respondent performed an exploratory laparotomy with sigmoid resection and appendectomy. Thereafter, Respondent admitted Patient C to Wyckoff for a planned colon resection for "recurrent diverticulitis" on December 27, 2011. However, on December 27, 2011, Respondent performed an exploratory laparotomy, lysis of adhesions and sigmoidoscopy and did not resect the colon. Respondent's care and treatment of Patient C deviated from accepted standards of care in that:

1. From the initial visit of September 2, 2010 and all office visits thereafter, through and including April 12, 2012, Respondent:
   a. Failed to obtain /or note and an adequate, complete and directed medical history and/or history of current complaint(s) and/or condition(s) from Patient C;
   b. Failed to perform and/or note a complete, appropriate and directed physical examination of Patient C;
   c. Failed to order appropriate diagnostic studies, including small bowel series;
   d. Failed to formulate an appropriate treatment plan for Patient C;
2. Respondent admitted Patient C to Wyckoff on December 30, 2010 through January 16, 2011, and, during this time, performed the laparotomy, appendectomy and sigmoidoscopy. In this hospitalization and in performing the January 11, 2011 surgery, Respondent:
   a. Failed to see and/or examine the patient in the hospital and/or appropriately follow the patient in the hospital both preoperatively and postoperatively;

b. Prior to electing to perform the January 11, 2011 surgery, failed to consider and/or appropriately evaluate, and/or knowingly and willfully ignored Patient C's condition and/or hospital course;

c. Performed the January 11, 2011 surgery without appropriate medical and/or surgical indication and justification;

d. Misinformed Patient C regarding the need for the surgery;

e. Knowingly and willfully, with intent to deceive, caused a surgical resident to add an addendum to a January 5, 2011 progress note to falsely state: "[Patient] has had 2 episodes of diverticulitis in this hospital admission. [Patient] cannot tolerate PO diet. – Plan for OR Tuesday for Ex Lap, Bowel Resection;"

f. On the January 11, 2011 operative report, knowingly and willfully, with intent to deceive, created and/or caused the assistant surgical resident to create an inaccurate and false Procedural Indications note for the surgery;

3. Regarding the surgery performed by Respondent on December 27, 2011, Respondent:

a. Inappropriately and without legitimate indication and justification, planned to perform a colon resection;

b. Failed to order, pre-operatively, any diagnostic studies, including a small bowel series, repeat abdominal CT scan and/or a repeat colonoscopy;

c. As part of the December 27, 2011 surgery, performed a sigmoidoscopy and inserted a JP drain, both of which were done without appropriate indication and justification;

d. Knowingly and willfully created and/or instructed the assisting surgical resident to dictate an operative report and post-operative note, on or about December 27, 2011, which contains false information, to wit that:

i. During the course of the surgery, Respondent caused a "small" serosal tear, when, in fact, it was a large serosal tear;

ii. Respondent performed "extensive lysis of adhesions, ([greater than] 2 hours)," when in fact the adhesions were not extensive and Respondent took far less time in tending to them;

iii. The surgery was abruptly stopped to minimize morbidity and mortality when, in fact, the surgery was stopped when Respondent caused the bowel to become ischemic;

iv. Respondent had "run" the bowel through to the rectosigmoid colon, when, in fact, he had not;

4. Failed to maintain a medical record for Patient C in accordance with accepted medical standards and which accurately reflected his care and treatment of the patient.

D. Respondent undertook the care and treatment of Patient D, both at his office(s) and Wyckoff from on or about April 6, 2005 through on or about April 17, 2007.On May 20, 2005, Respondent performed a laparoscopic cholecystectomy on Patient D. Within 24 hours after surgery, Patient D had a markedly sharp elevation in total bilirubin and hepatocellular enzymes, all of which were normal pre-operatively. An ERCP with stenting was performed under general anesthesia. Respondent discharged Patient D on May 24, 2005, despite the fact that the bilirubin and hepatocellular enzymes were still elevated. Patient D was next seen by Respondent at his offices on or about June 1, 2005, jaundice. An abdominal ultrasound of June 3, 2005 showed dilatation of the intrahepatic ducts and the patient was re-admitted to Wyckoff on that same day with a bilirubin of 16. MRCP performed on admission confirmed obstruction of the biliary system at the confluence of the left and right hepatic ducts. Respondent's care and treatment of Patient D deviated from accepted standards of care in that, Respondent:

1. In performing the laparoscopic cholecystectomy:

a. Failed to properly identify the ducts prior to division;

b. Fail to implement appropriate and acceptable surgical techniques and/or available means to properly identify the anatomy prior to division, to wit:

i. Failed to perform a cholangiogram;

ii. Failed to convert to an open laparotomy;

c. Caused injury to the common hepatic ducts and failed to recognize the injury.

2. Failed to appropriately manage the patient post operatively and prior to discharge in that, Respondent:

a. Failed to appropriately address the patient's elevated bilirubin;

b. Failed to confirm the integrity of the bile ducts;

c. Failed to provide drainage of the bile ducts;

d. Failed to timely recognize the injury he caused to the common hepatic ducts;

e. Inappropriately discharged the patient on May 24, 2005;

3. Inappropriately caused an unnecessary, inappropriate and surgically unacceptable delay in reconstruction of the biliary anatomy;

4. Failed to maintain a medical record for Patient D in accordance with accepted medical standards and which accurately reflected his care and treatment of the patient.

E. On or about March 16, 2009, Patient E, a patient with a long history of epigastric and right upper quadrant pain, went to LaMarca Family Health Clinic ("LaMarca", an offsite clinic of Wyckoff), with complaints of severe abdominal pain and nausea. The patient had a cholecystectomy sometime prior to 1999. The doctor affiliated with the LaMarca referred Patient E to Respondent for evaluation. Respondent undertook the care and treatment of Patient E from that first visit, on or about March 19, 2009 through on or about April 28, 2009. Respondent diagnosed the patient's right upper quadrant pain as due to cholecystitis and scheduled the patient for a laparoscopic cholecystectomy on April 14, 2009 at Wyckoff. During the course of the April 14th procedure, Respondent injured Patient E's liver causing a bile leak. Respondent's care and treatment of Patient E deviated from the standard of care in that, Respondent:

1. Failed to obtain and/or note and an adequate, complete and thorough history from the patient;

2. Failed to perform and/or note a complete, appropriate and directed physical examination of the patient;
3. Planned to perform a laparoscopic cholecystectomy on Patient E without medical indication and justification;
4. Performed the April 14th surgery on the basis of an inconclusive imaging study;
5. Failed to terminate the April 14th procedure when he could not locate the gall bladder;
6. Inappropriately converted the laparoscopy to an open laparotomy and did so without medical indication and justification;
7. ~~Failed to appropriately identify the cystic duct and cystic artery;~~ withdrawn DSL 10/30/14
8. Failed to timely recognize and to timely treat the injury he caused to Patient E's liver;
9. Failed to maintain a medical record for Patient E in accordance with accepted medical standards and which accurately reflected his care and treatment of the patient.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with as alleged in the facts of paragraphs:

1. A, A.1 – A.9;
2. B., B.1 through B.11 and all subparagraphs;
3. C, C.1 through C.4 and all subparagraphs;
4. D, D.1 through D.4 and all subparagraphs;

5. E., E.1 – E.9.

SIXTH THROUGH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of the following paragraphs:

6. A – E and all 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 paragraphs:

7. A – E and all subparagraphs.

EIGHTH THROUGH TENTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following paragraphs:

8. A, A.8, A.9;

9. B, B.9.c, B.9.d. B.9.e, B.10;

10. C, C.2.e, C.2.f, C.3.a, C.3.d, C.3.d.i – C.3.d.iv.

ELEVENTH THROUGH THIRTEENTH SPECIFICATION

MORAL UNFITNESS

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

11. A, A.3, A.8, A.9,

12. B, B.3.d, B.9.a, B.9.c, B.9.d. B.9.e, B.10;

13. C, C.2.b - C.2.f, C.3.a, C.3.d, C.3.d.i – C.3.d.iv.

FOURTEENTH THROUGH EIGHTEENTH 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 evaluation and treatment of the patient, as alleged in the facts of paragraphs:

14. A.8, A.9;

15. B.1.a - B.1.d, B.2.a, B.4.a, B.9.a, B.9.c, B.9.d. B.9.e, B.10, B.11;

16. C.1.a, C.1.b, C.2.e, C.2.f, C.3.d, C.3.d.i – C.3.d.iv, C4;

17. D.4;

18. E.1, E.2, E.9.

DATE: August 6, 2014
New York, New York

[redacted]

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct