



Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

C. Maynard Guest, M.D.
Executive Secretary

July 13, 1993

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Livia Helmer, M.D.
Apartment 5B
215 West 98th Street
New York, New York 10025

RE: License No. 144999

Dear Dr. Helmer:

Enclosed please find Order #BPMC 93-102 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

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

-----X

IN THE MATTER :
OF : ORDER
LIVIA HELMER, M.D. : BPMC # 93-102

-----X

Upon the application of LIVIA HELMER, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is ORDERED, that the application 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 Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 8 July 1993

Charles J. Vacanti
Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

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

-----X
IN THE MATTER : APPLICATION
OF : FOR
LIVIA HELMER, M.D. : CONSENT
: ORDER
-----X

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

LIVIA HELMER, M.D., being duly sworn, deposes and says:
That on or about January 23, 1981, I was licensed to
practice as a physician in the State of New York, having been
issued License No. 144999 by the New York State Education
Department.

I am currently registered with the New York State
Education Department to practice as a physician in the State of
New York for the period January 1, 1993 through December 31,
1994.

I understand that the New York State Board for
Professional Medical Conduct has charged me with eleven
Specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made
a part hereof, and marked as Exhibit "A".

I cannot successfully defend against the Fifth
Specification, including the facts in only Paragraphs A, A1,

A4, B, B1, and B4, in full satisfaction of the charges against me.

I hereby agree to the penalty of two years suspension, the last eighteen months of which is to be stayed with probation, subject to the terms attached as Exhibit "B".

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

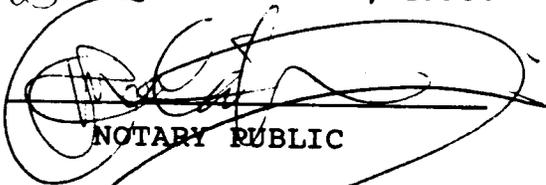
I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.



LIVIA HELMER, M.D.
RESPONDENT

Sworn to before me this
25th day of June , 1993.



NOTARY PUBLIC

MINDERPAL GULATI, JR.
COMMISSIONER OF DEEDS
City of New York - No. 1-3370
Certification Filed in New York County
Commission Expires: Nov. 1, 1994

NY, NY

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

-----X
IN THE MATTER : APPLICATION
OF : FOR
LIVIA HELMER, M.D. : CONSENT
: ORDER
-----X

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

Date:

6/25/93

Livia Helmer M.D.

LIVIA HELMER, M.D.
RESPONDENT

Date:

6/23/93

Walter Marcus

WALTER MARCUS
ATTORNEY FOR RESPONDENT

Date:

60-30-93

Paul Stein

PAUL STEIN
ASSOCIATE COUNSEL
BUREAU OF PROFESSIONAL
MEDICAL CONDUCT

Date:

July 13, 1993

Kathleen M. Tanner

KATHLEEN M. TANNER
DIRECTOR
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

Date:

8 July 1993

Charles J. Vacanti

CHARLES J. VACANTI, M.D.
CHAIRPERSON
STATE BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

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

-----X

IN THE MATTER : STATEMENT
OF : of
LIVIA HELMER, M.D. : CHARGES

-----X

LIVIA HELMER, M.D., the Respondent, was authorized to practice medicine in New York State on January 23, 1981 by the issuance of license number 144999 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994.

FACTUAL ALLEGATIONS

- A. On or about June 22, 1992, Respondent administered general anesthesia, with the use of an endotracheal tube, to Patient A (Patient A and all other patients are identified in the attached appendix), a 62 year old male, for elective surgery to transfer the left flexor digitorum longus tendon, for correction of left posterior tibial tendon insufficiency, at St. Lukes/Roosevelt Hospital Center, The Roosevelt Hospital, 428 West 59th Street, New York, New York. Patient A died on June 22, 1992 in the

operating room, after induction of anesthesia, but before commencement of surgery.

1. Respondent failed to monitor the quantitative carbon dioxide content of expired gases of Patient A through the use of end-tidal carbon dioxide analysis (capnography).
2. Respondent failed to conduct checks prior to the administration of anesthesia to Patient A to ensure that the capnograph that was to be used on Patient A was in proper working condition, including, but not limited to, failing to check the transducer calibration.
3. Respondent failed to calibrate the capnograph transducer before attempting to use it in the monitoring of Patient A.
4. Respondent failed to call off the planned general anesthesia with endotracheal intubation for Patient A, upon learning, prior to administration of anesthesia, that the capnograph to be used on Patient A was not in proper working condition.

5. Respondent failed to monitor Patient A's heart sounds and breathing sounds through the use of a precordial or esophageal stethoscope.
6. Respondent failed to timely and appropriately monitor Patient A's intubation and ventilation.
7. Respondent failed to timely and appropriately detect an esophageal intubation, timely change the endotracheal tube, and timely reintubate Patient A.
8. Before obtaining Patient A's consent for anesthesia, Respondent failed to inform Patient A that general anesthesia with an endotracheal tube would be administered to him without capnographic monitoring, and Respondent failed to inform Patient A of the risks involved in administering general anesthesia with an endotracheal tube without capnographic monitoring. At no time did Respondent provide this information to Patient A.
9. Respondent failed to keep an adequate anesthesia record for Patient A, including, but not limited to, failing to appropriately document the nonfunctional capnograph, the size and type of endotracheal tube used, and the readings of the oxygen analyzer.

10. Respondent, intentionally and with an intent to mislead, recorded an end-tidal carbon dioxide reading of "40" on Patient A's chart, although she knew that the capnograph was not properly functioning and could not give a valid end-tidal carbon dioxide reading.

B. On or about June 22, 1992, Respondent administered general anesthesia, with the use of an endotracheal tube, to Patient B, a 36 year old female, during an elective left subtalar arthrodesis with iliac crest bone graft, for tarsal coalition, at St. Lukes/Roosevelt Hospital Center, The Roosevelt Hospital, 428 West 59th Street, New York, New York. The surgery was uneventful.

1. Respondent failed to monitor the quantitative carbon dioxide content of expired gases of Patient B through the use of end-tidal carbon dioxide analysis (capnography).

2. Respondent failed to conduct checks prior to the administration of anesthesia to Patient B to ensure that the capnograph that was to be used on Patient B was in proper working condition, including, but not limited to, failing to check the transducer calibration.

3. Respondent failed to calibrate the capnograph transducer before attempting to use it in the monitoring of Patient B.
4. Respondent failed to call off the planned general anesthesia with endotracheal intubation for Patient B, upon learning prior to administration of anesthesia, that the capnograph to be used on Patient B was not in proper working condition.
5. Before obtaining Patient B's consent for anesthesia, Respondent failed to inform Patient B that general anesthesia with an endotracheal tube would be administered to her without capnographic monitoring, and Respondent failed to inform Patient B of the risks involved in administering general anesthesia with an endotracheal tube without capnographic monitoring. At no time did Respondent provide this information to Patient B.
6. Respondent failed to keep an adequate anesthesia record for Patient B, including, but not limited to, failing to appropriately document the nonfunctional capnograph and the readings of the oxygen analyzer.

SPECIFICATION OF CHARGES

FIRST THROUGH SECOND SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law section 6530(4) (McKinney Supp. 1993), in that Petitioner charges:

1. The facts in Paragraphs A and A1-9.
2. The facts in Paragraphs B and B1-6.

THIRD THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1993), in that Petitioner charges:

3. The facts in Paragraphs A and A1-9.
4. The facts in Paragraphs B and B1-6.

FIFTH SPECIFICATION
PRACTICING WITH NEGLIGENCE ON
MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed at least two of the following:

5. The facts in Paragraphs A and A1-9; and/or B and B1-6.

SIXTH SPECIFICATION
PRACTICING WITH INCOMPETENCE ON
MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that Petitioner charges that Respondent committed at least two of the following:

6. The facts in Paragraphs A and A1-9; and/or B and B1-6.

SEVENTH SPECIFICATION

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law section 6530(2) (McKinney Supp. 1993), in that Petitioner charges:

7. The facts in Paragraph A and A-10.

EIGHTH THROUGH NINTH SPECIFICATIONS

PERFORMING PROFESSIONAL SERVICES NOT DULY AUTHORIZED

Respondent is charged with performing professional services which have not been duly authorized by the patient or his or her legal representative under N.Y. Euc. Law 6530(26) (McKinney Supp. 1993), in that Petitioner charges:

8. The facts in Paragraphs A and A-8.
9. The facts in Paragraphs B and B-5.

TENTH THROUGH ELEVENTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993), in that she failed to maintain a record for each patient which

accurately reflects the evaluation and treatment of the patient. Petitioner specifically charges:

10. The facts in Paragraphs A and A-9.
11. The facts in Paragraphs B and B-6.

DATED: New York, New York

May 6, 1993



CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

EXHIBIT "B"

TERMS OF PROBATION

1. Livia Helmer, M.D., Respondent, during the period of probation, shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by her profession;
2. That Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Corning Tower Building, 4th Floor, Empire State Plaza Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, of any change in Respondent's employment, practice, residence, or telephone number within or without the State of New York;
3. 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;
4. Respondent shall submit written proof to the NYSDOH, 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 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 or 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;
5. Before commencing practice under the terms of this Probation Agreement, Respondent shall, at her own expense, submit to an evaluation of her current clinical competence in anesthesiology by a board-certified anesthesiologist who is a member of the State Board for Professional Medical Conduct, to be selected by the Director of the Office of Professional Medical Conduct (the "Director"). This

board-certified anesthesiologist (the "Evaluator") shall report the deficiencies, if any, in Respondent's current clinical competence, to the Director. The Evaluator shall also recommend a course of remediation for any such deficiencies found. Respondent shall pursue such recommended course of remediation during the period of probation until such time as the Evaluator determines the deficiencies to be remedied. Any deficiency that the Evaluator deems to present a risk to Respondent's patients must be remedied before Respondent commences practice under the terms of this Probation Agreement;

6. During the period of probation, Respondent shall practice only in a general hospital as that term is defined in Section 2801 of the Public Health Law;
7. Respondent shall cooperate in the quarterly monitoring of her practice through random record review and consultation by a board-certified anesthesiologist selected by the Respondent and approved by the Director of the Office of Professional Medical Conduct. Respondent shall make available for review by this practice monitor or the Office of Professional Medical Conduct complete copies of any and all medical and hospital records requested by the Office of Professional Medical Conduct. Any deviation from accepted medical practice identified during any of the reviews will be discussed with the Respondent. Any pattern of substandard care identified during the probation period may result in an independent medical review and could lead to additional investigation or charges. Respondent shall maintain legible and complete medical records which accurately reflect evaluation and treatment of patients;
8. Respondent shall comply with all terms, conditions, restrictions, and penalties to which she is subject pursuant to the order of the Board;
9. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.