



STATE OF NEW YORK DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 6, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Stanley Tyson West, M.D.
1015 Madison Avenue, Suite 302
New York, New York 10021

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza - 6th Floor
New York, New York 10001

Robert S. Deutsch, Esq.
Aaronson Rappaport Feinstein
& Deutsch, LLP
757 Third Avenue
New York, New York 10017

RE: In the Matter of Stanley Tyson West, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-304) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

A handwritten signature in black ink, appearing to read "Tyrone T. Butler". The signature is written in a cursive style with a large initial 'T'.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah

Enclosure

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

COPY

In the Matter of

Stanley Tyson West, M.D. (Respondent)

Administrative Review Board (ARB)

Determination and Order No. 02-304

**A proceeding to review a Determination by a
Committee (Committee) from the Board for
Professional Medical Conduct (BPMC)**

**Before ARB Members Lynch, Pellman, Price and Briber¹
Administrative Law Judge James F. Horan drafted the Determination**

**For the Department of Health (Petitioner):
For the Respondent:**

**Dianne Abeloff, Esq.
Robert Deutsch, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent committed professional misconduct in treating four patients and in answering falsely on a hospital application. The Committee voted to suspend the Respondent's License to practice medicine in New York (License) for one year, to stay the suspension and to put the Respondent on probation for one year. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2003), the Petitioner asks the ARB to modify that Determination by sustaining additional charges, placing the Respondent on actual suspension and extending and modifying the probation terms. After considering the hearing record and the parties' review submissions, the ARB overturns the Committee and sustains additional charges that the Respondent practiced with fraud and with gross negligence. We also overturn the Committee on penalty. We suspend the Respondent's License for three years and stay the suspension for all but three months. We place the Respondent on probation for three years, with the added requirement that the Respondent receive pre-approval for all surgery.

¹ ARB Member Stanley Grossman, M.D. recused himself from participation in this case. The ARB proceeded to consider the case with a four member quorum, see Matter of Wolkoff v. Chassin, 89 N.Y.2d 250(1996).

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-6), 6530(21) & 6530(35) (McKinney Supp. 2003) by committing professional misconduct under the following specifications:

- practicing fraudulently,
- practicing with negligence on more than one occasion,
- practicing with gross negligence,
- practicing with incompetence on more than one occasion,
- practicing with gross incompetence,
- willfully filing a false report, and,
- ordering excessive tests or treatments unwarranted by a patient's condition.

The charges related to the gynecological procedures, myomectomies, that the Respondent performed on six patients, A-F, and to the Respondent's answers on a re-appointment application to St. Vincent's Hospital. A myomectomy involves removing tumors from the wall of the uterus. The record refers to the Patients by initials to protect patient privacy.

Following a hearing on the charges, the Committee found that the Respondent failed to exercise the care that a reasonably prudent physician would exercise in providing post-operative care to Patient A and pre-operative care to Patients C, D and F. The Committee found that the Respondent failed to perform sufficient evaluations after Patient A developed symptoms consistent with post-operative complications from pelvic surgery, such as problems with urination. A subsequent CT scan identified a bladder perforation. As to Patient C, the Committee found that the Respondent failed to treat the Patient's anemia pre-operatively and failed to perform an endometrial pre-operative sampling to rule out the possibility of endometrial carcinoma. Concerning the care for Patient D, the Committee found that the Respondent failed to perform a pre-operative endometrial sampling to evaluate ovulatory status. As to Patient F, the Committee found that the Respondent recorded an inadequate history and the Patient's records gave no indication whether the Respondent performed a pap smear on the Patient.

The Committee concluded that the care the Respondent provided to Patients A, C, D and F constituted practicing with negligence on more than one occasion. The Committee dismissed all charges involving Patients B and E and the misconduct specifications that charged gross negligence, gross incompetence, incompetence on more than one occasion and ordering unwarranted tests and/or treatments.

The Committee also found that the Respondent answered falsely on an application (Application) for Reappointment to St. Vincent's Hospital and Medical Center by denying he had ever been subject of a professional misconduct inquiry, investigation or proceeding. The Respondent gave that answer three months following an interview (Interview) with an investigator from the Office for Professional Medical Conduct (OPMC). At the Interview, the investigator questioned the Respondent about his care for seven patients and the investigator informed the Respondent that the Respondent would learn in writing about the Investigation's result. Subsequent to the Interview, OPMC requested medical records from the Respondent. The Committee determined that the Respondent made a willful misrepresentation in his answer on the Application. The Committee found that the Application answer constituted willfully filing a false report, but the Committee dismissed the charge that the answer on the Application constituted practicing fraudulently. The Committee dismissed the fraud charge upon concluding that the Petitioner failed to prove intent to deceive.

The Committee voted to suspend the Respondent's License for one year, to stay the suspension and to place the Respondent on probation for one year. The probation terms include a requirement for a practice monitor. The Committee found the Respondent a competent physician, but they also expressed concern over the Respondent's pre-operative work-ups and the selection of the Patients for major gynecological surgery. The Committee concluded that the Respondent's practice required oversight.

Review History and Issues

The Committee rendered their Determination on September 27, 2002. This proceeding commenced on October 7, 2002, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's brief and response brief. The record closed when the ARB received the response brief on November 21, 2002.

The Petitioner requested that the ARB increase the sanction against the Respondent and correct inconsistencies in the Committee's Determination. The Petitioner asks that the ARB sustain additional factual allegations concerning Patients B-E and that the ARB sustain the allegation that the Respondent's answer on the St. Vincent Application constituted fraud. The Petitioner requests further that the ARB place the Respondent on actual suspension, increase the probation to three years and require prior approval for procedures.

The Respondent argues that he Committee imposed an overly harsh penalty, even with the stay against the one-year suspension for which the Committee voted. The Respondent stated that he improved his record keeping and he argued that no patient injury resulted from a deviation from acceptable care standards.

Determination

The ARB has considered the record and the parties' briefs. We overturn the Committee and vote 3-1 to affirm the charges that the Respondent committed fraud in his answer in the St. Vincent Application and that the Respondent practiced with gross negligence in treating Patient A. We vote further to overturn the Committee and place the Respondent on actual suspension for

three months. We modify the Committee's Determination by extending the Respondent's time on probation and by modifying the probation terms.

The Committee found that the Respondent made a willful misrepresentation on the St. Vincent Application. The three-member majority infers from the Committee's Findings of Fact 83-87 that the Respondent made the willful misrepresentation with the intent to deceive. At Finding 87, the Respondent admitted to undergoing questioning, by the State, to Dr. Koulos, the acting Director of Obstetrics at St. Vincent. The majority infers from that finding that the Respondent knew he was under investigation and that the Respondent withheld that information on the Application with intent to deceive. The dissenting member, Dr. Price, sees no intent to deceive and concludes that the statement to Dr. Koulos indicated no intent by the Respondent to conceal information.

In their Determination on the treatment for Patient A, the Committee sustained Factual Allegation A3, which alleged that the Respondent failed to timely recognize a post-operative complication suggested by urinary complaints and a subcutaneous hematoma extending to the umbilicus. The Committee also made Finding of Fact 26 that stated that the Respondent failed to determine the cause for the firm mass up to the umbilicus. That Finding also held that the Respondent should have performed a further evaluation, including but not limited to, bladder function. Finding of Fact 23 held that Patient A contacted the Respondent three times postoperatively complaining about symptoms common to post-operative complications. The Respondent, however, failed to manage the complication. The ARB votes 3-1 to overturn the Committee and to sustain the charge that the Respondent's care for Patient A constituted gross negligence. The majority concludes that the failure to manage the complication constituted a

grievous deviation from accepted care standards. Dr. Price again dissents and votes to affirm the Committee's Determination to dismiss the gross negligence charge.

The ARB agrees with the Committee that the Respondent's conduct justifies a suspension from practice, but we overturn the Committee's Determination to stay the suspension in full. We vote 4-0 to suspend the Respondent for three years and to stay all but three months in the suspension. We conclude that the Respondent's intentional misrepresentation on the St. Vincent Application warrants the actual time on suspension. We limit the actual suspension to three months to assure that the period away from practice will result in no deterioration in the Respondent's surgical skills.

The ARB agrees with the Committee that the Respondent's practice requires oversight, but we feel that the oversight by probation and monitoring should last three years rather than just one. We also agree with the Committee's concerns about the Respondent's selection of patients for the major gynecological surgeries and the Respondent's pre-operative work-ups. The probation the Committee placed on the Respondent's practice required a practice monitor to observe the Respondent's practice. We modify the conditions for the monitor to require that the monitor pre-approve all surgical procedures that the Respondent performs. We amend the Committee's Probation Terms at Appendix II, page 2, paragraph 8.a to add a new sentence, at the paragraph's beginning to read:

"The Respondent must obtain pre-approval from the Monitor for all surgical procedures the Respondent performs".

The ARB affirms all other provisions in the Probation Terms.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER**:

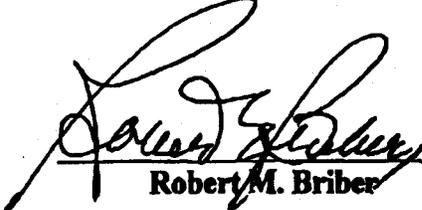
1. The ARB affirms the Committee's Determination that the Respondent practiced medicine with negligence on more than one occasion and willfully filed a false report.
2. The ARB overturns the Committee and sustains the charges that the Respondent practiced with gross negligence in treating Patient A and that the Respondent practiced fraudulently in filing the St. Vincent Application.
3. The ARB overturns the Committee's Determination to suspend the Respondent's License for one year, to stay the suspension and to place the Respondent on probation for one year, under terms that appear at Appendix II to the Committee's Determination.
4. The ARB suspends the Respondent's License for three years and stays all but the first three months of the suspension.
5. The ARB places the Respondent on probation for three years, under the terms from Appendix II of the Committee's Determination, but we modify those terms to require a practice monitor's pre-approval for surgical procedures, as our Determination provides.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Therese G. Lynch, M.D.

In the Matter of Stanley Tyson West, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. West.

Dated: February 1, 2003



Robert M. Briber

In the Matter of Stanley Tyson West, M.D.

**Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the
Matter of Dr. West.**

Dated: 2/3, 2003

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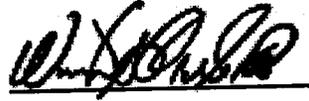
Thea Graves Pellman

In the Matter of Stanley Tyson West, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the Matter of

Dr. West.

Dated: Feb 3, 2003

A handwritten signature in black ink, appearing to read "Winston S. Price", written over a horizontal line.

Winston S. Price, M.D.

In the Matter of Stanley Tyson West, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in

the Matter of Dr. West.

Dated: February 1, 2003

Therese G. Lynch M.D.

Therese G. Lynch, M.D.