



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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 27, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence J. Sheehan, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Alan Lambert, Esq.
Lifshutz, Polland & Associates
675 Third Avenue
Suite 2400
New York, New York 10017

Roger Mason, M.D.
205 Windmill Lane
Southampton, New York 11968

RE: In the Matter of Roger Mason, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-126) 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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.

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., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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,

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:nm
Enclosure

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

COPY

**IN THE MATTER
OF
ROGER MASON, M.D.,
Respondent**

DETERMINATION

AND

ORDER

BPMC-00-126

A Notice of Hearing and a Statement of Charges, dated August 18, 1999, respectively, were served upon the Respondent, Roger Mason, M.D. **KENNETH KOWALD, M.D. (Chair), RALPH LUCARIELLO, M.D. and DANA O. MONACO, M.D.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter the Committee) in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Terrence J. Sheehan, Esq., Associate Counsel. The Respondent appeared by Lifshutz, Polland & Associates; Alan Lambert, Esq. of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges served:	August 26, 1999
Dates of Hearing:	October 21, 1999 November 4, 1999 November 12, 1999 November 18, 1999 November 19, 1999 December 17, 1999 January 21, 2000
Date of Deliberations:	February 18, 2000

STATEMENT OF CASE

The Statement of Charges alleged the Respondent violated six categories of professional misconduct, including gross negligence, negligence on more than one occasion, gross incompetence, incompetence on more than one occasion, excessive tests or treatments and failure to maintain accurate records.

A copy of the Statement of Charges is attached to this Determination and Order and made a part thereof as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the evidence presented in this matter. All Findings and Conclusions herein are the unanimous determination of the Committee. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact.

1. Roger Mason, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about April 2, 1984 by the issuance of license number 157824 by the New York State Education. (Exs. 1 & 2)

PATIENT A

2. Patient A was admitted to Central Suffolk Hospital, Riverhead, N.Y. on or about May 23, 1997. She had presented with incarceration and strangulation of a giant abdominal incisional hernia with evidence of obstruction and sepsis. (Ex. 3)

3. On or about May 23,1997, the Respondent examined Patient A preoperatively. (T. 45, 67, 490-492, 907; Ex. 3)

4. On that date, Respondent performed surgery on the patient. During surgery evidence of bowel strangulation and obstruction were found. The Respondent's

placement a long tube through the stomach and the small intestine was indicated by the patient's condition. (T. 119-120, 494-496, 911, 915-918; Ex. 3)

5. During the surgery of May 23, 1997, Respondent was unable to close the abdominal wall and used a Gore-Tex mesh material to close the abdominal wall. (T. 100, 132, 508-509, 925; Ex. 3)

6. On or about May 25, 1997, the Respondent performed a second surgery on Patient A. During that second surgery the Respondent found the sigmoid colon to be viable. If during surgery tissue appears viable, it is appropriate for a physician to leave it in situ even if this results in a subsequent surgery being necessary because the tissue left in situ becomes gangrenous. On or about May 28, 1997, the Respondent performed a third surgery on Patient A. During that third surgery the Respondent found the sigmoid colon to be gangrenous. (T. 118, 510-512, 926-929, 932; Ex. 3)

7. A physician has a duty to maintain a medical record for a patient which accurately reflect, among other things, the diagnosis and the treatment plan for the patient. The Respondent's record for Patient A did not do this. (T. 37-42, 61; Ex. 3)

PATIENT B

8. Patient B was admitted to Central Suffolk Hospital, Riverhead, N.Y. on or about October 7, 1997. He had presented with a mass protruding from the right lobe of the liver and the preoperative diagnosis was that he had cancer of the gallbladder. (T. 214; Ex. 4)

9. On or about October 8, 1997, Respondent performed a cholecystectomy with hepatic segmentectomy, prophylactic choledochojejunostomy and a prophylactic gastrojejunostomy. Upon proceeding with the operation the patient was found to have advanced cancer of the gallbladder and the surgery was palliative. Based on Patient B's presentation a prophylactic gastrojejunostomy was not indicated. (T. 983; Ex. 4)

10. A physician has a duty to maintain a medical record for a patient which accurately reflects, among other things, the patient's complaints, history, physical examination and the treatment plan. The Respondent's record for Patient B did not do this. (T. 204, 211, 215, 222; Ex. 4)

PATIENT C

11. Patient C was admitted to Central Suffolk Hospital, Riverhead, N.Y. on or about May 10, 1998. He had presented with a abdominal pain, a fever and persistent diarrhea. A CT scan of this patient indicated a perforated bowel. (T. 214; Ex. 5)

12. On or about May 10, 1998, based on the CT scan, the Respondent performed an exploratory laparoscopy. Based on his assessment of the appearance of the bowel during surgery, the Respondent suspected inflammatory bowel disease with toxic megacolon and therefore the Respondent justifiably performed a total abdominal colectomy. The obtaining of a frozen section during surgery was not medically necessary and would not have assisted in the intra-operative diagnosis of this patient. (T. 294, 1043-1053; Ex. 5)

13. A physician has a duty to maintain a medical record for a patient which accurately reflects, among other things, the diagnosis, operative reports and treatment plan. The Respondent's record for Patient C did this. (T. 283-284, 1056-1057; Ex. 5)

PATIENT D

14. Patient D was admitted to Southampton Hospital, Southampton, N.Y. on or about April 30, 1997. She had presented with right lower quadrant pain, recurrent abdominal pain over the last seven years and she had a diagnostic laparoscopy approximately eight months prior to admission. (Ex. 6)

15. Respondent did not make a diagnosis of apendicitis. (T. 328-329, 716, 1085; Ex. 6)

16. The Respondent did not order a pre-operative barium enema. Given the patient's symptoms a pre-operative barium enema would not have contributed relevant information for the patient's course of care and it was appropriate not to order that test pre-operatively. (T. 343, 1087-1089)

17. A pre-operative gynecological consult was equivocal in its suggestions as to the etiology of the patient's lower quadrant pain and therefore it was not improper for the Respondent to proceed with the diagnostic laparoscopy. (T. 1082; Ex.6)

18. A physician has a duty to maintain a medical record for a patient which accurately reflects, among other things, the diagnosis, operative reports and treatment plan. The Respondent's record for Patient D did this. (T. 353-355, 1090-1093; Ex. 6)

PATIENT F

22. Patient F was admitted to Central Suffolk Hospital, Riverhead, N.Y. on or about May 19, 1997 and remained in the hospital until about June 19, 1997, for the treatment of cancer. (Ex. 8)

23. Pre-operative radiation therapy was not appropriate for this patient because there was no indication that the patient's tumor was fixed. A physician need not document every thought and consideration relating to the management of his patient's care. (T. 420, 437, 1113; Ex. 8)

24. On or about June 6, 1997, Patient F underwent a low anterior resection using a GIA stapler. During this procedure the patient's ureter was transected and entrapped in the stapled anastomosis. Such an injury is a recognized risk of this type of surgery. (T. 424, 1119-1120; Ex. 8)

PATIENT G

25. Patient G was admitted to Central Suffolk Hospital, Riverhead, N.Y. on or about September 11, 1997. On or about September 12, 1997, the Respondent attempted to perform a laparoscopic cholecystectomy. This procedure was indicated. (T. 450-451,458, 1143-1146, 1178-1179; Ex. 9)

26. During the procedure which was converted to an open surgery, the Respondent placed a drain in the peritoneal cavity. This was indicated. (T. 462-463, 465-466, 1181-1182; Ex. 9)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A.7: (7) that part of the charge relating to the diagnosis and treatment plan;

Paragraph B.1.: (9) with the exception of that part of the charge relating to the performance of a cholecystectomy with hepatic segmentectomy and a Roux-en-Y choledochojejunostomy;

Paragraph B.2: (10) that part of the charge relating to the patient's complaints history, physical examination and treatment plan.

It should be noted that the Petitioner withdrew Paragraph A.2. and Paragraphs E. 1 through E.4. from the Statement of Charges.

The Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE

The Second Specification: (Paragraphs B. and B.1.);

FAILURE TO MAINTAIN RECORDS

The Nineteenth and Twentieth Specifications: (Paragraphs A. and A.7. and B. and B.2.).

The Committee voted to **not sustain** the first, third through eighteenth and twenty-first through twenty-third specifications.

DISCUSSION

Respondent was charged with violating six subdivisions of professional misconduct within the meaning of 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. During the course of its deliberations on these charges, the Committee consulted a memorandum from the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definition was utilized by the Committee during its deliberations:

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Using the above-referenced definition as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the specification of professional misconduct relating to gross negligence should be sustained. The rationale for the Committee's conclusions is set forth below.

The Petitioner presented Lee A. Pomeranz, M.D., as its sole expert witness. Dr. Pomeranz is a board certified general surgeon. There was no evidence of any bias on the part of Dr. Pomeranz or his unsuitability as an expert witness. The Respondent presented James C. Rosser, M.D. who is a board certified general surgeon as his expert witnesses. There was no evidence of any bias on the part of Dr. Rosser or his unsuitability as an expert witness.

The Committee found the testimony of Dr. Pomeranz to warrant a low level of credibility. At times during his testimony when questioned by the Committee members in detail regarding his opinion it became evident that he had not thoroughly read and reviewed the records upon which he based his opinion. He was found to be unprepared. For the most part his testimony was found to be unpersuasive. Furthermore, on some points the testimony of the Petitioner's expert did not support the charges. However, with respect to the allegation regarding the prophylactic gastrojejunostomy performed on Patient B, the medical record did not support the performance of this procedure and the Committee concurred with the Petitioner's expert. The Committee also found the Respondents medical record keeping to be lacking in various aspects relating to Patients A and B.

The Committee found the Respondent's expert to be knowledgeable in the area upon which he was called to testify and quite credible. They found his testimony to be persuasive.

The Committee concluded that with respect to Patients A and B, namely paragraphs A.7. and B.2. the charges were proven in part by the Petitioner. Those paragraphs related to the records surrounding the treatment of these two patients. The Committee's finding was based on the Petitioner's expert's testimony and a review of the records in evidence.

With respect to the prophylactic gastrojejunostomy performed on Patient B, the Committee found no evidence in the medical record which would warrant this additional surgery.

The Committee found that the remaining charges relating to Patients A through D, F and G were not supported by the evidence presented. Often the Petitioner's charges related to actions taken by the Respondent in the course of surgery which were judgement calls made by the Respondent and were not per se violative of the acceptable standard of care. Additionally as noted above in a number of instances the Petitioner's expert opined that the conduct in question did not represent a breach of standards.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be **suspended** for a period of 3 years with the entire period of said suspension stayed.

Additionally his license shall be on probation for a period of 3 years. The terms of the probation are more specifically set forth in Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee unanimously agreed that the Respondent's license should not be revoked. The record in this case established Respondent had a good knowledge of the surgery he was performing, however in one case there was a question of whether or not the surgery should have been performed and at what stage in the surgery the procedure should have been terminated. The Committee felt that the actions of the Respondent warranted a suspension of his license during which time the chief of the surgical service where he is working would have to give prior approval to all surgeries and his conduct should be subsequently reviewed.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

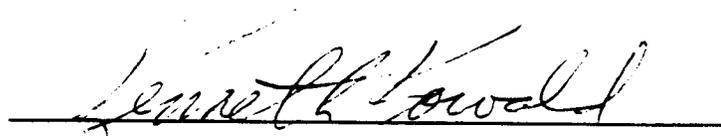
1. The Second, Nineteenth and Twentieth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I, attached hereto and made a part of this Determination and Order) are **SUSTAINED;**

2. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** , with said suspension stayed;

3. Respondent license is placed on **PROBATION FOR 3 YEARS**, the terms of the probation are contained in Appendix II, attached hereto and made a part of this Determination and Order.

DATED: New York, New York

April 26 , 2000

A handwritten signature in cursive script, reading "Kenneth Kowald", is written over a horizontal line.

**KENNETH KOWALD, CHAIR
RALPH LUCARIELLO, M.D.
DANA O. MONACO, M.D.**

Terrence J. Sheehan, Esq.
Associate Counsel
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New York, New York 10017

Roger Mason, M.D.
205 Windmill Lane
Southampton, New York 11968

APPENDIX I

**IN THE MATTER
OF
ROGER MASON, M.D.**

**STATEMENT
OF
CHARGES**

ROGER MASON, M.D., the Respondent, was authorized to practice medicine in New York State on or about April 2, 1984, by the issuance of license number 157824 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Between on or about May 23, 1997 and on or about June 1, 1997, Patient A was treated by Respondent at Central Suffolk Hospital for painful bilateral incisional hernias. (Patient names are contained in the attached Appendix) Respondent's conduct deviated from accepted medical standards in that:
1. Respondent improperly failed to examine Patient A pre-operatively.
 2. Respondent's pre-operative diagnosis of strangulated incisional hernia was not indicated.
 3. At surgery no evidence of strangulation or obstruction was found. Nevertheless, Respondent placed a long intestinal tube through the stomach and small intestine. This was not indicated.

4. Respondent was unable to close the abdominal wall. Instead he placed two double layers of mesh directly over the bowel. This was contra-indicated.
 5. Two days later, Patient A showed signs of sepsis and was returned to the operating room for exploration. She was found to have gangrenous changes of the entire abdominal colon. Respondent resected all of the involved bowel but left the sigmoid colon in situ; this was contra-indicated.
 6. Three days later, a laparotomy was performed to resect the gangrenous sigmoid colon Respondent had left behind in the second operation. Shortly after this operation the Patient died. Respondent's incomplete second operation unnecessarily caused Patient A to be subjected to the risks and stress of this third procedure.
 7. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient's complaints, history, physical examination, diagnosis, progress notes, operative reports, treatment plan and discharge summary.
- B. On or about October 8, 1998 Patient B, an 84 year old male, was treated by Respondent at Central Suffolk Hospital for stage IV gallbladder cancer. Respondent's conduct deviated from accepted medical standards in that:

1. On or about October 8, 1998. Patient B underwent a five hour operation, including cholecystectomy with hepatic segmentectomy, prophylactic Roux-en-Y choledochoduodenostomy and prophylactic gastrojejunostomy. These procedures were unnecessary and not indicated.
 2. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient's complaints, history, physical examination, diagnosis progress notes, operative reports, treatment plan and discharge summary.
- C. On or about May 10, 1998, Patient C was treated at Central Suffolk Hospital for abdominal pain. Respondent's conduct deviated from accepted medical standards in that:
1. On or about May 10, 1998, Respondent performed an exploratory laparotomy. Respondent performed a total abdominal colectomy based on his suspicion that Patient C had inflammatory bowel disease with toxic megacolon. Yet Respondent improperly failed to obtain a frozen section during surgery to confirm his suspicion. In fact, the Patient did not have inflammatory bowel disease, and as a result, Respondent's resection of the patient's ascending and transverse colon was unnecessary.
 2. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient's complaints, history, physical examination, diagnosis progress notes, operative

reports, treatment plan and discharge summary.

D. Between on or about April 30, 1997 and on or about May 6, 1997, Patient D was treated for abdominal pain at Southampton Hospital, Southampton, New York. Respondent's conduct deviated from accepted medical standards in that:

1. On or about May 2, 1997, Respondent performed a laparoscopic appendectomy for a normal-appearing appendix and a laparoscopic lysis of adhesions for a described internal hernias . These procedures were not indicated.
2. Respondent's diagnosis of appendicitis was not indicated.
3. Respondent improperly failed to order pre-operative barium enema which would have shown a normal appendix, eliminating any basis for the surgery.
4. Preoperatively, a gynecology consultation was obtained which suggested that the cause of the Patient's pain was a urinary tract infection. Respondent improperly and without reasonable justification, discounted or ignored this diagnosis.
5. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient's complaints, history, physical examination, diagnosis progress notes, operative reports, treatment plan and discharge summary.

E. Between or about February 8, 1997 and on or about February 10, 1997, Patient E was treated by Respondent for abdominal pain at Central Suffolk Hospital. Respondent's conduct deviated from accepted medical standards in that:

- 1. Respondent failed to obtain an indicated pre-operative CT scan, pelvic sonogram and/or barium enema.**
- 2. Respondent made a diagnosis of appendicitis which was not indicated.**
- 3. On or about February 11, 1997, Respondent performed an appendectomy which was not indicated.**
- 4. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient's complaints, history, physical examination, diagnosis progress notes, operative reports, treatment plan and discharge summary.**

F. Between on or about May 19, 1997 and on or about June 19, 1997, patient F was treated for cancer at Central Suffolk Hospital. Respondent's conduct deviated from accepted medical standards in that:

- 1. Respondent improperly failed to consider and/or order pre-operative radiation therapy for Patient F.**

2. On or about June 6, 1997, Patient F underwent a low anterior resection with EEA stapled anastomosis. During the procedure Respondent negligently transected the ureter and entrapped the stented ureter in the stapled anastomosis.
- G. On or about September 11, 1997 and September 12, 1997, Respondent treated Patient G for acute cholecystitis at Central Suffolk Hospital. Respondent's conduct deviated from accepted medical standards in that:
1. On or about September 12, 1997, Respondent attempted to perform a laparoscopic cholecystectomy. This procedure was not indicated.
 2. At the conclusion of the procedure, which had been converted to an open cholecystectomy, Respondent placed a drain in the peritoneal cavity. This drain was not indicated.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following paragraphs:

1. A and A(1) through A(6).
2. B and B(1).
3. C and C(1).
4. D and D(1) through D(4).
5. E and E(1) through E(3).
6. F and F(1) through F(2).
7. G and G(1) and G(2).

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

8. A and A(1) through A(6).
9. B and B(1).
10. C and C(1).

11. D and D(1) through D(4).
12. E and E(1) through E(3).
13. F and F(1) through F(2).
14. G and G(1) and G(2).

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

15. A and A(1) through A(6), B and B(1), C and C(1), D and D(1) through D(4), E and E(1) through E(3), F and F(1) through F(2) and/or G and G(1) and G(2).

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

16. A and A(1) through A(6), B and B(1), C and C(1), D and D(1) through D(4), E and E(1) through E(3), F and F(1) through F(2)

and/or G and G(1) and G(2).

SEVENTEENTH AND EIGHTEENTH SPECIFICATIONS

EXCESSIVE TEST OR TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1999) in that he ordered excessive tests or treatment not warranted by the condition of the patient, as alleged in the following paragraphs:

17. D and D(1).
18. E and E(3).

NINETEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

19. A and A(7).
20. B and B(2).
21. C and C(2).
22. D and D(5).
23. E and E(4).

DATED: August 18, 1999
New York, New York

A handwritten signature in black ink, appearing to read "Roy Nemerson", is written above a solid horizontal line.

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

TERMS OF PROBATION

Dr. Mason's license to practice medicine in the State of New York shall be on probation for a period of three (3) years.

TERMS AND CONDITIONS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.
2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.
3. Respondent shall submit prompt (within 20 days) written notification to the Board, addressed to the Director, Office of Professional Medical Conduct (OPMC), 433 River St., 4th Floor, Troy, New York 12180, regarding any change in employment, practice, residence or telephone number, within or without New York State.
4. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York State shall toll the probationary period, which shall be extended by the length of residency or practice outside New York State.
5. Respondent shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms and conditions of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.
6. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.
7. Prior to the Respondent's period of probation commencing the respondent shall submit to the OPMC for its prior approval a list of all

hospitals wherein the Respondent has surgical privileges and for each such hospital a written agreement that for all surgery performed by the Respondent the Respondent will get prior written approval of the performance of such surgery from the chief of the surgical service wherein the surgery is to be performed. If the Respondent obtains surgical privileges at any additional hospitals during the period of probation he shall be required to comply with the same terms noted above in this paragraph, prior to performing surgery in said hospital. Respondent's period of probation and his ability to resume the practice of medicine in this state shall not commence until he receives written approval from the Director of OPMC that he is in compliance with the terms of probation.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

- a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the practice monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than ten) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
- b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
- c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
- d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section (18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective of this Order.

9. If there is full compliance with every term and condition set forth herein, Respondent may practice as a physician in New York State in accordance with these terms of probation the Determination and Order of the Board for professional Medical Conduct; provided, however, that on receipt of evidence of non-compliance or any other violation

of the term(s) and condition(s) of probation, a violation of probation proceeding and/or such other proceeding as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §230 or §230(19) or any other applicable laws.