



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Barbara A. DeBuono, M.D., M.P.H.  
*Commissioner*

May 6, 1998

Dennis P. Whalen  
*Executive Deputy Commissioner*

**CORRECTED COPY**

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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

Robert Meals, Esq.  
Law Offices of Robert N. Meals, PLLC  
700 Fifth Avenue Suite 5600  
Seattle, Washington 98104-5056

Vincent Lobbato, M.D.  
43 West 61st Street  
New York, New York 10023

**RE: In the Matter of Vincent Lobbato, M.D.**

Dear Parties:

Enclosed please find the CORRECTED Determination and Order (No. 98-71) of the Hearing Committee in the above referenced matter (correction page 27, Fifteenth Specification). 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

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.

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., 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 cursive script that reads "Tyrone T. Butler".

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  
VINCENT LOBBATO, M.D.**

**DETERMINATION  
AND  
ORDER**

BPMC-98-71

The undersigned Hearing Committee consisting of **ELEANOR KANE, M.D.**, Chairperson, **GERALD WEINBERGER MD**, and **DENNIS GARCIA**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** (Administrative Law Judge) served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **VINCENT LOBBATO, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

**SUMMARY OF PROCEEDINGS**

Notice of Hearing and  
Statement of Charges:

October 14, 1997

Hearing dates:

October 23, 1997  
October 31, 1997  
November 18, 1997  
November 24, 1997  
December 1, 1997  
December 3, 1997  
December 5, 1997  
December 22, 1997  
December 23, 1997  
January 5, 1998  
January 6, 1998  
January 9, 1998  
January 13, 1998  
January 20, 1998  
January 22, 1998

Place of Hearing:

NYS Department of Health  
New York, New York

Date of Deliberation:

March 9, 1998

Petitioner appeared by:

Henry M. Greenberg  
General Counsel  
NYS Department of Health  
By: Terrence Sheehan, Esq.  
Patricia Moro, Esq.  
Assistant Counsel

Respondent appeared by:

Robert N. Meals, Esq.  
Law Offices of Robert N. Meals, PLLC  
700 Fifth Avenue Suite 5600  
Seattle, Washington 98104-5056

**WITNESSES**

For the Petitioner:

Norman S. Roome, M.D.  
Raymond La Raja, M.D.  
Patient D

For the Respondent:

Jameson L. Chassin, M.D.  
Carl Barosso, M.D.  
Herman Turndorf, M.D.  
Daniel Galvin, M.D.  
Vincent Lobbato, M.D., the Respondent  
Shawn McPartland, M.D.  
Paul Stewart  
Dr. Kelly  
Dr. Reisman  
Ms. Felice

### **SIGNIFICANT LEGAL RULINGS**

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

## FINDINGS OF FACT

### PATIENT A

1. On October 10, 1991, Respondent performed a laparoscopic cholecystectomy (LC) for gallstones. (Pet Exh 3, p. 28; T. 142, 29)
2. During the LC on October 10, 1991, Department's expert witness Dr. Roome as well as Respondent's witness, Dr. Chassin testified that Respondent injured the patient's common bile duct. The result is discontinuity of the duct and bile which forms in the liver, pouring through the opening into the abdominal area adjacent to the transection. (T. 40 - 43, 1080 - 1081, 1090; Pet. Exh. 5F, Pet Exh. 3, 341(a))
3. Dr. Roome and Dr. Chassin testified that Respondent delayed in ordering a HIDA scan until the seventh post-operative day. (T 56, T 1130, 1131) A biliary scan (HIDA Scan) was done on October 17, 1991 which showed a collection of the radiopharmaceutical agent in the subhepatic space. A possible biloma secondary to leakage of bile was noted at the level of the common bile duct. A CT scan or ERCP was recommended by the radiologist for further evaluation. (T 61, 62, 63; Pet. Exh. 341 (a))
4. Dr. Roome and Dr. Chassin testified that Respondent improperly failed to follow-up the results of the HIDA scan, which showed a major leakage of bile. (Pet. Exh 5F, T. 64,- 67, 70, 1130, 1131; Pet. Exh 3, p. 399)

5. An ERCP was done on October 21, 1991. Dr. Chassin testified that it showed complete retrograde obstruction in the most proximal portion of the common bile duct where two metallic clips were present. (T 70 - 73, 1130, 1131) The operative Report of October 10, 1991, indicated that two clips were placed in this area on what was thought to be the cystic duct. The Respondent then cut above the clips according to the testimony of Respondent's expert witness, Dr. Chassin. Dr. Salvioni, the radiologist states in the ERCP study that there was a complete obstruction of the proximal portion of the common bile duct. The common bile duct was clipped because the column of dye was at right angles to the two parallel clips. Respondent failed to properly follow-up the results of the ERCP in a timely fashion. (Pet. Exh. 3, p. 399, p. 28; T. 42, 93, 96, 57; Pet. Exh. 5A, B, T. 105, 149, T. 911, 1049)
  
6. Despite the results of the HIDA scan and ERCP, the Respondent "was not convinced that he had injured the common bile duct." (Pet. Exh. 3, p. 341, 399; T. 789, 790)
  
7. Dr. Roome testified that a reasonable prudent physician should be cognizant of the potential for common bile duct injury, whether the procedure is performed laparoscopically or by open technique. (T. 50 - 52) The patient exhibited signs and symptoms post-operatively that should have alerted a reasonably prudent physician that a common bile duct injury may have occurred at the time of surgery on October 11, 1991. The patient's total bilirubin was normal before surgery. On October 11, 1991, the day after surgery, the bilirubin was elevated to 2.1. This elevation continued on October 12, 1991 and on the 14th day the bilirubin was 3.54. (T. 54; Exh. 3, p. 233 - 235) On the 16th day it was 4.0. The significance of an elevated bilirubin is an indication that bile is backing up in the bloodstream and generally reflects a problem with the drainage ducts from the liver. Consultation by a specialist on October 21, 1991 shows elevated bilirubin and alkaline phosphatase. (T. 50, 54, 55, 132; Pet Exh. 3. p. 233 - 235; T. p. 128; Pet Exh 3. p. 183)

8. The patient also exhibited temperature elevations in the immediate post-operative period and a WBC of 26,500. In the progress notes dated October 12, 1991, the patient is described as "Extreme warm" by a physician. In general, a patient is usually discharged 3 - 4 days after gallbladder surgery. This patient was not having a normal recovery from gallbladder surgery. The Respondent improperly failed to respond to these findings and follow-up in a timely fashion. Respondent testified that "he saw no reason to order the HIDA Scan earlier" than October 17th, which was the 7th post-operative day. (T. 63, 54 - 56, 93, 865; Pet. Exh 3. p. 144) The Respondent improperly delayed ordering a HIDA scan until the seventh postoperative day. (T. 130, 131, Exh. 3. p. 523, 524, 60, 55)
  
9. Post-operatively, the patient experienced elevated temperatures and rising bilirubin levels. Respondent testified that the patient was only tolerating liquids post-operatively and not solid foods. Respondent also testified that he was not concerned with the signs and symptoms in the immediate post-operative period despite his original expectations for early discharge and the fact that laparoscopic cholecystectomies were a new procedure. (T. 858, 859, 860, 861, 872)
  
10. The Respondent admitted that one of the reasons for the HIDA scan result "dilatation of the common bile duct", which means an increase in size of the CBD, could be an injury to the CBD that occurred at the time of surgery. (T. 866, 867)

11. The Respondent failed to follow the radiologist recommending on October 17th to perform a CAT scan of the abdomen. A CAT scan was not ordered and done by the Respondent until October 30th. The Respondent testified that he agreed with the radiologist's finding at the time of the HIDA scan that there was an "obstructive process at the level of the CBD". The Respondent also testified that he felt it was a biloma or "extrinsic compression." Despite the Respondent's testimony that "a number of things could have been done", including drainage, nothing was done by the Respondent until October 21st then the ERCP was done. (Pet. Exh 3. p. 399; T. 869, 870, 872, 873, 874)
12. Prior to the ERCP being performed on October 21st, a GI consult was done by Dr. Dryska. His review of the HIDA scan (October 17, 1991), was that it "showed failure of drainage of dye into bowel." The Respondent failed to follow the radiologist's recommendation at the time of the HIDA scan on October 17, 1991 to perform and ERCP. It was not done until 4 days later. (Pet. Exh. 3, p. 341; T. 887 - 889)
13. A percutaneous cholangiogram was done on November 4, 1991, which showed a large perihepatic collection. During the procedure, approximately 2,000 cc of bile was aspirated by the radiologist. At this point the record was clearly documented that the patient "was having and continued to have a subphrenic collection of bile" which is a serious condition. The Respondent delayed 48 hours before taking surgical action. (Pet. Exh. 3, p. 391, Pet. Exh. 5 J and K, T. 109, 149, 76, 123, 125, 126, 130, 1133, 1134; Pet. Exh. 3, p. 40, Adm. Off. Exh 1)

14. On the 27th post-operative day, Respondent performed an exploratory laparotomy on the patient. A HIDA scan done November 2, 1991, demonstrated a persistent collection of bile. Both Dr. Roome and Dr. Chassin testified that this surgery is extremely difficult technically, even for a surgeon experienced in this specialized surgery. (T. 76, T. 1131, 1132, 1134, 1146) Respondent failed to obtain the assistance of an experienced surgeon proficient in this type of live/ductal surgery. (T 1131, 1132, 1154) Respondent also failed to have the radiologist pass a guide wire to help identify the structures. Respondent was unable to correct the iatrogenic biliary injury and the patient was closed with multiple drains. Respondent failed to gain control of this major biliary injury. (Pet. Exh. 3, T 79, 80) Respondent failed to transfer the care of this patient to a surgeon or hospital, experienced in the correction of these iatrogenic biliary injuries. Respondent medically abandoned the patient post-operatively who died 12 days after the surgery. (T. 76- 81, 163; Pet. Exh. 3, p. 40)
15. Respondent admitted his delay in the re-operation of this patient was the "main miss" in this case. (Pet. Exh 3. p. 40; T. 923, 943)
16. Dr. Roome testified that the patient's problems were clearly defined and documented by the HIDA scan and ERCP, as well as the radiologist consultations, lab results and temperature charts. The surgeon is responsible for the interpretations of test results and for decisions regarding when and what operative procedure are to be performed. (T. 135, 154; Pet. Exh. 3. p. 399, 341 (a))
17. Dr. Roome testified that the unnecessary delays by the Respondent from October 17, 1991 to October 21, 1991 and October 21, 1991 - November 4, 1991, are directly related to the patient's death. (T. 162, 163; Pet. Exh 3)

18. The Respondent failed to document any significant progress notes or any indication of his thought processes or the outcome of any conversations with other consulting physicians. (Pet. Exh 3, T 82 - 85) He made no notes while the patient was in ICU. The Respondent failed to document any significant findings in this patient.
  
19. In his testimony regarding Patient A, Dr. Chassin, the Respondent's expert, testified that the Respondent's care of the patient was "erroneous and the outcome was bad." (T. 1071, 1072; Administrative Exh. 1)
  
20. Dr. Chassin testified that any competent surgeon who reviewed the radiologist's report of the HIDA scan and/or the X-ray films should have reached the conclusion that the common bile duct was inadvertently transected. He admitted this is a very serious injury. The Respondent still contends that he doesn't know if the common bile duct was cut. (Pet. Exh. 3, p. 399; T. 839 - 965, 1080 -1088, 1125)
  
21. Dr. Chassin testified that based upon the HIDA scan, the Respondent should have been concerned regarding the possibility of the CBD injury. And that the Respondent's failure to do anything based upon the HIDA scan and waiting until the 11th post-operative day, when an ERCP confirmed the CBD injury constituted a failure to promptly follow -up this lethal complication. (T. 1130 1131)
  
22. Dr. Chassin admitted that the repair of the CBD injury is a very difficult procedure and expert assistance is required. Dr. Roome testified that the fact that the Respondent waited 26 days to attempt this repair, constitutes an egregious mistake and an inexcusable delay. The sooner the surgery is done, the greater the likelihood of success.

**PATIENT B**

23. Patient B was a 55 year old female who underwent laparoscopic lysis of intestinal adhesions performed by the Respondent. She was admitted to Cabrini Medical Center on April 26, 1995, with symptoms of recurring abdominal pain and bloating. She had prior multiple abdominal diagnostic surgical procedures and was now admitted with recurrent adhesions. There is no pre-operative note other than the admission history and physical. There is no indication of what pre-operative investigations were done. (Pet. Exh 6, p. 14 - 17; T. 184 - 185)
  
24. The patient's record does not document pre-surgical diagnostic testing which is necessary to perform this operation. (Pet. Exh. 6, p. 6; T. 265, 257, 2282, 2354)
  
25. This patient suffered a massive hemorrhage and injury to the intestine. Substantial inter-operative blood loss occurred during the operation. Sixty five centimeters of small bowel was remove. There were lacerations of mesenteric vessels. Approximately 11 units of blood and blood products were given to the patient. The patient's hematocrit was 8 and 9, indicating she lost 50% of her blood volume. (Pet. Exh 6, pgs. 21, , 24, 353 - 359, 369 - 370, 388 - 395; T. 22, 194, 195, 197, 195, 2175 - 78, 2282-83)
  
26. Dr. Galvin has been a physician at Cabrini Medical Center since 1987 and worked with the Respondent. On April 26, 1995, he was called by an OR nurse during another operation he was performing to "gain control" of bleeding in Patient B's wound. The source of the bleeding was a mesenteric vessel. The Respondent had left the patient during the procedure with a resident and was unreachable until 30 to 40 minutes later. (T. 2152, 2175 -2176, 2180, 2219)

27. The Respondent's characterizations in the operative report are factually incorrect. The report indicates "some bleeding" in the operative report which is inconsistent with the blood bank records and the patient's hematocrit and hemoglobin results. The bleeding complication that occurred during the surgery as well as the injury to the small bowel is the reason the surgery took 4 1/2 hours. (Pet. Exh 6. pgs 353 - 359, 369 370; T. 193 - 196, 239)
  
28. The Patient was transferred to the ICU. The patient received blood transfusions and she was on a respirator. A hematology consult was ordered. On April 27, 1995, the day after surgery, her blood pressure was 75 over 40 and her pulse was 110-125. On April 29, 1995, rectal bleeding occurred and the physical was notified. On April 30, the patient was running a temperature of 100 degrees. On April 27, 28, 29, 30 and May 1st, the patient's blood chemistries were abnormal. Her calcium was a critical value and subsequent to April 26th her liver function was abnormal. The Respondent abandoned this patient post-operatively. The patient was septic and unstable and the Respondent failed to timely and appropriately diagnose and treat these complications. There are no progress notes nor any indication in the record that the Respondent was aware of the patient's condition. (Pet. Exh 6, pg. 38, 45, 197, 333 - 338, 340; T. 206 - 207, 2255, 2284, 2317)
  
29. On May 4th, the patient continued to exhibit signs and symptoms of rectal bleeding. The physician was notified and a bedside sigmoidoscopy was performed. (Pet. Exh 6, pg. 61)
  
30. On May 4, 1995, an abdominal CAT scan was done on the 8th post-operative day. The CAT scan demonstrated a large mid-abdominal abscess with probable communication to the intestine. The abscess measured approximately 17 centimeters by 6 centimeters. Dr. Roome testified that this is considered a large collection. The CAT scan reported by the radiologist is consistent with the actual CAT scan x-ray studies. (Pet. Exh 6, p. 401, 8B; T. 198, 201, 202, 209, 211, 292 - 294, 2254 - 55, 197 - 198)

31. In addition to the above mentioned signs and symptoms indicating post-operative complications, the patient also had a persistently elevated white count over 10,000. On May 4, her white blood count was 18,000. On May 5th, the white blood count was 15,000 and on May 6, the white blood count was 14,000. The Respondent failed to make any notes in the chart or in the progress notes regarding these significant findings. (Pet. Exh 6, pgs. 334 - 337, 353 - 359; T. 206, 207, 212, 213, 240, 266, 284 - 285)
32. Dr. Roome testified that despite the patient's serious clinical condition, the laboratory results, temperature elevations, objective CAT scan report and films, all signs pointing to an abdominal abscess, the Respondent improperly delayed four days before attempting to surgically correct this condition. There was no documentation that the Respondent was even aware of the CAT scan results. Dr. Roome testified that this significant post-operative abscess was not addressed by the Respondent in a timely fashion. (Pet. Exh. 6, pgs. 401, 63 - 69, 32 -32; Pet. Exh 8; T 203, 207, 209)
33. Dr. Roome testified that the clinical picture as well as the objective data in the hospital record show no indication that the abscess was resolving. (T. 268)
34. A second surgical procedure was performed on the patient on May 8, 1995. 85 centimeters of the intestine was resected during the second procedure because of the initial iatrogenic injury. In addition, an ileostomy was performed. (Pet. Exh 6, pgs 32 - 33; T 213 - 214)
35. There is no clear indication in the operative report of May 8, 1995 why the bowel was removed. There was no explanation of where the leak might have occurred that was causing the abscess or whether there was a communication with the bowel. Both operative reports were confusing and dictated very long after the procedures. (Pet. Exh 6)

36. There were no notes written by the Respondent in the patient's chart during her critical stay in the ICU. The surgery was performed on April 26, 1995 and the operative report was dictated on June 4, 1995. (Pet. Exh 6, pgs. 21 - 24; T 1394)
37. Respondent's expert witness, Dr. Chassin testified that the patient should have had a work-up prior to the surgery including a GI series. (T. 1458 - 59)
38. Dr. Chassin admitted that what the CAT scan reported regarding peritonitis and "compatible with communication with the intestinal tract", would raise serious issues. (Pet. Exh 6, p. 401; T. 1483, 1487)
39. Dr. La Raja, chief of surgery at Cabrini Medical Center became involved with the care of Patient B when he was informed by the residents that the patient was "quite ill" and that the residents were having difficulty getting the Respondent to see the patient. Dr. La Raja saw the patient at which time he described the patient as "septic, going into shock." There was evidence that she had an intra abdominal infection that had to be drained. Dr. La Raja called the OR and told the Respondent "to get over here and take care of the patient immediately." Respondent then performed the re-operation on May 8th. (T. 2254 - 2256, 2280)
40. Dr. La Raja testified that as a result of the complication, the patient developed peritonitis and required two additional surgeries.
41. Dr. La Raja testified that the post-operative care by the Respondent between May 2nd and May 8th was not adequate because the Respondent did not "fully realize or accept the seriousness of what was happening to the patient during this period of time." Dr. La Raja also stated that the Respondent was not sufficiently involved in the post surgical management of the patient. (T. 2284 - 2285)

42. Dr. La Raja was asked to take over the care of Patient B by her family. Dr. La Raja would have operated immediately after the CAT scan which indicated an abscess. (T. 2320, 2338, 2342)
43. The Respondent testified that he "tore up" the operative report and was aware that the operative report was materially incomplete in omitting Dr. Galvin's emergency intervention in this case. (T. 1594, 2597)

### PATIENT C

44. The patient was a 60 year old male, who was known to have liver disease. A left inguinal herniorrhaphy was performed in 1994 and a right herniorrhaphy was performed in March 1995. Both hernias had recurred bilaterally. The patient was admitted under the Respondent's care to Cabrini Medical Center on March 4, 1996 with the plan to repair both recurring hernias by laparoscopic technique. (Pet. Exh 7A, pgs 5, 29, T. 430)
45. Dr. Roome testified that the Respondent failed to take and record an accurate history and physical of the patient. In addition, no pre-admission laboratory studies were recorded in the hospital record. (Pet. Exh p. 29; T. 507, 508, 335)
46. Patient had a history of liver disease with progressive liver failure, low platelet count, prolonged prothrombin time and elevated blood sugars. Patient's clinical presentation in March, 1996 was one of jaundice, ascites, bilateral gynecomastia. His platelet count was 46,000, PTT was 35.1 and PT was 15.8 over a normal of 11.6. His hematocrit was 38 and hemoglobin was 13. (Pet Exh. 7A, pgs. 25, 26, 29, 30, 187, 191, 200, 207; T. 335, 336, 337, 510)

47. Despite the patient's history of abnormal liver function, low platelet count, prolonged prothrombin time and elevated blood sugars, the Respondent improperly failed to arranged for pre-operative consultations with an internist, a gastroentrogist or a hematologist in this high risk surgical patient. (T. 341, 384, 389)
48. On March 4, 1996, the Respondent scheduled a hernia repair procedure for Patient C. The patient was jaundiced with ascites, low platelet count and an increased prothrombin time which indicated advanced liver disease. All findings indicated a sick patient with liver disease. The lab values clearly indicated that this gentleman was at risk for bleeding. The patient had a progressive type of cirrhosis, which was worsening each year. (Pet. Exhs. 7B, 7C, 7A, pgs. 29, 26, 28, T. 494, 495)
49. There was no indication of emergency surgery needed for this patient.
50. Dr. Roome as well as Dr. Chassin testified that the Respondent failed to type and cross match the patient's blood, that there were no blood products available for the patient's needs in the operative room. (Pet. Exhs. 7A, pgs 178, 187, 189- 191, 207, 214; T. 340, 341, 362; T. 1531, 1533, 1543- 1544, 1551 -1553, 1557 - 1559)
51. Dr. Roome testified that during the hernia repair operative procedure there was bleeding from the inferior epigastric vessel. (Pet. Exh 7, p. 30; T 366)
52. The Respondent minimized the blood loss in the operative report. The Respondent recorded an estimate of 500 cc blood loss, when the next blood count that is recorded shows that the patient has a hemoglobin of 7.1 grams and this was done after transfusion of 2 units of packed red blood cells. (Pet. Exhs. 7A, pgs 32, 178, 187, 189, 191, 207, 214; T. 366, 367)

53. Dr. Roome testified that the Respondent failed to maintain a proper medical record. (T. 368, 387)
54. Dr. Chassin testified that the patient was a high risk patient. He also testified that the hematology evaluation done in 1995 was sufficient to constitute pre-operative evaluation for the 1996 surgery.

#### PATIENT D

55. Patient D was a patient of the Respondent in February, 1995, when a breast biopsy was performed. Patient D was 45 years old and diagnosed with inflammatory breast carcinoma and underwent chemotherapy and radiation for several months after the biopsy. A mastectomy was anticipated and the Respondent discussed possible reconstruction surgery with the patient. (T. pgs. 2462 - 2464)
56. Patient D was next seen by the Respondent in his office once, approximately June, 1995. Patient D testified that no past medical history was taken, no vital signs were done and a cursory breast examination was performed by the Respondent. The office records maintained by the Respondent showing that a history and physical was done with vital signs taken is factually inaccurate and materially misleading. (Pet. Exh 21; T. 2465 - 2472)
57. On July 26, 1995, the Respondent performed a right modified medical mastectomy. (Pet. Exh 20; T. 2472)

58. The Respondent abandoned the patient until the 6th post-operative day. During that period, the patient developed a wound abscess, which would require a surgical procedure for incision and drainage on August 4th. (T. 2706)
59. Patient D telephoned the Respondent's office a few days after the surgery, told his office she was upset and needed to speak with the Respondent. Patient D testified that she was "scared" and had not received any information regarding the results of her surgery. (T. 2476 - 2477)
60. The patient was told by the Respondent's office that he was making rounds at Cabrini Medical Center and would see her on Monday. Patient D testified she "waited all day," but the Respondent did not appear. At this time she was running a fever. The patient testified she did not know the Respondent would be unavailable for several days. (T. 2477 - 2479)
61. Patient D testified that when the Respondent finally saw her on the 6th post-operative day, and she asked him for an explanation, he did not explain his absence. This was the only time the patient saw the Respondent post-operatively.
62. The Respondent's abandonment of this patient caused a delay in diagnosis and treatment of complications resulting in prolongation of the patient's hospital stay. (T. 2483 - 2484)
63. Dr. Roome testified that post-operative management after mastectomy was "particularly" important in this case since the patient had prior radiation to the breast, which is known to diminish "healing qualities" and increase the risk of complications. He testified that it "was not acceptable" for the Respondent to see the patient 6 days after the operation, not arrange for coverage from another doctor and not to inform the patient. (T. 2702 - 2705)

64. The Respondent saw the patient after July 26th surgery on one occasion when the patient was released. He made no note in the chart to this effect nor did he transfer the care of the patient to another physician. The Respondent's note dated August 1st regarding the patient "will continue present treatment" is misleading in that it does not indicate he was off the case. (T. 2709 -2711)

**PATIENT E**

65. Patient E was known to the Respondent and was admitted by the Respondent to Cabrini Medical Center for peripheral vascular problems.
66. No arteriogram was recorded for the patient's November 1995 hospital admission. Dr. Roome testified an arteriogram is the necessary diagnostic tool to perform on a patient prior to surgery of a femoral popliteal bypass in order to know where the obstruction is and whether or not a femoral popliteal bypass would be helpful under the patient's present situation. (T 549, 550, 534, 611, 612, 661, 662)
67. An arteriogram was performed on the patient in July 1995, one year before the operation. It showed arteriosclerosis, but essentially no obstruction. The x-ray films shows essentially no narrowing in the flow of blood and widely open patent femoral arteries. The anterior tibial artery is widely patent with open arteries into the foot. There is no area of major stenosis seen on the x-ray films. (Pet. Exhs. 10, 11, A,B,C; T. 531, 540, - 543, 550, 611, 612, 1995)

68. The Respondent performed a femoral popliteal bypass on November 29, 1995 which was not indicated because there was no evidence of any obstruction in the common or superficial femoral artery, the areas that were being bypassed. The angiogram films taken one year prior to operation are inadequate pre-surgical diagnostic information. The pathology report indicated that the patient was suffering from some kind of vascular disease of small vessels. (T. 535, 544- 547, 556, 570, 571, 651)
69. The clinical presentation of this patient did not support any need for the performance of a femoral popliteal bypass. Dr. Roome testified that infection, pain in the lower extremities and palpable peripheral pulses are not necessarily indications for major surgery. The medical resident attending documented that the patient had good peripheral blood flow. There was good peripheral circulation in the lower extremity. (Pet. Exh 10; T. 668, 582, 548, 638, 646, 664 - 668)
70. Dr. Roome testified that a physician can not conclude from one reading at the ankle that there is disease in the leg. A Doppler test may be used to evaluate a patient but cannot be determinative regarding whether or not the patient needs a femoral popliteal bypass. (T. 602, 603, 609, 610, 548, 550)
71. Dr. Roome testified that the patient's chart as maintained by the Respondent is inadequate and does not comport with accepted standards of record keeping. In the operative report, the pre-operative diagnosis, "occlusive arterial disease of the left lower extremity," was wrong. In addition, the operative report is vague and confusing. There is no discharge summary in the chart. (Pet. Exh. 10, pgs. 13, 14; T. 575, 554, 555)

72. The Respondent testified that one of the reasons he performed the femoral popliteal bypass was based upon an angiogram done prior to this hospitalization. Respondent's witness, Dr. Barosso testified that there must be blockage to justify this procedure and that "you should know at least the region where the blockage is." He also testified that the angiogram did not show a blockage at any location. (T. 1351 - 1354, 1346 - 1365)
73. The Respondent signed a certification of a document in which/he states that these are true and exact copies of his office records. There are no contemporaneous written office records and no indication when he first saw this patient. There should be office records of this patient, on whom the Respondent performed major vascular surgery. The Respondent failed to maintain a proper medical record.
74. Dr. Chassin testified that the Respondent's office records for this patient violated the generally accepted standards of record keeping. (T. 1593)
75. Dr. Chassin testified that at the time of the angiogram, there was no significant obstruction to justify a femoral popliteal bypass surgical procedure. (T. 1605)
76. There is no indication in the operative report that any obstruction was indeed found. (T. 1588, 1593, 1605, 1612)

#### **PATIENT F**

77. Patient F , a 77 year old male, was admitted on September 18, 1990 to Cabrini Medical Center with an infection in his right great toe. Patient F had prior admissions for pulmonary disease and peripheral vascular disease with infections in the right fore foot. (Pet. Exh 22, p. 19; T. 2736)

78. An arteriogram performed on August 28, 1990, indicated that the major arteries from the aorta in both legs were open. The femoral arteries were open in the groin. Arteriosclerotic plaques were present in both popliteal arteries but no obstruction to the blood flow is described. The Respondent's note in the patient's chart dated September 20th states that "angio previously done small vessel disease, in view of angio and system, I believe that bypass not possible." (Pet Exh 22, p. 100; T. 2736 - 2740, 2748 - 49)
79. During a prior admission on September 10th, a note by a medical attending stated that "angiograms revealed diffuse distal small vessel disease," which corroborates the Respondent's conclusion that the patient is not a candidate for surgery. (Pet. Exh. 24; T. 2747)
80. Dr. Roome testified that he agreed with the Respondent's statement that the angiogram militates against doing a bypass because there were "obstructive arteries" down the arterial tree and you do not visualize anything in the lower third of the leg to use as a plug in for a bypass procedure. (T. 2745 - 2746)
81. On September 24, 1990, the Respondent performed a femoral popliteal bypass graft on the patient, which was not indicated.
82. There was no documentation in the patient's record regarding the necessity of doing the femoral popliteal bypass. No pressure studies were done that would show an indication for surgery. There was no documentation of a problem in the femoral artery. The Respondent failed to properly assess and document the patient's peripheral vascular condition. He failed to take and record pulses and order Doppler vascular flow studies and other appropriate diagnostic studies. (T. 2832, 2749, 2752)

83. The operative report was dictated by the Respondent five months after the surgery. The contents of the operative report do not explain "what was accomplished, where the obstruction was, what was encountered and what the findings were." This report did not comport with the minimally accepted standards of medical record keeping. (Pet. Exh. 24; T. 2751 - 2752 -, 2756, 2816)

#### PATIENT G

84. Dr. La Raja testified that Patient G, as he awaited surgery, saw his name listed on the OR wall chart, for the wrong procedure. The patient expected to have hiatal hernia repair and was listed for a liver biopsy. The patient alerted the OR staff of the mistake. (Pet. Exh 19, p. 18; T. 2372)
85. According to Dr. La Raja, the Respondent performed a repair of hiatal hernia laparoscopically. (T. 2375 - 76, 2383, 2288)
86. The operative report was signed and dictated by the Respondent and did not reflect that a laparoscopic hiatal hernia repair was done, instead the operative report indicated that the Respondent repaired an abdominal wall hernia. The Respondent failed to accurately described the surgery he performed and testified that he dictated the operative report in a "deliberatively vague" manner. (Pet. Exh 19, p. 18; T. 2378, 2412, 2413, 2539, 2540)

87. Dr. Roome testified that there is no way a third party could deduce that a laparoscopic hernia repair was done from reading the operative report. That an operative report should explain what was done, what was repaired or removed and how it was done. It is a permanent record to protect the patient. He testified that it was improper for the Respondent to be "deliberately vague" in the report. Respondent failed to maintain accurate medical records. (Pet. Exh 19, p. 18; T. 2685 - 87, 2699, 2611)

### **DISCUSSION AS TO PATIENTS**

The panel found that as to Patient A, both the testimony of Department's expert witness, Dr. Roome and the Respondent's expert witness, Dr. Chassin, were in agreement. Both experts agreed that Dr. Lobbato had injured the common bile duct and he delayed in ordering additional tests. Dr. Lobbato's post operative treatment failed to recognize and acknowledge that the patient's signs and symptoms pointed to a well-known potential complication in this surgery. He contended that the common bile duct may have been compressed by a biloma despite no support for this contention. Dr. Lobbato testified that this surgery was video taped (T. 1282) yet he never reviewed the video tape. There was testimony as to a discussion of this patient's procedure during grand rounds (T. 1237) yet it was never documented in the Patient's chart. Dr. Lobbato failed at that time and does not recognize at this time that there was an iatrogenic complication (T 965). The panel agrees with Dr. Chassin's testimony that one of the hallmarks of a surgeon who should be disciplined is someone who does not admit that they made a mistake (T. 839 -965) This patient's subsequent surgery was delayed to a point where the patient was no longer curable.

The panel finds that as to Patient B, the allegation of "abandonment" of the patient is a moot point. Despite the lack of documentation to support "abandonment" of the patient, this patient received improper care by Dr. Lobbato. During the later part of this operation, the Respondent left the patient with a resident and could not be reached for 30 to 40 minutes despite the fact that there was an emergency (T. 2219) During the Respondent's testimony, he failed to state that he left during the operation and that another surgeon had to be called into the operating room to handle and emergency involving bleeding. It wasn't until, Dr. Galvin, the replacement doctor testified that the panel learned of this fact. This panel agrees with Dr. La Raja's testimony that the post-operative care by the Respondent between May 2nd and May 8th was not adequate because the Respondent did not "fully realize or accept the seriousness of what was happening to the patient during this period of time" (T. 2284 - 85)

As to Patient C, the panel disagrees with the Respondent's expert witness, Dr. Chassin that testing one year prior to surgery is adequate pre-operative evaluation to be relied upon by a surgeon. Such testing is untimely. The patient's record fails to indicate that there was need for emergency surgery despite his abnormal liver function, low platelet count, prolonged prothrombin time and elevated blood sugars. (T. 341, 384, 389)

The panel recognizes that as to Patient F, the artiogram film is not part of the hospital record in evidence and therefore could not be referred to by the witnesses. The film, of course would be the best evidence but they were non-existent. The Department's witness, Dr. Roome, could therefore testify only on the Radiologist's report of this film (Exh 24). This exhibit was the quitessential element to substantiate the charges brought in reference to Patient F. The panel has no reason to question the skill and ability of the radiologist who wrote the report and therefore accepts the report as an accurate relection of the artiogram film. The panel recognizes that the radiologist is a specialist trained to read such films and although there may be a margin of error, this report does not relect any questionable judgment on the part of the radiologist. The panel accepts this report in place of the films.

Dr. Lobbato agreed with the expert witness and this panel that a operative report made months after the operation is below the standard of care. The panel finds that Patient G's operative report was inadequate in that it did not reflect the actually surgery performed. Such a report could jeopardize the patient's care.

### DISCUSSION AS TO WITNESSES

The panel has carefully evaluated all witnesses and were particularly impress by two, Patient D and Dr. Raymond La Raja.

Patient D testified that after undergoing major surgery, a mastectomy performed by Dr. Lobbato, she was unable to contact him until the sixth post-operative day. She had not previously been informed that he would be out of town and that she would be attended by another physician. The panel found Patient D's testimony to be most persuasive. This patient clearly articulated the events of a traumatic surgery that possibly had a fatal prognosis. Her memory was clear and succinct as to the chronology of the Respondent's treatment. The Respondent does not deny that he did not see this patient until six days after the surgery. The patient recounts how she felt sick two days after surgery with fever and pain. She testified that she even called the Respondent's office three days after surgery but was told to wait another two days. The patient, in complete frustration with Respondent's treatment did the only possible thing she could do to get attention, which was to refuse all treatment. The Respondent characterized the patient as difficult but this panel found absolutely no evidence of such characterization. This patient underwent additional surgery for infection that was undoubtedly worsened by neglect.

The panel found Dr. La Raja's testimony credible and persuasive. Dr. La Raja, Chief of Surgery at Cabrini was apparently quite upset by his need to testify to the panel as to the events of the past. He had helped train Dr. Lobbato and had appointed him to a position of Resident Coordinator of the General Surgery Program at Cabrini. For a period of time, Dr. La Raja and Lobbato practiced together. They later separated. Dr. La Raja testified that Dr. Lobbato had

adversely jeopardized the care of his patients and at times his practice was life-threatening and therefore he had to take administrative action against him. The information regarding Cabrini's disciplinary proceeding against the Respondent was initiated by the Respondent. The panel has not considered Cabrini's internal disciplinary proceedings nor has it prejudiced them. The panel's decision is based solely on the testimony and evidence submitted at this hearing.

During the course of the hearing the panel recognized that the Respondent's expert testimony is in complete contradiction to Department's expert testimony. From time to time, the Respondent's witnesses testified to information that was provided to them personally by Dr. Lobbato outside the medical records of the patients. This information was disregarded since it was never provided to the panel nor was it documented in the patient's chart. At a minimum it would be incumbent on any physician to record critical information that would effect a patient's care.

### **CONCLUSIONS OF LAW**

#### **FIRST THROUGH SIXTH SPECIFICATIONS - GROSS NEGLIGENCE**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent practiced the profession with gross negligence on more than one occasion under N.Y. Educ. Law Section 6530 (4) (McKinney Supp. 1995), in that his care of Patients A, B, C, D, E and F deviated from accepted medical standards on more than one occasion.

The Committee therefore concludes that the First Specification is **SUSTAINED**.

#### **SEVENTH THROUGH TWELFTH SPECIFICATIONS - PRACTICING WITH GROSS INCOMPETENCE**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent practiced the profession with gross incompetence on more than one occasion under N.Y. Educ. Law Section 6530 (6) (McKinney Supp. 1996) as to Patients A, B, C, D, E, F and G.

The Committee therefore concludes that the Second Specification is **SUSTAINED**.

**THIRTEENTH SPECIFICATION - NEGLIGENCE ON MORE THAN ONE OCCASION**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent practiced the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530 (4) (McKinney Supp. 1995), in that his care of Patients A, B, C, D, E and F deviated from accepted medical standards on more than one occasion.

The Committee therefore concludes that the Third Specification is **SUSTAINED.**

**FOURTEENTH SPECIFICATION - INCOMPETENCE ON MORE THAN ONE OCCASION**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent practiced the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530 (6) (McKinney Supp. 1996) as to Patients A, B, C, D, E, F and G.

The Committee therefore concludes that the Second Specification is **SUSTAINED.**

**FIFTEENTH SPECIFICATION - FRAUDULENT PRACTICE**

**NOT SUSTAINED**

**SIXTEENTH SPECIFICATION - MAKING A FALSE REPORT.**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent did make and file a false report as alleged as to Patient G.

The Committee therefore concludes that the Sixth Specification is **SUSTAINED.**

**SEVENTEENTH SPECIFICATION - LACK OF INFORMED CONSENT**

**NOT SUSTAINED.**

**EIGHTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS - FAILURE TO MAINTAIN ADEQUATE RECORDS**

Based on a preponderance of the evidence, the Hearing Committee concludes that the Respondent did fail to maintain adequate records as to Patient's A, B, C, D, E, F, and G.

The Committee therefore concludes that the Eighth Specification is **SUSTAINED**.

**SANCTION**

Throughout the hearing the Respondent's demeanor was arrogant. He at times had uncontrollable bursts of temper and he refused to take responsibility for his mistakes. The Respondent to the present refuses to acknowledge and recognize his surgical errors. The Respondent is a danger to the public in the future. In careful consideration of all testimony given and evidence presented we find that it is unsafe to permit Respondent to continue practicing medicine in this State.

**RECOMMENDATION**

For all the above reasons, the Respondent's license to practice medicine in the State of New York is hereby **REVOKED**.

**DATED: Rhinebeck, New York**

3 April 1998

  
**ELEANOR KANE, M.D.**  
Chairperson

**GERALD WEINBERGER, M.D.**  
**DENNIS GARCIA**

APPENDIX I

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

IN THE MATTER  
OF  
VINCENT LOBBATO, M.D.

COMMISSIONER'S  
ORDER AND  
NOTICE OF  
HEARING

TO: VINCENT LOBBATO, M.D.  
43 West 61st Street  
New York, NY 10023

The undersigned, Barbara A. DeBuono, M.D., M.P.H., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by VINCENT LOBBATO, the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1997), that effective immediately VINCENT LOBBATO, Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12) (McKinney Supp. 1997).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1997), and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1997). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on October 23, 1997, at 10:00 a.m., at the offices of the New York State Health Department, 5 Penn Plaza, Sixth Floor, New

York, NY 10001, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. 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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, and by 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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 or sanction 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 FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a (McKinney Supp. 1997). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York  
October 17, 1997



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BARBARA A. DeBUONO, M.D., M.P.H.  
Commissioner of Health

Inquiries should be directed to:

Terrence Sheehan  
Associate Counsel  
N.Y.S. Department of Health  
Division of Legal Affairs  
5 Penn Plaza  
Suite 601  
New York, New York 10001  
(212) - 613-2601

IN THE MATTER  
OF  
VINCENT J. LOBBATO, JR., M.D.

STATEMENT  
OF  
CHARGES

VINCENT J. LOBBATO, JR., M.D., the Respondent, was authorized to practice medicine in New York State on or about November 9, 1979, by the issuance of license number 140606 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. Between on or about September 30, 1991 and on or about November 21, 1991, Respondent treated Patient A for gallstones at Cabrini Medical Center, (CMC), New York, N.Y. (The names of patients are contained in the attached Appendix).
1. Respondent failed to take and record an adequate history and physical of Patient A.
  2. On or about October 10, 1991, Respondent performed a laparoscopic cholecystectomy (LC). During the operation Respondent injured the bile duct. During the immediate postoperative period Patient A showed low grade fever and elevated bilirubin, which Respondent improperly failed to note and follow-up in a timely fashion.
  3. Respondent improperly delayed ordering a HIDA scan until the seventh postoperative day.
  4. Respondent improperly failed to follow-up the results of the HIDA

scan, which showed a major leakage of bile.

5. Subsequently, an ERCP demonstrated a complete obstruction of the common bile duct. Respondent improperly failed to follow-up this finding in a timely fashion.
6. Two weeks later yet another study was performed which also demonstrated a major leakage of bile. Respondent unnecessarily delayed another forty eight hours before taking surgical action.
7. On the 27th postoperative day, Respondent performed an exploratory laparotomy. Prior to this operation, Respondent failed to recognize the need for, and obtain, adequate surgical assistance to handle this very difficult surgical situation.
8. Respondent failed to properly correct the iatrogenic biliary injury.
9. After this surgery Respondent abandoned Patient A, who expired as a result of the intraoperative injury.
10. 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 and treatment plan.

B. Between on or about April 26, 1995 and on or about June 30, 1995, Respondent treated Patient B for abdominal pain at CMC.

1. Respondent failed to take and record an appropriate history and physical of Patient B.
2. On or about April 26, 1995, Respondent performed an endoscopic laparotomy on Patient B which was not indicated.
3. In addition, Respondent's selection of the endoscopic technique

for laparotomy in this patient was also inappropriate and resulted in massive hemorrhage and injury to the intestine.

4. - Respondent abandoned Patient B postoperatively. The patient was septic and unstable and Respondent failed to timely and appropriately diagnose and treat these complications.
5. Patient B developed an abdominal abscess. Respondent improperly delayed four days before attempting to surgically correct this condition.
6. The unnecessary operation performed by Respondent on April 26, 1995, the improper choice of operative technique and the subsequent abandonment of Patient B, lead to complications and a prolonged hospitalization of 65 days.
7. 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 and treatment plan.

C. Between on or about March 4, 1996 and on or about April 15, 1996, Respondent treated Patient C for recurrent bilateral inguinal hernias at CMC.

1. Respondent failed to take and record an adequate history and physical of Patient C.
2. Despite the patient history of abnormal liver function, low platelet count, prolonged prothrombin time and elevated blood sugar, Respondent improperly failed to arrange pre-operative consultations with an internist, gastroenterologist or hematologist in this high risk surgical patient.

3. On or about March 4, 1996, Respondent attempted to perform a bilateral hernia repair, which was not indicated.
4. - In addition, Respondent employed an improper technique, i.e., laparoscopic surgery, which unnecessarily increased the risks for complications and mortality in this patient.
5. Respondent improperly performed this operation while the patient was anemic, jaundiced and in liver failure, which caused complications and a prolonged hospital stay of 42 days.
6. Respondent failed to maintain a medical record for Patient C which accurately reflected the Patient's complaints, history, physical examination, diagnosis, progress notes, operative reports and treatment plan.

D. Between on or about July 26, 1995 and on or about August 19, 1995, Respondent treated Patient D for breast disease at CMC.

1. Respondent failed to take and record an adequate history and physical of Patient D.
2. On or about July 26, 1995, Respondent performed a right modified mastectomy. The pathology report was positive for ductal carcinoma metastatic to axillary lymph nodes. Thereafter, Respondent abandoned Patient D until the seventh postoperative day. During that period Patient D suffered a wound abscess. Respondent's abandonment of this patient caused a delay in diagnosis and treatment of this complication resulting in a prolongation of the patient's hospital stay.
3. Respondent failed to maintain a medical record for Patient D

- which accurately reflected the Patient's complaints, history, physical examination, diagnosis, progress notes, operative reports and treatment plan.

**E. Between on or about November 27, 1995 and on or about December 6, 1995, Respondent treated Patient E for a circulatory condition at CMC.**

- 1. Respondent failed to take and record an adequate history and physical of Patient E.**
- 2. In or about July 1995 an arteriogram performed on Patient E's left lower extremity revealed no stenosis or occlusion. Respondent made a diagnosis of occlusive arterial disease of the left lower extremity. This diagnosis was incorrect and without medical justification.**
- 3. On or about November 29, 1995, Respondent performed a femoral/popliteal bypass/graft which was not indicated.**
- 4. Respondent failed to obtain Patient E's informed consent for the femoral/popliteal bypass/graft.**
- 5. 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 and treatment plan.**

**F. Between on or about September 18, 1990 and on or about November 14, 1990, Respondent treated Patient F for peripheral vascular disease at CMC.**

- 1. Respondent failed to take and record an adequate history and**

physical of Patient F.

2. Respondent failed to properly assess and document the patient's peripheral vascular condition. He failed to take and record pulses and order Doppler vascular flow studies and other appropriate diagnostic studies.
3. On or about September 24, 1990, Respondent performed a femoral/popliteal bypass/graft which was not indicated.
4. Respondent failed to maintain a medical record for Patient F which accurately reflects the Patient's complaints, history, physical examination, diagnosis, progress notes, operative reports discharge summary and treatment plan.

G. Between on or about May 31, 1995 and on or about June 31, 1995, Respondent treated Patient G for reflux esophagitis at CMC.

1. On or about June 31, 1995, Respondent made a fraudulent entry in the hospital chart for Patient G. The fraudulent entry consisted of a statement by Respondent that on June 31, 1995 he had performed a laparoscopic abdominal repair and lysis of adhesions. Respondent knew this statement was false. The actual surgery Respondent performed was an endoscopic repair of a hiatal hernia, a procedure for which Respondent was not credentialed by CMC to perform.
2. Respondent failed to maintain a medical record for Patient G which accurately reflects the Patient's complaints, history, physical examination, diagnosis, progress notes, operative reports and treatment plan.

## **SPECIFICATION OF CHARGES**

### **FIRST THROUGH SIXTH SPECIFICATIONS PRACTICING WITH GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1997) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A(1) through A(10).
2. Paragraphs B and B(1) through B(7).
3. Paragraphs C and C(1) through C(6).
4. Paragraphs D and D(1) through D(3).
5. Paragraphs E and E(1) through E(5).
6. Paragraphs F and F(1) through F(4).

**SEVENTH THROUGH TWELFTH SPECIFICATIONS**  
**PRACTICING WITH GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1997) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

7. Paragraphs A and A(1) through A(10).
8. Paragraphs B and B(1) through B(7).
9. Paragraphs C and C(1) through C(6).
10. Paragraphs D and D(1) through D(3).
11. Paragraphs E and E(1) through E(5).
12. Paragraphs F and F(1) through F(4).

**THIRTEENTH 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. 1997) 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:

13. Paragraphs A, A(1) through A(10); B, B(1) through B(7); C and C(1) through C(6); D and D(1) through D(3); E and E(1) through E(5); and F and F(1) through F(4).

**FOURTEENTH 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. 1997) 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:

14. Paragraphs A, A(1) through A(10); B, B(1) through B(7); C and C(1) through C(6); D and D(1) through D(3); E and E(1) through E(5); and F and F(1) through F(4).

**FIFTEENTH SPECIFICATION**  
**FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1997) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

15. Paragraphs G and G(1).

**SIXTEENTH SPECIFICATION**  
**MAKING A FALSE REPORT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) in that he willfully made or filed a false report as alleged

in the facts of:

16. Paragraphs G and G(1).

**SEVENTEENTH SPECIFICATION**  
**LACK OF INFORMED CONSENT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(26)(McKinney Supp. 1997) in that he performed professional services which were not duly authorized by the patient or his legal representative, as alleged in the facts of

17. Paragraphs E and E(5).

**EIGHTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS**  
**FAILURE TO MAINTAIN ADEQUATE RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1997) in that he failed to maintain records for patients which accurately reflect the evaluation and treatment of the patients, as alleged in the facts of:

18. Paragraphs A and A(10).

19. Paragraphs B and B(7).

20. Paragraphs C and C(6).

21. Paragraphs D and D(3).

22. Paragraphs E and E(5).

23. Paragraphs F and F(4).

24. Paragraphs G and G(2).

DATED: October 14, 1997  
New York, New York



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ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct