



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*

Dennis P. Whalen  
*Executive Deputy Commissioner*

December 30, 1997

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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

Anthony Z. Scher, Esq.  
Wood & Scher  
The Harwood Building  
14 Harwood Court - Suite 512  
Scarsdale, New York 10583

Michael P. Moore, M.D.  
9 Cross Road  
Darien, Connecticut 06820

**RE: In the Matter of Michael P. Moore, M.D.**

Dear Mr. Sheehan, Mr. Scher and Dr. Moore:

Enclosed please find the Determination and Order (No. BPMC-97-330) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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" followed by a stylized flourish.

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:crc  
Enclosure

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

**COPY**

**IN THE MATTER  
OF  
MICHAEL P. MOORE, M.D.**

**DETERMINATION  
AND  
ORDER**

BPMC-97-330

**MICHAEL R. GOLDING, M.D.**, Chairperson, **JOSEPH B. CLEARY, M.D.** and **EUGENIA HERBST**, duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee. After consideration of the entire record, the Hearing Committee submits this Determination.

**SUMMARY OF PROCEEDINGS**

Notice of Hearing :	November 7, 1996
Amended Statement of Charges (Ex. 1A) :	April, 1997
Pre-hearing Conference:	December 17, 1996
Dates of Hearing:	December 20, 1996; February 20, 21, 24, 25, 1997; March 6, 7, 11, 21, 1997; April 10, 11, 24, 25, 1997; May 13, 15, 20 23, 1997; June 9, 10, 1997; July 10, 1997
Department of Health appeared by:	Henry M. Greenberg, General Counsel NYS Department of Health BY: <b>TERRENCE J. SHEEHAN, Esq.</b> Associate Counsel NYS Department of Health 5 Penn Plaza New York, New York 10001-1803

Respondent appeared by: **ANTHONY Z. SCHER, Esq.**  
The Harwood Building  
Scarsdale, New York 10583

Witnesses for the Department of Health: **Ronald S. Forlenza, M.D.;**  
**Father of Patient A;**  
**Patient B;**  
**Patient C;**  
**Patient F;**  
**Patient G;**  
**Patient H;**  
**Patient J;**  
**Patrick Borgen, M.D.;**  
**Denise Oswald;**  
**Rosalind Kleban;**  
**Murray F. Brennan, M.D.;**  
**Cynthia McCollum;**  
**Judy Hagerty**

Witnesses for the Respondent: **Frank Ernst Gump, M.D.;**  
**David W. Kinne, M.D.;**  
**Ted A. Chaglassian, M.D.**  
**Doris Chiarra DelMonaco, R.N.**  
**Michael P. Moore, M.D. (Respondent)**

Final Submissions: **August 19, 1997**

Deliberations held: **September 12, 15, 1997;**  
**October 6, 7, 1997;**  
**December 23, 1997**

### **AMENDMENTS TO THE STATEMENT OF CHARGES**

**An Amended Statement of Charges (Ex. 1A) was received in evidence on April 10, 1997. This exhibit contained several changes to the original Statement of Charges (Ex. 1) served on Respondent, including amendment of the date of treatment in Paragraphs B.1., B.2. and B. 4. and the addition of Factual Allegations related to Respondent's treatment of Patient J. The Department also stipulated to withdraw Factual Allegation F. 2. and all Factual Allegations**

related to Respondent's treatment of Patient I. A copy of Exhibit 1A is attached to this Decision and Order as Appendix I.

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE:           Petitioner's Exhibits are designated by Numbers.

                  Respondent's exhibits are designated by Letters.

                  T = Transcript

### **SIGNIFICANT LEGAL ISSUES**

On the morning of March 21, 1997, Respondent notified his counsel that he had been hurt in an accident and would be unable to attend that day's scheduled hearing. Respondent's counsel requested an adjournment, which was not opposed by the Department, based on his need for the assistance of the Respondent. The Administrative Law Judge, exercising the authority granted pursuant to 10 NYCRR 51.9, determined to deny the request and to proceed with the testimony of two Department witnesses, Dr. Borgen and Patient H. This decision was based on a determination that Respondent's counsel was capable of proceeding in Respondent's absence for one day and considered the fact that the two witnesses were present and prepared to testify. The Committee concurred with this decision by a majority vote. Respondent's counsel was advised of his opportunity to recall the witnesses at a later date for additional cross-examination. Counsel chose to not participate without the presence of Respondent and left the hearing room. The two witnesses proceeded to testify and were questioned by the Committee and each was advised to cooperate and return for additional questioning if they were recalled by the Respondent. Ultimately, Respondent chose to not recall either witness.

## **GENERAL FINDINGS OF FACT**

The Respondent was authorized to practice medicine in New York on or about July 1, 1981 by the issuance of license number 146462 by the New York State Education Department.

### **FINDINGS OF FACT RELATED TO PATIENT A**

1. Patient A, a 38 year old female, was first seen by Respondent on October 2, 1991 at the Memorial Sloan-Kettering Cancer Center (hereinafter "the Center"). The patient had felt a lump the size of a quarter during a breast self-examination. (Ex. 2A, p.15)

2. On October 8, 1991, Respondent performed a local excision and examination of the right breast mass. The pathological analysis of the specimen indicated a finding of multiple foci of intraductal carcinoma with a solid pattern of duct involvement. The gross description was that the portions of the specimen showed multiple areas of firm white tissue which ranged from 0.1 to 0.2 centimeters in largest dimension and were dispersed throughout the sections. (Ex. 2A, pp. 18-9, 21)

3. In a letter to Patient A dated November 26, 1991, Respondent informed her that he had reviewed the pathology with Dr. Peter Rosen, a pathologist at the Center. The letter described the patient as having "a minute focus of intraductal carcinoma involving several ducts found as an incidental finding." A recommendation by the Respondent of close observation was included in the correspondence. (Ex. 13)

4. It would have been appropriate for Patient A to have undergone a follow-up mammogram a short time after the the October 8, 1991 procedure based on the pathology of the right breast mass. (T. 99-100)

5. A mammogram performed on Patient A on February 12, 1992, four months subsequent to the local excision, indicated a right breast mass and associated fine calcifications which may have represented residual malignancy. A needle aspiration was performed on the same day and the cytology report was positive for malignant adenocarcinoma. (Ex. 2A, pp. 14, 20)

6. Respondent performed a second local excision and exploration of Patient A's right breast on March 17, 1992. The pathology report indicated intraductal and infiltrating poorly differentiated duct carcinoma 0.3 centimeters in size. (Ex. 2A, pp. 17, 23)

7. Patient A repeatedly telephoned Respondent's office for several months to learn the results of the second surgical procedure. She did not speak with the Respondent, nor was she advised of the pathology results, until approximately three months following the surgery. (T. 490)

8. Patient A, accompanied by her father, saw the Respondent on June 19, 1992. Respondent described the findings of the March excision as "microscopic". (T.491)

9. A needle biopsy of Patient A's liver was performed in August, 1992. The results indicated metastatic adenocarcinoma, moderately differentiated, compatible with primary mammary duct carcinoma. (Ex. 29, p. 73; T. 39)

#### **FINDINGS OF FACT RELATED TO PATIENT B**

10. Patient B, a 43 year old female, first saw Respondent on January 7, 1994 following the discovery of a suspicious mass in her right breast seen on a screening mammogram. The mass was non-palpable and Respondent ordered a stereotactic biopsy, which was performed on

January 18, 1994. The results of this procedure were positive for infiltrating ductal cancer.  
(Ex. 3A, pp. 28-9, 37, 192)

11. Respondent noted in Patient B's medical record in entries dated January 21, 1994 that his plan of treatment was to perform a needle localization with ultrasound and right wide local excision and right axillary dissection. He recorded that he discussed options, risks and benefits with the patient. Patient B signed a consent form for such procedures on January 21, 1994.  
(Ex. 3A, pp. 150, 193-4)

12. On January 27, 1994, Respondent performed a right axillary lymph node dissection and right breast wide excision of an ill-defined right upper quadrant mass. Respondent did not perform a pre-operative needle localization with ultrasound. (Ex.3A, pp.152-3)

13. The pathology report for the January 27, 1994 procedures indicated that no carcinoma was identified in the entirely submitted specimen. One of thirteen lymph nodes was reported to be positive for metastatic carcinoma. (Ex. 3A, pp. 163-6)

14. Based on the failure to perform a pre-operative needle localization and the pathology report which indicated that no carcinoma was identified in the submitted specimen, accepted standards of medical practice required that a post-operative mammogram or sonogram be performed to confirm that the mass had been removed. (Ex. 3A, pp.129-30)

15. Patient B had a mammogram and sonogram performed in January, 1995 which confirmed the presence of a right breast mass. Dr. Patrick Borgen performed a right breast biopsy on January 10, 1995 which resulted in a diagnosis of in situ and invasive ductal carcinoma. (Ex. 3A, pp. 24-5, 30, 34-6)

16. Respondent did not advise Patient B that he had failed to remove the breast mass during the January 27, 1994 procedure. (T. 916-7)

17. Respondent referred Patient B for chemotherapy and radiation therapy subsequent to the January 27, 1994 wide excision. Patient B underwent eight cycles of chemotherapy treatment from March 3 through August 4, 1994 followed by about two months of radiation therapy. (Ex. 3A , pp. 200-6, 213-7; T. 915 )

18. It was not appropriate to treat Patient B with radiation therapy because the breast mass had not been removed and invasive cancer remained in her breast. (T. 132-3)

#### **FINDINGS OF FACT RELATED TO PATIENT C**

19. Patient C, a 59 year old woman, was first seen by Respondent on August 3, 1988 and presented with a mammogram which showed a suspicious looking lesion in her left breast. He noted that the lesion was less suspicious following palpation and recommended a local excision and examination. (Ex. 4A, p. 6)

20. On August 29, 1988, Respondent operated to remove the left breast lesion. The pathology report identified no lesions suspicious for carcinoma. (Ex. 4A, pp. 9-11)

21. Respondent should have realized that there was a likelihood that he failed to remove the lesion, based on the pathology findings, and should have ordered a follow-up mammogram to confirm that it had been removed. (T. 1093-4)

22. If the lesion on the mammogram seen by Respondent on Patient C's initial office visit was considered to be suspicious and only benign tissue was removed by the local excision, it

would have been appropriate for Respondent to have ordered a follow-up mammogram approximately six months following the initial biopsy. (T. 254-5)

23. Respondent did not order a mammogram for Patient C following the August, 1988 procedure until on or about December 21, 1989. The test was performed on January 8, 1990 and indicated the presence of a left breast nodule. Another physician performed a mastectomy and axillary dissection on February 8, 1990. The pathology of the tissue recovered from such procedures indicated a 2.0 centimeter infiltrating duct carcinoma and metastatic carcinoma to one of twenty-six axillary lymph nodes. (Ex. 4A, p. 14, Ex. 4B, pp. 3, 8-9)

#### **FINDINGS OF FACT RELATED TO PATIENT D**

24. Patient D, a 56 year old female, was first seen by Respondent on March 3, 1989. A right breast mass and bilateral microcalcifications had recently been seen on a mammogram. Respondent's plan of treatment was to perform bilateral needle localizations and a local excision and exploration. (Ex. 5, pp.7- 8, 16)

25. On March 9, 1989, Patient D underwent surgery to remove the right breast mass and bilateral microcalcifications, which had been pre-operatively needle localized. (Ex. 5, pp. 4, 6)

26. The pathology report of the right breast specimen made no reference to a mass and indicated "benign" findings of the frozen section and findings of "fibrocystic mastopathy; duct papilloma" of the paraffin section. Findings of the left breast specimen were calcifications and intraductal carcinoma. (Ex. 5, p. 2)

27. The patient was seen by Respondent on August 9, 1989 with a complaint that a right breast mass remained. Another surgeon performed a re-excision of the right breast and right modified radical mastectomy on August 30, 1989 and removed a mass measuring 2.4 centimeters which proved to be an infiltrating duct carcinoma. (Ex. 5, pp. 10-12, 48; T. 2039)

28. The operative note for the March 9, 1989 procedure notes that " X-rays denoted calcifications were removed". A mammogram report dated August 25, 1989 states that "the previously observed calcifications are no longer present. a few radiographically benign calcifications are scattered in the right breast". (Ex. 5, p. 4; Ex. 22, p. 1)

29. Respondent saw Patient D following the March 9 surgery on March 17 and March 31, 1989. He next saw her approximately four months later on August 9, 1989. He did not inform her that he had not removed the mass and of the consequent need for additional surgery. Based on the pathology of the removed specimens, appropriate and adequate management of the patient's condition would have included an office visit every three months and a repeat mammogram within three months. (Ex. 5, p.9; T. 400)

#### **FINDINGS OF FACT RELATED TO PATIENT E**

30. Patient E, a 46 year old female, was a patient of Dr. Patrick Borgen. A mammogram report dated December 16, 1992 referred to a left breast nodule that had been present since 1989 and which appeared to be stable and was presumed to be benign. The report also indicated an impression of microcalcifications, representing an interval change. A biopsy was recommended. Patient E signed a consent form that day authorizing Dr. Borgen to perform a left breast local excision and examination and a needle localization. (Ex. 6A, pp. 229-30, 232)

31. Dr. Borgen was most concerned about the findings related to the microcalcifications. Although the patient was concerned about the presence of a cystic nodule, the surgery was not planned with the intention of removing the nodule. (T.1225, 1231, 1238)

32. Respondent saw the patient on or about December 18, 1992 in anticipation of performing the surgery as a substitute for Dr. Borgen. A copy of the earlier consent form was modified by the addition of Respondent's name to reflect the fact that he was to perform the surgery instead of Dr. Borgen. The patient did not initial the change of the form. Respondent did not write a note related to this visit in the patient's medical record. (Ex. 6A, pp. 231, 243)

33. On December 22, 1992, Respondent operated on Patient E to remove microcalcifications of the left breast. Respondent aspirated a cystic nodule during the surgery, but failed to note such action in the operative report. (Ex. 6A, pp. 236, 243; T. 2052-5)

34. The aspiration of a cyst during surgery is not a routine matter and it is a standard of practice to record in an operative report that a cyst has been aspirated. (T. 1117)

35. Patient E attempted to contact Respondent to discuss her medical condition on numerous occasions between the date of the surgery and March, 1993. The patient was concerned about the status of the cystic nodule that had been observed on the pre-operative mammogram. (T. 1017-8, 1030-2, 2055-6)

36. A patient representative, Denise Oswald, was asked to assist in resolving the situation. The patient, her husband and Ms. Oswald met with the Respondent in or about late February or early March, 1993. Respondent performed a physical examination of the patient. During the course of such examination, Respondent made a statement to the effect of "do you have a gun so that I can put this patient out of her misery?". (Ex. 6A, pp. 240-2; T. 1019-21)

37. Respondent informed both Patient E and Ms. Oswald at this meeting, and in the course of other conversations before and after such meeting, that the cystic nodule had been aspirated during the December, 1992 surgery. He also indicated, in a letter to Ms. Oswald dated April 1, 1993, that the patient "also had an aspiration of a cyst at time of surgery. The patient was informed of the benign nature...in the first post-operative visit".

(Ex. 6A, p. 243; T. 1042, 1048-9, 2056)

38. A request was made by the Office of Professional Medical Conduct to the Center's Medical Records Department in 1993 for a certified copy of Respondent's medical records of Patient E. In attempting to obtain a full and accurate record, staff of the Center noted discrepancies between copies of certain documents contained within the medical record. It was determined that notes had been added to the record subsequent to its being copied, including the following:

- a. an entry dated either March 19, or May 19, 1993 (Ex. 16, p.2);
- b. an entry dated February 24, 1993 (Ex. 16, pp. 7-8);
- c. an undated entry below a note dated "2/93" (Ex. 16, p. 12);
- d. a note "pt. informed" and underlined portion of the diagnosis written on a copy of the pathology report for the December 22, 1992 surgery  
(Ex. 16, p.13).

Senior members of the Center's administration were notified of these discrepancies, including the Chairman of the Department of Surgery, Dr. Murray F. Brennan. (T.674-6, 679, 685-692)

39. Dr. Brennan met with Respondent on or about May 27, 1993 to address the subject of the discrepancies found in Patient E's medical record. Respondent was advised by Dr. Brennan that the alteration of medical records was unacceptable and that if it occurred again it could result in his dismissal. Respondent offered no explanation for the questionable chart entries.

A letter dated June 8, 1993 from Dr. Brennan which confirmed the discussion was sent to the Respondent. He did not respond to such letter. (Ex. 18, T.2074-6, 2115-6, 2919-21)

40. The signature which appeared to have been added to Patient E's medical record in an entry dated February 28, 1993 was not the Respondent's, but was the signature of a nurse, Janice Hayes Davis. (Ex. 16, pp. 3, 6; T. 2110, 2128)

41. The note of a social worker dated May 12, 1993 and included in Patient E's chart was written after that date and was predated at the author's initiative and not at the request of the Respondent. (Ex. 16, pp. 9-10; T. 2906-7)

42. The record maintained by Respondent for Patient E failed to meet the minimally accepted standards of medical recordkeeping. (T. 1116)

#### **FINDINGS OF FACT RELATED TO PATIENT F**

43. Patient F, a 64 year old female, was first seen by Respondent on March 16, 1994 following bilateral breast biopsies which demonstrated in situ and invasive carcinoma in both breasts. (Ex. 7A, pp. 230-2)

44. Respondent performed a left lumpectomy, an axillary lymph node dissection and right breast modified radical mastectomy with tissue expander placement on Patient F on March 28, 1994. (Ex. 7A,, p.224)

45. The pathology report described both in situ and invasive carcinoma at the biopsy margins, meaning that the excision did not remove all the cancer present in the left breast. Respondent did not re-excise the tumor margins. (Ex. 7A, pp. 260-3; T. 425, 2279-81)

46. Respondent referred Patient F to an oncologist for chemotherapy treatment. The patient was assessed by the oncologist on or about May 5, 1994 who noted in the patient's chart that Respondent wanted Patient E to receive chemotherapy first and that he thereafter intended to perform further surgery on the left breast. (Ex. 7A, pp. 31-4, 219, 326)

47. The decision to administer chemotherapy to a patient with tumor margins which are not clear is a judgement call which may be appropriate treatment when a patient is at risk for the development of metastatic disease. (T. 429, 2583-7)

48. A discharge summary dated April 4, 1994 was prepared for Patient F in which it inaccurately recorded negative findings of right breast lymph nodes and negative margins of the left breast. Respondent did not sign the discharge summary. (Ex. 7A, pp.230-1)

49. The medical record for Patient F, as maintained by Respondent, did not constitute a minimally acceptable medical record. (T. 433)

#### **FINDINGS OF FACT RELATED TO PATIENT G**

50. In or about June, 1988, a surgical biopsy performed in New Jersey demonstrated extensive intraductal carcinoma and lobular carcinoma in Patient G's right breast. Patient G, a 41 year old female, saw Respondent at an initial office visit on July 7, 1988. On July 14, 1988, Respondent re-excised the biopsy site and performed a right axillary lymph node dissection. No residual carcinoma or tumor was identified. (Ex. 8A, pp. 151-7, 169)

51. Patient G was at risk for local recurrence and for development of cancer in her left breast. Appropriate monitoring of her condition would have included regular office visits and annual mammograms. (T. 1151)

52. Patient G underwent radiation therapy from August through October, 1988 as performed by oncologists in New Jersey. In May, 1989 she received a mammogram and in August, 1990 a xerogram was performed; results from both tests were normal.

(Ex. 8G, pp. 5, 7-8, Ex. 28, p. 149 [reverse side])

53. A note by the oncologist dated April 9, 1991 stated that "patient is being seen by her surgeon regularly and has had mammography since last visit here" (which was October 26, 1990). Respondent recorded in Patient G's chart, in an entry dated June 12, 1991, "mammo this August". Another entry in the oncologist's records, dated October 15, 1991, stated "patient to have a mammography this month". (Ex. 8G, pp.8-11, Ex. 28, p. 149 [reverse side])

54. Patient G was seen by Respondent on or about March 27, 1992. He recorded "NED", representing "no evidence of disease" in the patient's medical record. She had not felt any lump in her breast at that time. (Ex. 28, p. 149 [reverse side]; T. 563)

55. Patient G found a small lump in her right breast in approximately late May, 1992. On or about May 27, 1992, Respondent performed a fine needle aspiration of the lump. The cytology report indicated "negative findings for malignant cells, scanty duct epithelium, poorly preserved specimen". Respondent recorded that "the patient will return in one month if (the mass) persists". (Ex. 28, pp. 150, 171; T. 519, 562-4)

56. The results of the aspiration could be characterized as non-definitive based on the cytology report. Due to the patient's history of disease, appropriate treatment would have been to remove the mass surgically by an excisional biopsy or to order further diagnostic studies, such as a mammogram. Any surgery should have been performed as quickly as possible.

(T.1158-60; 1201-2)

57. Two or three days following the procedure, Respondent informed Patient G that the results of the aspiration were benign. The patient was advised to return three weeks thereafter. Patient G called Respondent's office at that time and was told the Respondent was out of the office following a leg injury. She was told to call back in a few days. The patient delayed calling Respondent back until approximately late July, 1992. Respondent excised the right breast mass on August 11, 1992. (Ex. 28, p. 150 [reverse side]; T. 519-20)

58. On or about September 28, 1992, a total mastectomy of Patient G's right breast was performed, revealing an invasive ductal carcinoma measuring 3.5 cm. (Ex. 28, pp. 160-1)

#### **FINDINGS OF FACT RELATED TO PATIENT H**

59. Patient H, a 36 year old female with a history of Hodgkin's disease at age 18, was referred to Respondent following the performance of a mammogram which revealed a cystic lesion in her right breast. The patient's initial office visit with Respondent was on May 4, 1994, at which time he performed a needle aspiration of the cyst. (Ex. 9A, pp. 4-5)

60. The cyst recurred and, on July 13, 1994, Respondent aspirated it a second time. The cytology for the aspirated fluid was found to contain cells suspicious for adenocarcinoma. (Ex. 9A, pp. 7-8)

61. On or about August 9, 1994, Respondent performed an excisional biopsy of the cystic lesion. The paraffin section pathology report of the surgery states, in part, "Intraoperative consultation:, frozen section diagnosis: invasive cystic carcinoma, focally invading the lateral margin." No finding of pre-cancerous cells was noted in the report. Respondent did not re-excise the tumor which was focally invading the lateral margin. (Ex. 9A, pp. 10-13)

62. Respondent spoke with Patient H in the recovery room following the excisional biopsy. He assured her that she had no reason to be concerned and that no malignancy had been found. Patient H did not see the Respondent following her discharge from the recovery room. (T. 1303-6)

63. A few days thereafter, Respondent telephoned Patient H and advised her that the mass had been removed, that she had been diagnosed as having intracystic carcinoma and that the pathology report had indicated the presence of a combination of cancerous and pre-cancerous cells. (T. 1304-6, 2485, 2503)

64. Any reference to the presence of precancerous cells was not accurate and would constitute a departure from accepted standards of practice. (T. 2673-4)

65. Respondent referred Patient H to a radiation therapist to have her evaluated for "further therapeutic options" and to establish whether she would be a candidate for radiation therapy based on her history of having received radiation therapy as treatment for Hodgkin's disease. The therapist examined the patient on or about August 18, 1994 and recommended that "further radiation therapy at this time is contraindicated". (Ex. 9A, p. 114)

66. On August 25, 1994, Patient H underwent a right breast modified radical mastectomy which was performed by another surgeon. (Ex. 9A, p. 17)

67. The medical records for Patient H, as maintained by Respondent, did not meet accepted standards for medical recordkeeping. (T. 1368, 1391-2, 1415-6)

## **FINDINGS OF FACT RELATED TO PATIENT J**

68. Patient J, a 46 year old female, was first seen by Respondent on December 14, 1995. She had been referred following the discovery of a nodular density in her right breast which was observed by mammograms to have increased in size over a period of several years. (Ex. 31A, pp. 4, 15)

69. Respondent performed a right breast biopsy with needle localization on Patient J on December 20, 1995. A specimen radiograph was obtained during the surgery. The report indicated that "the mass is not clearly seen in the specimen radiogram. However, the lesion is probably within the specimen and a three month mammogram is recommended for verification." Respondent did not order additional films and did not excise additional tissue. (Ex. 31A, pp. 6-7)

70. There were no additional studies that could have been performed to obtain a more definitive determination as to whether the lesion had been removed. (T. 1486, 1488)

71. Subsequent to the surgery, Respondent caused the patient to believe that the lesion had been removed and did not inform Patient J that it had not been conclusively determined that, in fact, the mass had been excised from her right breast. (T.1450-55)

72. Patient J had a follow-up mammogram performed on or about April 23, 1996, the results of which indicated the presence of a right breast nodular density. The mammography report suggested the performance of a stereotactic core biopsy. (Ex. 31A, p. 9)

73. A note in the patient's chart, written by a nurse employed by Respondent, indicated that numerous telephone calls were made to the patient's home to inform her of the test results. The note states that these calls were not answered and that no message was left by Respondent or his staff on the patient's answering machine. Although dated April 29, 1996, there is a notation that this chart entry was "written late: after the fact". Patient J was not informed of the test results until May 23, 1996. (Ex. 31A, p 16; T. 1454-7)

74. The medical record of Patient J maintained by Respondent was a complete and accurate record of his treatment of her. (T. 1505)

### CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A. 1. :	( 2-4 );
Paragraph A. 2. :	( 5-7 );
Paragraph A. 3. :	( 3, 7-8 );
Paragraph A. 4. :	( 9 );
Paragraph B. 1. :	( 10, 12);
Paragraph B. 3. :	( 12-14 );
Paragraph B. 4. :	( 15);

Paragraph B. 5. :	( 16 );
Paragraph B. 6. :	( 17-8 );
Paragraph C. 1. :	( 20 );
Paragraph C. 1. a. :	( 20, 23 );
Paragraph C. 1. b. :	( 20-1 );
Paragraph C. 2. :	( 22-3 );
Paragraph C. 3. :	( 23 );
Paragraph D. 1. :	( 25 );
Paragraph D. 1. a. :	( 26-7 );
Paragraph D. 2. :	( 29 );
Paragraph D. 3. :	( 29 );
Paragraph D. 4. :	( 27 );
Paragraph E. 4. ( 2-1 majority vote ) :	( 38 );
Paragraph E. 5. :	( 36 )
Paragraph E. 6. (2-1 majority vote) :	( 32-4, 38, 42 );
Paragraph F. 1. :	( 44 );
Paragraph F. 3. :	( 45 );
Paragraph F. 6. :	( 48-9);
Paragraph G. 1. :	( 50 );
Paragraph G. 2. :	( 53 );
Paragraph G. 4. :	( 55-7 );
Paragraph G. 5. :	( 58 );
Paragraph H. 1. :	( 61 );
Paragraph H. 1. a. :	( 61 );
Paragraph H. 1. b. :	( 63 );
Paragraph H. 2. :	( 63-4 );
Paragraph H. 4. :	( 66 );

Paragraph H. 5. : ( 67 );

Paragraph J. 3. : ( 71 );

Paragraph J. 4. : ( 72-3).

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that the following Specifications of Professional Misconduct should be **SUSTAINED** based on the Factual Allegations which were sustained as set out above:

Nineteenth Specification, as it related to the following Paragraphs only:

A. 1., A. 2., A. 3.;

B. 1., B. 3., B. 5., B. 6.;

C. 1. b., C. 2.;

D. 2., D. 3.;

E. 4.;

G. 2., G. 4.;

H. 2.;

J. 3., J. 4.;

Twenty-third Specification;

Twenty-eighth Specification;

Thirty-seventh Specification;

Thirty-eighth Specification, as it related to Paragraph F. 6. only;

Fortieth Specification.

The Hearing Committee determined that all other Specifications of Professional Misconduct should **NOT BE SUSTAINED.**

### **DISCUSSION**

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for certain types of professional misconduct.

The following definitions were utilized by the Hearing Committee during its deliberations:

**Negligence** is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

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

**Incompetence** is a lack of the skill or knowledge necessary to practice the profession.

**Gross Incompetence** is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

**Fraudulent practice of medicine** is an intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

The Committee recognized that it was essential to determine the acceptable standard of medical practice for each case at issue. It was therefore necessary to evaluate the credentials and testimony of each expert witness to determine his credibility and the appropriate weight to be assigned to each witness' testimony.

Dr. Forlenza was considered by the Committee to be very familiar and experienced with the practice of breast surgery. The preciseness and clarity of his testimony was appreciated and his opinions were based on open-minded thinking and were not seen as dogmatic. He was not always in full agreement with the Department's positions and was honest and persuasive. The Committee found his testimony to be most credible and relied heavily on his expert opinions.

Dr. Gump and Dr. Kinne were acknowledged to have great expertise in their fields and the extent of their experience was noted. A majority of the Committee felt that Dr. Forlenza was more objective. An example which led to this impression was Dr. Kinne's testimony, related to Respondent's care of Patient H, in which he appeared to state that it could be acceptable to misinform a patient about her condition in some circumstances. The opinions of Dr. Gump and Dr. Kinne were accorded less significance by the Committee. It was also noted that both experts offered testimony which supported some of the Allegations made by the Department, particularly those related to Patients A and H.

A majority of the Committee felt that the Respondent offered credible testimony on some specific points, but observed that he failed to acknowledge and assume responsibility for what were clear deviations from accepted practice standards. Blame was placed on patients or other health care professionals for missed diagnoses or inadequate records. More than once he referred to the psychiatric history of patients, inferring that the complaints were made by irrational individuals. His answers were frequently evasive or argumentative and it was obvious that he felt that the criticisms of his practice amounted to no more than the bureaucratic nit-picking of small technicalities. He demonstrated little remorse for his errors.

## **THE STATEMENT OF CHARGES**

The Committee felt it necessary to address the language of the Department's Statement of Charges as it believed that the lack of precision and the often inaccurate language unnecessarily extended this proceeding. Numerous Factual Allegations, while factually correct, clearly did not constitute professional misconduct. These Allegations are not discussed in the Conclusions of Law section, below. Although simple statements of fact, it was noted that the Department's position was that each was evidence of the practice of the profession with negligence, gross negligence, incompetence and gross incompetence. The Committee believed that this blanket application of charges served no purpose. The Factual Allegations which were sustained because they were true, but which were not found to be evidence of misconduct were as follows:

Factual Allegation A. 4.;

Factual Allegation B. 4.;

Factual Allegations C. 1., C. 1. a. and C. 3.;

Factual Allegations D. 1., D. 1. a. and D. 4.;

Factual Allegations F. 1. and F. 3.;

Factual Allegations G. 1. and G. 5.;

Factual Allegations H. 1., H. 1. a., H. 1. b., and H. 4.;

Factual Allegation J. 1.

Factual Allegations B. 4., C. 1. a., D. 1. a., H. 1. a. and J. 1. each allege misconduct based on Respondent's failure to completely remove a breast lesion. Each of the three medical experts testified that excisions are sometimes not successful. The failure to remove a mass does not, in and of itself, constitute misconduct. The Committee considered the issue more accurately to be whether it met accepted standards of practice for the Respondent to believe that a lesion had been excised and, if not within those standards, what subsequent actions were taken to ensure that the original plan of treatment was accomplished. A more accurate charge would have alleged that Respondent knew, or should have known, that a lesion had not been removed.

However, he was charged with failing to perform diagnostic tests to confirm that the lesions had been removed in only two cases; Patients B and C. The Committee was concerned that the language of certain Allegations did not adequately address the deficiencies of Respondent's medical practice. It did not believe that it was the responsibility of the Committee to broaden its interpretation of the charges so as to address those concerns.

### CONCLUSIONS RELATED TO PATIENT A

The Hearing Committee sustained Factual Allegation A. 1. based on the pathology of the right breast mass excised by the Respondent on October 8, 1991. It agreed with Dr. Gump that the pathology demonstrated multi-focal intraductal carcinoma distributed throughout the specimen. The Committee believed that appropriate follow-up would have required a mammogram sooner than four months after the excision. It did not accept Respondent's explanation that his consultation with Dr. Peter Rosen, a respected pathologist with the Center, led him to believe that the findings demonstrated an isolated focus of ductal carcinoma in situ; a less significant finding than that described in the pathology report. There was no testimony that the original report was ever amended or that Respondent recorded Dr. Rosen's conclusions. There is no evidence that Dr. Rosen ever wrote a note reflecting his findings. The Committee reasoned that a change in diagnosis or treatment would necessitate documentation in the medical record. The delay of a follow-up mammogram until February, 1992 was considered to not be responsive or appropriate treatment of Patient A's condition as reflected in the pathology report.

Factual Allegations A. 2. and A. 3. were sustained primarily because of the testimony of Patient A's father. The Committee found his testimony to be very credible. His answers were honest and he did not appear embittered by his family's experiences with the Respondent. His testimony that Patient A did not learn of the results of the second excision for about three months

thereafter was considered believable. His statement that the patient was unable to speak with the Respondent to discuss the pathology of the March, 1992 biopsy contradicted Respondent's testimony that Patient A chose to observe her condition and to not undergo further therapy at that time. The Committee found the father's testimony on that point to be more credible than Respondent's contention that he made notes of a discussion with the patient as to her treatment options which were subsequently not found in any of the medical records provided for this proceeding.

Factual Allegation A. 3. was sustained with the modification that Respondent failed to advise the patient of the need for "appropriate" treatment. The Committee considered the letter of November 26, 1991 to be an incorrect and inadequate interpretation of the pathology report of the October, 1991 procedure. Dr. Gump testified that the intraductal carcinoma was not an incidental finding because she presented with a lump. The inaccurate letter and failure to discuss the results of the second excision with the patient were failures to accurately advise her of her condition.

The Committee could not determine whether or not Respondent's medical record met acceptable standards of practice because it could not find that they were adequately maintained by the Center. It was noted that three separate charts, Exhibits 2A, 29 and C, were each certified as being accurate and complete, yet were not identical. Respondent's letter to Patient A of November 26, 1991 was not found in any of those three exhibits. Factual Allegation A. 5. was not sustained because it could not be established that the patient's full record was provided.

### **CONCLUSIONS RELATED TO PATIENT B**

The Committee believed that the results of the biopsy performed on Patient B on January 18, 1994 indicated the performance of a needle localization prior to the January 27, 1994 surgery. Respondent testified that on the day of surgery he was able to palpate the previously non-palpable lesion and therefore cancelled the scheduled localization. The Committee relied on

Dr. Forlenza's testimony that hemorrhages could have occurred along the needle track if the tissue had been manipulated during the January 18 stereotactic biopsy, thereby making it more difficult to palpate the lesion. Respondent should have considered the possibility that he was not palpating the lesion itself before the needle localization was cancelled. Factual Allegation B. 1. was sustained.

The record of the patient clearly indicates that she was made aware of the nature and purpose of the January 27, 1994 surgery. She signed a patient consent form which listed the performance of an axillary lymph node dissection and Respondent recorded that options, risks and benefits of the procedure had been discussed. Factual Allegation B. 2. was not sustained.

The Committee believed that diagnostic tests should have been ordered and performed to confirm that the mass had been removed pursuant to the wide excision. The contention by Respondent that he felt it most important to treat the positive lymph node by systemic therapy before confirming that the lesion had been removed was rejected by the Committee as being an inadequate response to the positive findings. It was felt that the performance of an imaging test would not have interfered with the administration of chemotherapy and would have been beneficial to the patient. Factual Allegation B. 3. was sustained.

Patient B testified that she was not told of the possibility that the lesion had not been removed during the January 27 surgery. Respondent could not recall if he advised her of that possibility, but testified that he believed that he had, in fact, excised the mass and that he did not feel additional surgery would be necessary. Dr. Gump testified that Respondent should have had a strong feeling that he may have missed the mass. The Committee agreed and concluded that it was unreasonable for him to be confident that the mass had been removed in view of the cancellation of the needle localization and pathology report which indicated that no carcinoma had been identified. This was particularly so because a discrete lesion had previously been identified during the January 18 biopsy. Respondent did not meet acceptable standards of practice in that he failed to confirm that the mass had been removed. Factual Allegation B. 5. was sustained.

The Committee concluded that a decision to repeat the excision to remove the mass would not have significantly delayed administration of systemic therapy to treat the positive lymph node. It did not believe that the positive finding presented such an urgency that any other treatment needed to be postponed. The Respondent should have recognized the possibility that the mass remained and should have made a further attempt to remove it prior to the start of chemotherapy and radiation therapy. Factual Allegation B. 6. was sustained.

As with Patient A, the Committee could not determine whether the records maintained by Respondent for Patient B met acceptable standards of medical record keeping because it could not be established that the records received in evidence were complete. Three exhibits (Ex. 3A, 30 and G) were received which related to Respondent's records for the patient. Pages found in exhibits 30 and G were not seen in exhibit 3A, which was certified by the Center to represent the accurate and complete medical record for Patient B. Accordingly, Factual Allegation B. 7. was not sustained.

### **CONCLUSIONS RELATED TO PATIENT C**

Respondent should have questioned whether the excision performed on Patient C on August 29, 1988 was successful based on the pathology report's findings which made no mention of a discrete nodule. In light of the pathology report, the Committee reasoned that it would have been appropriate to have ordered a follow-up mammogram to confirm that the lesion had actually been excised. Respondent may have erred in believing that what he felt on palpation was the same lesion noted on the earlier mammogram. A reasonably prudent physician would have verified that it had been removed. Factual Allegation C. 1. b. was sustained.

The Committee relied on Dr. Forlenza's testimony that, if the lesion observed on the mammogram was considered to be suspicious and if the pathology report found only benign tissue, appropriate management of Patient C's condition would have included a follow-up

mammogram approximately six months subsequent to the surgery. Respondent's ordering of a mammogram about sixteen months thereafter was considered to be inappropriate for the patient's history. The Respondent's testimony that he ordered no treatment subsequent to the surgery because he believed he had removed a benign lesion was considered and the Committee concluded that he did not "abandon" the patient; he inappropriately monitored and managed her follow-up care. It sustained the second sentence of Factual Allegation C. 2.

The Committee could not determine whether the exhibits representing the records maintained by Respondent for Patient C (exhibits 4A, 23 and 25) reflected the complete record. Accordingly, Factual Allegation C. 4. was not sustained.

#### **CONCLUSIONS RELATED TO PATIENT D**

The operative note for the March 9, 1989 surgery clearly stated that "X-rays denoted calcifications were removed". The report for the August 25, 1989 mammogram stated that the "previously observed calcifications are no longer present". Factual Allegations D. 1.b. and D. 1. c. were not accurate and were not sustained.

The Respondent contended that he believed that he had removed the mass based on the reference to the duct papilloma in the pathology report. The Committee felt it unlikely that this papilloma was actually the palpable mass and concluded that it was unreasonable for him to believe that the mass had successfully been excised based on such a finding. There was no evidence that Respondent ever attempted to ascertain the the size of the papilloma to confirm his feeling that the mass had been removed. The Committee determined that Respondent should have been aware of the possibility that the mass remained and should have so informed Patient D. Factual Allegation D. 2. was sustained.

The record demonstrates that Respondent did not see Patient D between March 31 and August 9, 1989. The Committee relied on Dr. Forlenza's opinion that the pathology results following the surgery would have required an office visit and follow-up mammogram within

three months. While Respondent stated that Patient D chose the treatment option of watchful observation, the record does not reflect this fact. The Committee concluded that Respondent inadequately monitored and managed the patient's condition and sustained Factual Allegation D. 3.

The Committee could not determine whether the records received as those of Patient D (Exhibits 5 and 22) did, in fact, constitute the complete medical record as maintained by Respondent. Therefore, Factual Allegation D. 5. was not sustained.

### **CONCLUSIONS RELATED TO PATIENT E**

The Committee determined that Dr. Borgan transferred care of Patient E to the Respondent prior to the December 22, 1992 surgery. Dr. Borgen's testimony that he became sick on that day and asked Respondent to replace him and to perform the surgery was contradicted by evidence in the record and was rejected as not credible. Respondent's name was added to a copy of the previously signed consent form to reflect that he was to perform the surgery first scheduled by Dr. Borgan. An addressograph stamp at the top of that copy bears the date of December 18, 1992. The fact Respondent saw the patient on that day is verified in his letter to Denise Oswald, dated April 1, 1993, which states that "...we also changed our schedule to to accommodate a biopsy within four days of her being seen". The Committee could infer no intent to misrepresent or conceal the fact that Respondent was to perform the surgery and believed that the office visit of December 18 would have included an examination of the patient. Factual Allegations E. 1. and E. 2. a. were not sustained.

Factual Allegation E. 2. b. could be interpreted as a factual statement that would not, of itself, constitute professional misconduct. However, the Committee chose to directly address the absence of any evidence to support the contention that the purpose of the surgery was to remove the left breast cystic nodule. Dr. Borgan testified that he was most concerned with the findings of microcalcifications and that he did not plan the surgery to remove the nodule. The consent

form signed by the patient made no reference to an intent to remove the nodule. The patient may have desired such an outcome, but there was no evidence that it was a purpose of the surgery. This Factual Allegation was not sustained.

Respondent aspirated the cystic nodule during the surgery and did not remove it. Apparently, Patient E was either unable or unwilling to understand the distinction. There was no evidence presented which demonstrated that Respondent ever told either the patient or her advocate, Ms. Oswald, that he had actually removed the cyst. Ms. Oswald specified in her testimony that Respondent told the patient that it had been aspirated. His letter to her also states that the patient "...also had an aspiration of a cyst...". Factual Allegation E. 3. was not sustained.

By a 2-1 majority vote, Factual Allegation E. 4. was sustained. The majority believed there was no independent means to conclusively determine how the discrepancies in copies of the medical record for Patient E occurred. Explanations by Center staff and by the Respondent were both considered and were found to be equally plausible. The majority relied on the actions and conclusions of the Center in determining that Respondent improperly altered the medical record by adding and antedating four separate notes. The Respondent was not found to be responsible for adding two other entries to the chart; one being a signature by Respondent's nurse and the other a note prepared by a social worker. The majority considered Respondent's entry dated February 24, 1993 to be questionable in that it was uncharacteristically detailed and extensive and was over a page in length, thus distinguishing it from almost all other medical record entries created by him.

The majority further relied on testimony by Dr. Brennan and Respondent concerning their meeting on May 27, 1993 and the subsequent letter sent to Respondent. Testimony by Dr. Brennan that he felt the facts related to the alterations of the chart by Respondent to be clear was considered credible. The absence of any objection by Respondent to the reprimand and warning from Dr. Brennan was viewed as being significant. The majority reasoned that if Respondent took strong exception to Patient E's intent to submit to the Center a letter of complaint regarding his treatment of her, as expressed in his April 1, 1993 letter to Ms. Oswald, then he would have

been expected to have defended himself against serious accusations by Dr. Brennan of the alteration of medical records. His testimony that he did not defend himself because he knew he had not altered the records was rejected as unrealistic and not worthy of belief.

The Committee member voting in the minority accepted Respondent's explanation that the discrepancies in copies of the chart were the result of the practice of maintaining portions of the out-patient charts at the 64th Street Lauder Breast Center separate from the main campus on 68th Street. This member considered the facts that Dr. Brennan testified that he conducted no independent investigation of the allegations and that addressograph stamps were not necessarily probative of the date of the creation of a medical record as indications that the Department did not prove the Factual Allegation by a preponderance of the evidence.

The Respondent admitted that he may have made a statement such as that alleged in Factual Allegation E. 5. While the record indicated that the patient was difficult to manage, the Committee felt such a fact did not justify making such an insensitive statement. A social worker with an office near the Respondent's testified that she had previously heard Respondent make similar statements relative to other patients. The Committee determined that such a statement was made to Patient E by the Respondent and sustained the Factual Allegation.

The inadequacy of the records maintained by Respondent for this patient directly caused much of the difficulties in communication between them. Respondent's failure to note the aspiration of the cyst in the operative report for the December 22, 1992 surgery caused her to doubt whether it had been either aspirated or removed during the procedure. A majority of the Committee relied on the testimony of Dr. Forlenza that an aspiration of a cyst during surgery is not routine and requires documentation to conclude that the operative note did not meet acceptable standards of medical recordkeeping. The testimony of Respondent that he did not record the aspiration because it was routine was rejected. Respondent should have noted it, if only because the patient was so concerned with the cystic nodule prior to surgery.

The majority also felt the records for Patient E were not complete because there was no information in the chart as to how Respondent assumed her care from Dr. Borgan. In addition,

the Respondent's pre-operative visit on December 18, 1992 and the examination which presumably took place could only be inferred from the letter written to Ms. Oswald several months thereafter and the addressograph stamp placed at the top of the modified patient consent form. While the majority was willing to accept that such a visit and examination occurred, it did not agree that those events were adequately documented. The majority found Respondent's contention that he recorded no notes because the patient's status was unchanged from that seen two days earlier by Dr. Borgan to be particularly unconvincing.

The final, and most obvious, basis for the majority's determination to sustain Factual Allegation E. 6. was the fact that it had determined that entries to the chart had been improperly added. Thus, it could not possibly represent an accurate record of the patient's condition and treatment.

The member voting in the minority, having determined that Respondent did not improperly alter the medical record, concluded that the records met acceptable standards. This member felt that the letter to Ms. Oswald provided sufficient evidence that the patient was seen and examined on December 18, 1992.

### **CONCLUSIONS RELATED TO PATIENT F**

There was a noted difference of opinion expressed by the expert witnesses concerning the appropriateness of referring Patient F for chemotherapy prior to performing a re-excision on her breast. The Committee felt that Dr. Forlenza equivocated in his testimony by stating that whether such a practice was appropriate depended on the particular circumstances of the individual patient. He indicated that it was a judgement call and that chemotherapy is administered before radiotherapy in certain situations. Dr. Kinne stated that the surgeon must judge the patient's risk for a subsequent spread of disease and balance the systemic risks. The Committee concluded that the propriety of such treatment could only be determined on a case-by-case basis and was not willing to judge Respondent's choice of treatment for Patient F as being inappropriate. Factual

Allegation F. 4. was not sustained.

The Respondent did not deny that Patient F's discharge summary was incorrect in that negative findings for the patient were recorded. He testified that discharge summaries were prepared for the Center by an outside service and then forwarded to the appropriate physician for review and signature. The copy of the discharge summary in evidence as part of Exhibit 7A was not signed by the Respondent. The Department attempted to move into evidence during cross-examination of Respondent a copy of a discharge summary allegedly signed by him which had apparently been misplaced (Ex. 33, for identification only). This document had not previously been produced and the Administrative Law Judge ruled it inadmissible. The Committee believed that the Department had the responsibility to ensure that all appropriate records be provided in a timely manner, particularly when an Allegation so clearly rested on a specific document. Factual Allegation F. 5. was not sustained as there was no evidence that Respondent signed the discharge summary in question.

The Committee concluded that the medical record maintained for Patient F by Respondent did not meet acceptable standards of record keeping. The members were most concerned with the discharge summary which inaccurately described the patient's condition. The Committee noted Respondent's testimony that he did not recall whether he reviewed the summary and believed that he would have seen such a document in the normal course of his duties, notwithstanding the fact that no signed copy was in evidence. The Committee felt that he would have had the responsibility to ensure that the records were accurate even if an outside service prepared the document and that a note correcting the inaccuracies should have been prepared and placed in the chart. Factual Allegation F.6. was sustained.

### **CONCLUSIONS RELATED TO PATIENT G**

Subsequent to the July, 1988 surgery, Respondent recorded office visits for Patient G that occurred in July, 1988, September, 1988, January, 1989, February and September, 1990,

June, 1991 and March, May, August and September, 1992. While the notes from such visits were sparse, the Committee considered them as evidence that Respondent did perform physical examinations of Patient G on a regular basis during that period. However, it concluded that there was insufficient evidence in the records of Respondent and the New Jersey radiation oncologists to establish that Patient G actually had any mammograms performed and the results of such tests read following the August, 1990 xerogram. There was no indication that Respondent actually reviewed a mammographic study between October, 1990 and August, 1992. The Committee felt that appropriate monitoring of the patient's condition would have required an annual mammogram and that Respondent should not have relied on either the patient or the oncologists and should have ordered the test himself. The contention by Respondent that the patient had a mammogram performed between October 26, 1990 and April 9, 1991 and again in either August or October, 1991 was expressly rejected as not proven by any of her medical records. Factual Allegation G. 2., as it related to the performance of periodic diagnostic tests, was sustained.

Patient G testified that she felt a small lump in her right breast in late May, 1992 and not on or about the time of the March 27, 1992 office visit with the Respondent. Factual Allegation G. 3. was inaccurate and was not sustained.

Respondent performed a fine needle aspiration on the right breast lump on May 27, 1992; the cytology report was non-definitive. Respondent advised the patient to return within three weeks to a month if the lump persisted. The Committee relied on Dr. Forlenza's opinion that a follow-up excision should have been promptly scheduled to conclude that such a delay was inappropriate. Patient G's history should have created a high degree of suspicion of malignancy. The non-definitive cytology should have caused Respondent to promptly perform further diagnostic studies instead of requesting that the patient return a few weeks thereafter if the condition persisted. While some of the delay in treatment until August 11, 1992 was caused by the patient's failure to follow-up from late June until July of that year, the Committee believed that appropriate treatment necessitated an excisional biopsy or further diagnostic tests sooner than three weeks after the fine needle aspiration. Factual Allegation G. 4. was sustained.

The Committee found that the exhibits representing the record maintained by Respondent for Patient G (Exhibits 8A, 28 and K) constituted a minimally acceptable medical record. The complaints, history, physical examinations diagnoses, progress and operative notes, discharge summary and treatment plan were each found to be present in some form. While it was felt that certain entries were succinct, more entries than in some other patient charts were found which enabled the Committee to evaluate the overall adequacy of the records related to Patient G. Factual Allegation G. 6. was not sustained.

### **CONCLUSIONS RELATED TO PATIENT H**

The Committee determined that Respondent did not deliberately mislead Patient H about her condition because he truly believed that the August 9, 1994 excision had been successful and that he had removed the entire lesion. The Department's contention that the phrase in the pathology report "intra-operative consultation" demonstrated that Respondent was informed of the pathology results during the surgery was rejected by the Committee. It was noted that he made no mention in the operative report of a request for a frozen section and he testified that the specimen was sent to pathology fresh for markers to determine if it was a lymphoma. The Committee found this testimony credible and believed the note of an "intraoperative consultation" referred to the fact that a frozen section was performed by the pathologist. Patient H testified that her only conversation with Respondent about the results of the excision occurred in the recovery room immediately following the procedure. The Respondent testified that he had not seen any pathology results and only told her what he believed to be true at that time. The patient did not testify that she had a subsequent conversation with Respondent following her discharge from the recovery room. Factual Allegation H. 1. b. was sustained as being an accurate statement of fact that did not constitute professional misconduct. Factual Allegation H. 1. c. was not sustained.

Respondent testified that he spoke by telephone with Patient H about one week after the surgery and told her that the pathology indicated the presence of a combination of cancerous and pre-cancerous cells. The Committee agreed with Dr. Kinne's opinion that such a statement was inaccurate and constituted a departure from accepted standards of practice. However, it did not believe that Respondent intended to deliberately mislead the patient about her condition. The statement was viewed as an attempt by Respondent to soften the impact of a significant positive finding of disease. The Committee considered this intent to be reasonable but definitely believed that such an objective could not be obtained through the provision of false information. The pathology report made no reference to pre-cancerous cells. Factual Allegation H. 2. was sustained.

Factual Allegation H. 3. was considered to be clearly false and was not sustained. The Committee agreed that the phrase "short course of radiation" was meaningless. While the Department devoted significant effort to establishing the fact that the Respondent recommended that Patient H undergo radiation therapy, the consultation notes prepared by the radiation therapist clearly indicated that he saw the patient for the purpose of evaluating her for "further therapeutic options" and to establish whether she could be a candidate for radiation therapy. Furthermore, the radiation therapist, and not the Respondent, would have made the ultimate determination regarding such treatment.

There was no contention by Respondent that records he created related to Patient H were missing. There were no notes in the record regarding any treatment or contact with the patient by him subsequent to the August 9, 1994 surgery, including any reference that she was informed of the pathology results. The radiation therapist's consult note indicated a referral of the patient by Respondent. There was no evidence that Respondent wrote any chart entry to reflect this referral. The Committee believed that such a note was necessary to address his plan of treatment and felt that he should not have relied on other providers to create an adequate record, as in this case. Factual Allegation H. 5. was sustained.

## **CONCLUSIONS RELATED TO PATIENT J**

As set forth above, the Committee did not determine that a failure to remove a mass pursuant to a surgical procedure constituted, in and of itself, professional misconduct. No expert testimony was elicited which suggested such a contention. The failure of Respondent to remove Patient J's right breast mass was not improper. Factual Allegation J. 1. was not sustained.

Factual Allegation J. 2. incorrectly addresses the action which Respondent could have taken to determine whether the surgery had been successful. Dr. Forlenza testified that no further studies were available during the December, 1995 biopsy which would have provided a more definitive indication of the location of the mass. In his opinion, Respondent could have removed more tissue to attempt to locate the proper area. However, the Factual Allegation does not contend that the failure to remove additional tissue was improper. The Committee concluded that the decision to do so would have been an issue of judgement for the surgeon and did not sustain Factual Allegation J. 2.

Patient J's testimony that Respondent informed her after the surgery that the mass had been removed and did not convey an uncertainty as to its' success was found by the Committee to be credible. It determined that it was unreasonable for the Respondent to have been so certain that the excision had been successful and that he should have more accurately advised Patient J of the non-definitive specimen radiograph report. The Committee felt the distinction was more than one of style and wording and sustained Factual Allegation J. 3.

The cause of the approximately one month delay in informing the patient of the results of the April, 1996 follow-up mammogram was considered by the Committee to be remarkable. It was recognized that it is not the best practice to relay unfavorable test results to a patient by telephone. In a case such as this whereby the patient could not be reached for several weeks, an exception should have been made. At a minimum, a message for Patient J to call Respondent should have been left on her telephone answering machine. The contention of Respondent's nurse that she called numerous times during the one month period in an attempt to reach the

patient, yet never left a message was considered not worthy of belief. The Committee found it difficult to believe that Respondent, engaged in a very busy surgical practice, had not developed an office policy for addressing a situation that was not uncommon. One Committee member also questioned the authenticity of the April 29, 1996 chart entry which noted that it was "written late...after the fact". The Committee believed that greater efforts should have been made to inform the patient of the significant mammographic findings. Factual Allegation J. 4. was sustained.

Dr. Forlenza testified that he believed that the medical record for Patient J was a complete and accurate record of Respondent's treatment of her. The Committee did not sustain Factual Allegation J. 5.

### **SPECIFICATIONS OF PROFESSIONAL MISCONDUCT**

The Committee sustained seventeen Factual Allegations as constituting the practice of medicine with negligence. The Specification that Respondent practiced with negligence on more than one occasion was therefore sustained. These Factual Allegations, in general, represented errors in judgement which did not meet accepted standards of practice. Respondent failed to appropriately follow or manage the treatment of Patients A, B, C, D, G, and J. Such negligence relied on unjustifiable beliefs that surgeries scheduled to excise breast lesions had been successful. These beliefs often were based on unreasonable interpretations of pathology reports and diagnostic test results in a manner which led the Respondent to ignore or minimize other significant findings. The Committee determined that these interpretations did not meet the minimally accepted standards of practice and concluded that his treatment choices were not the result of sound medical decisions.

The acts of negligence were not considered to be so egregious as to rise to the level of gross negligence. The Committee took strong exception to the Department's attempt to portray

Respondent's actions as intentional. Failures to accurately inform patients of their conditions were the result of his own misunderstanding of those conditions. Delays in appropriate follow-up were due to Respondent's unjustified confidence in the success of his surgical procedures and did not arise from a deliberate failure to act. The Committee distinguished acts of carelessness or inattentiveness from conspicuous deviations from accepted standards of practice and did not believe that those acts met the definition of gross negligence.

The alteration of Patient E's medical record by the addition of four notes was the most serious of those Factual Allegations which were sustained. The Committee observed that those notes did not relate to the medical care he rendered, but addressed the unwillingness of the patient to accept the fact that he had aspirated the cystic nodule that so concerned her. There was no doubt in the Committee's collective mind that he did not tell her that he removed the cyst. The majority of the Committee could not explain why the record was changed and declined to speculate because the motive was irrelevant. The alteration of medical records was considered not acceptable and Specifications that such act constituted the fraudulent practice of medicine and the making of a false report were sustained. However, the Committee did not find that it rose to the level of gross negligence because patient care was not affected by the inclusion of the four entries.

The Committee made no finding that Respondent practiced with incompetence. It was clear that he possessed significant skill and knowledge related to his specialty. It was errors in the application of those attributes that led to the findings that he had practiced with negligence. The Respondent overestimated his own skills by failing to utilize pathology and diagnostic tests to consider the need for alternative diagnoses and treatments. This was viewed not as evidence of a lack of skill or knowledge, but instead as poor exercises of judgement that did not meet accepted standards of practice.

The issue of the adequacy of Respondent's records preoccupied this proceeding and considerably lengthened it. The manner in which the Center maintained its records was obviously brought into question by its' inability to produce complete and accurate copies of each

patient's chart. The Committee was overburdened with multiple copies of patient records, each purporting to be complete and each, in fact, differing to some degree. Based on what transpired at this proceeding, the Committee agreed to include, as a part of this Decision and Order, a recommendation that a request be made to the appropriate office within the New York State Department of Health to investigate the Center's record keeping practices. The Committee was sympathetic to the contention by Respondent that copies of out-patient records from his office practice were not always included in the medical records received from the Center. Certain relevant documents were discovered only in the Center's "correspondence files" and not in the main chart. The "correspondence files" originally were not offered into evidence and the parties may not have known of their existence until the Center made them available for this proceeding. The Committee concluded that it could not be sure that a complete and accurate copy of each chart had been received in evidence.

Respondent did not contend that records were missing from the charts of Patients E and H. It was observed that the Statement of Charges incorrectly referred to Factual Allegation E. 5. as supporting Specification Thirty-Seven. The Committee considered this error as further evidence of the poor preparation of the Charges by the Department and assumed that Factual Allegation E. 6. was intended to be the correct reference for that Specification. Allegation E. 6. was sustained based on a determination that the record had been altered, that Respondent failed to document the circumstances related to his assumption from Dr. Borgan of her surgery and his failure to note the aspiration of the cyst in the operative report. The record of Patient H contained no entry related to her post-operative care. Patient F's chart included an inaccurate discharge summary which the Committee assumed was seen, but not corrected, by the Respondent. Accordingly, Specifications related to the failure to maintain an accurate medical record were sustained in those three cases only. However, the Committee also determined that all Specifications of professional misconduct which were sustained were sufficiently supported by the documents that were received in evidence.

The Committee felt that the statement made by Respondent to Patient E represented great insensitivity, even if made because of his frustration in convincing the patient that he had addressed her concerns about the presence of the cystic nodule. While clearly inappropriate, the Committee did not conclude that it was made to intentionally harass, abuse or intimidate Patient E and did not sustain that Specification of misconduct. The Committee did believe, however, that the incident provided insight as to Respondent's character.

The Committee did not feel that Factual Allegations E. 4. and/or H. 2. demonstrated that Respondent engaged in conduct evidencing moral unfitness and did not sustain such Specifications.

### **DETERMINATION AS TO PENALTY**

By a 2-1 majority vote (Dr. Golding and Ms. Herbst), the Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, determined that Respondent's license to practice medicine in New York State should be revoked. 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.

While the majority did not sustain Specifications related to the practice of medicine with gross negligence, it felt that the repeated acts of negligence added together justified the imposition of a severe penalty. The contention that the nine patient cases addressed at this proceeding were somehow not representative of Respondent's overall practice was rejected as being irrelevant. The negligent care rendered to multiple patients was seen as demonstrating a pattern of practice that was more than merely a temporary lapse. Overconfident and incorrect applications of pathology and test results led to delays in appropriate treatments for Patients B, C, D and H. Respondent frequently relied on optimistic assumptions instead of confirming the

success of his surgeries by performing appropriate tests. The majority of the Committee noted the pattern of testimony from the father of Patient A, Patient B and Patient J regarding unreasonable delays in learning of test results. It was incumbent for the Respondent to immediately share test results with patients, including those results with positive findings. The chart entries of conversations with patients which were available in evidence relating to treatment options were most often unnecessarily brief and frequently only stated "options discussed". Few, if any, entries were ever seen which revealed Respondent's thought processes concerning future plans of treatment. Respondent relied on other medical providers to provide documentation of treatments instead of rightfully assuming that responsibility himself.

The majority felt, at the conclusion of this extended proceeding, that Respondent's practice of medicine was careless and at times reckless. He demonstrated an indifference to the needs of his patients which the majority of the Hearing Committee members found to be remarkable. His inadequate style of communication caused physical and psychological harm. The finding that the chart of Patient E was fraudulently altered was an additional indication of his lack of character. It was also noted that he never admitted to making errors of judgement in his treatment of any of the patients. Respondent's shortcomings were perceived to be not a lack of necessary skills and knowledge, but instead an absence of the judgement and compassion required to practice as a physician. Accordingly, the majority felt that any penalty other than revocation would not be appropriate because such character attributes cannot be taught or monitored.

The member voting in the minority (Dr. Cleary) felt that a penalty less harsh than license revocation was appropriate. This member did not vote to sustain the Factual Allegation that the Respondent altered the records of Patient E and further believed that certain sustained Factual Allegations, including J. 3. and J. 4., represented poor judgement which did not rise to the level of the practice of the profession with negligence. He also noted that several of the sustained Allegations were the natural result of the original failure to successfully remove breast lesions and believed they did not represent separate or additional instances of misconduct.

## ORDER

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

1. The Nineteenth Specification of professional misconduct as set forth in the Amended Statement of Charges (Ex. 1A), as it related to the following Factual Allegations only, is

**SUSTAINED:**

- a. A. 1., A. 2., A.3.;
- b. B. 1., B. 3., B. 5., B. 6.;
- c. C. 1. b., C. 2.;
- d. D. 2., D. 3.;
- e. E. 4.;
- f. G. 2., G. 4.;
- g. H. 2.;
- h. J. 3., J. 4.

2. The following additional Specifications of professional misconduct, as set forth in the Amended Statement of Charges (Ex. 1A), are **SUSTAINED:**

- a. Twenty-third Specification;
- b. Twenty-eighth Specification;
- c. Thirty-seventh Specification;
- d. Thirty-eighth Specification, as it related to Factual Allegation F. 6. only;
- e. Fortieth Specification.

3. The license of Respondent to practice medicine in New York State be, and hereby is, **REVOKED.**

4. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

**DATED: Albany, New York**

*December 26, 1997*

*Michael R. Golding, M.D.*  
**MICHAEL R. GOLDING, M.D. Chairperson**

**JOSEPH B. CLEARY, M.D.  
EUGENIA HERBST**

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*AB*

APPENDIX I

IN THE MATTER  
OF  
MICHAEL P. MOORE, M.D.

MICHAEL P. MOORE, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1981, by the issuance of license number 146462 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about October 2, 1991 and on or about June 19, 1992, Respondent treated Patient A for breast disease at Memorial Sloan Kettering Cancer Center, New York, New York. (The names of patients are contained in the attached Appendix.)

1. On or about October 8, 1991, Respondent excised a mass in Patient A's right breast. The pathology report contained significant positive findings of cancer. Respondent failed to follow-up these findings or to treat or manage Patient A's condition.
2. On or about February 12, 1992, a mammogram and the pathology report of a needle aspiration biopsy were positive for adenocarcinoma of the right breast. On or about March 17, 1992, Respondent performed an excisional biopsy. The resulting

PLAINTIFFS  
 DEFENDANT'S  
 CO-COMPLAINANTS  
 DEPARTMENT'S  
 PETITIONERS  
 for identification  
 RESPONDENT'S  
 STATE REPORTER  
 MERLING REPORTING SERVICE, INC.

**EXHIBIT 1A**

pathology report described poorly differentiated infiltrating carcinoma. Respondent failed to follow-up these findings or to treat or manage Patient A's condition.

3. Between on or about October 2, 1991, and on or about June 19, 1992, Respondent repeatedly failed to accurately advise Patient A of the nature of her condition, of the findings contained in her pathology reports and of the need for aggressive treatment.
4. In or about June, 1992, Patient A's family physician ordered a CAT Scan which confirmed the presence of metastatic tumor in the liver. Patient A died in October, 1993 of metastatic disease.
5. Respondent failed to maintain a medical record for Patient A which accurately reflects the Patient's complaints, history, physical examination, diagnoses, progress notes and treatment plan.

B. Between in or about January, 1994 to in or about October, 1994, Respondent treated Patient B for breast disease at Memorial Sloan Kettering.

- 27 JA 12/20/96*
1. On or about January [21] 1994, Respondent performed a wide excisional biopsy of Patient B's right breast and an axillary lymph node dissection. Respondent failed to order pre-operative sonographic localization of a non palpable tumor, which was indicated.

2. Respondent failed to inform Patient B of the nature and purpose of an axillary lymph node dissection and that he intended to perform such a procedure on January [21] 1994.

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3. Respondent failed to order appropriate diagnostic tests to confirm that the tumor had been removed.

4. In fact, Respondent failed to remove the tumor in the January [21, ] 1994 operation.

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5. Respondent failed to inform Patient B that the tumor had not been removed and of the need for additional surgery to remove it.

6. After the surgery, Respondent inappropriately ordered chemotherapy and radiation treatment even though he knew that the tumor remained in Patient B's right breast.

7. Respondent failed to maintain a medical record for Patient B which accurately reflects the Patient's complaints, history, physical examination, diagnoses, progress notes, operative reports and treatment plan.

C. Between on or about August 3, 1988 and on or about December 21, 1989, Respondent treated Patient C for breast disease at Memorial Sloan Kettering

1. On or about August 29, 1988, Respondent operated to remove a left breast nodule which had shown up on a mammogram.

- a. Respondent failed to remove the nodule.
    - b. Respondent failed to order a timely mammogram to confirm whether the nodule had been removed.
  2. Following the August 29, 1988 procedure, Respondent abandoned Patient C. Respondent failed to monitor, follow-up, treat or manage Patient C's condition.
  3. On or about February 8, 1990, the nodule was removed by another physician. A mastectomy and axillary dissection were performed which revealed a 2 cm. infiltrating duct carcinoma and metastatic carcinoma in one of twenty-six lymph nodes.
  4. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient's complaints, history, physical examination, diagnoses, progress notes and treatment plan.
- D. Between on or about March 3, 1989, and on or about August 25, 1989, Respondent treated Patient D for breast disease at Memorial Sloan Kettering
1. On or about March 9, 1989, Patient D underwent surgery to remove a right breast mass and bilateral micro calcifications, which had been pre-operatively needle-localized.
    - a. Respondent failed to remove the mass.



1. On or about December 16, 1992, Patient E signed a surgery consent form authorizing a Dr. Borgen to perform breast surgery. Several days later Respondent fraudulently altered this consent form by adding his name as the authorized surgeon.
2. On or about December 22, 1992, Respondent operated to remove a cystic nodule and micro calcifications in Patient E's left breast.
  - a. Respondent failed to examine Patient E prior to the date of surgery.
  - b. Respondent failed to remove the cystic nodule.
3. After the operation, Respondent deliberately misled Patient E and Denise Oswald, a patient representative at Memorial Sloan Kettering, by informing them that he had in fact removed the cyst.
4. Respondent made numerous fraudulent alterations to Patient E's hospital chart including the addition of four notes, a signature and other entries.
5. In or about March, 1993, Patient E, accompanied by Denise Oswald, visited Respondent's office. Respondent examined Patient E's breast. Patient E found the exam very painful and she

screamed. When Ms. Oswald asked what was going on, Respondent replied: "Do you have a gun on you? Give it to me and I'll shoot her and put her out of her misery".

6. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient's complaints, history, physical examination, diagnoses, progress notes, operative report and treatment plan.

F. Between on or about March 18, 1994, and in or about November, 1994, Respondent treated Patient F for breast disease at Memorial Sloan Kettering.

1. On or about March 28, 1994, Respondent performed, inter alia, an excisional biopsy of Patient F's left breast and an axillary lymph node dissection.
2. Respondent improperly permitted Patient F to sign the consent for surgery in the operating room after she had been pre-medicated.
3. The pathology report described both in situ and invasive carcinoma at the biopsy margins. Respondent failed to address these findings by re-excising the tumor margins.
4. After the surgery, Respondent inappropriately ordered chemotherapy even though he knew that tumor remained in Patient F's left breast.

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5. Patient F's discharge summary, which was signed by Respondent, contains numerous misstatements including the claims that no metastatic lymph nodes were found, that the left breast excision had negative margins and that the patient received routine peri-operative care.

6. Respondent failed to maintain a medical record for Patient F which accurately reflects the Patient's complaints, history, physical examination, diagnoses, progress notes, operative notes, discharge summary and treatment plan.

G. Between on or about July 7, 1988, and on or about October 1992, Respondent treated Patient G for breast disease at Memorial Sloan Kettering

1. In or about June, 1988, a surgical biopsy performed in New Jersey demonstrated extensive intraductal carcinoma and lobular carcinoma in Patient G's right breast. On or about July 19, 1988, Respondent re-excised the site of the biopsy and performed an axillary lymph node dissection. No additional cancer was found

2. After the July, 1988 procedure, Respondent failed to appropriately monitor Patient G for tumor recurrence, including comprehensive physical examinations and periodic mammograms or sonograms.

3. On or about March 27, 1992 Patient G visited Respondent's

office. Respondent failed to diagnose a lump in the Patient's right breast or to order a mammogram or sonogram.

4. In or about May, 1992, Respondent unsuccessfully attempted to perform a needle aspiration biopsy of the lump. Respondent then inappropriately delayed proper treatment of Patient G until August 11, 1992, when he performed an excisional biopsy in the office.
5. On or about September 28, 1992, a total mastectomy was performed, revealing an invasive ductal carcinoma measuring 3.5 cm.
6. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient's complaints, history, physical examination, diagnoses, progress notes, operative notes, discharge summary and treatment plan.

H. Between on or about May 4, 1994, and on or about August 15, 1994, Respondent treated Patient H for breast disease at Memorial Sloan Kettering

1. On or about August 9, 1994, Respondent performed an excisional biopsy of a mass in the Patient's right breast.
  - a. Respondent failed to remove the entire mass. Despite an intraoperative frozen section describing invasive carcinoma at the lateral margin of the

specimen, Respondent did not remove the remaining tumor.

- b. Respondent failed to inform Patient H that he had not removed the entire mass and of the consequent need for additional surgery.
  - c. Respondent saw Patient H after she was discharged from the recovery room. At that time Respondent deliberately mislead Patient H by falsely telling her that everything was fine and that there was nothing wrong with her.
2. Several days later Respondent telephoned Patient H from an airport, as he was leaving on a trip. Respondent deliberately mislead Patient H by falsely telling her that the final report on her biopsy demonstrated only pre-cancerous cells.
  3. Respondent recommended that Patient H be treated with a short course of radiation, which was inappropriate, given her previous treatment with radiation for Hodgkins disease.
  4. In or about September, 1994 Patient H underwent a mastectomy which was performed by another surgeon.
  5. Respondent failed to maintain a medical record for Patient H which accurately reflects the Patient's complaints, history,

physical examination, diagnoses, progress notes and treatment plan.

I. Between in or about October 27, 1993 and in or about March 7, 1995 Respondent treated Patient I for breast disease at Memorial Sloan Kettering.

1. On or about October 15, 1994, Patient I complained of a lump in her left breast. Respondent failed to order a sonogram or to biopsy the lump.
2. Respondent failed to maintain a medical record for Patient I which accurately reflects the patient's complaints, history, physical examination, diagnoses, progress notes and treatment plan.

J. Between on or December 14, 1995, and in or about April, 1996, Respondent treated Patient J for breast disease at Columbia Presbyterian Hospital.

1. On or about December 20, 1995, Patient J underwent surgery to remove a right breast mass which had been pre-operatively needle localized. Respondent improperly failed to remove the mass.
2. A specimen radiograph was obtained. The report stated that the mass was not clearly seen in the specimen, but was "probably" within the submitted. Respondent failed to order additional films to obtain a definitive opinion.

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ja

3. After the operation Respondent falsely informed Patient J that he had removed the lesion and that it was benign.
4. In April, 1996, a mammogram was ordered which revealed that the lesion remained in Patient J's right breast. Respondent improperly delayed approximately four week before informing Patient J of the results of this mammogram.
5. Respondent failed to maintain a medical record for Patient J which accurately reflects the Patient's complaints, history, physical examination, diagnoses, progress notes and treatment plan.

### **SPECIFICATION OF CHARGES**

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

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Sec. 6530(4)(McKinney Supp. 1996), in that he practiced with gross negligence as alleged in the following facts:

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

6. Paragraphs F and F(1) through F(6).
7. Paragraphs G and G(1) through G(6).
8. Paragraphs H and H(1) through H(5).
9. Paragraphs I and I(1) through I(2).

**TENTH THROUGH EIGHTEENTH SPECIFICATIONS**  
**PRACTICING WITH GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Sect. 6530(6)(McKinney Supp. 1996) in that he practiced with gross incompetence as alleged in the following facts:

10. Paragraphs A and A(1) through A(5).
11. Paragraphs B and B(1) through B(7).
12. Paragraphs C and C(1) through C(4).
13. Paragraphs D and D(1) through D(5).
14. Paragraphs E and E(1) through E(6).
15. Paragraphs F and F(1) through F(6).
16. Paragraphs G and G(1) through G(6).
17. Paragraphs H and H(1) through H(5).
18. Paragraphs I and I(1) through I(2).

**NINETEENTH SPECIFICATION**  
**PRACTICING WITH NEGLIGENCE ON**  
**MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1996) in that he practiced the profession with negligence on more than one occasion as alleged in the facts of at least two of the following:

19. Paragraphs A, A(1) through A(5); B, B(1) through B(7); C and C(1) through C(4); D and D(1) through D(5); E and E(1) through E(6); F and F(1) through F(6); G and G(1) through G(6); H and H(1) through H(5); I and I(1) through I(2) and J and J(1) through J(5).

**TWENTIETH SPECIFICATION**  
**PRACTICING WITH INCOMPETENCE ON**  
**MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Section 6530(5)(McKinney Supp. 1996), in that he practiced the profession with incompetence on more than one occasion as alleged in the facts of at least two of the following:

20. Paragraphs A, A(1) through A(5); B, B(1) through B(7); C and C(1) through C(4); D and D(1) through D(5); E and E(1) through E(6); F and F(1) through F(6); G and G(1) through G(6); H and H(1) through H(5); and I(1) through I(2) and J and J(1) through J(5).

## **TWENTY-FIRST THROUGH TWENTY-SIXTH SPECIFICATIONS**

### **FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as under N.Y. Educ. Law §6530(2)(McKinney Supp. 1996) in that he practiced the profession fraudulently as alleged in the following facts:

21. Paragraphs E and E(1).
22. Paragraphs E and E(3).
23. Paragraphs E and E(4).
24. Paragraphs H and H(1)(c).
25. Paragraphs H and H(2).
26. Paragraphs J and J(3).

## **TWENTY SEVENTH AND TWENTY-EIGHTH SPECIFICATIONS**

### **MAKING A FALSE REPORT**

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

27. Paragraphs E and E(1).
28. Paragraphs E and E(4).

## **TWENTY-NINTH THROUGH THIRTIETH-FIRST SPECIFICATIONS**

### **FAILURE TO OBTAIN INFORMED CONSENT**

Respondent is charged with committing professional misconduct under N.Y.

Educ. Law §6530(26) in that he performed professional services which had not been duly authorized by the patient or his or her legal representative as alleged in the following facts:

29. Paragraphs B and B(2).
30. Paragraphs E and E(1)(a).
31. Paragraphs F and F(2).

### **THIRTY-SECOND SPECIFICATION**

#### **WILLFUL HARASSMENT**

Respondent is charged with committing professional misconduct under N.Y. Educ. Law §6530(31) (McKinney Supp. 1996), in that he willfully harassed, abused or intimidated a patient wither physically or verbally as alleged in the following facts

32. Paragraphs E and E(4).

### **THIRTY-THIRD THROUGH FORTIETH SPECIFICATIONS**

#### **FAILURE TO MAINTAIN ADEQUATE RECORDS**

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1995), in that he failed to maintain records for patients which accurately reflect the evaluation and treatment of the patients, as alleged in the following facts:

33. Paragraphs A and A(5).
34. Paragraphs B and B(7).
35. Paragraphs C and C(4).
36. Paragraphs D and D(5).
37. Paragraphs E and E(5).

38. Paragraphs F and F(5) and F(6).
39. Paragraphs G and G(6).
40. Paragraphs H and H(5).
41. Paragraphs I and I(2).
42. Paragraphs J and J(5).

**FORTY-THIRD SPECIFICATION**  
**MORAL UNFITNESS**

Respondent is charged with committing professional misconduct under N.Y. Educ. Law Section 6530(20)(McKinney Supp. 1996), in that he engaged in conduct in the practice of medicine which evidences moral unfitness to practice medicine as alleged in the following facts:

43. Paragraphs E and E(1), E(3), E(4) and H and H(1) and H(2).

DATED: April , 1997  
New York, New York

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ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct