



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

**PUBLIC**

Dennis P. Whalen  
*Executive Deputy Commissioner*

June 4, 1999

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Denise Lepicier, Esq.  
NYS Department of Health  
5 Penn Plaza – Sixth Floor  
New York, New York 10001

Stuart G. Selkin, M.D.  
6 Tuxedo Drive  
Melville, New York 11747

Anthony Z. Scher, Esq.  
Wood & Scher  
The Harwood Building  
Scarsdale, New York 10583

**RE: In the Matter of Stuart G. Selkin, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No.99-122) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,



Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:nm  
Enclosure

FILE NO: S-4800-S

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

COPY

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IN THE MATTER OF	:	<b>DETERMINATION</b>
STUART G. SELKIN, M.D.	:	<b><u>AND ORDER</u></b>
	:	
-----X		BPMC-99-122

A Notice of Hearing and Statement of Charges, both dated October 14, 1998, were served upon the Respondent, Stuart G. Selkin, M.D. Kenneth Kowald (Chair), Dr. John T. Frazier and Dr. Gerald S. Weinberger, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Edwin L. Smith, Administrative Law Judge, served as the Administrative Officer. The Department of Health appeared by Denise Lepicier, Esq., Associate Counsel. Respondent appeared by Anthony Z. Scher, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

**PROCEDURAL HISTORY**

Date of Service of Notice of Hearing and Statement of Charges:	October 19, 1998
Answer to Statement of Charges:	November 29, 1998
Pre-hearing Conference:	November 30, 1998

Dates of Hearings:

December 28, 1998  
January 4, 1999  
January 5, 1999  
January 6, 1999  
January 11, 1999  
January 12, 1999  
March 3, 1999  
March 10, 1999  
March 11, 1999  
March 17, 1999  
March 18, 1999  
March 19, 1999

Received Petitioner's  
Proposed Findings of Fact,  
Conclusions of Law and  
Recommendation:

April 5, 1999

Received Respondent's  
Proposed Findings of Fact,  
Conclusions of Law and  
Recommendation:

April 5, 1999

Witnesses for Department of  
Health:

Stuart G. Selkin, M.D.  
Anne Yodis  
S. L.  
Francis DeBobes  
Mayra Dominguez, M.D.  
Marvin I. Matz, M.D.  
Peter Ciminera, M.D.  
Tano Carbonaro, M.D.  
A. Robert Tantleff, M.D.

Witnesses for Respondent:

Stuart G. Selkin, M.D.  
Claudia Russos, V.G.  
Paul L. Goldiner, M.D.  
Taryn Anne Flynn  
John C. Quinn

Deliberations Held:

April 16, 1999

#### STATEMENT OF CASE

The Petitioner has charged Respondent, Stuart G. Selkin M.D., with twenty-six specifications of professional misconduct.

The allegations concern Respondent's medical care and treatment of eight patients at his former ambulatory surgical facility located at 1171 Old Country Road, Plainview, New York. In particular, the Respondent is charged with two specifications of gross negligence, two specifications of gross incompetence, one specification of negligence on more than one occasion, one specification of incompetence on more than one occasion, three specifications of fraudulent practice, four specifications of immoral unfitness, three specifications of responsibilities not competent to perform, three specifications of performing services not authorized, one specification of excessive tests or treatment, three specifications of failing to exercise appropriate supervision, two specifications of failing to maintain records and one specification of failing to respond to a request for records.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

#### **FINDINGS OF FACT**

The following Findings of Fact were made after a review of the entire record in this matter. The numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in

arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

1. Stuart G. Selkin, M.D. (hereinafter "Respondent") was authorized to practice medicine in New York State by the issuance of license number 098873 by the New York State Education Department. (Not contested.)

2. Respondent concedes that he had sexual relations with Patient E while she was a patient. (162-163)\*

3. Respondent concedes to having sexual relations with Patients G, H & I. (162-165)

#### **Patient A**

##### **A1. Failure to perform or record adequate histories, physical examinations, findings, diagnoses and/or procedures**

4. Patient A, a six-year-old child, was seen by Respondent between January 17, 1991 to March 7, 1992 at his ambulatory surgical facility located at 1171 Old Country Road, Plainview, New York. A tonsillectomy and adenoidectomy was performed on March 7, 1992 at Respondent's facility, at the end of which procedure, Patient A suffered respiratory and cardiac arrest and was transported to the Nassau County Medical Center at which she subsequently died. (Exhibit 3 and Exhibit 9)

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\* Page and exhibit references are to the transcript of proceedings and exhibits admitted into evidence.

5. On January 17, 1991 Patient A presented to Respondent with a history of sore throats. (Exhibit 3, pages 2-4). Respondent recommended that Patient A return in one month after a regimen of chewable antibiotics. (Exhibit 3, page 4; 175, 708-709)

6. Petitioner's expert, Dr. Matz, is of the opinion that a "deeper" history should have been taken on January 17, 1991. (705)

7. Petitioner's expert, Dr. Matz, agreed that the physical examination of January 17, 1991 met accepted standards except for there being no notation as to any examination of patient's neck. (707-708).

8. Dr. Selkin testified that his computer program in the early 1990's did not include the neck on the format, but that he did, as a matter of routine, examine the neck and if there were any positive findings, they would be noted. (1102-1114)

9. Respondent did not record the frequency of the episodes of tonsillitis, how the infections responded to antibiotics, a family history nor medical history including any history of ear infections. (704-705, 709-711, 715-717)

10. The history taken did not reflect a history of allergies, drug reactions, bleeding, ear aches or whether hearing was within normal limits. (Exhibit 3, page 4)

11. There is no mention in the history as to the identification of the antibiotics that Patient A was taking. (Exhibit 3, page 4)

12. Notes of the physical examination reflects that the turbinates were edematous and pale (Exhibit 3, page 4), yet Respondent testified that he was not able to see those areas on examination. (396-397)

13. On Patient A's second visit, January 30, 1992, there is no mention of an examination of the lymph nodes. (Exhibit 3, page 6). References to Patient A having trouble swallowing do not specify frequency, incapacity, loss of weight and whether there was fever. (Exhibit 3, page 6)

14. The pre-operative physical before surgery was prepared on a form from the Respondent's office, which form did not ask for details relating to a physical examination, heart rate, lungs, weight. (Exhibit 3, page 12). Respondent's testimony that this was not intended to be a pre-operative physical is noted. (381)

15. Respondent's testimony as to a separate pre-anesthesia history and physical record is noted as is the Respondent's certification on January 29, 1993 that Exhibit 3 was a complete copy of Patient A's chart. (Exhibit 3, page 1) The Committee further notes that this certification was made long before Respondent closed his office on January 19, 1997 after which he claims to have been unable to locate many records

including those of the CRNA's pre-operative anesthesia records.  
(2014)

16. On the date of Patient A's surgery, March 7, 1992, while there is a report of operation (Exhibit 3, page 15), there is no pre-operative anesthetic record which is part of the chart.

17. Respondent's expert, Dr. Paul Goldiner, acknowledged that the absence of a pre-operative anesthetic record as part of the chart did not comport with the standard of care. (1814-1815)

18. There is no mention of Patient A's weight which would be a factor in determining dosage of medications. (Exhibit 3)

**A2. Failure to adequately supervise the administration of anesthesia to Patient A by the CRNA on March 7, 1992**

19. CRNA John Quinn administered anesthesia to Patient A during the course of the surgery on March 7, 1992 at Respondent's ambulatory surgical facility in Plainview, New York. (Exhibit 3)

20. Petitioner's expert, Dr. Matz, testified that he was not familiar with the type of ambulatory surgery facility utilized by Respondent and he has no knowledge as to the standard of care in the community in 1990 as to such facilities. (1641-142, 1656-1658)

21. Respondent's expert, Dr. Goldiner, testified that the ambulatory surgical facility maintained by Respondent was within the standard of care. (1813)

22. Dr. Goldiner, testified that the ideal would be to have only anesthesiologists administering anesthesia, but that was not the standard in New York State in 1992. (1789)

23. The circumstances of Respondent's supervision of the CRNA was at the time in question appropriate. (1788-1790)

**A3. Failure to call for emergency services in a timely fashion**

24. Francis DeBobes, a Nassau County Police Department Ambulance Medical Technician (468) testified that upon arrival at Respondent's facility on a 911 call, he found that Patient A's condition was stabilized. (497-498)

25. The period of time involving the arrest and recovery of Patient A, and the stabilization of the Patient was proper. (1814).

26. Mayra Dominguez, M.D. was an attending physician in the pediatric emergency room of Nassau County Medical Center to which institution Patient A was taken from Respondent's facility on March 7, 1992. (516-517)

27. Dr. Dominguez testified that the medications administered to Patient A at the time of her arrest in Respondent's facility were appropriate. (531)

**A4. Failure to adequately inform Patient A's parents concerning (1) the risks of anesthesia or (2) that a nurse anesthetist would administer the anesthesia to Patient A without knowledgeable supervision**

**(a) Intentionally misleading Patient A's parents concerning (1) the risks of anesthesia and (2) the identity and qualifications of the individual who would administer the anesthesia**

28. Respondent's consent form adequately informed Patient A's parents of the situation where a surgeon such as Respondent would be supervising a CRNA. (Exhibit 3, pages 10-11, paragraph 4; 1760-1762)

29. The discussion of anesthetic risks by a CRNA was appropriate. (1763-1765).

30. Respondent did not depart from accepted standards with regard to his calling for emergency services in this case. (1765)

31. Respondent's consent form adequately informed patients or the patient's guardian of reasonable risks. (1819-1820)

**Patient B**

**B1. Failure to adequately diagnose and treat Patient B's condition**

32. Patient B, a 58 year old male, was treated by Respondent at his facility in Plainview, New York from March 5, 1990 to January 7, 1992. (Exhibit 11)

33. A CT examination of Patient B's neck and mediastinum on March 12, 1990 revealed a mass in the left erythnoid process. (Exhibit 11, page 8)

34. The Respondent had Patient B undergo a chest x-ray on March 12, 1990. (Exhibit 11, page 9)

35. Respondent had Patient B undergo an esophogram on May 23, 1990. (Exhibit 11, page 13)

36. Respondent noted some movement of the left cord on June 26, 1990, October 22, 1990 and January 22, 1991. (Exhibit 11, pages 14, 15 and 18)

37. Patient B testified at deposition on May 14, 1993 that Respondent examined his neck. (Exhibit U, pages 34-37, 78-82 and 85-86)

38. Patient B was seen by another ENT specialist in January 1992, who, upon physical examination, was unable palpate any abnormality in the thyroid area, nor detect a mass with a fibreoptic scope. (Exhibit 12, page 28)

39. There were no CT scans between the examination ordered by Respondent in March 1990 and the CT scan ordered by Patient B's next ENT, Dr. Zelman, in January 1992. (Exhibit 11)

#### **Patient C**

**C1. Failure to perform or record adequate histories, physical examinations, findings and/or diagnoses**

40. Patient C, a 21 year old male was treated by Respondent from February 1990 to December 1990 at Respondent's facility in Plainview, New York for complaint of difficulty in breathing and the appearance of Patient C's nose. (Exhibit 14)

41. The initial history taken on February 7, 1990 has no mention of trauma, infection, sinusitis, fever, medication or bleeding. (Exhibit 14, page 3)

42. The pre-operative surgical clearance by Dr. Hoschander did not reflect a history or actual physical examination. (Exhibit 14, page 12)

43. The pre-anesthetic examination reflects nothing of family history other than abnormal bleeding. (1580-1581)

44. The pre-anesthetic report of history and physical examination were not part of Patient B's chart. (Exhibit 14)

45. Exhibit 14 was certified as a complete copy of Patient C's chart by Respondent on September 11, 1991. (Exhibit 14, page 1)

**C2. Performing unnecessary and/or unjustified procedures and performing these procedures knowing they were unnecessary and/or unjustified**

46. Petitioner's expert, Dr. Matz, testified it is within the scope of good practice to use a fiberoptic scope if it is justified and/or there is no additional charge. (1632-1633)

47. Prior to surgery, Patient C was examined by Respondent using a fiberoptic scope on February 7 and 21, 1990

for which Respondent billed \$175 for each examination. (Exhibit K, pages 47, 66, 128 and 138). Following surgery, Patient C was examined endoscopically on four more occasions, March 2, 10, 21 and August 1, 1990 (Exhibit K, pages 34, 41-43) for which no additional charges were made.

48. Surgery was performed by Respondent on Patient C on February 24, 1990. (Exhibit K, page 48)

49. Thereafter, Kenalog injections were given to Patient C by Respondent on 13 occasions from March 10, 1990 through September 5, 1990 (Exhibit K, pages 30-42), for which no billing was rendered by Respondent.

50. Respondent testified that he gave Patient C Kenalog injections to correct cartilage deflection, edema and/or subperichondral hematoma. (1732-1733)

51. Petitioner's expert was unfamiliar with injection of Kenalog or a similar substance through a madja jet. (1601)

**C3. Intentionally billed in a misleading manner for procedures performed**

52. Two operative reports were submitted to Patient C's health insurer by Respondent for surgery on Patient C, one a report on the operation and the other a report of operation aesthetic. (Exhibit 15, pages 4, 5 and 6; 1647-1648)

53. Respondent's request for payment to the insurance company included both operative reports. (1648-1649)

**C4. Respondent treated Patient C inappropriately**

54. Surgery was performed by Respondent on Patient C on February 24, 1990 (Exhibit K, page 48)

55. Kenalog injections were thereafter administered to Patient C by Respondent between March 10 and September 5, 1990. (Exhibit K, pages 30-42)

56. Respondent testified that he administered the Kenalog injections to Patient C to correct cartilage deflection, edema and/or subperichondral hematoma. (1732-1733)

57. There was no negative testimony or evidence as to the quality and nature of the surgery performed by Respondent on Patient C.

**C5. Failure to adequately inform Patient C concerning (1) the risks of anesthesia or (2) that a nurse anesthetist would administer the anesthesia to Patient C without knowledgeable supervision**

**(a) Respondent intended to mislead Patient C concerning the risks of anesthesia and the fact that a nurse anesthetist would administer the anesthesia in the absence of knowledgeable supervision**

58. Respondent's consent form adequately informed patients of the situation where a surgeon such as Respondent would be supervising a CRNA. (Exhibit K, page 4, paragraph 4; 1760-1762)

59. Discussion of anesthetic risks by a CRNA is appropriate (1763-1765)

60. Respondent's consent form adequately informed patients of reasonable risks. (1819-1820)

**C6. Failure to adequately supervise the administration of anesthesia to Patient C by the CRNA on February 24, 1990**

61. CRNA John Quinn administered anesthesia to Patient C during the course of surgery on February 24, 1990 at Respondent's ambulatory surgical facility in Plainview, New York. (Exhibit 14)

62. Petitioner's expert, Dr. Matz, testified that he was not familiar with the type of ambulatory surgery facility utilized by Respondent and he has no knowledge as to the standard of care in the community as to such facilities. (1641-142, 1656-1658)

63. Dr. Goldiner testified that the ideal would be to have only anesthesiologists administering anesthesia, but that was not the standard in New York State. (1789)

64. Respondent's expert, Dr. Goldiner, testified that the facility utilized by Respondent was within the standard of care. (1813)

65. The circumstances of Respondent's supervision of the CRNA was at the time in question appropriate. (1788-1790)

**Patient D**

**D1. Respondent performed unnecessary and/or unjustified procedures; Respondent performed these procedures knowing they were unnecessary and/or unjustified**

66. Patient D, a 35 year old female, was treated by Respondent from March 1985 to February 1991 at his Plainview, New

York facility during the course of which he performed several flexible endoscopies and laser surgery. (Exhibit 16)

67. Respondent testified that in using the fiberoptic scope on Patient D, he was looking for bends in the septum that he could not observe without a scope, abnormalities in the turbinates, adequacy of a strut for the septum and that repeat endoscopic examinations were performed because the nose is not static organ and that anatomically conditions and physiology can change. (1717-1720)

68. Petitioner's expert testified that if there was no specific additional billing for repeat endoscopies then it was within the standard of practice. (1632-1633)

**D2. Intentionally billing in a misleading manner for procedures performed**

69. Petitioner's expert testified that the billing for Patient D was done essentially in the same manner as for Patient C (1685) and his testimony with respect to Patient C was that the billing was not misleading. (1648-1649)

**D3. Failure to adequately inform Patient D concerning (1) the risks of anesthesia or (2) that a nurse anesthetist would administer the anesthesia to Patient D without knowledgeable supervision**

- a. Intentionally misleading Patient D concerning (1) the risks of anesthesia and (2) the fact that a nurse anesthetist would administer the anesthesia in the absence of knowledgeable supervision

70. Respondent's consent form adequately informed patients of the situation where a surgeon such as Respondent would be supervising a CRNA (Exhibit 16, pages 10-11, paragraph 4; 1760-1762)

71. Discussion of anesthetic risks by a CRNA is appropriate. (1763-1765)

72. Respondent's consent form adequately informed the patient of reasonable risks. (1819-1820)

**D4. Failure to adequately supervise the administration of anesthesia to patient by the CRNA on October 13, 1990**

73. CRNA John Quinn administered anesthesia to Patient D during the course of surgery on October 13, 1990 at Respondent's ambulatory surgical facility in Plainview, New York. (Exhibit 16)

74. Petitioner's expert, Dr. Matz, testified that he was not familiar with the type of ambulatory surgery facility utilized by Respondent and he has no knowledge as to the standard of care in the community as to such facilities. (1641-142, 1656-1658)

75. Respondent's expert, Dr. Goldiner, testified that the facility utilized by Respondent was within the standard of care. (1813)

76. Dr. Goldiner, testified that the ideal would be to have only anesthesiologists administering anesthesia, but that was not the standard in New York State. (1789)

77. The circumstances of Respondent's supervision of the CRNA was at the time in question appropriate. (1788-1790)

**E. Respondent engaged in a sexual relationship with his patient, Patient E**

78. Respondent testified that he had sexual relations with Patient E while she was a patient for an 18 month period ending in early 1990 and that she was a patient of his from 1986 until early 1990. (162-163)

79. After Patient E's husband, Mr. N, discovered the sexual relationship between Respondent and his wife, Patient E, there was an armed confrontation, with guns drawn, between Respondent and Mr. N, resulting in the arrest of Mr. N. (331-335)

80. Respondent's relationship with Patient E was in violation of a long-standing consensus within the medical profession that sexual contact or sexual relations between physicians and patients are unethical. (Exhibit 18)

**F. Respondent engaged in a sexual relationship with his patient, Patient F**

81. Respondent testified that he had a sexual relationship with Patient F for a period of 8 months beginning in the latter part of 1990 but that she had not been a patient of his since the early part of that year, 1990, and that she was not subsequently a patient. (163-164)

82. Tano Carbonaro, M.D., Medical Coordinator for OPMC, did not question Respondent as to when he had the sexual relationship with Patient F. (1008)

**G. Respondent engaged in a sexual relationship with his patient, Patient G**

83. By letter dated December 29, 1994, Respondent wrote to John Flynn, an investigator with OPMC, that he had a sexual relationship with a single woman, later identified as Patient G, who was a patient at the time of that relationship. (Exhibit 17, page 2)

84. Respondent testified at the hearing that his letter (Exhibit 17) was an incorrect statement based, not on his recollection, rather on "information" from Patient G that it was her son that was a patient at the time that she and Respondent had a sexual relationship. (170-171)

85. Patient G did not testify at the hearing, nor did Respondent produce corroborating documentation as to the dates in question.

86. Respondent's relationship with Patient G was in violation of a long-standing consensus within the medical profession that sexual contact or sexual relations between physicians and patients are unethical. (Exhibit 18)

**H. Respondent engaged in a sexual relationship with his patient, Patient H**

87. Respondent testified that he had a sexual relationship with Patient H in 1990 and 1991, at a time that she was not a patient. His last professional relationship with her terminated in 1988 although he did continue to treat her children. (165-166)

**I. Failure to produce medical records of Patients F and G**

88. By letter dated October 31, 1994, OPMC demanded of Respondent that he produce medical records concerning Patients F and G. (Exhibit 20)

89. By letter dated December 29, 1994, Respondent replied: as to Patient F, he no longer had the records because the doctor/patient relationship ended 8+ years prior; as to Patient G, he saw her as a patient until 1992, and offered no justification to refuse production of those records other than they involved a personal relationship he had with Patient G. (Exhibit 17, 127, 1006-1007)

90. Respondent did not produce any records in response to the subpoena of November 27, 1995 or the letter of July 2, 1997. (Exhibit 21)

**J. Failure of Respondent to produce medical records of Patient I**

91. By letter dated June 28, 1995, Respondent was asked by OPMC to produce records as to Patient I. (Exhibit 23)

92. Respondent did not respond to the letter of June 28, 1995. (Exhibit 24)

93. Dr. Carbonaro testified that in his interview of Respondent, Respondent said that he last treated Patient I in 1989. (996)

94. Dr. Carbonaro testified that a physician is legally required to keep medical records for a period of six years. (1009)

95. Dr. Carbonaro testified that when he interviewed Respondent in August 1998, Respondent told him at that time that he no longer had the records of Patient I. (1011-1012)

**K. Failure to produce patient sign-in record for March 7, 1992**

96. Respondent was served with a subpoena dated August 19, 1997 requesting production of the patient sign-in book for March 7, 1992. (Exhibit 27).

97. Respondent testified that the patient sign-in book for that period was missing as a result of his having to suddenly move his office on 72 hours notice on July 19, 1997. (2014)

98. No testimony or evidence was submitted to qualify the patient sign-in book as a medical record.

**CONCLUSIONS OF LAW**

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

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.

- A. (4-18);
- A1 (4-18);
- A2 (not sustained);
- A3 (not sustained);
- A4 (not sustained);
- A4a (not sustained);
- B. (not sustained);
- B1 (not sustained);
- C. (40-45);
- C1 (40-45);
- C2 (not sustained);
- C2a (not sustained);
- C3 (not sustained);
- C4 (not sustained);
- C5 (not sustained);
- C6 (not sustained);
- D. (not sustained);
- D1 (not sustained);
- D2 (not sustained);
- D3 (not sustained);
- D4 (not sustained);

- E. (78-80);
- F. (not sustained);
- G. (83-85);
- H. (not sustained);
- I. (not sustained);
- J. (not sustained);
- K. (not sustained).

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each Specification:

First and Second Specifications - Gross negligence as to Patients A and B - not sustained.

Third and Fourth Specifications - Gross incompetence as to Patients A and B - not sustained.

Fifth Specification - Negligence on more than one occasion - (Paragraphs A, A1, C and C1); the balance of the Specifications not being sustained.

Sixth Specification - Incompetence on more than one occasion as to Patients A, B, C and D - not sustained.

Seventh through Ninth Specifications - Fraudulent practice - not sustained.

Tenth through Thirteenth Specifications - Moral unfitness - Specification Tenth (Paragraph E); Specification

Twelfth (Paragraph G); Specification Eleventh and Specification Thirteenth are not sustained.

Fourteenth through Sixteenth Specifications - Responsibilities not competent to perform - not sustained.

Seventeenth through Nineteenth Specifications - Performance services not authorized - not sustained.

Twentieth Specification - Excessive tests or treatment - not sustained.

Twenty-first through Twenty-third Specifications - Failing to exercise appropriate supervision - not sustained.

Twenty-fourth through Twenty-fifth Specifications - Failing to maintain records (Paragraphs A, A1, C and C1).

Twenty-sixth Specification - Failing to respond to a request for records - not sustained.

#### **DISCUSSION**

Respondent is charged with twenty-six Specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Henry M. Greenberg, Esq., General Counsel for the Department of Health, dated January 9, 1996. This document, entitled "Definitions of Professional

Misconduct under the New York Education Law", sets forth suggested definitions for negligence, gross negligence, incompetence and gross incompetence.

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 a 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 a profession.

**Unwarranted Treatment:** Is the ordering of excessive tests, treatment or use of treatment facilities not warranted by the condition of the patient. (Education Law § 6530(35)).

**Fraudulent Practice:** Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

**Moral Unfitness:** Conduct in the practice of medicine which evidences moral unfitness to practice the profession as determined by standards which are commonly accepted by those practicing medicine in the community.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Petitioner has sustained, in part, its burden of proof regarding serious charges brought against Respondent. The rationale for the Hearing Committee's conclusions is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the various witnesses presented by the parties. The Petitioner presented one expert witness, Dr. Marvin Matz, who presented as an expert in the field of otolaryngology. The Committee noted that certain representations made in Dr. Matz's credentials with respect to his academic appointments proved to be inaccurate. As well, the Committee notes that Dr. Matz could not provide expert testimony in the fields of anesthesia nor, as a medical ethicist.

Respondent presented Dr. Paul Goldiner, a board certified anesthesiologist, eminently qualified, whose testimony with respect to the use and supervision of certified registered nurse anesthetists in ambulatory surgical facilities was compelling. In addition, his testimony with respect to the consent form that was utilized by Respondent was likewise persuasive. Dr. Matz, on the other hand, was admittedly

unfamiliar with ambulatory surgical facilities such as the one operated by Respondent. As such, his testimony with respect to the use and supervision of CRNA's was not controlling.

Insofar as the Respondent's efforts to resuscitate Patient A and the alleged time delay in calling for 911 assistance, the Hearing Committee was impressed with the testimony of Dr. Paul Goldiner, Dr. Myra Dominguez and ambulance medical technician, Francis DeBobes, as to the resuscitation equipment that was available at the facility, the response of the medical personnel at the Respondent's facility, the medications prescribed and administered and the stabilization of Patient A's condition. The Hearing Committee notes that the cause of this unfortunate incident involving Patient A remains unknown.

Respondent's regular usage of a flexible fiberoptic scope in the normal course of his examinations was criticized by Petitioner's expert, Dr. Matz. However, the Hearing Committee was not persuaded that Respondent's frequent endoscopic examinations were unwarranted or that he excessively billed for this type of examination.

The Hearing Committee notes and agrees with Dr. Goldiner's position that anesthesia is best administered by anesthesiologists. Notwithstanding, Dr. Goldiner testified that it was and is standard practice in ambulatory surgical clinics to use the services of a CRNA under the supervision of a licensed physician, i.e., plastic surgeon, ENT or oral surgeon. The Hearing Committee is uniformly of the opinion that this practice

is not in the best interest of the public but inasmuch as the practice was within the custom and usage, it could not find that such practice did not conform with the standard of care.

Insofar as Respondent's billing practice was concerned, the Hearing Committee was persuaded that Respondent either explicitly or implicitly told the insurance companies through his billing methods that there was cosmetic surgery taking place and then left it up to the insurance companies to decide to what extent it would pay for the medical treatment as opposed to the aesthetic surgical intervention. Similarly, with respect to the billing for endoscopic examinations, the Hearing Committee was not persuaded that the Respondent's use of the fiberoptic scope was to pad his billing to the insurance companies as opposed to his rational explanation for the use of a flexible fiberoptic scope. The Hearing Committee was not persuaded by Dr. Matz's criticism of Respondent's examination techniques.

The Respondent's record keeping was deficient. Certainly, the Hearing Committee uniformly felt that the pre-anesthetic record of history and physical examinations should be part of the patient's chart. It is not sufficient that there was a CRNA record separate and apart from the chart. That information is material and germane to a subsequent treating physician's review of a patient's medical chart and should be part of that chart. The fact that it was not, in the ordinary course, made part and parcel of the patient's records was unsatisfactory. The Hearing Committee notes the Respondent's

explanation for the disappearance of the CRNA's records but even giving credit for that explanation, does not take away from the fact that it was not the Respondent's practice to make a CRNA's record a part of the patient's chart.

Moreover, the history and physical examination recorded by the Respondent as to Patients A and C left much to be desired. There was information that the Hearing Committee expected would be noted on the chart and even the Respondent's expert, Dr. Goldiner, agreed that there was a deficiency in this respect.

The Committee notes Respondent's failure to comply with appropriate requests for medical records. With respect to Patient G, Respondent took the untenable position that disclosure of her medical records would somehow subject that patient to the threat of harm. Perhaps Respondent's conduct might have that untoward result but not the medical records which only reflect upon medical treatment, not personal relationships. Consequently, there was no justification for Respondent's failure to respond to further requests, including subpoena of these records.

Insofar as Patient I is concerned, it would appear that more than six years had elapsed from the time the doctor/patient relationship ended to the date of request for medical records. Respondent was not required to maintain these records. Notwithstanding, the Committee notes that it would have been "simple courtesy" on the part of Respondent to have responded to

the records request by indicating he did not have the records, rather than ignoring the request.

Similarly with respect to the sign-in book, while it would appear that this is not a "medical record" required to be maintained, Respondent should have had the professionalism to timely respond to this request, rather than ignoring same.

The most significant finding, however, relates to the Respondent's predilection for engaging in sexual relations with patients and former patients. The Committee notes the observation made by the Council on Ethical and Judicial Affairs of the American Medical Association, Report on Sexual Misconduct in the Practice of Medicine,

There is a long-standing consensus within the medical profession that sexual relations between physicians and patients are unethical. This prohibition against sexual relations with patients was incorporated into the Hippocratic Oath ... (Exhibit 18)

While the Committee recognizes that not every aspect of the Hippocratic Oath is relevant in today's world, it is uniformly of the opinion and agrees with the AMA Council's observation that

Current ethical thought uniformly condemns sexual relations between patients and physicians. (Exhibit 18)

In this respect, the Committee notes Opinion 8.14 of the Code of Medical Ethics, issued in 1986, that "sexual misconduct in the practice of medicine violates the trust the patient imposes on the physician and is unethical." (Exhibit 30)

Respondent argues that the relationships were consensual. Given the nature of the doctor/patient relationship, there cannot be consent to an act which is *per se* unethical. The need to maintain the doctor's objectivity in the treatment of a patient and to avoid unnecessary complications in that relationship not only with the patient but, as well, with the patient's family such as witnessed by Patient E's husband and Respondent confronting each other with armed weapons, leave no doubt that this activity must be viewed with abject condemnation.

In this respect, the Hearing Committee is also impressed with the fact of the Respondent having sexual relations with Patient G either at a time when she was a patient of his or her children were patients. The fact that Patient G "corrected" Respondent's statement that she was a patient at the time of their sexual relationship, does not take away from the fact that the Respondent did not change his testimony nor did he produce any documentation to corroborate his newly found position that Patient G was not a patient at the time of their sexual relationship.

Insofar as Patients F and H are concerned, while Respondent did not engage in a sexual relationship at a time that he was treating them, it is not lost upon the Hearing Committee that this physical relationship stems out of a professional relationship.

To condone such a pattern of behavior both with respect to those acts which are *per se* unethical and as to those acts

which support a continuing concern for Respondent's predilection to engage in such acts leads to the ineluctable conclusion that Respondent is morally unfit to practice the profession.

DETERMINATION AS TO PENALTY

With respect to the specification of moral unfitness to practice the profession as set forth in the Tenth and Twelfth Specifications, the Hearing Committee has determined that the Respondent is morally unfit to practice the profession and his license should be revoked.

With respect to the failure on the part of the Respondent to maintain appropriate records as set forth in the Twenty-Fourth and Twenty-Fifth Specifications, the Hearing Committee has determined that a fine of \$10,000 is appropriate.

With respect to Respondent's negligence on more than one occasion as set forth in the Fifth Specification, the Hearing Committee concluded that a fine of \$10,000 is appropriate.

ORDER

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

1. The Fifth, Tenth, Twelfth, Twenty-Fourth and Twenty-Fifth Specifications of professional misconduct as set forth in the Statement of Charges (Petitioner's Exhibit "2") are **SUSTAINED;**

2. The First, Second, Third, Fourth, Sixth, Seventh, Eight, Ninth, Eleventh, Thirteenth, Fourteenth, Fifteenth, Sixteenth, Seventeenth, Eighteenth, Nineteenth, Twentieth,

Twenty-First, Twenty-Second, Twenty-Third and Twenty-Sixth Specifications of professional misconduct are **DISMISSED**;

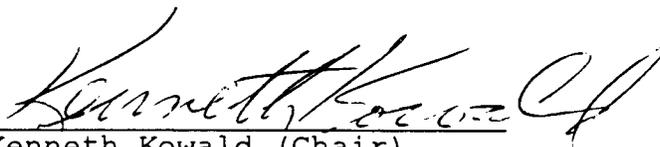
3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED** on the effective date of this Determination and Order;

4. Respondent is ordered to pay a fine of \$20,000 within seven (7) days of the effective date of this Determination and Order.

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and service shall be effective upon receipt or seven (7) days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

Dated: Albany, New York  
~~May~~ 1999

*June 2*

  
Kenneth Kowald (Chair)  
Gerald S. Weinberger, M.D.  
John T. Frazier, M.D.

TO: Denise Lepicier, Esq.  
Associate Counsel  
New York State Department  
of Health  
5 Penn Plaza  
New York, New York 10001

Stuart G. Selkin, M.D.  
6 Tuxedo Drive  
Melville, New York 11747

Anthony Z. Scher, Esq.  
Wood & Scher  
Attorney for Respondent  
The Harwood Building  
Scarsdale, New York 10583

RECORD OF PROCEEDINGS

The following is a list of documents comprising the record In the Matter of Stuart G. Selkin, M.D.

Report Dated: May , 1999

Order/Recommendation/Resolution: May , 1999

The Proposed Findings of Fact:

Petitioner	Received April 5, 1999
Respondent	Received April 5, 1999

Memorandum of Law:	Petitioner: None submitted
	Respondent: Included in proposed findings

Respondent's Exhibits:

Exhibit A, Letter dated 1/22/92 to Warren H. Zelman from Douglas Kiviat, M.D. on letterhead of Nassau Radiologic Group relating to Patient F;

Exhibit G, pre-operative package distributed by Respondent to patients undergoing certain types of nasal surgery;

Exhibit I, verified answer of Respondent;

Exhibit J, CV of Dr. Selkin;

Exhibit K, Copies of Dr. Selkin's office records relating to Patient C;

Exhibit L-1, Color photograph;

Exhibit L-2, Color photograph;

Exhibit L-3, Color photograph;

Exhibit M, Article entitled "Kinelaryngoscopy for Documentation of Laryngeal Pathophysiology";

Exhibit N Article entitled "Laryngeal Candidiasis and Ketoconazole";

Exhibit O, Article entitled "Otolaryngology - Head and Neck Surgery - Routine Use of Office Endoscopy in Otolaryngology";

Exhibit P, Safety glasses;

Exhibit Q, Printed form of Dr. Selkin;

Exhibit R, Records of Helen Yoon, M.D. for Patient A with *subpoena duces tecum* as a cover page;

Exhibit S, CT films subpoenaed from Shayne, Dachs re: Patient B;

Exhibit T, CT films subpoenaed from Rivkin, Radler & Kremer re: Patient B;

Exhibit U, EBT of Patient B dated May 14, 1993;

Exhibit V, Fax from New York Medical College to Dr. Selkin dated 3/9/99;

Exhibit W, Letter dated March 16, 1999 on the letterhead of New York Medical College faxed to Dr. Selkin;

Exhibit X, Blank consent form

Petitioner's Exhibits:

Exhibit 1, License and registration file of Stuart Selkin, M.D. certified May 5, 1998;

Exhibit 2, Notice of Hearing and Statement of Charges with affidavit of service dated October 16, 1998;

Exhibit 3, Medical records for Patient A from Stuart Selkin, M.D. certified January 29, 1993;

Exhibit 4, Two additional pages of medical records of Patient A from Stuart Selkin, M.D. certified August 25, 1994;

Exhibit 5, Copies of an appointment long certified August 25, 1994;

Exhibit 6, 911 time log;

Exhibit 7, Pre-hospital care report for Patient A certified October 19, 1993;

Exhibit 8, AMT DeBobes medical book pages certified by AMT Frances DeBobes;

Exhibit 9, Nassau County Medical Center Record for Patient A, certified September 30, 1993;

Exhibit 10, Report of autopsy for Patient A, certified by Andrew Woldzko, M.D.;

Exhibit 11, Medical record for Patient B from Stuart Selkin, M.D., certified August 24, 1995;

Exhibit 12, Medical record for Patient B from Warren Zelman, M.D. certified January 8, 1998;

Exhibit 13, Manhattan Eye, Ear, Nose & Throat Hospital record for Patient B, certified December 3, 1997;

Exhibit 14, medical record for Patient C from Stuart Selkin, M.D. with a letter dated September 11, 1991;

Exhibit 15, insurance claims record for Patient C certified December 16, 1997;

Exhibit 16, Medical records for Patient D from Stuart Selkin, M.D. certified August 29, 1995;

Exhibit 17, letter from Stuart Selkin, M.D. dated December 29, 1994;

Exhibit 18, Report of AMA on sexual misconduct;

Exhibit 20, 230 Letter dated October 31, 1994 for records of Patients F and G;

Exhibit 21, *Subpoena duces tecum* served November 27, 1995 for records of Patients F and G;

Exhibit 22; 230 letter dated July 23, 1997 for records of Patients F and G;

Exhibit 23, 230 letter dated June 28, 1995 for records of Patient I;

Exhibit 24, Letter confirming non-receipt of Patient I records dated August 30, 1995;

Exhibit 25, 230 letter requesting records of Patient I and patient sign-in book sent May 7, 1998;

Exhibit 26, 230 letter dated May 12, 1998 for records of Patient I and patient sign-in book for March 7, 1992;

Exhibit 27, *Subpoena duces tecum* served August 19, 1997 for patient sign-in book of March 7, 1992;

Exhibit 28, Envelope postmarked August 25, 1995;

Exhibit 29, CV of Dr. Matz;

Exhibit 30, Cover letter of May 20, 1998 from Blair Osgood at the AMA, plus redacted opinion 8.14 as it appeared in code issued in 1986;

Exhibit 31, Excerpt from 1987 Current Procedural Terminology Code Book;

Exhibit 32, Excerpt from 1990 Current, Procedural Terminology Code Book;

Exhibit 33, Excerpt from 1991 Current Procedural Terminology Code Book;

Exhibit 34 Article entitled "Laser Turbinectomy as an Adjunct to Rhinoseptoplasty";

Exhibit 35, Article entitled "Rhinoplasty and General Anesthesia";

Exhibit 36, Deposition transcripts of Dr. Selkin's testimony from August 1, 1994 and August 12, 1994 regarding Patient A;

Exhibit 37, Inter-office memorandum from John C. Flynn, Sr. dated September 20, 1994;

ALJ Exhibits:

Exhibit 1, Memorandum of law dated November 24, 1998 to Hon. Tyrone Butler from Stuart G. Selkin, M.D.;

Exhibit 2, Letter dated June 16, 1998 to Dr. Selkin from Ms. Lepicier, letter from Dr. Selkin dated June 28, 1998, letter to Dr. Selkin dated July 9, 1998 and memorandum dated August 4, 1998 from Ms. Lepicier;

Exhibit 3, Letter dated November 25, 1998 to Dr. Selkin from Edwin L. Smith, ALJ;

Exhibit 4, Notice of Combined Demands;

Exhibit 5, Letter dated November 10, 1998 to Edwin L. Smith, ALJ from Ms. Lepicier;

Exhibit 6, Letter of February 19, 1999 from Ms. Lepicier to Mr. Smith, copy to Mr. Scher, together with department's memorandum relating to sexual misconduct and the production of records, as well as copies of certain pages of the AMA current procedural terminology code books for 1987, 1990 and 1991;

Exhibit 7, Letter of February 22, 1999 from Ms. Lepicier to Mr. Smith, copy to Mr. Scher, together with the decision of the Regents Review Committee relating to the matter of Paul M. Katz, plus Hearing Committee decision;

Exhibit 8, Cover letter from Mr. Scher to Mr. Smith, with Respondent's memorandum of law relating to the two subject matters, sexual misconduct and records production;

Exhibit 9, Reply memorandum of law from the Department of Health relating to sexual misconduct and production of records

Exhibit 10, Letter of February 23, 1999 from Mr. Scher to Mr. Smith, copy to Ms. Lepicier, which is Mr. Scher's reply to the memorandum of law submitted by the Petitioner;

Exhibit 11 (deemed marked), Letter of March 24, 1999 from Mr. Smith to Mr. Scher and Ms. Lepicier admitting Exhibit 37 into evidence;

Exhibit 12 (deemed marked), Respondent's letter motion of April 2, 1999 to dismiss predicated on undue delay in prosecution;

Exhibit 13 (deemed marked), Petitioner's affirmation in opposition to Respondent's motion to dismiss

Hearing Committee Exhibits: Not applicable.

Transcript Pages:     December 28, 1998, pages 1 through 219  
                          January 4, 1999, pages 222 to 463  
                          January 5, 1999, pages 464-694  
                          January 6, 1999, pages 695-933  
                          January 11, 1999, pages 934-1177  
                          January 12, 1999, pages 1178-1445  
                          March 3, 1999, pages 1446-1535  
                          March 10, 1999, pages 1536-1747  
                          March 11, 1999, pages 1748-1840  
                          March 17, 1999, pages 1841-1883  
                          March 18, 1999, pages 1884-2091  
                          March 19, 1999, pages 2092-2145

Intra-hearing Conference Transcripts:

                          December 28, 1998, pages 1 through 20  
                          January 6, 1999, pages 21 through 52  
                          January 11, 1999, pages 53 through 71  
                          January 12, 1999, pages 72 through 95  
                          March 3, 1999, pages 96 through 133  
                          March 10, 1999, pages 134 through 147  
                          March 11, 1999, pages 148 through 157

March 17, 1999, pages 158 through 179  
March 19, 1999, pages 180 through 215

Additional Documents: Not applicable

EXHIBIT LIST

Case: The Matter of Stuart G. Selkin, M.D.

ALJ: Edwin L. Smith

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
<b>PETITIONER'S EXHIBITS:</b>			
Exhibit 1	License and registration file of Stuart Selkin, M.D. certified May 5, 1998		11/30/98
Exhibit 2	Notice of hearing and statement of charges with affidavit of service dated October 16, 1998		11/30/98
Exhibit 3	Medical records for Patient A from Stuart Selkin, M.D. certified January 29, 1993		11/30/98
Exhibit 4	Two additional pages of medical records of Patient A from Stuart Selkin, M.D. certified August 25, 1994		11/30/98
Exhibit 5	Copies of an appointment log certified August 25, 1994		11/30/98
Exhibit 6	911 time log		11/30/98
Exhibit 7	Pre-hospital care report for Patient A certified October 19, 1993		11/30/98
Exhibit 8	AMT DeBoves medical book pages certified by AMT Frances DeBoves		11/30/98
Exhibit 9	Nassau County Medical Center record for Patient A certified September 30, 1993		11/30/98

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
Exhibit 10	Report of autopsy for Patient A certified by Andrew Woldzko, M.D.		11/30/98
Exhibit 11	Medical record for Patient B from Stuart Selkin, M.D. certified August 24, 1995		
Exhibit 12	Medical record for Patient B from Warren Zelman, M.D. certified January 8, 1998		11/30/98
Exhibit 13	Manhattan Eye, Ear, Nose & Throat Hospital record for Patient B certified December 3, 1997		11/30/98
Exhibit 14	Medical record for Patient C from Stuart Selkin, M.D. with a letter dated September 11, 1991		11/30/98
Exhibit 15	Insurance claims record for Patient C certified December 16, 1997		11/30/98
Exhibit 16	Medical records for Patient D from Stuart Selkin, M.D. certified August 29, 1995		11/30/98
Exhibit 17	Letter from Stuart Selkin, M.D. dated December 29, 1994		11/30/98
Exhibit 18	Report (redacted) of AMA on sexual misconduct		3/3/99
Exhibit 19	Code of Medical Ethics	X	
Exhibit 20	230 letter dated October 31, 1994 for records of Patients F and G		11/30/98
Exhibit 21	<i>Subpoena duces tecum</i> served November 27, 1995 for records of Patients F and G		11/30/98

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
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Exhibit 23	230 letter dated June 28, 1995 for records of Patient I		11/30/98
Exhibit 24	Letter confirming non-receipt of Patient I records dated August 30, 1995		11/30/98
Exhibit 25	230 letter requesting records of Patient I and patient sign-in book sent May 7, 1998		11/30/98
Exhibit 26	230 letter dated May 12, 1998 for records of Patient I and patient sign-in book for March 7, 1992		11/30/98
Exhibit 27	<i>Subpoena duces tecum</i> served August 19, 1997 for patient sign-in book of March 7, 1992		11/30/98
Exhibit 28	Envelope postmarked August 25, 1995		12/28/98
Exhibit 29	CV of Dr. Matz		1/6/99
Exhibit 30	Cover letter of May 20, 1998 from Blair Osgood at the AMA, plus redacted opinion 8.14 as it appeared in code issued in 1986		3/17/99
Exhibit 31	Excerpt from 1987 Current Procedural Terminology Code Book		3/10/99
Exhibit 32	Excerpt from 1990 Current Procedural Terminology Code Book		3/10/99
Exhibit 33	Excerpt from 1991 Current Procedural Terminology Code Book		3/10/99

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
Exhibit 34	Article entitled "Laser Turbinectomy as an Adjunct to Rhinoseptoplasty"		3/10/99
Exhibit 35	Article entitled "Rhinoplasty and General Anesthesia"		3/10/99
Exhibit 36	Deposition transcripts of Dr. Selkin's testimony from August 1, 1994 and August 12, 1994 regarding Patient A		3/11/99
Exhibit 37	Inter-office memorandum from John C. Flynn, Sr. dated September 20, 1994		3/24/99
<b>RESPONDENT'S EXHIBITS:</b>			
Exhibit A	Letter dated 1/22/92 to Warren H. Zelman from Douglas Kiviat, M.D. on letterhead of Nassau Radiologic Group relating to Patient F		11/30/98
Exhibit B	Article entitled "Otolaryngology," by Gerald English, published by Harper & Row	X	
Exhibit C	Article entitled "Aesthetic Plastic Surgery," page 337 by T.D. Rees	X	
Exhibit D	Article entitled "Complications in Head & Neck Surgery," by Y.P. Krespi & R.H. Ossoff	X	
Exhibit E	Article entitled "Essential Otolaryngology, Head & Neck Surgery," by K.J. Lee	X	
Exhibit F	Furukawa articles	X	
Exhibit G	Pre-operative package distributed by Respondent		11/30/98

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
	to patients undergoing certain types of nasal surgery		
Exhibit I	Verified answer of Respondent		11/30/98
Exhibit J	CV of Dr. Selkin		12/28/98
Exhibit K	Copies of Dr. Selkin's office records relating to Patient C		1/5/99
Exhibit L-1	Color photograph		1/11/99
Exhibit L-2	Color photograph		1/11/99
Exhibit L-3	Color photograph		1/11/99
Exhibit M	Article entitled "Kinelaryngoscopy for Documentation of Laryngeal Pathophysiology"		1/11/99
Exhibit N	Article entitled "Laryngeal Candidiasis and Ketoconazole"		1/11/99
Exhibit O	Article entitled "Otolaryngology - Head and Neck Surgery - Routine Use of Office Endoscopy in Otolaryngology"		1/11/99
Exhibit P	Safety glasses		1/11/99
Exhibit Q	Printed form of Dr. Selkin		1/11/99
Exhibit R	Records of Helen Yoon, M.D. for Patient A with <i>subpoena duces tecum</i> as a cover page	X	
Exhibit S	CT films subpoenaed from Shayne, Dachs re: Patient B		3/18/99
Exhibit T	CT films subpoenaed from Rivkin, Radler & Kremer re: Patient B		3/18/99
Exhibit U	EBT of Patient B dated		3/19/99

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
	May 14, 1993		
Exhibit V	Fax from New York Medical College to Dr. Selkin dated 3/9/99		3/19/99
Exhibit W	Letter dated March 16, 1999 on the letterhead of New York Medical College faxed to Dr. Selkin		3/19/99
Exhibit X	Blank consent form	X	
<b>ALJ EXHIBITS:</b>			
Exhibit 1	Memorandum of law dated November 24, 1998 to Hon. Tyrone Butler from Stuart G. Selkin, M.D.		11/30/98
Exhibit 2	Letter dated June 16, 1998 to Dr. Selkin from Ms. Lepicier, letter from Dr. Selkin dated June 28, 1998 letter to Dr. Selkin dated July 9, 1998, memorandum dated August 4, 1998 from Ms. Lepicier		11/30/98
Exhibit 3	Letter dated November 25, 1998 to Dr. Selkin from Edwin L. Smith ALJ		11/30/98
Exhibit 4	Notice of combined demands		11/30/98
Exhibit 5	Letter dated November 10, 1998 to Edwin L. Smith, ALJ from Denise Lepicier		11/30/98
Exhibit 6	Letter of February 19, 1999 from Ms. Lepicier to Mr. Smith, copy to Mr. Scher, together with department's memorandum relating to sexual misconduct and the		3/3/99

<u>Exhibit Designation</u>	<u>Description</u>	<u>I.D. Only</u>	<u>Date Received in Evidence</u>
	production of records, as well as copies of certain pages of the AMA current procedural terminology code books for 1987, 1990 and 1991		
Exhibit 7	Letter of February 22, 1999 from Ms. Lepicier to Mr. Smith, copy to Mr. Scher, together with the decision of the Regents Review Committee relating to the matter of Paul M. Katz, plus Hearing Committee decision		3/3/99
Exhibit 8	Cover letter from Mr. Scher to Mr. Smith, with Respondent's memorandum of law relating to the two subject matters, sexual misconduct and records production		3/3/99
Exhibit 9	Reply memorandum of law from the Department of Health relating to sexual misconduct and production of records		3/3/99
Exhibit 10	Letter of February 23, 1999 from Mr. Scher to Mr. Smith, copy to Ms. Lepicier, which is Mr. Scher's reply to the memorandum of law submitted by the Petitioner		3/3/99
Exhibit 11 (deemed marked)	Letter of March 24, 1999 from Mr. Smith to Mr. Scher and Ms. Lepicier admitting Exhibit 37 into evidence		3/19/99
Exhibit 12 (deemed marked)	Respondent's letter motion of April 2, 1999 to dismiss predicated on undue delay in prosecution		3/19/99

Exhibit  
Designation

Description

I.D.  
Only

Date  
Received  
in  
Evidence

Exhibit 13  
(deemed  
marked)

Petitioner's affirmation  
in opposition to  
Respondent's motion to  
dismiss

3/19/99

ADDENDUM I

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

IN THE MATTER  
OF  
STUART G. SELKIN, M.D.

NOTICE  
OF  
HEARING

RECEIVED

TO: STUART G. SELKIN, M.D.  
6 Tuxedo Drive  
Melville, N.Y. 11747

OCT 28

NYSDHEPT. C  
DIVISION OF LEGAL AFFAIRS  
BUREAU OF ADJUDICATION

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1998) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1998). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on December 9, 1998, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date.

Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 (McKinney Supp. 1998) and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE  
MEDICINE IN NEW YORK STATE BE REVOKED OR  
SUSPENDED, AND/OR THAT YOU BE FINED OR  
SUBJECT TO OTHER SANCTIONS SET OUT IN NEW  
YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp.  
1998). YOU ARE URGED TO OBTAIN AN ATTORNEY TO  
REPRESENT YOU IN THIS MATTER.

DATED: New York, New York  
October 14, 1998



ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

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IN THE MATTER  
OF  
STUART G. SELKIN, M.D.

STATEMENT  
OF  
CHARGES

STUART G. SELKIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 19, 1967, by the issuance of license number 098873 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. Respondent treated Patient A, a six year old female at her last visit, from on or about January 17, 1991, to on or about March 7, 1992, at his office at 1171 Old Country Road, Plainview, New York. On or about March 7, 1992, Respondent performed a tonsillectomy and adenoidectomy on Patient A at his ambulatory surgical facility at his office at 1171 Old Country Road. On or about the end of the procedure, Patient A suffered respiratory and cardiac arrest. Patient A was transported to the Nassau County Medical Center on or about March 7, 1992, where she was subsequently declared brain dead.
1. Respondent failed to perform or record adequate histories, physical examinations, findings, diagnoses and/or procedures.
  2. Respondent failed to adequately supervise the administration of anesthesia to Patient A by the Certified Registered Nurse Anesthetist on March 7, 1992.
  3. Respondent failed to call for emergency services in a timely fashion.
  4. Respondent failed to adequately inform Patient A's parents

concerning the risks of anesthesia or the fact that a nurse anesthetist would administer the anesthesia to Patient A without knowledgeable supervision.

- a. Respondent intended to mislead Patient A's parents concerning the risks of anesthesia and the identity and qualifications of the individual who would administer the anesthesia.

B. Respondent treated Patient B, a fifty-eight year old male at his last office visit, from on or about March 5, 1990, to on or about January 7, 1992, at his office at 1171 Old Country Road, Plainview, New York. On or about March 5, 1990, Respondent ordered a computerized tomographic examination of Patient B's neck and mediastinum. The examination revealed a mass in or around the posterior left vocal cord.

1. Respondent failed to adequately diagnose and treat Patient B's condition.

C. Respondent treated Patient C, a twenty-one year old male on his first office visit, from on or about February of 1990 to on or about December of 1990, at his office at 1171 Old Country Road, Plainview, New York. Respondent performed repeated flexible endoscopies and laser surgery on Patient C. Respondent treated Patient C with repeated injections of Kenalog.

1. Respondent failed to perform or record adequate histories, physical examinations, findings and/or diagnoses.
2. Respondent performed unnecessary and/or unjustified procedures.
  - a. Respondent performed these procedures knowing they were unnecessary and/or unjustified.
3. Respondent intentionally billed in a misleading manner for

procedures performed.

4. Respondent treated Patient C inappropriately.
5. Respondent failed to adequately inform Patient C concerning the risks of anesthesia or the fact that a nurse anesthetist would administer the anesthesia to Patient C without knowledgeable supervision.
  - a. Respondent intended to mislead Patient C concerning the risks of anesthesia and the fact that a nurse anesthetist would administer the anesthesia in the absence of knowledgeable supervision.
6. Respondent failed to adequately supervise the administration of anesthesia to Patient C by the Certified Registered Nurse Anesthetist on February 24, 1990.

D. Respondent treated Patient D, a thirty-five year old female at her first office visit, from on or about March of 1985, to on or about February of 1991, at his 1171 Old Country Road, Plainview, New York. Respondent performed repeated flexible endoscopies and laser surgery on Patient D.

1. Respondent performed unnecessary and/or unjustified procedures.
  - a. Respondent performed these procedures knowing they were unnecessary and/or unjustified..
2. Respondent intentionally billed in a misleading manner for procedures performed.
3. Respondent failed to adequately inform Patient D concerning the risks of anesthesia or the fact that a nurse anesthetist would administer the anesthesia to Patient D without knowledgeable supervision.

- a. Respondent intended to mislead Patient D concerning the risks of anesthesia and the fact that a nurse anesthetist would administer the anesthesia in the absence of knowledgeable supervision.
- 4. Respondent failed to adequately supervise the administration of anesthesia to Patient D by the Certified Registered Nurse Anesthetist on October 13, 1990.
- E. Respondent engaged in a sexual relationship with his patient, Patient E.
- F. Respondent engaged in a sexual relationship with his patient, Patient F.
- G. Respondent engaged in a sexual relationship with his patient, Patient G.
- H. Respondent engaged in a sexual relationship with his patient, Patient H.
- I. On or about October 31, 1994, Respondent was sent a letter requesting the medical records of Patient F and Patient G. On or about November 27, 1995, Respondent was served with a subpoena requesting the medical records of Patient F and Patient G. On or about July 2, 1997, Respondent was sent a letter by certified mail, return receipt requested, requesting the medical records of Patient F and Patient G. Respondent failed to comply with any of these requests.
- J. On or about June 28, 1995, Respondent was sent a letter by certified mail, return receipt requested, requesting the medical records of Patient I. On or about May 7, 1998, Respondent was sent a letter by certified mail, return receipt requested, requesting the medical records of Patient I. On or about May 12, 1998, Respondent was served with a letter requesting the medical records of Patient I. Respondent failed to comply with any of these requests.
- K. On or about August 19, 1997, Respondent was served with a subpoena requesting his patient sign-in book for March 7, 1992. On or about May 7, 1998, Respondent was sent a letter by certified mail, return receipt requested,

requesting his patient sign-in book for March 7, 1992. On or about May 12, 1998, Respondent was served with a letter requesting his patient sign-in book for March 7, 1992. Respondent failed to comply with any of these requests.

## **SPECIFICATION OF CHARGES**

### **FIRST AND SECOND SPECIFICATIONS**

#### **GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1998) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A, A1, A2, A3 and/or A4;
2. Paragraphs B and B1.

### **THIRD AND FOURTH SPECIFICATIONS**

#### **GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1998) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraphs A, A1, A2 and/or A3;
4. Paragraphs B and B1.

### **FIFTH SPECIFICATION**

#### **NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1998) by practicing the profession of

medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

5. Paragraphs A, A1, A2 and/or A3; Paragraphs B and B1;  
Paragraphs C, C1, C2, C4 and C6; Paragraphs D, D1 and D4.

#### **SIXTH SPECIFICATION**

#### **INCOMPETENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1998) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraphs A, A1, A2 and/or A3; Paragraphs B and B1;  
Paragraphs C, C1, C2, C4 and C6; Paragraphs D, D1 and D4.

#### **SEVENTH THROUGH NINTH SPECIFICATIONS**

#### **FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

7. Paragraphs A, A4 and A4a;
8. Paragraphs C, C2, C2a, C3 and C5 and C5a ;
9. Paragraphs D, D1, D1a, D2 and D3 and D3a.

## **TENTH THROUGH THIRTEENTH SPECIFICATIONS**

### **MORAL UNFITNESS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 1998) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

10. Paragraph E;
11. Paragraph F;
12. Paragraph G;
13. Paragraph H.

## **FOURTEENTH THROUGH SIXTEENTH SPECIFICATIONS**

### **RESPONSIBILITIES NOT COMPETENT TO PERFORM**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(24)(McKinney Supp. 1998) by accepting and performing professional responsibilities which the licensee knows or has reason to know that he is not competent to perform as alleged in the facts of:

14. Paragraph A and A2;
15. Paragraph C and C6;
16. Paragraph D and D4.

## **SEVENTEENTH THROUGH NINETEENTH SPECIFICATIONS**

### **PERFORMING SERVICES NOT AUTHORIZED**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(26)(McKinney Supp. 1998) by performing professional services which were not duly authorized, as alleged in the facts of:

17. Paragraph A and A4;

18. Paragraph C and C5;
19. Paragraph D and D3.

**TWENTIETH SPECIFICATION**  
**EXCESSIVE TESTS OR TREATMENT**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35)(McKinney Supp. 1998) by ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

20. Paragraphs C2 and D1.

**TWENTYFIRST THROUGH TWENTYTHIRD SPECIFICATIONS**  
**FAILING TO EXERCISE APPROPRIATE SUPERVISION**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(33)(McKinney Supp. 1998) by failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensee, as alleged in the facts of:

21. Paragraph A and A2;
22. Paragraph C and C6;
23. Paragraph D and D4.

**TWENTYFOURTH THROUGH TWENTYFIFTH SPECIFICATIONS**  
**FAILING TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1998) by failing to maintain records, as alleged in the facts of:

24. Paragraphs A and A1.

25. Paragraphs C and C1.

**TWENTYSIXTH SPECIFICATION**

**FAILING TO RESPOND TO A REQUEST FOR RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(28)(McKinney Supp. 1998) by failing to respond to a request for records from the Department of Health, as alleged in the facts of:

26. Paragraphs I, J and/or K.

DATED: October 14, 1998  
New York, New York



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**ROY NEMERSON**  
Deputy Counsel  
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