



STATE OF NEW YORK DEPARTMENT OF HEALTH

Office of Public Health

Corning Tower

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

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

Karen Schimke
Executive Deputy Commissioner

July 5, 1995

RECEIVED
JUL 06 1995
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Shapiro, Esq.
Timothy Gibbons, Esq.
Shapiro, Uchman & Myers
220 Old Country Road
Mineola, New York 11501-4280

Inez Diana Monti, M.D.
2863 Buhre Avenue
Bronx, New York 10461

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

RE: In the Matter of Inez Diana Monti, M.D.

Dear Mr. Shapiro, Dr. Monti and Mr. Nemerson:

Enclosed please find the Determination and Order (No. 94-17) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

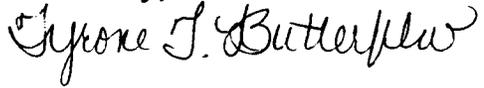
All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

-----X

**IN THE MATTER OF
INEZ DIANA MONTI, M.D.**

**DETERMINATION
AND
ORDER**

-----X

Pursuant to a Determination and Order of a Committee of Professional Medical Conduct dated February 7, 1994, a copy of which is attached, the above Respondent entered and completed the Phase I Evaluation section of the Physician Prescribed Education Program (PPEP) during the period October 17, 1994 through October 20, 1994. A final evaluation report was issued by the PPEP dated December 19, 1994 and signed by William Grant, M.D. Director of the Program.

The Administrative Review Board of the Board of Professional Medical Conduct, by its Determination and Order #94-17, attached hereto, has returned this matter to the Hearing Committee, **THEA GRAVES PELLMAN**, Chairperson, **MACHELLE ALLEN, M.D.** and **RICHARD N. PIERSON, JR., M.D.** for clarification of its original decision.

The Committee has reviewed the testimony of the entire original hearing and studied the findings of the PPEP evaluation, most significantly, the following test scores: Part I General Obstetrics and Gynecology (43% correct); Part II, General Practice Concepts Area Scores - Internal

Medicine (26% correct); Obstetrics & Gynecology (35% correct); Pediatrics (38% correct); Surgery (38% correct); Psychiatry (15% correct); and Preventive Medicine (14%) correct. It is the Committee's finding that serious cognitive and behavioral deficiencies have been demonstrated by the Respondent, both at the hearing and during the PPEP evaluation, and that the depth of these deficiencies is reflected in the very low scores obtained by Respondent in all areas.

The Hearing Committee therefore, finds the Respondent lacks the cognitive ability to benefit from any retraining to correct her deficiencies; and that based upon its original order and the Respondent's failure to comply with the terms set forth therein, the Respondent's license to practice medicine in the State of New York is hereby revoked.

DATED: Albany, New York

June 29, 1995



THEA GRAVES PELLMAN
Chairperson

MACHELLE ALLEN, M.D.
RICHARD N. PIERSON, JR., M.D.

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

-----X

IN THE MATTER	:	<u>ADMINISTRATIVE</u>
	:	<u>REVIEW BOARD</u>
OF	:	<u>DETERMINATION</u>
	:	<u>AND ORDER</u>
Inez Diana Monti, M.D.	:	<u>ARB-94-17</u>

-----X

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., and EDWARD C. SINNOTT, M.D. held deliberations on May 10, 1994¹ to review the Professional Medical Conduct Hearing Committee's (Hearing Committee) February 17, 1994 Determination finding Inez Diana Monti, M.D., (Respondent) guilty of professional misconduct. The Office of Professional Medical Conduct (Petitioner) requested the Review through a notice which the Board received on March 3, 1994. James F. Horan, Esq. served as Administrative Officer to the Review Board. Stacey B. Mondschein, Esq. submitted a brief for the Petitioner on March 30, 1994. Timothy K. Gibbons, Esq. filed a brief for Dr. Monti on April 11, 1994 and a reply to the Petitioner's brief on May 6, 1994.

¹Dr. William Stewart recused himself from taking part in the deliberations in this case.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with gross negligence, with negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records. The charges arise from the care which the Respondent, a gynecologist provided to three patients, A through C.

The Committee found the Respondent practiced with gross negligence in treating patients A through C. In the case of Patient A, the Committee found the Respondent had failed to perform an appropriate history or physical and had chosen an

inappropriate procedure that placed the Patient at risk of misdiagnosis of a squamous cell carcinoma. In the case of Patient B, the Committee found that the Respondent failed to act immediately or permit a second physician to act expeditiously to treat severe multiple cervical lacerations after the patient had given birth. The Committee also found that the Respondent refused to appreciate that Patient B was effectively bleeding to death. In the Case of Patient C, the Committee found that the Respondent had failed to diagnose the Patient as suffering from amenorrhea, and had misdiagnosed the Patient as being pregnant for approximately six months. The Committee found that the Respondent noted fetal heart tones that could not have existed and failed to reconcile the inconsistency of her evaluation with a pathology report in Patient C's case.

The Committee found the Respondent guilty of negligence on more than one occasion in the treatment of all three patients, failing to obtain basic histories and physical information, failing to order appropriate laboratory studies, refusing to act in an emergency situation in which her patient's condition was severely compromised and misdiagnosing a medical condition.

The Committee found that the Respondent was guilty of incompetence on more than one occasion, because the Respondent displayed a lack of elementary knowledge and ability regarding physical diagnosis, an inability to interpret and reconcile physical findings, and a lack of comprehension of medical reality in the cases of all three patients.

The Committee found that the Respondent failed to maintain adequate records for all three patients, because the records lacked basic information required for the most fundamental medical care.

The Committee recommended that the Respondent's license to practice medicine in New York State be revoked, but that the revocation be stayed if the Respondent would undergo an evaluation of her medical skills at the Physician Prescribed Education Program (PPE Program), in Syracuse. The Committee provided further that if the evaluation indicates that the Respondent can be retrained that she be accepted in PPE Program and that the stay of the revocation be limited to the extent necessary for evaluation and retraining. If the Respondent successfully completes the evaluation and retraining, she would be on probation for two years.

REQUESTS FOR REVIEW

The Petitioner has asked that the Review Board overturn the Hearing Committee's penalty and revoke the Respondent's license to practice medicine in New York State. The Petitioner contends that the stayed revocation/evaluation penalty is not appropriate in this case in which the Committee found the Respondent guilty of gross negligence, negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records. The Petitioner contends further that a conditional stay of revocation does not fall within the sanctions enumerated in Public Health Law §230-a. The Petitioner contends

that the facts do not support any significant chance for retraining, but rather demonstrate a pervasive pattern of negligence and incompetence in every fact of the Respondent's practice.

The Respondent contends that the Hearing Committees Determination and Penalty are inconsistent with the Committee's findings and conclusions. The Respondent contends that Patient A was successfully treated for cancer, that Patient B left the hospital with a healthy child and that Patient C eventually did give birth to a child.

The Respondent feels that the Hearing Committee's penalty is appropriate and notes that Dr. Monti participates in fifty hours of continuing medical education per year. The Respondent contends that the three cases considered at the hearing were not similar and do not demonstrate repeated instances of the same mistake. The Respondent contends that Dr. Monti's mistakes are of a nature that can be addressed in retaining.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of negligence on more than one occasion, incompetence on more than one occasion and failure to maintain adequate records. The Determination is consistent with the Committee's extensive and detailed findings of fact concerning the negligent and incompetent

care which the Respondent provided to Patients A through C.

The Review Board votes to sustain the portion of the Hearing Committee's penalty that stays the revocation of the Respondent's license and orders that the Respondent undergo retraining. That portion of the penalty is consistent with the Committee's Determination that Respondent was guilty of negligence and incompetence on more than one occasion in providing care to Patients A through C. The Respondent's misconduct rose to a level which could justify revocation, but The Review Board will not override the Hearing Committee's finding that the Respondent may improve her practice through retraining.

The Review Board votes to modify the provisions of the penalty dealing with the retraining, as those provisions are not all appropriate. The Hearing Committee's penalty is unclear as to the status of the Respondent's license during the evaluation and retraining period.

The Review Board modifies the penalty as follows.

The Hearing Committee's Revocation of the Respondent's license is stayed. The Respondent shall undergo an evaluation of her skills as a physician at the PPE Program in Syracuse.² If the evaluation indicates that the Respondent is a candidate for retraining, the Respondent shall complete successfully the Phase II PPE Program retraining either at Syracuse or at one of the New York City metropolitan area hospitals which participate in

²Department of Family Medicine, SUNY Health Service Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Medical Center, Syracuse, 479 Irving Avenue, No. 200, Syracuse, New York 12210.

the PPE Program Phase II Retraining.

The Respondent shall be suspended during the Evaluation and Retraining, except that the suspension is stayed and the Respondent shall be on probation during that period, if the Respondent arranges to undergo the PPE Program Phase I Evaluation within thirty days from the effective date of this Determination. The suspension will be further stayed during the period of retraining, if the Respondent arranges to commence the retraining within thirty days from the date of the PPE Program Evaluation indicating that retraining will be necessary, and the suspension will continue stayed while the Respondent participates in this Retraining Program.

If the Respondent completes the Phase II Retraining successfully, she shall be on probation for a period of two years.

If the PPE Program Evaluation indicates that the Respondent is not a candidate for retraining following the initial Evaluation, then this case shall be remanded to the Hearing Committee for additional deliberations to determine a new penalty. In that event, the Hearing Committee shall issue a Supplemental Determination on the penalty that they should serve upon the Review Board and upon the parties. Either party may then request an additional Review of the Supplemental Determination penalty by filing a Notice with the Review Board within fourteen days from the receipt of the Supplemental Determination. In the event there is an additional Review, the parties will have thirty days from the filing of the Notice to serve briefs upon the Review Board. In the event the PPE Program Evaluation indicates that the Respondent is not a candidate for Retraining, the Respondent shall

remain on probation until the Hearing Committee issues its Supplemental Determination, and in the event that a party files a Notice for an additional Review, the Respondent shall remain on probation until the Review Board issues a final Determination.

ORDER

NOW, based upon this Determination, the Review Board issues the following ORDER:

1. The Review Board sustains the Hearing Committee on Professional Medical Conduct's February 17, 1994 Determination and Order finding Inez Diana Monti guilty of Professional misconduct.

2. The Review Board sustains that portion of the Hearing Committee penalty that stays the revocation of the Respondent's license to practice medicine and orders the Respondent to undergo an evaluation of her skills as a physician at the Physician Prescribed Education Program and to undergo any retraining which that Evaluation indicates is necessary.

3. The Review Board modifies the Hearing Committee Penalty to provide that, in the event the PPE Program Evaluation indicates that the Respondent is not a candidate for retraining, this case shall be remanded to the Hearing Committee for deliberations on an additional penalty.

4. In the event the Hearing Committee issues a Supplemental Penalty Determination, either party may request an additional Administrative Review of the Supplemental Penalty, under the terms which the Review Board set out in this Determination.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

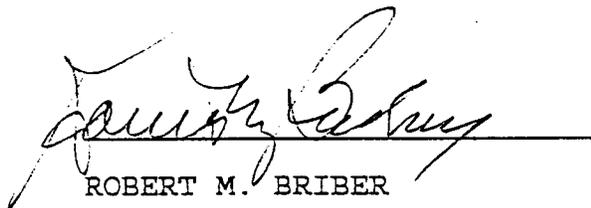
EDWARD SINNOTT, M.D.

IN THE MATTER OF INEZ DIANA MONTI, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Monti.

DATED: Albany, New York

June 15, 1994


ROBERT M. BRIBER

IN THE MATTER OF INEZ DIANA MONTI, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Monti.

DATED: Syracuse, New York

June 13, 1994

Mary Claire B. Sherwin

MARYCLAIRE B. SHERWIN

IN THE MATTER OF INEZ DIANA MONTI, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Monti.

DATED: Roslyn, New York

June 13, 1994

A handwritten signature in cursive script, appearing to read "Edward C. Sinnott, M.D.", written over a horizontal line.

EDWARD C. SINNOTT, M.D.

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

-----X
IN THE MATTER : DETERMINATION
OF : AND
INES DIANA MONTI, M.D. : ORDER

-----X No. BPMC 94-17

The undersigned Hearing Committee consisting of THEA PELLMAN, chairperson, MACHELLE ALLEN MD, and RICHARD PIERSON, MD, were duly designated and appointed by the State Board for Professional Medical Conduct. MARY NOE, Esq. Administrative Law Judge, served as Administrative Officer.

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

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

SUMMARY OF PROCEEDINGS

Notice of Hearing and

Statement of Charges:	August 11, 1993
Pre-Hearing Conferences:	September 10, 1993
Hearing dates:	September 23, 1993
	October 7, 1993
	October 28, 1993
Place of Hearing:	NYS Department of Health New York, New York
Date of Deliberation:	November 17, 1993
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Stacey B. Mondschein Assistant Counsel
Respondent appeared by:	Daniel Shapiro 200 Old Country Rd. Ste. 250 Mieola, N.Y. 11501

WITNESSES

For the Petitioner:

Joel Evans, M.D.

Timothy Vinciguerra, M.D.

For the Respondent:

Deana Monti, M.D., the Respondent

SIGNIFICANT LEGAL RULINGS

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

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

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

The following findings of fact were made after review of the entire record. Numbers in parenthesis (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. All findings and conclusions herein were unanimous unless otherwise noted.

FINDINGS OF FACT WITH REGARD TO PATIENT "A"

1. Ines Diana Monti, M.D., Respondent, was authorized to engage in the practice of medicine in the State of New York on September 10, 1962 by the issuance of license number 089501 by the New York State Education Department (Pet. 2)
2. Respondent is registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 2863 Buhre Avenue, Bronx New York 10461 (Pet. 2).
3. On or about May 6, 1988, Patient A, a 51 year old woman presented to Respondent's office with a history of menopause at age 48 and episodes of bleeding lasting 3 days in January and 3 days in February 1988. On May 9 1988, Respondent performed a D&C and biopsy on Patient A at Westchester Square Medical Center which revealed squamous cell carcinoma. (Pet. 3; Pet. 4 at 1)

4. Respondent failed to perform and record the results of an adequate history for Patient A. (T.137-138; 145-146, 166)
5. Respondent failed to perform and record the findings of an adequate physical examination for Patient A. (T.138-142, 165-167)
6. Although Respondent may have performed a PAP test, (P. Ex. 4, P. 28) there is no notation in the medical record giving either the date or results (P. Ex. 3, T. 139, 57)
7. Had Respondent conducted a PAP test for Patient A on May 6, 1988, the appropriate procedure would have been a colposcopic examination of the cervix or a cone biopsy of the cervix. (T. 143-144)
8. If Respondent had a Class 4 PAP result in hand on May 9, 1988 her selection of procedure for Patient A's condition was inappropriate and could have missed the source of Patient A's cancer. (T. 143-144, 157, 162-165)
9. Respondent made a note in Patient A's hospital. record that Dr. Robert Dyson, Chief of Gynecology at Westchester Square Medical Center, reviewed Patient A's slides with a pathologist and made a recommendation of treatment by external radiation. (Pet. 4, T. 431)
10. Respondent failed to record a plan for subsequent treatment and/or referral to a gynecologist or oncologist for Patient A after her biopsy revealed squamous cell carcinoma. (T. 149-150, 152-153)

PATIENT "B"

11. Patient B. a 33 year old woman, was under the obstetrical care of Respondent between March 26, 1987 and January 21, 1988. On or about January 21, 1988 Respondent delivered Patient B's baby. Upon delivery of the placenta, the cord separated and Respondent attempted to manually remove the placenta. (Pet. 5, 6)

12. Respondent failed to perform and record the results of an adequate history for Patient B. (Pet 5; T. 58-60, 71, 75, 80)

13. Respondent failed to perform and record the findings of an adequate physical examination of Patient B. (Pet, 5; T. 58, 61-68-72, 76-77)

14. Respondent failed to conduct, order or note appropriate laboratory studies reflecting the condition of Patient B. (Pet. 5; T. 77-78, 81)

15. The office records reflecting the care of Patient B were incomplete in that they failed to include a presenting complaint (T. 57, 60, 70, 425-526)

16. The office records reflecting the care of Patient B were incomplete in the they were cards very limited in space and allowed for little information (Pet. 5; T. 58, 134)

17. The office records reflecting the care of Patient B were incomplete in that they failed to include details sufficient to constitute adequate interval obstetrical visits. (Pet. 5; T. 79-82)

18. On or about December 30, 1987, Respondent inappropriately prescribed Aldomet to Patient B in that the prescription was not indicated, the risk of the prescription outweighed the benefit to Patient. (Pet. 5; T. 83-84, 111-112, 115-116)

19. On or about January 5, 1988, Respondent failed to document why patient was placed on Ampicillin at Einstein Medical Center and failed to document the dosage prescribed. (Pet. 5; T. 85, 116, 441)

20. Respondent's testimony that a hospital prescribed Ampicillin to Patient B is unsubstantiated by a hospital record. (Pet. 5; T. 441)

21. Respondent's notation for Ampicillin is strikingly similar to the notations and lack of detail the prescriptions for Aldomet and Keflex by Respondent (Pet. 5)

22. On or about January 21, 1988, after the delivery of Patient B's baby, Respondent failed to manually explore Patient B's uterus and remove all fragments of the placenta after it separated from the cord. (Pet. 6 at 7, 10, 11; T. 20-21, 26 97-98)

23. Respondent failed to recognize Patient B's cervical lacerations and take timely action to forestall additional blood loss. (Pet. 6 at 7, 10, 11; T. 20-21, 26, 29, 98)

24. Respondent failed to recognize and repair the cervical lacerations suffered by Patient B. Respondent herself testified "you cannot repair what you have not seen." (T. 97-98, 280)

25. At approximately 7:10 p.m. on January 21, 1988, Dr. Joel Evans, the chief resident of Obstetrics and Gynecology at the Weiler Hospital of Montifiore Medical Center, arrived to see Patient B. (Pet. 7; T. 18, 25)

26. Respondent was not at the bedside when Dr. Evans was called in to see Patient B. (T. 25)

27. Dr. Evans informed Respondent of the life-threatening nature of Patient B's condition, and recommended that Patient B immediately be returned to the operating room for an examination to determine both the cause and the extent of Patient B's medical problem. (Pet. 6 at 7; T. 18)

28. Dr. Evans conducted a preliminary examination and was ready and able to repair the cervical lacerations and to remove retained blood clot and placenta. (Pet. 6 at 7; T. 18)

29. Respondent refused to allow Dr. Evans to proceed immediately to the operating room although Patient B was in severe hemorrhagic shock with a blood pressure of 60/30. (Pet. 6 at 7; T. 20, 29)

30. Respondent was authorized to act or have someone act on her behalf in this emergency situation, but she failed or refused to recognize the severity of Patient B's condition. (Pet. 11; T. 315)

31. While Dr. Evans was taking care of Patient B, Respondent was not giving patient care. (T. 20, 32)

32. Respondent did not understand that Patient B was in a

life-threatening situation. (T. 315)

33. When Dr. Sultan arrived at 7:40 p.m., Dr. Sultan and Dr. Evans proceeded to the operating room. (Pet. 6 at 8; T. 20, 30, 33-34)

34. Dr Evans repaired multiple cervical lacerations and removed a large amount of retained placenta and blood clot from Patient B's uterus, then proceeded to correct the amount of Patient B's blood and clotting factors. (Pet. 6 at 10, 11; T. 21, 42-44)

35. Patient B had a total blood loss of approximately 2500 cc's. (pet. 6, at 11)

36. A chairman's meeting was held regarding this case, and the hospital chart reviewed. (T. 35)

37. The Quality Assurance Committee of Montifiore Medical Center sent Respondent a letter which stated that it was "critical of the delay in recognition of severe post-partum hemorrhage and cervical laceration." (Respondent's B)

38. In November, 1991, Respondent still failed to appreciate the severity of Patient B's condition, stating that "this case was blown out of proportion" and that "this case was reviewed by Quality Insurance (sic) and they said it was handled correctly." (Pet. 10)

39. Respondent, on October 28, 1993 testified that the Quality Assurance letter from Montifiore Medical Center states that the case of Patient B was managed well. (T. 410)

40. Although Respondent had been advised of Patient B's

critical condition by Dr. Evans, she denied she had been so advised. (Pet. Ex. 6, P. 7; T. 402)

41. Respondent, in her testimony, blamed Patient B for the fact that the umbilical cord separated from the placenta in the delivery room, claiming that the patient was "hysterical" and that the "patient jumped back". No indication of such behavior by Patient B appears in the hospital record and we find that this did not occur. (Pet. 6; T. 397)

42. Respondent testified that she examined the placenta after Patient B's delivery, that it was intact, and that what was removed from Patient B upon her return to the operating room was possibly placenta succenturiate. While this is a possibility, there is no indication of this as a diagnosis in the hospital record. (Pet. 6; T. 410)

43. Respondent refused to admit that she may have caused cervical lacerations during delivery of Patient B's baby, and, instead attempted to blame another physician for the occurrence. (T. 399, 401)

PATIENT "C"

44. Patient C, a 24 year old woman, was under the care of Respondent during a period including on or about May 14, 1982 and to or about October 16, 1982. Respondent diagnosed Patient C as pregnant and followed her as an obstetrical patient. (Pet. 7)

45. Respondent failed to perform and record the results of an adequate history of Patient C. (Pet. 7; T. 186-187, 195)

46. Among other things, Respondent failed to include a presenting complaint on her office chart regarding Patient C. (Pet. 7; T. 186, 425)

47. Among other things, Respondent failed to inquire about Patient C's allergies other than to note that Patient C was not allergic to penicillin. Patient C was found to be allergic to novocaine according to the history taken by a Westchester Square Hospital resident. (Pet. 7, 8 at 2; T. 187, 247, 252)

48. Respondent failed to inquire or note that Patient C, an obstetrical patient, had family history of diabetes, which was later recorded by a resident at Westchester Square Hospital. (Pet. 7, 8 at 2; T. at 187, 253-254)

49. Respondent failed to perform and record the results of an adequate physical examination of Patient C. (Pet. 7; T. 191-194, 195-197)

50. Respondent failed to obtain or note the height, weight or blood pressure of Patient C on her first purported obstetrical visit. (Pet. 7; T. 195-196, 456-457)

51. Respondent diagnosed and treated Patient C for pregnancy without performing and recording the results of an adequate evaluation of the patient's amenorrhea. (Pet 7; T. 197, 245, 411-412)

52. After diagnosing pregnancy, Respondent failed to perform and record the results of a routine prenatal blood testing for Patient C. (Pet. 7; T. 205)

53. Respondent claims that she ordered laboratory tests of

Patient C, however, she failed to note or include evidence of such tests in what she termed a "true copy of the office records in my possession" relating to Patient C and we find that this did not occur. (Pet. 7; T. 412-415)

54. Respondent failed to conduct adequate interval obstetrical visits regarding Patient C, in that, among other things, she failed to elicit or note interval history, weight, laboratory tests, diagnoses or treatment on various dates. (Pet. 7; T. 198-206)

55. Between May 14, 1982 and September 1, 1982, Respondent noted a continually growing uterus on the chart reflecting Patient C's condition. (Pet. 7; T. 194-202)

56. Respondent noted that she heard fetal heart tones in the lower left quadrant of Patient C's abdomen on Patient C's visits of August 5, 1982 and September 1, 1982. (Pet. 7; T. 201-202)

57. Respondent noted a questionable fetal heart beat on her September 13, 1982, notation regarding Patient C, yet waited until October 12, 1982 to address the problem. (Pet. 7; T. 203, 417-418)

58. A two centimeter loss in uterine size and a lack of fetal heart tones were noted on October 12, 1982. (Pet. 7 at 4)

59. Respondent stated that she had ordered a sonogram and that one was performed. (T. 418) In the hospital admission record of 10/14/82, Respondent notes that a sonogram was performed but no documentation or date is provided. (Ex. 8, p.

14)

60. A D&C was performed on Patient C on October 15, 1982 at Westchester Square Hospital. (Pet. 8 at 8)

61. Respondent notes and hospital records reflect two discrepancies: (a) Pregnancy by dates of 26 weeks and sonographic results of an 8-10 weeks pregnancy; and (b) physical examination by respondent on 10/12/82 showing a 22 cm. uterus and a physical exam by Respondent on 10/14/82 "12 weeks size uterus". (E. 8, p. 14, Ex. 7, p.4)

62. The pathology report which evaluated the total tissue removed by the D&C concluded that there was "no evidence of decidual reaction or products of conception." (Pet. 8 at 9)

63. The total amount of tissue removed from Patient C was 1 cc., or a volume equivalent to the size of approximately one chickpea. (Pet. 8 at 9; T. 213-214)

64. In her operative report, Respondent stated that a "moderate amount of currettings were obtained." (Pet. 8 at 8)

65. One cc. of tissue would be a minuscule amount compared to the amount expected for a pregnancy which had progressed as far as Respondent's records indicated regarding Patient C. (Pet. 7, 8 at 8; T. 217)

66. In the discharge summary for Patient C, Respondent failed to reconcile her evaluation of the patient's uterine size with that revealed by the sonogram. Respondent also used the terminology "uneventful post-partum course" where after having performed the D&C, Respondent could see that she had not removed

a fetus from Patient C's uterus. (Pet. 8 at 1, 9)

67. A missed abortion is the term used when a pregnancy ends, but the fetal tissue is retained inside the body. (T. 209-210)

68. Had Patient C had a missed abortion, the removed fetus would have been of approximately 26 weeks gestational age, approximately 1000 grams, too large to fit in the palm of the hand. (T. 219)

69. Respondent stated that when asked by the husband of Patient C what sex the baby was, she responded "It's impossible to tell the sex in a fetus" (T. 421-422) rather than admitting that only 1 cc. of tissue had been removed from Patient C's uterus. (Pet. 8 at 9)

70. Respondent based her diagnosis of missed abortion on the fact that she firmly believed Patient C had been pregnant in May of 1982. (T. 48)

71. Patient C had not been pregnant when Respondent made notations of Patient C's increased uterine size, fetal heart tones and fetal movement. (Pet. 7 at 3-4; Pet. 8 at 9; T. 221-222)

72. Had Patient C been pregnant according to Respondent's office records, Respondent's diagnosis of missed abortion was incorrect. (Pet. 7; 8 at 1; T. 209-210)

73. Had Patient C been pregnant on September 13, 1982 or October 12, 1982, the pathology report of October 20, 1982 would have shown some decidual reactions or product of conception. (T.

222)

74. Respondent is unable to reconcile her evaluation and diagnoses with the pathology report. (T. 460-465)

75. Respondent was effectively discharged by Patient C after the D&C of October 14, 1982. Patient C never returned to Respondent's offices; Respondent called Patient C several times and Patient C told her she was doing fine. Patient C subsequently went to Dr. Dyson who never requested Respondent's records (T. 419)

76. Throughout the hearing, Respondent exhibited selective recall regarding the case of Patient C. For example, Respondent was unable to remember whether she agreed with a hospital note which she co-signed (Pet. 8 at 2; T. 282-283) or whether she wrote a statement in 1987, a copy of which she was holding in her hand on the October 7, 1993 hearing date. (Pet. 9; T. 291., 294-295. 299) However, Respondent testified that she did recall Patient C being "very, very nasty" on the telephone in 1982. (T. 419)

77. Only after speaking with Patient C's husband did Respondent "find all I could find out on this case. That is how that lab report came out." Respondent had withheld the truth of patient C's condition prior to that discussion with Patient C's husband on the telephone, although she testified she knew that pregnancy was very important to Patient C and her husband. (T. 419, 421)

78. Although Respondent claims to have spoken with a Dr.

LaSalle, a Dr. LoVerdi and a Dr. Rand about Patient C, (T. 418-420), none of these individuals ever saw Patient C or provided a consultation report or evidence of participation in the care of Patient C. (T. 443-444)

RECORDS - GENERALLY

79. Respondent's card format, which only allowed a space of approximately one inch by two inches for the recording of obstetrical visits, falls below the standard of care in medical recordkeeping for gynecological and obstetrical patients. (Pet. 3, 5, 7,; T. 57, 134, 207-209, 238-239)

80. Respondent does not recognize the inappropriate nature of her index card format of recordkeeping, testifying that the method she adopted in 1963 was "very nifty", and that "the charts were complete and it was convenient for me to carry." (T. 284)

81. Respondent testified that in taking the history and physical of a patient, she believed she had recorded both the positive and negative findings, but "since it does not appear...I would have to say that I omitted the negative findings but recorded all the positive findings." (T. 389)

82. With regard to Patients A, B and C, Respondent failed to record vital and basic information required for an adequate history and physical. (Pet. 3, 4, 7; T. 58-68, 71-77, 137-142, 145-146, 165-167, 186-187, 191, 196, 425, 456-457)

83. Respondent testified that she now uses the long form,

although she finds it very inconvenient. (T. 353)

WITNESS CREDIBILITY

The Committee finds the testimony of Dr. Timothy Vinciguerra and Dr. Joel Evans to be highly credible. Each answered questions appropriately and directly. We find that Dr. Evans provided an intelligent and objective version of the facts as supported by the evidence in this case, and that Dr. Vinciguerra gave a thorough opinion of the Respondent's failure to meet adequate medical standards in her treatment of Patients A, B, and C.

The Committee finds the testimony of the Respondent to be thoroughly incredible. The Committee finds extremely troubling that Respondent does not take responsibility for her conduct, but instead continues to view herself as a victim and blames other physicians and her patients for the circumstances regarding this matter. (T. 346-347, 397, 399, 405, 419)

The Committee is critical of the fact that Respondent was extremely evasive under cross examination, and refused to answer relevant questions. (Pet. 9, 10; T. 282, 325, 279-280, 282-283, 298-299, 475-580)

The Committee recognizes and is troubled by the inappropriate or evasive responses and untruths told by Respondent during her examination by the Petitioner and by Committee Members. (T. 286, 312-13, 319, 323-324, 346-47, 449, 450, 466-67, 475-476)

The Committee notes that Respondent acted confused and was unable or unwilling to answer direct questions. (T. 312, 315, 457-458, 480)

The Committee is critical of the fact that Respondent fails to appreciate the effect her omissions may have had on the patients in this case, particularly regarding her failure to tell Patient C and her husband the examination results of the pathology report and about Patient C's conditions following the D&C.

PROPOSED CONCLUSIONS OF LAW

LEGAL ELEMENTS PROVEN

Petitioner has proven the required elements of professional misconduct sufficiently to sustain the Specifications of Charges as follows:

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Gross negligence may consist of a "single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct..." Rho v. Ambach, 74 NY 2d 318, 322, 546 NYS 2d 1005 (1989). The term "egregious", in turn, has been defined as "conspicuously bad". Spero v. Board of Regents, 158 A.D. 2d 763, 764, 551 NYS 2d 352 (3rd Dept. 1990).

Respondent's conduct with regard to Patients A, B and C

was egregious. Her failure to conduct an appropriate history and physical and her choice of inappropriate diagnostic procedure put Patient A at risk for misdiagnosis and constitutes gross negligence.

Respondent's failure to act immediately or to permit Dr. Evans to act expeditiously and her refusal to appreciate that Patient B was effectively bleeding to death constitutes gross negligence.

Respondent's misdiagnosis of Patient C's amenorrhea for approximately six months, the fact that she noted fetal heart tones which did not and could not have existed, and her knowing failure to reconcile the inconsistency of her evaluation with pathology report constitutes gross negligence.

Therefore, Specifications One through Three are sustained.

FOURTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Negligence has traditionally been defined as the failure to exercise the care that would be exercised by the reasonably prudent person under the circumstances. Physicians owe a duty to their patients to exercise reasonable care under the circumstances, and a deviation from acceptable medical standards is a breach in that duty of care, or negligence.

Negligence does not require that an injury actually result from a licensee's deviation from acceptable medical standards. *Morfesis v. Sobel*, 172 AD 2d 897, 5a67 NYS 2d 954 (3rd Dept. 1991), appeal denied, 78 NY 2d 856, 574 NYS 2d 937 (1991).

In all three patient cases, Respondent deviated from acceptable medical practice at the most fundamental level including 1) failing to obtain basic historical and physical information from each patient, 2) failing to order appropriate laboratory studies, 3) refusing to act in an emergency situation and where her patient's condition was severely compromised and 4) misdiagnosing medical conditions.

Respondent has acted negligently on more than one occasion.

Therefore, the Fourth Specification is sustained.

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

A licensee/physician who does not possess the requisite skill or knowledge to practice medicine and lacks the ability to discharge the required duty of care to her patients because of a want of such skill or knowledge is considered incompetent.

Respondent has demonstrated her incompetence to practice medicine throughout each of the patient cases in this matter. Respondent displayed, among other things 1) a lack of elementary knowledge and ability regarding physical diagnosis, 2) an

inability to interpret or reconcile physical findings and 3) a lack of comprehension of the medical reality in each case. In addition, Respondent was often incapable of answering direct medical questions posed to her during her examination as a witness at the hearing on disciplinary charges against her.

Given the numerous examples of Respondent's lack of knowledge and sound judgment, as well as her unskillful medical practice with regard to Patients A, B and C, the Fifth Specification is sustained.

SIXTH THROUGH NINTH SPECIFICATION

INACCURATE RECORDS

Respondent's office records regarding the treatment of Patients A, B and C lack the basic information required for the most fundamental medical care. The card format, which only allowed an approximately one-by-two-inch space for interval obstetrical visits, appears to be created only for portability, not for completeness and patient welfare.

RECOMMENDATION

The Committee of the Board for Professional Medical Conduct recommends that Respondent's license to practice medicine in the State of New York be revoked. That such revocation is stayed if Respondent complies with the following conditions:

- 1) That Respondent apply for and participate in an evaluation of her knowledge and ability to practice medicine at

the Physician Prescribed Educational Program (PPEP) at the Health Science Center, Syracuse, New York; and

2) That if her evaluation by the PPEP indicates she can be retrained, that she be accepted into the PPEP; and

3) That if Respondent is accepted for retraining at the PPEP, that the stay of the revocation of her license to practice medicine be limited to the extent necessary for the PPEP evaluation and retraining; and

4) That she successfully complete such course of study and present proof of such completion to the New York State Department of Health; and

5) That upon the successful completion of her evaluation and retraining and presentation of proof of same, the Respondent shall be placed on probation for a period of two years.

Dated: New York, New York

Feb. 7, 1994



THEA PELLMAN
Chairperson

Machelle Allen, M.D.
Richard Pierson, M.D.

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

-----X

IN THE MATTER : STATEMENT
OF : OF
INES DIANA MONTI, M.D. : CHARGES

-----X

INES DIANA MONTI, M.D., the Respondent, was authorized to practice medicine in New York State on September 10, 1962 by the issuance of license number 089501 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 2863 Buhre Ave., Bronx, N.Y. 10461.

FACTUAL ALLEGATIONS

- A. On or about May 6, 1988, Patient A, a 51 year-old woman, presented to Respondent's office at 2863 Buhre Avenue, Bronx, New York 10461, with a history of menopause at age 48 and episodes of bleeding lasting 3 days in January and 3 days in February of 1988. On May 9, 1988, Respondent performed a D & C and biopsy on Patient A at Westchester Square Medical Center, 2475 St. Raymond Avenue, Bronx, New York 10461, which revealed squamous cell carcinoma. (Patient A and all other patients are identified in the attached Appendix.)

1. Respondent failed to perform and record the results of an adequate history for Patient A.
2. Respondent failed to perform and record the findings of an adequate physical examination for Patient A.
3. Respondent failed to formulate and/or record a plan for subsequent treatment and/or referral to a gynecologist or oncologist for Patient A after her biopsy revealed squamous cell carcinoma.

B. Patient B, a 33 year-old woman, was under the obstetrical care of Respondent between March 26, 1987 and January 21, 1988. On or about January 21, 1988, Respondent delivered Patient B's baby at Montefiore Medical Center, The Jack D. Weiler Hospital of the Albert Einstein College of Medicine Division, 1825 Eastchester Road, Bronx, New York 10461. Upon delivery of the placenta, the cord separated and Respondent attempted to manually remove the placenta.

1. Respondent failed to perform and record the results of an adequate history for Patient B.

2. Respondent failed to perform and record the findings of an adequate physical examination of Patient B.
 3. On or about December 30, 1987, Respondent inappropriately prescribed Aldomet to Patient B.
 4. On or about January 5, 1993, Respondent inappropriately prescribed Ampicillin to Patient B.
 5. On or about January 21, 1988, after the delivery of Patient B's baby, Respondent failed to manually to remove all fragments of the placenta after it separated from the cord.
 6. Respondent failed to timely recognize Patient B's cervical lacerations and to take timely action to forestall additional and excessive blood loss.
- C. Patient C, a 24 year-old woman, was under the care of Respondent during a period including on or about May 14, 1982 and or about October 16, 1982. Respondent diagnosed a pregnancy on Patient C's initial office visit and followed

her as an obstetrical patient. At or about 29 weeks following Patient C's last menstrual period a sonogram was performed which showed that there was no fetus. On or about October 15, 1982, Respondent performed a D & C at Westchester Square Medical Center. The pathology findings of the D & C showed no evidence of any decidual tissue or products of conception. These pathology findings were inconsistent with Respondent's diagnoses of pregnancy and missed abortion.

1. Respondent failed to perform and record the results of an adequate history of Patient C.
2. Respondent failed to perform and record the results of an adequate physical examination of Patient C.
3. Respondent diagnosed and treated Patient C for pregnancy without performing and recording the results of a pregnancy test or performing and recording the results of an adequate evaluation of the patient's amenorrhea.
4. After diagnosing pregnancy Respondent failed to perform and record the results of routine prenatal blood testing for Patient C.

5. Respondent failed to provide appropriate follow-up care for Patient C after her D & C at Westchester Square Medical Center.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1993) by practicing the profession with gross negligence, in that, Petitioner charges:

1. The facts in paragraphs A and A(1), A(2), and/or A(3).
2. The facts in paragraphs B and B(1), B(2), B(3), B(4), B(5) and/or B(6).
3. The facts in paragraphs C and C(1), C(2), C(3), C(4), and/or C(5).

FOURTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion, within the meaning of N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993) in that,

petitioner charges Respondent committed two or more of the following:

4. The facts in paragraphs A and A(1) through A(3); B and B(1) through B(6); and/or C and C(1) through C(5).

FIFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with incompetence on more than one occasion, within the meaning of N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993) in that, Petitioner charges Respondent committed two or more of the following:

5. The facts in paragraphs A and A(1) through A(3); B and B(1) through B(6); and/ or C and C(1) through C(5).

SIXTH THROUGH NINTH SPECIFICATIONS

INACCURATE RECORDS

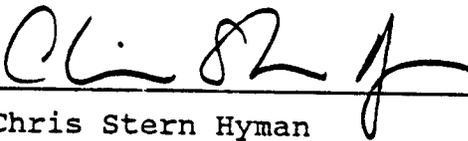
Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1993) in that Respondent failed to maintain a record for

each patient which accurately reflected the evaluation and treatment of the patient, specifically Petitioner charges:

6. The facts in paragraphs A, A(1), A(2) and/or A(3).
7. The facts in paragraphs B, B(1) , B(2), B(3) and/or B(4).
8. The facts in paragraphs C, C(1), C(2), C(3) and/or C(4).

DATED: New York, New York

August 4, 1993



Chris Stern Hyman
Counsel
Bureau of Professional
Medical Conduct