STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner
Paula Wilson
Executive Deputy Commissioner

October 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dawn A. Dwier, Esquire
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

Moshe Hachamovitch, M.D.
185 Maple Avenue Suite 111
White Plains, New York 10601

Wood & Scher, Esquires
14 Harwood Court, Suite 512
Scarsdale, New York 10583
Anthony Z. Scher of Counsel

RE: In the Matter of Moshe Hachamovitch, M.D.

Dear Ms. Dwier, Dr. Hachamovitch, and Mr. Scher:

Enclosed please find the Determination and Order (No. 94-232) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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), "(t)he 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

TB:rlw
Enclosure

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

IN THE MATTER
-OF-
MOSHE HACHAMOVITCH, M.D.

DECISION AND ORDER OF THE HEARING COMMITTEE ON REMAND

ORDER NO. BPMC-94 -232

The undersigned Hearing Committee consisting of **PRISCILLA R. LESLIE, Chairperson, MILTON O. D. HAYNES, M.D., and ROBERT J. O'CONNOR, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) 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 **MOSHE HACHAMOVITCH, M.D.** (hereinafter referred to as "Respondent"). The Committee issued a decision and order dated August 18, 1993.

By a decision entered July 14, 1994, The Supreme Court, Appellate Division, Third Judicial Department, modified the Order of the Committee. The Court annulled the findings of the Committee with regard to Specification 5 (Allegation A.8) and remanded the proceeding for further consideration of the penalty in light to the Court's ruling.

Both parties submitted briefs which were distributed to the Committee members along with a copy of the ruling by the Third Department. On October 20, 1994, the Committee convened to reconsider their decision based upon the findings of the Court. Now, upon consideration of the decision of the Court, the briefs submitted by the parties and upon reconsideration of the record as a whole, the Committee hereby issues its Decision on Remand.

The Committee hereby affirms its earlier findings and conclusions except as modified by the court. The Committee affirms its earlier decision, except as modified by the Court, and makes it a part of this decision. Finally, the Committee affirms the penalty imposed in their decision of August 18,1993.

In so finding, the Committee understands that as a matter of law, their finding that there was no continuous oxygenation by mask was annulled. Hence, the earlier finding by the Committee that Respondent committed fraud in his representation that there was continuous oxygenation by mask is also annulled. However, the Committee also understands that their finding of fraud based upon Respondent's statement of "no" blood loss was not overturned. Hence, the Committee is free to find that Respondent committed fraud in his representation of blood loss, and pass judgement accordingly.

It is the conclusion of this Committee that Respondent's statements regarding blood loss in this matter were clear and deliberate misrepresentations designed to mislead future reviewers and avoid culpability on his part. The findings regarding oxygenation were by far the lesser of the grounds upon which the conclusion of fraud was based. Therefore, the Committee has no reservations about affirming their earlier finding that Respondent committed fraud. The Committee also affirms the penalty set forth in the decision of August 18,1993. The penalty then was based upon fraud and inadequate records. While one of the points upon which fraud was based has been annulled, the other point, and in this instance the far stronger basis, remains. Therefore, it is the conclusion of the Committee that the original penalty and order should not be changed.

Therefore, it is hereby **ORDERED:**

That the license of Respondent **MOSHE HACHAMOVITCH, M.D.** shall be **SUSPENDED** for a period of one year; and

it is further **ORDERED**:

That eleven months of said suspension shall be **PERMANENTLY STAYED**; and

it is further ORDERED:

That the license of Respondent shall be actually **SUSPENDED** for a period of **thirty (30)**

days; and

it is further **ORDERED:**

That this **ORDER** shall take effect thirty days after service upon Respondent or his counsel by personal service or service by mail.

Dated: Syracuse, New York

26 October, **1994**

PRISCILLA R. LESLIE
Chairperson

MILTON O. C. HAYNES, M.D.
ROBERT J. O'CONNOR, M.D.

APPENDIX I

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

IN THE MATTER OF MOSHE HACHAMOVITCH, M.D.	DECISION AND ORDER OF THE HEARING COMMITTEE BPMC No. 93-127

The undersigned Hearing Committee consisting of **PRISCILLA R. LESLIE, Chairperson, MILTON O.C. HAYNES, M.D., and ROBERT J. O'CONNOR, M.D.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 230(10) 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 **MOSHE HACHAMOVITCH, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

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

RECORD OF PROCEEDING

Notice of Hearing
and Statement of Charges: September 16, 1992

Notice of Hearing returnable: November 18, 1992

Place of Hearing: 5 Penn Plaza
New York, New York 10001

Respondent's answer served: None

The State Board for
Professional Medical Conduct
appeared by: Dawn A. Dwier, Esq.
Associate Counsel and
Roy Nemerson, Esq.,
Deputy Counsel, Bureau of
Professional Medical Conduct
5 Penn Plaza
New York, New York 10001

Respondent appeared in person
and was represented by: Wood & Scher, Esqs.
14 Harwood Court
Suite 512
Scarsdale, New York 10583
Anthony Z. Scher of Counsel

Respondent's present
address: 185 Maple Ave.
Suite 111
White Plains, New York 10601

Hearings held on: November 18, 1992
December 23, 1992
January 11, 1993
February 3, 10, 11, 17, 18, 1993
April 20, 1993

Conferences held on: November 18, 1992
February 3, 11,17, and 18 1993

Closing briefs received: May 20, 1993

Record closed: June 2, 1993

Deliberations held: June 2 and August 4, 1993 [1]

---

[1] Respondent requested and the Commitee granted a waiver of the 120 day limit created by Part 230 (10) (f) of the Public Health Law.

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with gross negligence, negligence on more than one occasion, that he has practiced medicine fraudulently and that he failed to maintain appropriate patient records. The allegations arise from treatment of three patients in 1988 through 1990. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Paul Jules Poppers, M.D.	Expert Witness
Enayat Elahi, M.D.	Expert Witness
Christine Ann Segatto	Fact Witness
Guy C. Peifer	Fact Witness
B.D.S. (Patient A's Boyfriend)	Fact Witness
Patient B	Fact Witness

Respondent testified in his own behalf and called these witnesses:

Lisa Fournier Faillace	Fact Witness
Warren Martin Hern, M.D.	Expert Witness
Irene Sylvor	Fact Witness
Harold Schulman, M.D.	Expert Witness
William Kohlman Rashbaum, M.D.	Expert Witness
Paul L. Goldiner, M.D.	Expert Witness

SIGNIFICANT LEGAL RULINGS

By motion dated February 20, 1993 Respondent moved to have exhibits 12, 13 and 14 precluded. Both parties were heard on the issue and briefs were submitted. By written Order, dated March 12, 1993, the Administrative Law Judge granted Respondent's motion. The basis of the decision is set forth in the decision and order which is part of the record herein, along with all relevant briefs and correspondence with regard to this motion or any other legal issue in this proceeding. Subsequently, on March

5, 1993, Respondent moved to have certain descriptive comments regarding exhibits 12, 13 and 14 redacted from the transcripts to be distributed to the Committee. Recognizing the prohibition against redacting testimony (10 NYCRR 51.9 (d) (1), it was the ruling of the Administrative Law Judge that comments made by counsel regarding exhibits, could be redacted from the transcript as counsel's comments did not constitute sworn testimony. Had the comments been submitted to the trier of fact, the ruling designed to exclude the documents would have been vitiated. Therefore the comments in issue were redacted from the transcripts distributed to the Committee but remain in the original transcript for review. Moreover, the exhibits themselves remain part of the record for subsequent review, though not distributed to the triers of fact.

By motion Respondent demanded any exculpatory material held by the State under the Brady doctrine (see Brady v. Maryland, 373 U.S. 83). The State opposed the demand. The Administrative Law Judge denied Respondent's motion on the grounds that Brady was applicable to criminal proceedings but not Administrative Hearings. Furthermore the doctrine was particularly inapplicable to proceedings under section 230 of the Public Health Law given the potential conflict with statutory confidentiality standards and the Commissioner's regulations prohibiting discovery (See Public Health Law section 230(10)(a)(v) and 10 NYCRR part 51.8 and 51.11).

In a motion dated November 5, 1992, Respondent moved to voir dire the Committee members. The State opposed this motion. In a

letter decision of November 9, 1992, the Administrative Law Judge denied this motion.

After the submission of closing briefs, Respondent noted an apparent error in the submissions by the State. Respondent sought an opportunity for a supplementary submission. Respondent was granted his request over the State's objection. Both parties made final supplementary submissions which were distributed to the Committee members on the day of deliberations.

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 accepted standards of medical practice in this state. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. 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 meant a conspicuously bad act or severe deviation from standards.

The Committee was instructed that to sustain a charge of fraud, they must find that the state proved by a preponderance of the evidence, that Respondent made a false representation, whether verbally, in writing or by conduct or concealment; that he knew it

to be a false representation; and that he intended the falsehood to result in a deception. Actual deception need not take place for the charge to be sustained. The Committee was further instructed that knowledge and intent may be inferred from facts in the record.

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.

The Committee was further under instructions that with regard to a finding of medical misconduct, it must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.

The following findings of fact were made after review of the entire record. Numbers in parentheses (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. Some evidence and testimony was rejected as irrelevant. The Petitioner was required to meet the burden of proof by a preponderance of the

evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence.

GENERAL FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State on September 20, 1966, by the issuance of license number 097500 by the New York State Education Department (Ex. 1).

FINDINGS OF FACT WITH REGARD TO PATIENT A

1. Patient A first came to Respondent's office at 2100 Eastchester Road, Bronx, New York on October 17, 1990 (Ex. 4).

2. Patient A was referred by a Dr. Braz Bortot whom she consulted with on or about October 11, 1990, concerning her pregnancy (Ex. V).

3. Patient A was accompanied by her boyfriend, BDS, when she went to Dr. Bortot's office. Patient A was informed by Dr. Bortot that she was about 22 1/2 weeks pregnant and Dr. Bortot's records estimate the gestation between 20 and 24 weeks (T.514; Ex. V).

4. At Respondent's office on October 17, 1990, Patient A met with several of Respondent's employees in order to be counseled as to the abortion procedure and to be sure that she understood that once the laminaria were inserted, she would have to follow through on her decision to terminate her pregnancy (Ex. 4, pp. 3-4, 9-10).

5. After all pre-operative forms were signed, Patient A was

examined by Respondent (Ex. 4, p. 3-4, 9-10, 13).

6. The examination findings were normal. Immediately after the examination, Lisa Fournier, a Licensed Practical Nurse (LPN) employed and trained by Respondent, inserted 10 laminaria to bring about cervical dilation (Ex. 4, pp. 9 and 13).

7. Patient A was then sent home (T. 522). She was given instructions as to what to expect from the laminaria including possible problems she might encounter (Ex. 4, pp. 9 and 10).

8. Patient A was advised that she could expect some slight bleeding and cramping. She was further advised to call a Hot Line number provided to her at Respondent's office in the event of heavy bleeding, severe pain or contractions, or the sudden loss of watery fluid through the vagina (Ex. 4, pp. 9 and 10).

9. During the evening of October 17, 1990, Patient A experienced no significant problems and did not call the Hot Line number.

10. Patient A returned to Respondent's office on October 18, 1990, for the insertion of additional laminaria (T. 523). Ms. Fournier inserted 10 more laminaria to bring about cervical dilation (T. 523; Ex. 4, p. 9).

11. Patient A's abortion was scheduled to take place on October 19, 1990. During the evening of October 18, 1990, however, BDS called the Hot Line at about 8:30 p.m. (Ex. B; Ex. 4, p. 5).

12. Lisa Fournier, who was responsible for the Hot Line calls at that time, was contacted by Respondent's answering

service and she returned BDS's call (T. 526, 809-810).

13. During this telephone conversation, BDS advised Ms. Fournier that Patient A had cramps and had taken one Vicodin, an analgesic. In response to questioning by Ms. Fournier, he reported that there was no bleeding and no fever. Ms. Fournier advised BDS to call back in 20-30 minutes if Patient A did not get relief from the Vicodin (T. 814-818; Ex. B; Ex. 4, p. 5).

14. At about 11:00 p.m., BDS called again. He spoke again to Ms. Fournier and he reported that Patient A was sleeping and that she felt warm to him. He told Ms. Fournier that he could not take Patient A's temperature. Ms. Fournier advised BDS to wake Patient A up to see how she felt. Patient A told BDS that she felt much better and that she was just tired. BDS reported this to Ms. Fournier who was also able to overhear the conversation between Patient A and BDS. BDS reported that there was no bleeding at this time. Ms. Fournier advised BDS to call back in the event of fever or bleeding (T. 818-820; Ex. B; Fx. 4, p. 5).

15. At about 3 a.m. on October 19, 1990, BDS called the Hot Line again. He reported that Patient A had experienced extensive bleeding into the toilet bowl. He also reported that Patient A was experiencing cramping and vomiting. Ms. Fournier asked to speak directly to Patient A. Ms. Fournier asked Patient A about the bleeding. Patient A indicated that she had broken her water and had some slight bleeding. Patient A further stated that she had bled through one pad and that she was in labor. Ms. Fournier

told BDS to bring Patient A to Respondent's office at that time (T. 820-824; Ex. B; Ex. 4, p. 5).

16. Following her telephone conversation with BDS and Patient A, Ms. Fournier called Respondent at his home to advise him that he had a patient in labor and that she had just directed the patient to come to the office. Respondent indicated that he would come to the office (T. 824). Ms. Fournier did not advise Respondent that BDS had reported that Patient A was bleeding. Ms. Fournier believed that what BDS observed was red stained amniotic fluid in the toilet bowl rather than heavy bleeding (T. 824).

17. Ms. Fournier was the first person to arrive at Respondent's office in the early morning of October 19, 1990 (T. 825). She began to set up the various equipment and supplies that Respondent would need to perform the abortion procedure on Patient A (T. 825-826).

18. BDS arrived with Patient A at Respondent's office at about 3:50 a.m. on October 19, 1990. He carried her into the office because she was in pain (T. 858-860; Ex. B; Ex. 4, p. 5).

19. BDS came down the corridor leading to the recovery room door at Respondent's office where he was met by Ms. Fournier. He put Patient A down on her feet and he then went to the front of the office where the general waiting area is located (T. 501-508, 858-862).

20. Ms. Fournier helped Patient A get out of her clothes. While Patient A was stepping out of her jogging pants, she had an

involuntary bowel movement. Ms. Fournier helped Patient A clean up and took her to the bathroom (T.861-864; Ex. 4, p. 6).

21. After they left the bathroom, Ms. Fournier took Patient A to the operating room where she helped her get on the operating table (T. 864-865).

22. Ms. Fournier took Patient A's vital signs and recorded a temperature of 98 degrees, a pulse of 100 and a blood pressure of 120/70 (T. 865; Ex. 4, p. 6).

23. Ms. Fournier started an intra-venous (I.V.) administration of Ringer's lactate. Ms. Fournier noted that Patient A was ashen in color and administered oxygen via mask (T. 865-866; Ex. 4, p. 6).

24. Respondent arrived at his office at about 4:05 a.m. on October 19, 1990 (Ex. 4, p. 6). Ms. Fournier told Respondent of Patient A's vital signs, her ashen color and the bowel movement. She did not mention that BDS had reported bleeding (T. 867; Ex. 4, p. 6).

25. Respondent noted that Patient A was in a great deal of pain from her contractions. He administered Valium and Demerol to ease her discomfort (T. 868-869, 1348-1350; Ex. 4, p. 6).

26. Respondent did a pelvic examination which revealed a dilated cervix easily accommodating the fetal vertex. His handwritten note states the following: He "delivered the products of conception in toto. The uterine cavity was reviewed (sic) <explored> by sharp and suction curettage and there was no bleeding at all" (Ex. 4, p. 8). Respondent also states in the

patient record there was an estimated blood loss of 50 cc. (Ex. 4, p. 14). The procedure took about two or three minutes (T. 872, 1352-1353).

27. At the end of the procedure Respondent noticed that Patient A's uterus was "boggy." The term "boggy" is an accepted medical term which refers to a uterus which is soft and not contracting. At this point in the procedure, the uterus should have been contracting (T. 872, 1356; Ex. 4, pp. 6 and 8).

28. Respondent administered 0.2 mg of Methergine and 1 cc. of Prostaglandin. These drugs facilitate contraction of the uterus (Ex. 4, pp. 6 and 8).

28. Respondent noted that Patient A's blood was slightly dark and that her breathing was a somewhat shallow. He administered Narcan (T. 1359-1360). He decided to admit Patient A to the hospital for observation (T. 872-873, 1356). Toward this end, he called his office manager, Irene Sylvor, who routinely handles hospital admissions when they are necessary (T. 873-874, 1360-1361).

29. While Respondent was on the telephone with Ms. Sylvor, Ms. Fournier was with Patient A. She noted that Patient A stopped breathing and she immediately called for Respondent (T. 874, 1248, 1361-1362, 1365).

30. Respondent told Ms. Sylvor to come to the office and rushed back to Patient A (T. 1248, 1361-1362, 1365).

31. Respondent quickly examined Patient A and then advised Ms. Fournier to call Emergency Medical Services (911) (T. 1363-

1364). He then began to administer CPR to Patient A. The CPR consisted of chest compressions and mouth-to-mouth resuscitation (T. 1366-1367).

32. Ms. Fournier called 911 at 4:26 a.m. (Ex. 6, p. 7).

33. She remained on the telephone with the Emergency Medical Services (EMS) dispatcher for about 3 minutes. By the time Ms. Fournier returned to assist Respondent in the care of Patient A, the first EMS team arrived on the scene and buzzed to be let in to the building (T. 878-879, 1368).

34. The first EMS team to arrive consisted of Mr. Peifer and his partner. Mr. Peifer testified at the hearing. (Ex. 6, p. 7).

35. There is a corridor which runs from the entrance way of Respondent's building to a point past the doorway which leads to the recovery area of Respondent's office. This distance is about 1/2 of a Bronx block. There was no blood in this hallway (T. 450, 319).

36. Mr. Peifer entered the operating room where Patient A was located. She was still on the operating table. He performed a "ten second scene survey" primarily to insure his own safety and then assumed control over the effort to resuscitate Patient A (T. 431, 436-437).

37. There was a significant amount of dark blood in the operating room (T. 415-416).

38. Christine Segatto, another EMS worker, arrived at Respondent's office about two minutes after the first EMS team. (Ex. 6, p. 5).

39. Respondent owned or leased extensive equipment including an EKG machine, defibrillator, multiple analgesia machines, pulse oximeters, oxygen tanks and an emergency kit. This equipment was in the operating room on October 19, 1990 (T. 826-858, 1257-1259, 1383-1385 Ex. C-1, C-17; Ex. T; Ex. Z; Ex. AA; Ex. DD).

40. Patient A remained at Respondent's office for about half an hour after the first EMS team arrived (Ex. 6, pp. 5-8).

41. During this half hour, the EMS personnel administered various medications to Patient A and administered aproximately 1000 cc. I.V. fluid (Ex. 6, pp. 5-8). At about 5:00 a.m., she was transported to the Bronx Municipal Hospital Center (BMHC) (Ex. 6, pp. 5-8).

42. Upon arrival at BMHC, Patient A was immediately given I.V. fluids (Ex. 6, p. 3). Her hematocrit was taken and found to be 27 (Ex. 6, p. 3).

43. Patient A's hematocrit on October 17, 1990 was 38 (Ex. 4, p. 13). The same value was obtained less than a week earlier at Dr. Bortot's office (Ex. V).

44. By the time she arrived at BMHC, Patient A was experiencing symptoms of disseminated intravascular coagulopathy (DIC). This is a condition which often follows an amniotic fluid embolism in which the body uses up most of its clotting factors thus resulting in an inability of the blood to clot. The body will then bleed profusely (T. 1503-1505).

45. Patient A was given approximately 1000 cc. of fluid by EMS workers (Ex. 6, p.8). At BMHC, a spun hematocrit, done in the

emergency room upon arrival was reported as 27. A 10 point drop in hematocrit is equivalent to approximately 1500 cc. of blood loss. A hematocrit, drawn upon arrival at BMHC, and analyzed by the laboratory was reported at 5:35 A.M. The value reported was 27.3 (Ex.6, p. 31, T. 1500-1505).

46. Patient A died as a result of a cardiopulmonary arrest secondary to an amniotic fluid embolism (Ex. P).

47. The amniotic fluid embolism occurred at some point during the procedure performed on Patient A by Respondent. The diminished cardiac output which resulted from the amniotic fluid embolism contributed to the uterus being boggy (T. 1478-1479, 1494, 1561).

48. The amniotic fluid embolism was unpredictable and undiagnosable (T. 78, 1469, 1493, 1568, 1576-1577).

CONCLUSIONS WITH REGARD TO PATIENT A

In allegation A.1, Respondent is charged with the failure to record the identity of the person who performed and interpreted the sonography on this patient. The record discloses that only one person performed sonography and only one person interpreted sonography in Respondent's office. Furthermore, the person who performed the sonogram is listed on the back of the sonogram. Moreover, the expert witness for the state acknowledged that it is not necessary to list the name of the person who takes and interprets a sonogram in a small office where only one person has

that responsibility.

Therefore:

Allegation A.1 **is NOT SUSTAINED.**

In Allegation A.2, Respondent is charged with the failure to record the size and type of laminaria used in this procedure. While the allegation is factually accurate, Respondent did not record the size and type of laminaria used, such a recording was unnecessary. Respondent testified, and the panel believes, that only one type and size of laminaria was routinely used in Respondent's practice. When another type was used, the size and type was recorded.

Because of the manner in which the charges in this proceeding are drafted, this factual allegation must be sustained as true. However, it will not form the basis of any finding of medical misconduct.

Therefore:

Allegation A.2 **is SUSTAINED.**

In Allegation A.3, Respondent is charged with a failure to "properly address" the possibility that this patient might need emergency care near her home after the insertion of laminaria. The Committee finds that Respondent made entirely adequate arrangements for this patient. The Committee finds credible the testimony of Ms. Fournier and Respondent that emergency procedures existed and were explained to this patient. These procedures included a "Hot Line" telephone number which would put the patient in contact with Ms. Fournier, an experienced Licensed Practical

Nurse. That the system worked is evidenced by the events of the night in question. Patient A and BDS were able to reach Ms. Fournier within minutes and received advice and instructions. In addition to the hot line telephone number, the system developed by Respondent included Ms. Fournier having a list of patients and their location at hand when she was taking emergency calls. The Committee can see no additional precautions that were necessary. The Committee believes that the system utilized by Respondent was adequate for the situation which did indeed develop. The Committee finds it credible that had Ms. Fournier believed hemorrhaging was taking place or that some other life threatening condition existed, the patient would have been referred to the nearest emergency facility. Under all the facts, Respondent was appropriately prepared to meet emergency situations.

Therefore:

Allegation A.3 **is NOT SUSTAINED.**

In Allegation A.4, Respondent is charged with a failure to provide for "local and immediate" care for Patient A at 3 A.M. on the morning in question. Essential to this charge is the allegation that Patient A was experiencing "heavy bleeding" and that Respondent knew this. Allegation A.4 cannot be sustained for two reasons. First, Patient A was not experiencing heavy bleeding; second, Respondent was not informed of any heavy bleeding.

The Committee finds credible the testimony of Ms. Fournier and Respondent with regard to this issue. The Committee believes

that while BDS may have reported that Patient A was suffering from heavy bleeding, upon speaking to the patient, Ms. Fournier concluded that the patient had actually broken her water. Exhibit F (Patient A's pants) and the testimony of others present at Respondent's office support the contention that Patient A was indeed not suffering from severe bleeding. Thus not only was Respondent not informed of any bleeding but Ms. Fournier made a factually correct judgement at the time. Based upon the information available to her at the time, Ms. Fournier saw an urgent but by no means life threatening situation. Under the circumstances, there was no reason for Ms. Fournier to make any report of heavy bleeding to Respondent. Nor were the instructions to proceed to Respondent's Bronx office inappropriate.

Therefore:

Allegation A.4 **is NOT SUSTAINED.**

In Allegation A.5 and its six subdivisions, Respondent is charged with performing an abortion on Patient A in his office. The thrust of the State's allegations is that based upon the symptoms known to Respondent, a prudent practitioner would not have performed the procedure in his office, but rather, would have sent the patient to a hospital immediately. To assist in understanding the analysis by the Committee of the various individual charges, a narrative of the overall conclusions of the Committee arising from the evidence about this incident is presented. This narrative represents a distillation and compilation of the various, and at times contradictory, witnesses

and items in evidence.

On the night in question, Ms. Fournier was contacted several times by BDS. After conferring with the patient, she concluded that Patient A had broken her water and was in labor. She did not believe that any heavy bleeding or other life threatening condition existed. She told the Patient to come to the office of Respondent immediately. She then informed Respondent that he had a patient in labor. Because Ms. Fournier did not believe that there was any heavy bleeding or other life threatening condition exhibited by this patient at the time, she made no report of heavy bleeding to Respondent. Upon hearing Ms. Fournier's report, Respondent took the appropriate action by going directly to his office to meet the patient.

When Patient A arrived, she was in pain from labor, but was otherwise in good condition. She experienced an involuntary bowel movement. This too was a result of labor and is not unusual. Likewise, her color was described as "ashen" but this type of coloration is often seen in a patient undergoing the pain of labor.

Respondent administered Valium and Demerol, which are appropriate medications for sedation and control of pain. He began the abortion. The products of conception were delivered without incident, in toto. Respondent examined the patient and discovered bleeding. The uterus was "boggy," meaning it was soft and not contracting. This caused appropriate concern on the part of Respondent. He administered Methergine and Prostaglandin.

agents which facilitate the contraction of the uterus, in adequate doses. At this point the procedure was proceeding within parameters that could be anticipated.

Respondent re-examined the patient. He discovered continued bleeding. He packed her vagina to stem the bleeding. He further noted that her breathing was shallow and administered Narcan to counteract the effects of the anesthetics. At this point, Respondent became concerned with the condition of the patient. He could not stop the bleeding. He decided to admit her to the hospital. He left the operating room to arrange for the admission through Ms Sylvor.

Unbeknownst to Respondent, Patient A was suffering from an amniotic fluid embolism. This is an uncommon and almost always fatal complication of delivery and labor. While Respondent was on the telephone, the full impact of the embolism took effect. The patient stopped breathing. Respondent attempted resuscitation and cardiac compression. Emergency Medical Services (911) was called. Emergency Medical Technicians (EMTs) arrived very quickly and, as is their protocol, they took charge of the patient.

The Committee has considered the various evidence to the contrary and rejected it. For instance, the Committee does not believe that the operating room was devoid of medical equipment, including oxygen tanks. The EMTs, who testified that there was the only equipment in the room, are credited, by the Committee, with good faith attention to the emergency in progress. The Committee thus concludes that their description was based upon

lapses of memory and total attention to the crisis at hand, and coloration by tragic circumstances. Whatever the reason for the contradiction, it is illogical that Respondent would not have the equipment described in finding of fact 39 in the operating room.

With regard to the condition of the patient upon her arrival, the Committee heard and rejected testimony to the effect that Patient A was bleeding very heavily and that a trail of blood and feces led from the front door of the facility to the operating room. The two witnesses responsible for these observations included BDS, the boyfriend of Patient A, and EMT Segatto. The testimony of the boyfriend was undoubtedly colored by his personal involvement in the tragedy. Furthermore, the testimony of EMT Peifer, who saw no such trail, as well as the condition of exhibit F (Patient A's clothing), are objective sources which contradicted the assertion of heavy bleeding and ongoing bowel movements prior to the procedure.

Having rejected the assertion that Patient A was bleeding heavily when she arrived at Respondent's office, the Committee finds that the appropriate course of conduct for Respondent was to evacuate the uterus. This would have stopped the contractions of labor which would have ended the pain, cramping, vomiting (if indeed any occurred) and involuntary bowel movements. Ordinarily, upon evacuation of the uterus, the case would have essentially concluded and the patient would have gone home. Tragically, this patient suffered an amniotic fluid embolism. Such a condition can only be conclusively diagnosed upon autopsy and is virtually

always fatal. While there was no need, based upon the presentation of the patient, to refer her to a hospital, had she been in a hospital, it is very unlikely that the outcome would have been different.

Each Allegation will now be addressed separately.

In Allegation A.5(a) Respondent is charged with a failure to arrange for this patient to be treated in a hospital prior to performing any procedure on her. This charge assumes that the patient was suffering from heavy bleeding and that she exhibited vomiting, severe cramps and more than one involuntary bowel movement. As stated above, the credible evidence shows cramping and one involuntary bowel movement. The management for these symptoms was evacuation of the uterus. Since this patient was not in any immediate danger (that could have reasonably been foreseen by the practitioner), Respondent took the appropriate steps to aid his patient: He performed the abortion.

Therefore:

Allegation A.5 (a) **is NOT SUSTAINED.**

In Allegation A.5 (b), Respondent is charged with failing to have proper monitoring and resuscitative equipment in his operating room. As stated above, it is illogical that Respondent would not have had the equipment listed in finding of fact A.39. The testimony to the effect that the EMTs entered a room which was empty, but for a table is not credible. The Committee believes

Respondent had the equipment that was recognized as necessary by the State's experts.

Therefore:

Allegation A.5 (b) **is NOT SUSTAINED.**

In Allegation A.5 (c) Respondent is charged with failing to "adequately prepare the patient for foreseeable complications during the performance of the abortion." It is not clear what this charge refers to. However, there is certainly no evidence that Respondent was lacking in any equipment or that he failed to perform appropriate pre-operative procedures.

Therefore:

Allegation A.5 (c) **is NOT SUSTAINED.**

In Allegation A.5 (d), Respondent is charged with the failure to have a licensed physician or certified registered nurse anesthetist (CRNA) present during the surgery to "manage the sedation and resuscitation of the patient". The evidence shows that Respondent had a physician (anesthesiologist) in his office during the day when he was performing abortions. The Committee finds that this established a personal subjective standard of care which Respondent violated on the night in question. It is the position of the Committee that where a physician has an anesthesiologist available at all times during the day, he should have had such assistance, or at least made a good faith effort to have such assistance, on the night in question. Respondent was well aware that the nature of his practice involved off hour surgery. Anesthesia assistance could have been part of his Hot

Line system.

Nevertheless, while the Committee believes Respondent violated his own subjective standards of practice, the real issue is whether he violated objective standards of practice. In that regard, both Dr. Elahi, the State's expert witness, and each of Respondent's experts testified that where general anesthesia is not contemplated, the services of another doctor or CRNA is not necessary. Respondent used Valium and Demerol for I.V. sedation and to control the patient's pain. At no time did he utilize or anticipate general anesthesia. It follows then, that under all the facts and circumstances, the evidence indicates that Respondent did not need another doctor or CRNA to comply with objective standards of care.

Therefore:

Allegation A.5 (d) **is NOT SUSTAINED.**

In Allegation A.5 (e), Respondent is charged with inappropriately sedating Patient A. The Committee finds that the drugs used and the amounts given were entirely appropriate under the circumstances.

Therefore:

Allegation A.5 (e) **is NOT SUSTAINED.**

In Allegation A.5 (f) Respondent is charged with a failure to properly attempt to resuscitate Patient A. The evidence shows Respondent utilized cardiac compressions and mouth to mouth resuscitation. Under the circumstances, this is all that could have been expected.

Therefore:

Allegation A.5 (f) **is NOT SUSTAINED.**

In Allegation A.7, Respondent is charged with a failure to perform and or record a gross examination of the uterine contents. The Committee is convinced that Respondent must have viewed the contents. Therefore the first part of the charge is not sustained. Furthermore, Respondent's note states that the products of conception were "delivered in toto." This constitutes a sufficient record of a gross examination.

Therefore:

Allegation A.7 **is NOT SUSTAINED.**

In Allegations A.8 and A.9 Respondent is charged with intentionally misrepresenting that Patient A received continuous oxygen by mask (A.8) and intentionally misrepresenting the amount of bleeding sustained by this patient as "no bleeding at all" (A.9). The committee sustains this allegation. At page 1366 of the transcript, Respondent explained that he administered CPR using external cardiac massage and mouth-to-mouth resuscitation. Since an oxygen mask would be in the way of mouth-to-mouth resuscitation, there could not have been continuous oxygenation by mask. Moreover, where the patient has stopped breathing, an oxygen mask, without forced ventilation, is useless.

With regard to the bleeding of this patient, Respondent wrote in his note that the patient exhibited "no bleeding at all." There is also a reference to a blood loss of aproximately 50 , which is a very small amount of blood. Respondent's position that

Patient A suffered minimal bleeding is belied by several facts including the testimony of the EMS workers that they saw a significant amount of dark red blood, and the hematocrits which appear in the patient record.

The testimony of the EMS personnel (T.322; 415-416) must be given credibility in light of the clinical status of Patient A. The hearing Committee has accepted the fact that Patient A had no significant bleeding prior to the beginning of the procedure on October 19, 1990. Thus, a logical explanation, other than pre-surgical hemorrhaging, must be found to explain a drop in her hematocrit from an office baseline, prior to surgery, of 38 to hospital readings after the surgery of 27.[2] Respondent's experts agree that it is unusual to have a large, boggy, post-partum uterus that does not bleed (T.1467). Physiologically, the description of no bleeding at all (or 50 cc.) defies explanation. One of the theories offered by Respondent was that of "shunting". Shunting refers to a bodily mechanism by which blood from peripheral tissues is diverted to vital organs during times of physiological crisis. It is well accepted that this phenomenon does indeed occur. However, the uterus is a major organ which is supplied by major blood vessels and would not be significantly affected by shunting of blood. A boggy, non-contracted uterus from a 23 week gestation would be expected to bleed, even in the

---

[2] A spun hematocrit which was done in the ER upon arrival was reported as 27. Later, a hematocrit which was analyzed in the hospital laboratory, was reported as 27.3 (Ex. 6, pp. 8, 31). The Committee finds the difference to be clinically insignificant.

presence of some shunting. Thus the observations of the EMTs of much blood in the operating room is corroborated by physiological fact. This corroboration erodes the credibility of Respondent's reports of minimal bleeding from shunting.

The presence of significant bleeding in Respondent's operating room is also the reason for the drop in the patient's hematocrit. The explanation for the hematocrit which was offered by Respondent is hemodilution. Since hematocrit is a measurement of the percentage of red blood cells to a given quantity of blood, it stands to reason that extensive infusion of fluids would cause the blood to be diluted and thus lower the percentage of blood cells to total blood volume. However, the credible facts are not consistent with this explanation. The total fluids given to Patient A by EMS workers was approximately 1000 cc. (Ex. 6, P.8). A spun hematocrit done in the Emergency Room upon arrival is reported as 27. A 10 point drop in Hematocrit is equivalent to approximately a 1500 cc. blood loss. The infusion of 1000 cc. thus would not cause sufficient hemodilution to produce a hematocrit of 27 or a hematocrit of 27.3 which was reported at 5:35 A.M. and was performed by the hospital laboratory (Ex. 6, P.31).

Indeed, the far more plausible explanation is that Patient A started to bleed profusely while in Respondent's operating room, he packed her vagina to stop the bleeding but was unsuccessful. Patient A continued to bleed while at BMHC where attempts to stop the flow were also unsuccessful. The hospital record shows that

the physician in the ER removed a vaginal packing from Patient A. She continued to bleed and the vagina was repacked (Ex. 6, P. 10). Respondent's experts agreed that vaginal packing is used to control bleeding (T. 1471, 1576). Respondent, however, claimed that the "packing" referred to was a routinely placed 4x4 of rolled gauze, which Respondent uniformly applies to all his patients following all abortions to measure ordinary bleeding. Given the clinical situation of this patient, it seems hardly likely that the object removed in the E.R was a routinely placed piece of rolled gauze. Rather, the more credible inference is that Respondent inserted a true vaginal packing, which entails a significant amount of absorptive material, in an appropriate attempt to control the post-partum bleeding.

Unknown to Respondent at the time, Patient A had an amniotic fluid embolism. It is known that clinically, DIC develops soon after the initial respiratory distress. DIC leads to significant bleeding, particularly if the placenta has already separated, and uterine atony is present. The Committee believes that Patient A had significant bleeding following the procedure which was performed by Respondent. This significant bleeding was due to DIC, and was intensified by the separation of the placenta and uterine atony, all of which were secondary to physiologic forces beyond the control of Respondent and unknown to him at them time. All Respondent knew was that a young, generally healthy patient had bled profusely and expired. Since the only obvious life threatening aspect of the procedure was the bleeding, Respondent

chose not to report it accurately.

Having so found, it is important to explain that the Committee believes Respondent intentionally falsified his records. At the time of the incident, Respondent could not have known that the patient died of an amniotic fluid embolism. Thus, he was justifiably concerned about a myriad of possible causes. The Committeee finds that in his note, which was written after the patient expired, Respondent intentionally tried to mislead future readers into believing that the patient was mechanically oxygenated and suffered no blood loss. This is because he believed that the death was related to hemorrhaging and insufficient blood supply. The Committee does not believe that this was a case of writing the record truthfully, but in the best light possible. Rather, the Committee finds that the written record is so significantly far from the truth that the intent to deceive may be inferred.

Therefore:
Allegation A.8 **is SUSTAINED.**
Allegation A.9 **is SUSTAINED.**

In Allegation A.10, Respondent is charged with failing to provide EMS workers with a "complete and accurate" account of what had taken place "so that treatment could be appropriately and expeditiously rendered" to patient A. Reading the two quoted portions of the charge together, the Committee concludes that the charge cannot be sustained as drafted. While Respondent did not give a complete and accurate account of what took place before the EMS workers arrived, it made no difference to the treatment given.

The finding that Respondent was untruthful about oxygenation by mask and the amount of blood loss was irrelevant to EMS personnel. An accurate report would not have changed the emergency treatment rendered within the time frame between the arrival of the EMS personnel and the transport of the patient to the hospital.

Therefore:
Allegation A.10 **is NOT SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT B

1. Patient B first came to Respondent's office in Queens, New York, seeking an abortion on or about October 29, 1988 (Ex. 7, pp. 3, 4, 7). For reasons not explained during the hearing, she did not follow through at the time and returned to the Queens office on November 2, 1988 (Ex. 7, pp. 3, 4, 5, 7).

2. Prior to meeting Respondent, Patient B was advised by Ms. Sylvor that it would be necessary for the abortion procedure to be performed at Respondent's office in the Bronx rather than the Queens office (T. 1314). This was due to the fact that Dr. Sussman, the physician who was scheduled to be in the Queens office, was unavailable and also because Patient B had requested general anesthesia and anesthesia was not going to be available in the Queens office on November 3, 1988 (T. 1311-1314; Ex. [illegible] p. 4).

3. On the November 2nd visit, a sonogram of Patient B was taken by Ms. Fournier for the purpose of determining the stage of

gestation by measuring the fetus' biparietal diameter. Patient B was approximately 19.9 weeks pregnant (T. 1028; Ex. 7, p. 4).

4. At the time, Ms. Fournier was the only person at Respondent's office performing sonograms (T. 807, 1004-1006). All sonograms were reviewed by a physician (T. 1028-1029).

5. On the November 2nd visit, Patient B saw a receptionist, a counselor (Karen Hamilton), Respondent's office manager (Irene Sylvor), a laboratory technician (Rita Hendrickson); Respondent's nurse (Lisa Fournier) and Respondent (Ex. 7, pp. 3, 5, 6; Ex. A; Ex. H, Ex. J).

6. The record for Patient B states that on November 2, 1988, Respondent performed a physical examination of Patient B including a pelvic examination (Ex. H). The examination was recorded in the record by Ms. Fournier as it was dictated to her by Respondent (T. 1027-1028, 1030; Ex. H).

7. On November 2, 1988, after Respondent performed the physical examination Ms. Fournier inserted seven laminaria to bring about cervical dilatation (Ex. 7, p. 4; Ex. K). She recorded the number of laminaria inserted and indicated that one of the laminaria was a medium sized laminaria Japonica (Ex. K). It was the practice at Respondent's office to use the large sized laminaria. When other than the large sized laminaria are used, it is recorded in the chart, as is the case for patient B. (T. 1047-1048).

8. Patient B was advised to return to the Queens office on the morning of November 3, 1988. She was further advised that

transportation to and from the Bronx location would be arranged for her (T. 1318).

9. Patient B returned to the Queens office on November 3, 1988. Arrangements were made for a taxi to take her to the Bronx office (T. 1319-1320).

10. At the Bronx office, Patient B underwent an abortion by dilatation and evacuation. Respondent performed this abortion. The procedure was uneventful (Ex. H).

11. The record maintained by Respondent describes the procedure performed, the anesthesia given, the blood lost during the procedure and monitoring of the patient in the recovery room until discharge (T. 965-966; Ex. H).

12. Respondent performed a gross examination of the products of conception with respect to Patient B and sent the products of conception to a laboratory for pathological analysis Respondent did not record in his chart for Patient B whether all of the products of conception were accounted for (Ex. 7).

CONCLUSIONS WITH REGARD TO PATIENT B

In Allegations B.1 and B.4, Respondent is charged with a failure to perform and record an adequate physical examination of the patient prior to inserting laminaria (Allegation B.1) or before evacuating the uterine contents (Allegation B.4). The Committee sustains these allegations on the following grounds: Respondent's record for this patient does not indicate the

clinical size, shape or location of the uterus. There is no indication of the clinical nature of the cervix. For example, Respondent does not describe it as soft or firm. Nor does Respondent indicate if there was any dilatation and if so, the extent of same. Moreover, there is no indication of the position of the cervix or uterus.

The status of the pelvic organs, as outlined above, is very important at the time of any surgery. To prevent injury and anticipate potential difficulties, it is essential that the surgeon know the clinical status of any organ system upon which surgery is contemplated. Furthermore, such status must be noted and recorded with specificity. Respondent's note to the effect that all relevant structures were within normal limits (W.N.L.) was inadequate as the universe of normal limits is simply too large for any sort of precision. Respondent testified that he performed an adequate physical examination for the purposes of his procedure. It is the position of the Committee that the failure to record such an examination is tantamount to the failure to perform it. In any event, Respondent clearly did not record an adequate physical examination.

Therefore:
Allegation B.1 **is SUSTAINED.**
Allegation B.4 **is SUSTAINED.**

In allegation B.2, Respondent is charged with the failure to record the identity of the person who performed and interpreted the sonography on this patient. The record discloses that in Respondent's office, only one person performed sonography and

only one person interpreted sonography.

Because of the manner in which the charges in this proceeding are drafted, this factual allegation must be sustained as true. However, it will not form the basis of any finding of medical misconduct.

Therefore:

Allegation B.2 **is SUSTAINED.**

In Allegation B.3, Respondent is charged with the failure to record the size and type of laminaria used in this procedure. As set forth under Allegation A.2, while the allegation is factually accurate, such a recording was unnecessary. Furthermore, Respondent used only one type and size of laminaria routinely. When another type was used, the size and type was recorded. This constitutes adequate office practice.

Because of the manner in which the charges in this proceeding are drafted, this factual allegation must be sustained as true. However, it will not form the basis of any finding of medical misconduct.

Therefore:

Allegation B.3 **is SUSTAINED.**

In Allegation B.5, Respondent is charged with the failure to record the procedure used to terminate the pregnancy. This charge cannot be sustained. Respondent's records clearly show "L.D.E." which is accepted as meaning laminaria, dilatation, evacuation. This constitutes a description of the procedure. Since the charge does not refer to the adequacy of the notation, the Committee

expresses no opinion as to the sufficiency of the note.

Therefore:

Allegation B.5 **is NOT SUSTAINED**

In Allegation B.6, Respondent is charged with the failure to monitor and or record this patient's vital signs in the recovery room. In fact, the patient record shows the vital signs were recorded 3 times. This is entirely adequate for the time this patient was in the recovery room.

Therefore:

Allegation B.6 **is NOT SUSTAINED.**

In Allegation B.7, Respondent is charged with the failure to record the amount of blood loss during the procedure. In fact, the patient record shows that there was a "small" blood loss. The Committee does not sustain this charge because the notation does indeed describe the amount of blood loss. As the charge makes no reference to the adequacy of the notation, the Committee expresses no opinion regarding adequacy in its analysis.

Therefore:

Allegation B.7 **is NOT SUSTAINED.**

In Allegation B.8, Respondent is charged with a failure to perform and or record a gross examination of the uterine contents. The Committee is convinced that Respondent must have viewed the contents. Therefore the first part of the charge is not sustained. However, it is equally clear that Respondent did not

record his observations.

Therefore:

Allegation B.8 **is SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT C

1. Patient C came to Respondent's office in Queens, New York on November 2, 1988, seeking an abortion (Ex. 8).

2. Prior to meeting Respondent, Patient C was advised by Ms. Sylvor that it would be necessary for the abortion procedure to be performed at Respondent's office in the Bronx rather than the Queens office (T. 1314). This was due to the fact that Dr. Sussman, the physician who was scheduled to be in the Queens office, was unavailable and also because Patient C had requested general anesthesia and anesthesia was not going to be available in the Queens office on November 3, 1988 (T. 1311-1314; Ex. 8, r 4).

3. On the November 2nd visit, a sonogram of Patient C was performed by Ms. Fournier for the purpose of determining the gestation by measuring the fetus' biparietal diameter. Patient C was 14.6 weeks pregnant (T. 1028-1029, 1051-1052; Ex. 8, p. 3).

4. At the time (as noted above with respect to Patient B), Ms. Fournier was the only person at Respondent's office performing sonograms (T. 807, 1004-1006). All sonograms were reviewed by a physician (T. 1028-1029, 1051-1052).

5. On November 2, 1988, Respondent performed a physical

examination of Patient C including a pelvic examination (Ex. I). The examination was recorded in the medical record by Ms. Fournier as dictated to her by Respondent (T. 1027-1028, 1051-1052; Ex. I).

6. On November 2, 1988, after Respondent performed the physical examination, Ms. Fournier inserted three laminaria to bring about cervical dilatation (Ex. 8, p. 4).

7. Patient C was advised to return to the Queens office in the morning of November 3, 1988, and that transportation to and from the Bronx would be arranged for her (T. 1318).

8. Patient C returned to the Queens office on November 3, 1988. Arrangements were made for a taxi to take her to the Bronx office (T. 1319-1320).

9. At the Bronx office, Patient C underwent an abortion by dilatation and evacuation which was performed by Respondent. The procedure was uneventful (Ex. I).

10. The record maintained by Respondent reflected the procedure performed, the anesthesia given, the blood lost during the procedure and the patient's monitoring in the recovery until discharge (T. 994-995; Ex. I).

11. Respondent performed a gross examination of the products of conception with respect to Patient C and sent the products of conception to a laboratory for pathological analysis (Ex. 8). Respondent did not record in his chart for this patient whether all of the products of conception were accounted for.

CONCLUSIONS WITH REGARD TO PATIENT C

In Allegation C.1 and C.4, Respondent is charged with a failure to perform and/or record an appropriate physical examination either prior to the insertion of laminaria (C.1) or before evacuating the uterus (C.4). For the reasons set forth with regard to Allegations B.1 and B.4, the Committee sustains these charges. As stated before, it is essential that a surgeon examine and note the size shape and presentation of the structures upon which surgery is to take place. Respondent failed in both these regards. He failed to perform an examination of sufficient specificity and he certainly failed to record same.

Therefore:

Allegation C.1 **is SUSTAINED.**
Allegation C.4 **is SUSTAINED.**

In Allegation C.2, Respondent is charged with a failure to identify the individual who performed and interpreted the sonogram of this patient. As set forth under Allegation B.2, while this is factually correct, it is equally correct that only one person in Respondent's practice did the sonography and only one person in Respondent's office interpreted sonography. Therefore there was no need to specifically identify the persons in the record.

Because of the manner in which the charges in this proceeding are drafted, this factual allegation must be sustained as true.

However, it will not form the basis of any finding of medical misconduct.

Therefore:

Allegation C.2 **is SUSTAINED.**

In Allegation C.3, Respondent is charged with a failure to record the size and type of laminaria used. As stated regarding Allegation B.3, there was no need to state the size and type of laminaria since this practice routinely used only one size and type. On the occassions when a different size or type was used, a notation was made. The Committee finds that this is an acceptable practice.

Because of the manner in which the charges in this proceeding are drafted, this factual allegation must be sustained as true. However, it will not form the basis of any finding of medical misconduct.

Therefore:

Allegation C.3 **is SUSTAINED.**

In Allegation C.5, Respondent is charged with a failure to record the procedure used in this abortion. As was found in Allegation B.5, the notation "L.D.E." is an accepted abbreviation for Laminaria, dilatation and evacuation. This constitutes a description of the procedure, and is thus sufficient to overcome the charge as drafted.

Therefore:

Allegation C.5 **is NOT SUSTAINED.**

In Allegation C.6, Respondent is charged with a failure to

have appropriate personnel present to properly manage this patient's anesthesia. Page 2 of exhibit I shows that Dr. Fuertes, an anesthesiologist, was present and cared for this patient.

Therefore:

Allegation C.6 **is NOT SUSTAINED.**

In Allegation C.7, Respondent is charged with a failure to monitor this patient in the recovery room. In fact however, the record of this patient's vital signs during the recovery period is in the chart and is entirely adequate.

Therefore:

Allegation C.7 **is NOT SUSTAINED.**

In Allegation C.8, Respondent is charged with a failure to record the blood loss during the procedure. Again, the patient record does contain a reference to a "small" amount of blood loss. This reference is sufficient to overcome the charge as drafted.

Therefore:

Allegation C.8 **is NOT SUSTAINED.**

In Allegation C.9, Respondent is charged with a failure to perform and record a gross examination of the uterine contents. The Committee believes Respondent did view the contents. However, he did not record his observations.

Therefore:

Allegation C.9 is SUSTAINED.

CONCLUSIONS WITH REGARD TO THE FIRST, SECOND AND THIRD SPECIFICATIONS (GROSS NEGLIGENCE)

The first three specifications ask the Committee to consider

whether Respondent committed gross negligence. While the Committee has sustained many of the factual allegations, the members find no evidence of egregious conduct. In many instances, as pointed out above, the specifications were sustained as accurate allegations but not as elements of medical misconduct. Therefore, given that many of the allegations sustained do not constitute medical misconduct and none demonstrate either a single act of egregious conduct or a pattern of acts that demonstrate eggregious conduct, no gross negligence can be found.

Accordingly:

The **First Specification is NOT SUSTAINED.**
The **Second Specification is NOT SUSTAINED.**
The **Third Specification is NOT SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE FOURTH SPECIFICATION (NEGLIGENCE ON MORE THAN ONE OCCASSION)

With regard to the allegations sustained in reference to Patient A, Patient B and Patient C, the committee finds no acts which constitute a failure to demonstrate that level of care and diligence expected of a prudent practitioner in this state. While the Committee finds that Allegations A.8, A.9, B.1, B.4, C.1 and C.4 are noteworthy, they are more related to issues of fraud and the adequacy of the patient records. The Committee does not find that any of the listed charges demonstrate that Respondent failed to act with appropriate care and diligence. Likewise, in reference to the two charges which address Respondent's failure to

examine the uterine contents (B.8 and C.9), the Committee concludes that Respondent did not demonstrate negligence so much as a failure to keep appropriate records. These charges will be addressed under the Fifth, Seventh, Eighth and Ninth Specifications.

The **Fourth Specification is NOT SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE FIFTH SPECIFICATION (FRAUD)

In the Fifth Specification, Respondent is charged with practicing medicine fraudulently. To establish fraud, the State must show that with regard to the notations about continuous oxygen by mask (Allegation A.8) and "no" blood loss (Allegation A.9):

1. Respondent made a false representation, and;
2. Respondent intended his falsehoods to deceive.

The Committee finds that both elements of fraud apply to both Allegation 8 and Allegation 9. As set forth earlier, the Committee finds that Respondent knew that there had not been continuous oxygen given by mask. While such a falsehood might be excused under all the facts and circumstances, the Committee finds that Respondent gave this information to make it appear that his efforts at resuscitation were more extensive than they were in fact. Likewise, with regard to the blood loss, the evidence clearly shows that there was significant blood loss of which

Respondent was well aware. Yet Respondent was concerned that the cause of death would be associated with blood loss. Therefore he intended to deceive future readers into believing that the blood loss was minimal.

Therefore:

The **Fifth Specification is SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE SIXTH SPECIFICATION (IMPROPER DELEGATION OF PROFESSIONAL RESPONSIBILITIES)

This charge refers the Committee to Allegation B.1. This Allegation cites Respondent for his failure to "perform and/or record the results of an adequate physical examination prior to the insertion of laminaria by a licensed practical nurse (emphasis supplied)". The essence of this allegation refers to the performance and recording of a physical examination. However, under the Sixth Specification, the State asks the Committee to consider whether it constitutes medical misconduct for a licensed practical nurse to insert laminaria, after training by, and under the general supervision of, a physician.

It was admitted by Respondent that Ms. Fournier inserted the laminaria routinely in his office. Respondent would examine the patient, give Ms. Fournier instructions, and Ms. Fournier would perform the insertion. Ms. Fournier has worked for Respondent for aproximately 22 years and has been trained by Respondent to insert laminaria. On these facts, the Committee finds no medical misconduct. The Committee concludes that by training and

experience and with appropriate supervision, there is no prohibition against delegating the insertion of laminaria to a licensed practical nurse. Clearly, Ms. Fournier had the experience, she was trained and she was supervised by Respondent. Therefore there was no improper delegation.

Therefore:

The **Sixth Specification is NOT SUSTAINED.**

CONCLUSIONS WITH REGARD TO THE SEVENTH, EIGHTH AND NINTH SPECIFICATIONS (INADEQUATE RECORDS)

In the Seventh, Eighth and Ninth Specifications, Respondent is charged with the failure to keep records which adequately reflect the evaluation and treatment of his patients based upon the Allegations regarding Patient A (Specification Seven), Patient B (Specification Eight), and Patient C (Specification Nine).

As the Committee found under each of the stated charges, the records kept by Respondent were clearly substandard in that they failed to memorialize information which was essential to him and which would be essential to successor practitioners and reviewers. As previously stated, for a record to meet accepted standards, it must enable future readers to understand the condition of the patient, the treatment rendered and the thinking of the physician at the time. While the Committee recognizes that the patients seen by Respondent were always seen for a very limited purpose with only the remotest chance of follow-up, Respondent's records were nevertheless substandard because they do not record the

clinical presentation of the organ system which Respondent was treating. The Committee does not find notations such as W.N.L. (within normal limits) to be sufficient since the universe of normal limits is too large to provide understanding of what Respondent observed. Likewise, with regard to blood loss, the committee finds references to "scant", "small" etc. to be too imprecise to meet standards. Of course, it stands to reason, that the intentional falsification of a record renders that record substandard as well because future readers must be able to rely upon the truth and accuracy of a record. For these reasons, the Committee finds Respondent's records were inadequate as charged.

Therefore:

The **Seventh Specification is SUSTAINED.**
The **Eighth Specification is SUSTAINED.**
The **Ninth Specification is SUSTAINED.**

CONCLUSIONS WITH REGARD TO PENALTY AND ORDER

This Committee has found two kinds of violations. The first involves insufficient record-keeping. The second involves fraud. It is understandable that Respondent would have limited records since his practice is so strictly limited. Nevertheless, even for the purposes of Respondent's practice, the records were substandard, as noted. This situation is easily rectified by Respondent. Were this the only shortcoming found in this proceeding, the penalty would surely be minimal. However, intentional misrepresentations in a medical record is far more

serious. The Committee can understand that in light of the tragic circumstances, the temptation to tinker with the truth is enormous. This temptation is even greater, given the controversial nature of Respondent's practice. Still, the Committee cannot countenance or forgive intentional misrepresentation of significant medical details. Against these findings must be weighed other mitigating circumstances as well. First, the record clearly shows Respondent was in no way responsible for the death of this patient. Next, there was no failure or deficiency by Respondent with regard to clinical patient care. The record also shows that Respondent has performed a significant number of late second trimester abortion procedures. He has developed appropriate office procedures to provide this highly specialized service. He has served as a referral agent for Planned Parenthood. In addition, there are very few physicians who offer the services provided by Respondent. By the penalty set forth herein, the Committee wishes to express its disapproval of serious acts while at the same time acknowledging Respondent's acceptable level of skill and practice.

Therefore, it is hereby **ORDERED:**

That the license of Respondent **Moshe Hachamovitch, M.D.** shall be **SUSPENDED** for a period of one year; and

it is further ORDERED:

That eleven months of said suspension shall be **PERMANENTLY STAYED**; and

it is further ORDERED:

That the license of Respondent shall be actually **SUSPENDED** for a period of **thirty (30) days**; and

it is further **ORDERED:**

That this **ORDER** shall take effect thirty days after service upon Respondent or his counsel by personal service or service by mail.

Dated: Syracuse, New York

18 August, **1993**

Priscilla R. Leslie

PRISCILLA R. LESLIE
Chairperson

MILTON O. C. HAYNES, M.D.
ROBERT J. O'CONNOR, M.D.

APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
MOSHE HACHAMOVITCH, M.D.	:	CHARGES

----------X

MOSHE HACHAMOVITCH, M.D., the Respondent, was authorized to practice medicine in New York State on September 20, 1966 by the issuance of license number 097500 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, 1991 to December 31, 1992 at 2100 Eastchester Road, Bronx, NY 10461.

FACTUAL ALLEGATIONS

A. On or about October 17, 1990, Patient A, (Patient A is identified in the Appendix) a 19 year-old woman in at least the second trimester of pregnancy sought medical care from Respondent at his medical office located at 2100 Eastchester Road, Bronx, N.Y. in order to terminate the pregnancy. During the initial office visit on October 17 and on October 18, a total of 20 laminaria were inserted by a licensed practical nurse for cervical dilatation. During

the night of October 18 and the early morning of October 19, Patient A's boyfriend telephoned Respondent's office to relate Patient A's symptoms of bleeding, severe pain and contractions. At or about 3:00 a.m. on October 19, Patient A's boyfriend was directed to bring Patient A to Respondent's office. Following their arrival at Respondent's office Patient A was witnessed moving her bowels involuntarily. At or about 4:05 a.m., on October 19, Respondent performed an abortion on Patient A. While at Respondent's office on October 19, Patient A went into cardiopulmonary arrest. EMS was called at or about 4:20 a.m. on October 19. Patient A was pronounced dead at 6:11 a.m.

1. Respondent included a notation of "5.6 cm - 23.3 wks" in his office record for Patient A without recording the identity of the individual who performed and interpreted a sonogram of Patient A.

2. Respondent failed to record the size and type of laminaria used for cervical dilatation.

3. Respondent failed to properly address the possibility that Patient A might require emergency medical care near her home in

Babylon, Long Island in the course of the two days between the insertion of laminaria on October 17 and the scheduled performance of an abortion on October 19.

4. Respondent made no effort to provide for more local and immediate medical care for Patient A at or about 3:05 a.m. on October 19, when he learned that Patient A was experiencing heavy bleeding, vomiting and severe cramps and that a member of his office staff had just directed Patient A's boyfriend to transport Patient A from West Babylon, Long Island to Respondent's office in the Bronx.

5. At or about 4:00 a.m. in the face of heavy bleeding, severe cramps and vomiting and involuntary bowel movements, Respondent performed an abortion and D & E on Patient A in his office.

   a. Respondent failed to arrange for Patient A to be taken to a hospital before performing any procedure on her so that her condition could be properly managed.

b. Respondent performed the abortion and D & E without proper monitoring and resuscitative equipment.

c. Respondent failed to adequately prepare the patient for foreseeable complications during the performance of the abortion.

d. Respondent failed to have a licensed physician or certified nurse anesthetist present during the surgery to manage the perioperative sedation and resuscitation of the patient.

e. Respondent inappropriately sedated Patient A.

f. Once Patient A went into cardiopulmonary arrest Respondent failed to properly attempt her resuscitation.

6. Respondent failed to describe adequately in Patient A's record the procedure used to terminate the pregnancy.

7. Respondent failed to perform and/or record the findings of a gross examination of Patient A's uterine contents immediately post-abortion.

8. Respondent intentionally represented in his record for Patient A that she received continuous oxygen by mask despite knowing that this was untrue.

9. Respondent intentionally represented in his record that Patient A had no bleeding at all despite knowing that this was untrue.

10. On October 19, Respondent failed to provide EMS personnel with a complete and accurate account of what had taken place in his office so that treatment could be appropriately and expeditiously rendered to Patient A.

B. On or about November 2, 1988, Patient B, a 20 year-old female at or about 19.9 weeks gestation, sought medical care at Respondent's medical office located at 98-76 Queens Blvd., Rego Park, New York, in order to terminate her pregnancy. A total of 10 laminaria were inserted prior to evacuation of the uterine contents for cervical dilitation. Respondent

evacuated Patient B's uterine contents at his medical office located at 2100 Eastchester Road, Bronx, New York.

1. Respondent failed to perform and/or record the results of an adequate physical examination of Patient B prior to the insertion of laminaria by a licensed practical nurse.

2. Respondent included a notation of "4.5 cm = 19.9 wks" in his office record for Patient B without recording the identity of the individual who performed and interpreted a sonogram of Patient B.

3. Respondent failed to record the size and type of laminaria used for cervical dilatation.

4. Following the insertion of laminaria Respondent failed to perform and/or record the results of an adequate physical examination before evacuating Patient B's uterine contents.

5. Respondent failed to describe in Patient B's record the procedure used to terminate the pregnancy.

6. Respondent failed to monitor and/or record the results of monitoring, or arrange to have a qualiified health care professional monitor and/or record the results of monitoring of Patient B's vital signs following her arrival in the recovery room until her discharge from Respondent's office.

7. Respondent failed to record the amount of blood lost by Patient B during the abortion.

8. Respondent failed to perform and/or record the findings of a gross examination of Patient B's uterine contents immediately post-abortion.

C. On or about November 2, 1988 Patient C, a 20 year-old female at or about 14.6 weeks gestation, sought medical care from Respondent at his office located at 98-76 Queens Blvd., Rego Park, New York, in order to terminate her pregnancy. A total of 3 laminaria were inserted prior to the evacuation of uterine contents for cervical dilatation. Respondent evacuated Patient C's uterine contents at his medical office located at 2100 Eastchester Road, Bronx, New York.

1. Respondent failed to perform and/or record the results of an adequate physical examination of Patient C prior to the insertion of laminaria.

2. Respondent included a notation of "2.9 = 14.6" in his office record for Patient C without recording the identity of the individual who performed and interpreted a sonogram of Patient C.

3. Respondent failed to record the size and type of laminaria used for cervical dilitation.

4. Following the insertion of laminaria Respondent failed to perform and/or record the results of an adequate physical examination before evacuating Patient C's uterine contents.

5. Respondent failed to describe in Patient C's record the procedure used to terminate the pregnancy.

6. Respondent failed to have a licensed physician or certified nurse anesthetist present perioperatively to properly manage the administration of anesthesia to Patient C.

7. Respondent failed to monitor and/or record the results of the monitoring or have a qualified health care professional monitor and/or record the results of the monitoring of Patient C upon her arrival to the recovery room until her discharge.

8. Respondent failed to record the amount of blood lost by Patient C during the abortion.

9. Respondent failed to perform and/or record the findings of a gross examination of Patient C's uterine contents immediately post-abortion.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law sec. 6530(4) (McKinney Supp. 1992), in that Petitioner charges:

1. The facts in Paragraph A and all the subparagraphs contained therein.

2. The facts in Paragraph B and all the subparagraphs contained therein.

3. The facts in Paragraph C and all the subparagraphs contained therein.

FOURTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law sec. 6530(3)(McKinney Supp 1992), in that Petitioner charges two or more of the following:

4. The facts in paragraphs A and A.1., A.2.,A.3, A.4, A.5(a), A.5(b), A.5(c), A.5(d), A.5(e), A.5(f), A.6, A.7; A.8, A.9, A.10; B and B.1,B.2, B.3, B.4, B.5, B.6, B.7, B.8; and/or C and C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9.

FIFTH SPECIFICATION

FRAUD

Respondent is charged with professional misconduct by reason of practicing medicine fraudulently within the meaning of N.Y. Educ. Law sec. 6530(2) (McKinney Supp. 1992) in that Petitioner charges:

5. The facts in Paragraphs A and A.8 and A.9.

SIXTH SPECIFICATION

IMPROPER DELEGATION OF PROFESSIONAL RESPONSIBILITIES

Respondent is charged with professional misconduct by reason of delegating orofessional responsibilities to a person when he knew or had reason to know that such person was not qualified by training, by experience, or by licensure, to perform them within the meaning of N.Y. Educ. Law sec. 6530(25) (McKinney Supp. 1992) in that Petitioner charges:

6. The facts in Paragraphs B and B.1.

SEVENTH THROUGH NINTH SPECIFICATIONS

INADEQUATE RECORDS

Respondent is charged with committing professional misconduct by reason of failing to maintain a record for Patient A which accurately reflects the evaluation and treatment

of Patient A, within the meaning of N.Y. Educ. Law sec. 6530(32) (McKinney Supp. 1992) in that Petitioner charges:

7. The facts in Paragraphs A and A.1, A.2, A.6, A.7, A.8, and A.9.

8. The facts in Paragraphs B and B.1, B.2, B.3, B.4, B.5, B.6, B.7 and B.8.

9. The facts in Paragraphs C and C.1, C.2, C.3, C.4, C.5, C.7, C.8. and C.9.

DATED: New York, New York
September 16, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct