DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

October 20, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Neils Helth Lauersen, M.D.
REDACTED

Aaronson, Rappaport, Feinstein &
& Deutsch, LLP
Robert S. Deutsch, Esq.
757 Third Avenue
New York, New York 10017

Paul Stein, Esq.
NYS Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001

RE: In the Matter of Neils Helth Lauersen, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-286) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

HEARING COMMITTEE'S DETERMINATION AND ORDER

BPMC – 00-286

The undersigned Hearing Committee consisting of **MICHAEL R. GOLDING, M.D.** (Chairperson), **REVEREND THOMAS KORNMEYER,** and **FRED LEVINSON, M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct, and served as the Hearing Committee in this matter. **MARY NOE, ESQ., ADMINISTRATIVE LAW JUDGE**, served as the 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 **NIELS HELTH LAUERSEN 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.

SUMMARY OF PROCEEDINGS

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Pre-Hearing Conferences:	May 11, 2000,
Hearing dates:	May 18, 2000 June 5, 2000 July 17 - 28, 2000 August 18, 2000
Dates of Deliberation:	September 11, 2000 September 22, 2000 September 28, 2000
Petitioner appeared by:	NYS Department of Health By: Paul Stein, Esq., Associate Counsel
Respondent appeared by:	Aaronson, Rappaport Feinstein & Deutsch. 757 Third Avenue New York, New York 10017 By: Robert Deutsch, Esq.

WITNESSES

For the Department:	Patient B Patient B's husband Dr. Emanuel A. Friedman Michael Y. Divon, M.D. Nurse LHHDRN Joseph Finkelstein, M.D. Peter Kalina, M.D. Lauretta Jaysura, M.D. Debra Tangarone Maria DeLuca-Pronzo Mary McLeod Robert Neuwirth, M.D. Thomas Hotz Michael Tepedino M.D.

Joseph M. Jabbour, M.D.
Lisa Ann Janis
Oxford Health Plans Nurse Reviewer

For the Respondent:

Niels Helth Lauersen, M.D.
Edmund Funai, M.D.
Victor Reyniak, MD.
Reginald Puckett, M.D.
Patient E
Patient E's husband
Patient F
Patient D
Denise Bock
Wilfred Reguero, M.D.

SIGNIFICANT LEGAL RULINGS

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. 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.

FINDINGS OF FACT

1. NIELS HELTH LAUERSEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969 by the issuance of license number 104954 by the New York State Education Department. (Petitioner's Ex. 50)

2. Respondent was served with Notice of Hearing, Statement of Charges, and Summary of Department of Health Hearing Rules for the instant case on April 24, 2000. (Petitioner's Ex. 1)

FINDINGS OF FACT AS TO FRAUD

3. Mary McLeod, Supervising Investigator for the New York State Department of Health, Office of Professional Medical Conduct testified that the Respondent came into her office located at 5 Penn Plaza, New York, New York for two investigative interviews on April 20, 1995 and May 18, 1995. (T. 1284)

4. Respondent testified that he brought two lawyers, William Kuntsler and Robert Deutsch to the interviews at the Health Department. (T. 3448)

AETNA/US HEALTHCARE

5. On or about October 21, 1996, Respondent executed, certified the truth of, and submitted a Confidential Information form for recertification to Aetna/US Healthcare, P.O. Box 150428, Hartford, Connecticut 06115. (P's Ex. 22 at 133-134, T. 1271-1272)

6. In this application: Question 8 asks "Are you presently under investigation by any state licensing board or federal agency?", Respondent, with intent to deceive, answered "No" although he knew this statement to be false. (P's Ex. 22 at 133)

7. In this application: Question 9 asks "Have you been investigated by any state licensing board or federal agency during the past five years?", Respondent, with intent to deceive, answered "No" although he knew this statement to be false. (P.'s Ex. 22 at 133)

OXFORD HEALTH PLAN

8. On or about April 24, 1998, Respondent executed, affirmed the truth of, and submitted a Recredentialing Addendum to Oxford Health Plans, Westchester One, 44 South Broadway, White Plains, New York 10601 (Ex. 23B p. 9)

9. In this application, Respondent, intentionally, with intent to deceive, initialed the statement, "I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payer, Medicare, or Medicaid, or governmental licensing or other authority.", although Respondent knew this statement to be false. (P's Ex. 23B at 9)

PRIOR PROCEEDINGS

10. In September 1998, the Respondent was served with the prior Statement of Charges from NYS Department of Health (P. Ex. 52)

11. The Respondent attended hearings on that case on October 8, 1998 and November 5,15, 1998.(T. 3527, 8)

LENOX HILL HOSPITAL

12. Dr. Michael Divon, Director of OB-GYN at Lenox Hill Hospital, testified that on December 1st, 1998 the Respondent's privileges were summarily suspended (T. 283) and that he personally hand delivered a letter to the Respondent informing him of the suspension. (T. 284. P. Ex. 38)

13. On December 9,1998, Respondent wrote a letter to Lenox Hill Hospital: "I have decided to resign my medical staff membership and clinical privileges with Lenox Hill Hospital (the "Hospital") today...." (Ex.28b)

CONTINUUM HEALTH PARTNERS, INC.

14. On or about December 10, 1998, Respondent executed, affirmed the truth of, and submitted an Application for Medical Staff Appointments of Continuum Health Partners, Inc. for appointment to Beth Israel Medical Center and to St. Luck's-Roosevelt Hospital Center, both in New York City. (P's Ex. 24 at 6-17)

15. In this application: Question 9. 3. Asks "Are any professional misconduct proceedings pending against you in any state or other jurisdiction?" Respondent, with intent to deceive, answered "No" although he knew this statement to be false. (P's Ex. 24 at 13)

16. In this application, Question 9. 7. asks "Have your medical/dental staff appointment/employment status or clinical privileges in any hospital or health care facility ever been denied, revoked, suspended, restricted, reduced, limited, placed on probation, not renewed, voluntarily relinquished, discontinued or otherwise changed, including any leaves of absence?" Respondent, with intent to deceive, answered "No" although he knew this statement to be false. (P's Ex. 24 at 13)

ST. VINCENT'S HOSPITAL AND MEDICAL CENTER

17. On or about December 21, 1998, Respondent executed, verified the truth of, and submitted an Application for Appointment to the Medical/Dental/Ancillary Staff at Saint Vincent's Hospital and Medical Center, 153 West 11th Street, New York, N.Y. 11111. (P's Ex. 25 at 28-32)

18. In this application, Respondent, listed Lenox Hill Hospital under the section "ALL HOSPITAL APPOINTMENT". As to question: "V. Was any employment, privilege or practice related to *ANY* Hospital and Faculty Appointments discontinued, *or have your clinical privileges*

at any listed facilities been limited, reduced or lost? (italics and underlining in original). Respondent, with intent to deceive, answered "No" although he knew this statement to be false. (P's Ex. 25 at 30)

19. In this application, under "Professional Conduct History", question "IX. A. Have you ever, during your professional career, been the subject of a disciplinary proceeding in this state or any other state?", Respondent, with intent to deceive answered "No" although he knew this statement to be false. (P's Ex. 25 at 31)

20. At the Saint Vincent's Hospital Credentials Committee meeting of February 5, 1999, whose purpose was in part to clarify the details of Respondent's loss of privileges and resignation from Lenox Hill Hospital, Respondent informed the Committee that to his knowledge he had not been suspended from Lenox Hill Hospital and that he still had privileges there at the time of his resignation. (P's Ex. 25B, T. 1392-1393)

21. Respondent, in his letter of February 6, 1999 to Godfrey Burns, M.D., the Chairman of the Saint Vincent's Hospital Credentials Committee, falsely characterized the actual summary suspension as "possible pending disciplinary proceedings". (P's Ex. 25 at 38)

SAINT VINCENT'S PHO

22. On or about March 16, 1999, Respondent executed and submitted a Membership Application for participation in Saint Vincent's PHO, 130 West 12th Street, New York, NY 10011. (P's Ex. 26 at 8-30, T. 1242)

23. On page 9 of this application, Respondent, after listing Lenox Hill Hospital under the section "Discontinued Hospital Affiliations", intentionally, with intent to deceive, wrote under

the heading "Reason for Terminating Privileges" the words "Patients Requests", although Respondent knew this statement to be false and/or misleading. (P's Ex. 26 at 14, T. 1243-1244)

24. Department's witness, Assistant Director of the PHO, testified that on or about April 13, 1999, she called the Respondent regarding his answer "Patients Requests" and the Respondent told her that "...he left Lenox Hill Hospital at his patient's requests, and that he had left over disagreements with the new chairperson of OB/GYN." (T. 1244, 1245-6)

25. In a letter dated April 14, 1999 from the Respondent to "To Whom It May Concern," the Respondent stated the following: "This is to state that I, Niels H. Lauersen, MD as well as other physicians, have left Lenox Hill Hospital because of disagreements with the direction the department was taking after a new Chairman was appointed." (P's Ex. 26 at 2)

OXFORD HEALTH PLANS

26. Department's witness, Nurse Reviewer (identified in Appendix A) for Oxford Health Plans, testified that on or about April 7, 1999, she spoke with Respondent by telephone as part of her investigation of Respondent's care and treatment of Patient A. (P's Ex. 23A, Tr. 1426-1428)

27. The Nurse testified that during that telephone conversation with the Respondent, he stated that he resigned from the Lenox Hill Hospital. (T. 1426-1428)

PATIENT A

28. On or about April 1, 1998 through December 2, 1998, Respondent provided obstetrical care for Patient A in his New York City offices and at Lenox Hill Hospital, New York City.

29. On or about November 28, 1998, Patient A was admitted to Lenox Hill Hospital in labor. (Ex. 10 p. 39)

30. Dr. Friedman, Department's expert witness, testified that at 10:13 p.m. on November 28, 1998, Patient A's fetus' heart rate decreased and lasted for a prolonged period of time necessitating an immediate delivery.(T. 1744, 1745)

31. The Nurse (identified as LHHDRN in transcript), who was present at the delivery of Patient's A's baby, testified that according to her note in the labor flow sheet (P. Ex. 10 p. 21) the first application of mid-forceps was attempted at 10:13 p.m. (T. 345, 346)

32. Respondent testified that the first forceps application was "...not placed correctly." (T. 3340)

33. The Nurse, LHHDRN, testified that on both the first and second forceps application, the Respondent "...would wait for a contraction and when the patient pushes and [the Respondent would] pull on the forceps at the same time.", and the Respondent did that three times. (T. 349)

34. Dr. Friedman testified that based on the labor notes (Ex. 10 p. 39); the Respondent recognized the forceps were incorrectly applied yet he tried to rotate the fetus' head. (T. 1651)

35. Dr. Reguero, Respondent's expert witness, testified that when using forceps, if you have a bad application and you try to turn them but can't, you must reapply them. (T. 2603)

36. Dr. Friedman testified "Misapplication requires correction. One cannot apply traction. One cannot do rotation until the application is exactly correct, of the fetal head." (T. 1780)

37. The Nurse (LHHDRN) testified that the Respondent "...attempted the second application of forceps."(T. 350) and pulled three times. (T. 350)

38. The Nurse, LHHDRN, testified that "The bed for some reason was moving forward towards him [Respondent] while he was doing the push - the pulling." She also stated the bed did not move when the Respondent was not pulling on the forceps (T. 425) and that the bed was locked. (T. 355)

39. Dr. Friedman testified that there were only two possibilities to explain why the bed moved; "One is that the lock wasn't functioning, that the bed was not truly locked, and the other is that the obstetrician was using considerably excessive traction force pulling on the head and thereby moving the bed." (T. 1811)

40. Dr. Kalina, a neuroradiologist, testified that he basically agreed with the Lenox Hill Hospital CT scan regarding two fractures on the baby's head.(T. 834, Ex. 11 p. 139)

41. Dr. Kalina testified that he had a difference with the report of the Lenox Hill Hospital CT scan (T. 807) as to the location of one fracture located on the right frontotemporal region and the other on the left parietal region of the baby's head. (T. 834)

42. Dr. Kalina testified that there was soft tissue injury where the fractures were located. (T. 842)

43. Petitioner's Exhibit 11 page 130 is the Lenox Hill Hospital Department of Radiology Report dated December 2, 1998. This represents a CT head scan report of Patient A's baby. The report states, "There is evidence of subcutaneous hemorrhage and edema involving the right temporal region and occipital region. Skull fractures are noted involving the temporal bones bilaterally...There are extensive areas of hemorrhagic contusion involving the cerebral hemispheres bilaterally...An area consistent with cerebral ischemia is seen involving the left parieto-occipital region."

44. Dr. Kalina testified that the injuries were caused by the use of forceps or vacuum extraction where the bone is in direct contact with the forceps to cause the swelling and fracture. (T. 843)

45. Dr. Friedman testified that the proper position of forceps is to anchor on to the zygomas, the cheek process, which is attached to the base of the skull. (T. 1646-7)

46. Dr. Friedman testified that what is described in the Lenox Hill Hospital CT scan (P. Ex. 11 p. 139) is called a brow-mastoid application which is condemned because it causes irreparable damage to the brain. (T. 1648-9)

47. Dr. Friedman testified that to pull or attempt to rotate the head while in that position [brow-mastoid] is below the standard of care and unacceptable because of the terrible damage that will occur as a consequence. (T. 1650)

48. Dr. Friedman testified that the Respondent used excessive, inappropriate, unskillful, inept application of forceps and their use in rotation and traction. (T. 1659)

49. The Nurse (LHHDRN) testified that midforceps deliveries are not done at Lenox Hill Hospital. (T. 436) She told the Respondent that she had never had such a bad delivery in all the ten years she worked at the Lenox Hill Hospital or in the previous ten years as labor and delivery room nurse in the Phillipines. (T. 360)

50. The Nurse (LHHDRN) testified that approximately two hours after the delivery, (T. 421), the Respondent, while looking at the monitor strips, pointed to the time he wanted her to write the first application of forceps, which was a different time than the actual time of the application. (T. 359-340)

51. Dr. Friedman testified that Respondent failed to keep an adequate record for Patient A, including failure to keep complete notes of the events that took place, particularly with regard to the complicated features of the delivery such as failure to record station, the degree of molding, the rotation, the position of the head in the pelvis, the overlapping of the cranial bones, the degree of caput, that is the thickening, the edema within the scalp itself, the relationship between the head and the pelvis. (P. Ex. 10, T. 1659 - 1660)

PATIENT B

52. Patient B testified that she was a patient of the Respondent from mid 1980 up until 1998. (T. 40 - 43)

53. Patient B testified that the Respondent performed approximately 13 laparoscopies for endometriosis (T. 43) approximately one every year. (T. 45)

54. Dr. Tepedino, Medical Coordinator for the Office of Professional Medical Conduct, Department of Health, testified that during an investigative interview with the Respondent on July 26, 1999, he told him that he had performed two laparoscopies and possibly a third ten years later. (T. 239)

55. Respondent testified he did not recall how many laparoscopies he had performed on Patient B. (T. 3205)

56. Patient B testified that she had insurance claims for the past six laparoscopies performed by the Respondent. (T. 209, 217, P. Ex. 21A) Patient B testified that insurance claims records are only kept for seven years. (T. 141)

57. Patient B testified that she had no physical complaints and the only reason she had the original laparoscopy and repeat laparoscopies until the early 1990's were because the Respondent told her she had endometriosis and the condition had returned each year. (T. 43-44, 145, 148) Patient B testified that in the early 1990's she first developed pelvic pain; (T. 44, 149) but never suffered from heavy menstrual bleeding. (T. 71, 157)

58. Dr. Friedman testified that based on the Respondent's Operative Report dated 5/9/97 (Ex.4 p. 7) the Respondent recorded a 5 by 5 centimeter ovarian cyst with a large endometrioma. (T. 1570, 1205)

59. Dr. Friedman testified that the pathology report for this procedure dated May 15, 1997, indicates that what was removed was a normal structure in the ovary that did not require surgery. (T. 1577, Ex. 4 p. 12)

60. In a second surgical procedure on Patient B by the Respondent, Dr. Friedman testified that the Respondent's operative report dated May 11, 1998 states that a left ovarian cyst of approximately five centimeters in diameter was excised, right ovarian cystectomy performed, and endometriosis found and vaporized. (T. 1205, Ex. 4 p. 19)

61. Dr. Friedman testified that a biopsy should have been obtained to objectively document endometriosis. (T. 1216)

62. Dr. Friedman testified that cystectomy means removal of the cyst intact. (T. 1220)

63. Dr. Friedman testified that the pathology report dated May 13, 1998, showed only fragments of a corpus luteum, a normal physiological structure. Endometriosis was not documented. (T. 1206, 1215 Ex. 4 p. 23)

64. Patient B testified that the Respondent told her that her medical records were unavailable and that he was forced to give them to the Department of Health.

65. Dr. Tepedino testified that the Respondent told him he had no records because Patient B was not returning as a patient. (T. 244-5)

66. The Respondent testified that he told Patient B her records were lost in a flood. (T. 3229)

67. Patient B testified that she saw her record at the Respondent's office in May 1998. (T. 83)

68. Petitioner's Exhibit 29, a letter from the Respondent to Patient B dated April 23, 1999 states: "Please fill out the enclosed history sheet as of January 1997, not necessarily what doctors, but indicating your previous surgeries and cases for endometriosis. Also indicate how the pain reoccurred with pressure, bleeding and cramping."

69. Patient B testified that during a telephone conversation with the Respondent in April 1999 the Respondent asked her to fill out a new medical history form, date it back to 1997, (T. 63) and he suggested that she say that the surgeries were helpful and the medications were ineffective. (T. 67, 179)

70. Patient B testified that part of the information the Respondent requested she write on the medical history form was inaccurate. (T. 68, 179)

71. Patient B testified that she agreed to lie for him on the medical forms because, although she was angry with him, she found out he was in a little bit of trouble and she wanted to help. (T. 176, 206, 207, 218)

72. Dr. Friedman testified that the Respondent failed to keep adequate records for Patient B in that a large portion of the record is missing, and that the existing record does not contain consistent recordings of the patient's symptoms or verifiable recordings of the findings at examinations and procedures. (T. 1213)

73. Petitioner's Exhibit 31, a letter from the Respondent to Patient B dated September 10, 1999 states: "I do not believe that you should talk to any one in the Health Department or anywhere without having legal advice."

PATIENT C

74. Patient C was a patient of the Respondent from March 10, 1987 through on or about October 22, 1992. (P. Ex. 5, 14 T. 1080)

75. When Patient C went to the Respondent on her first office visit dated March 10, 1987 she was taking the drug Danocrine. (Ex. 5 p. 1)

76. Dr. Friedman testified that based on the Respondent's office records for Patient C, the Respondent failed to perform a pregnancy test before continuing the prescription of Danocrine. (Ex. 5, T. 1081,2) The patient was pregnant at the time. (Ex. 5)

77. Dr. Friedman testified that the Respondent's care of Patient B as it related to prescribing Danocrine was a departure from the standard of care because Danocrine is contraindicated in pregnancy. (T. 1082,3)

78. Dr. Friedman testified that based on the Respondent's office records for Patient C, the Respondent failed to screen the patient for gestational diabetes while she was pregnant. (T. 1097-8, Ex. 5 p. 33)

79. Dr. Friedman testified that the Respondent used excessive force in the delivery of Patient C's baby in order to deliver the baby's shoulders. (T. 1106, 7)

80. Dr. Friedman testified that the baby's injury of Erb's palsy is a result of Respondent's excessive traction pulling on the brachial plexus. (T. 1106,7,8, 1149)

81. Dr. Friedman testified that based on the Respondent's note in the hospital record (Ex. 14 p. 26) the Respondent applied fundal pressure on Patient C. (T. 1112)

82. Dr. Friedman testified that fundal pressure is contraindicated in the presence of shoulder dystocia. (T. 11551)

83. Dr. Friedman testified that the Respondent failed to keep an accurate medical record for Patient C. (T. 1113)

PATIENT D

84. Patient D was a patient of the Respondent from May 1, 1997 through March 25, 1999. (Ex. 6, 17)

85. Dr. Friedman testified that Respondent's office record states that Patient D's uterus is enlarged. (T. 1019)

86. Dr. Friedman testified that based on the Respondent's operative report dated October 8, 1997, the Respondent found a right ovarian cyst of 4 by 4 centimeters, a "large" posterior fibroid tumor in the posterior aspect of the uterus about 3 by 3 centimeters, nodularity around the uterosacaral ligament due to endometriosis, and endometriosis on the posterior aspect of the uterus. (T. 1013,4,5 Ex. 6 p. 23- 25)

87. Dr. Friedman testified that based on the pathology report, there is no evidence of malignancy or endometriosis. (T. 1017, Ex. 6 p. 29) He states that the pathology report indicates there was a small subserosal nodule of 2.5 centimeters in diameter, that is one small fibroid attached to the outside uterus, and that the uterine size is quite normal. (T. 1020,1; Ex. 6 p. 44)

88. Dr. Friedman testified that a prudent physician would have submitted a specimen of endometriosis to demonstrate objectively that that is indeed what the patient had. (T. 1017, 1018)

89. Petitioner's Exhibit 17, Lenox Hill Hospital record for Patient C, page 35 is the Operative Report dated January 26, 1998 signed by the Respondent states under "Operation" "6. TOTAL ABDOMINAL HYSTERECTOMY".

90. Dr. Friedman testified that based on is the Pathology Report dated January 28, 1998 stating no cervix is identified, this operation was a supracervical hysterectomy and not a total abdominal hysterectomy. (T. 1032, Ex. 17 p. 44)

91. Dr. Friedman testified that the Respondent failed to diagnose and treat Patient D because he misrepresented the size of the uterus, size of the fibroids, the size of the ovarian cyst and undertook an unnecessary hysterectomy. (T. 1037, 1060; Ex. 17 p. 44)

92. Dr. Friedman testified that the Respondent failed to maintain an adequate and accurate medical record for Patient D because a record is intended to be an accurate, honest and a complete representation of what occurred and what was seen. (T. 1028, 9, Ex. 17)

PATIENT E

93. Patient E was a patient of the Respondent from February 25, 1997 to February 27, 1998 (T. 876, Ex. 7)

94. Dr. Friedman testified that the Respondent failed to objectively corroborate Patient E's complaints of heavy menstrual and intermenstrual bleeding in light of the patient's seven prior laparoscopies and relatively normal hemoglobin and hematocrit. (T. 977, 979, Ex. 7)

95. Dr. Friedman testified that the Respondent improperly performed a hysterectomy on this patient without medical indication to do so on February 2, 1998. (T. 881) He stated that the only physical finding the Respondent found was an enlarged uterus. (T. 881, 891, 2; Ex. 7 p.21)

96. Dr. Friedman testified that the Respondent did not correctly record Patient E's symptoms in the hospital record for her admission of February 1998. (T. 904, 5)

97. Dr. Friedman testified that there is inconsistent information regarding Patient E's symptoms in the hospital record versus the Respondent's records. (T. 906)

98. Dr. Friedman testified that the Respondent did not correctly record the size and condition of Patient E's uterus in his preoperative office record notes of February 2, 1998. (T. 907, 908; Ex. 7, 18)

99. In a prior procedure dated March 12, 1997; Petitioner's Exhibit 7 page 8, Respondent's operative record states that the Respondent did the following procedure: "...examination under anesthesia, fractional dilatation and curettage, exploratory laparoscopy, lysis of pelvic adhesions,

second puncture laparoscopy, right ovarian cystectomy, laser vaporization of pelvic endometriosis, tubal perfusion and pelvic lavage,." (Ex. 7 p. 8)

100. Dr. Friedman testified that if the Respondent had vaporized parts of the cyst, the operative report contradicts that statement and it is a failure of the standard of care to perform a vaporization without indicating same on the operative report. (T. 990, 991)

101. Dr. Friedman testified that a prudent physician would obtain a biopsy to prove objectively that what the physician saw was truly endometriosis and not another lesion that resembled endometriosis to the naked eye. (T. 997)

102. Dr. Friedman testified that the pathology report dated March 17, 1997 fails to substantiate any of the findings in the Respondent's operative report. (Ex. 7 p. 12, T. 898, 899) and the Respondent removed a tiny follicular cyst, which is a normal structure in the ovary. (T. 897)

103. Dr. Friedman testified that the surgery of March 12, 1997 performed by the Respondent was not medically indicated. (T. 897, 898, 899)

104. Dr. Friedman testified that the Respondent medical records for Patient E failed to meet the standard of care. (T. 905, 1002, 3)

PATIENT F

105. Patient F was a patient of the Respondent from January 30, 1998 through May 7, 1999. (T. 618, Ex. 8, Ex. 19)

106. Dr. Friedman testified that the Respondent inappropriately attributed Patient F's pain to endometriosis and adhesions. (T. 622)

107. Dr. Friedman testified that based on the Patient's prior procedures where endometriosis was minimally present, diminishing the probability of her pain due to endometriosis, plus the

Patient's prior presacral neurectomy (severing sensory pelvic nerves) indicated that the Respondent had no indication that the Patient's pain was due to endometriosis. (T. 622, 3)

108. Dr. Friedman testified that the Respondent's surgery on Patient F was a departure of the standard of care considering the Patient's long history including multiple surgical procedures and the failure of those procedures to ameliorate her pain. (T. 627,8, 633,4)

109. Dr. Friedman testified that there was no medical indication for the Respondent to perform surgery on Patient F. on March 9, 1998. (T. 619, 627, Ex. 8 p. 48, Ex. 19 p. 40)

110. Dr. Friedman testified that Respondent removed a corpus luteum, which is a normal structure in the ovary, and thereby did surgery on Patient F without adequate medical indication. (T. 632, 3)

111. Dr. Friedman testified that the pathology report from the surgery performed by the Respondent on Patient F failed to confirm the presence of endometriosis. (T. 633, Ex. 19 p. 40)

112. Dr. Reguero testified that when you have a patient with endometriosis, you are not sure "... whether that is endometria, whether it is an endometriotic implant..." A physician should make sure you get some biopsies of it and send it to pathology. (T. 3043, 3063)

113. Dr. Friedman testified that the Respondent failed to keep adequate records for Patient F because there are discrepancies between what is described in the procedure and what actually appeared in the pathology report pertaining to the tissue he removed at surgery. (T.633, 4)

PATIENT G

114. Patient G was a patient of the Respondent from March 10, 1998 through May 13, 1998. (Ex. 20; T. 561)

115. Petitioner's Exhibit 20 p. 29 Respondent's operative report indicates that on March 30, 1998 the Respondent performed myomectomies removing fibroids, right ovarian cystectomy and suspended the uterus. (Ex. 20 p.29)

116. Dr. Friedman testified that cystectomy means removal of the entire cyst intact. (T. 608)

117. Dr. Friedman testified that the Respondent's Operative Report inaccurately described the tissue he removed at surgery which he labeled "...right ovarian cyst four centimeters..." (Ex. 20 p. 29, T. 566) when the pathology report identifies the tissue as "fragment of ovary with corpus luteum..."(Ex. 20 p. 37; T. 567)

118. Dr. Friedman testified that removal of a normal structure, such as a corpus luteum cyst, is inappropriate. (T. 568, 602)

119. Dr. Friedman testified that the Respondent incorrectly recorded the size of Patient G's uterus in the operative report and in his office records. (T. 572)

120. Dr. Friedman testified that the Respondent failed to keep an adequate medical record for Patient G because the Respondent's findings were not adequately recorded, nor accurately recorded, not fully recorded, and the presenting symptoms were also not properly and accurately recorded. (T. 573)

DISCUSSION

The first hearing date was May 18th and the last was August 18th. There were thirteen hearing days and seventeen witnesses for the Department and ten witnesses for the Respondent. The Respondent testified for several hours on the following days: Friday, July 21st, Monday, July 24th, Tuesday, July 25th, Wednesday, July 26th, and for 6 hours on Friday July 28th and Friday, August 18th. The Panel listened carefully to each witness' testimony and examined each document in evidence thoroughly and with an open mind.

The Panel identified two main issues as to the statement of charges, one in fraud and the other in negligence. The Panel found that the documentary evidence supporting the charge of fraud to be compelling and the Respondent's explanations to be implausible. The Respondent has been licensed to practice medicine in New York State for approximately 31 years.

LENOX HILL HOSPITAL

The Panel found Dr. Divon's testimony to be credible nor was he contradicted by Respondent's testimony.(T. 3489) Dr. Divon, Director of OB-GYN at Lenox Hill Hospital, testified that on December 1, 1998 he, along with the Head of Security for Lenox Hill Hospital went to the Respondent's office, personally handed him the summary suspension letter and told the Respondent "...to come up with some form of a coverage because he may have had patients in the building in the hospital at that moment, and if that was not the case, then he could have at any moment had a patient walk in....So I told him that he needs to make arrangements, and that I had made some arrangements to take care of his patients until he comes up with his own arrangement."(T. 484) The Respondent testified that he forwarded the letter to his attorneys. (T. 3589) On December 9, 1998 the Respondent sent a letter of resignation to Lenox Hill Hospital.

(Ex. 28b) Repeatedly the Respondent answered "no" to questions on various applications as to whether his privileges were suspended by a hospital.(Ex. 24, 25, 26, T. 1426 - 14 28) At the hearing, when the Respondent was asked the question: "Is it your testimony that during the period of time that Dr. Puckett covered your patients that you were or were not suspended by Lenox Hill Hospital?"(T. 3490) The Respondent answered: "I don't know, Mr. Stein. It was a legal thing and I believe it was summary suspended. You are not suspended until the hearing had been done completely. You need the hearing and since I did not elect to do it, I elected to resign, for me it was, it was a resignation."(T. 3490) When Respondent was confronted with specific applications he completed and was asked to address his answers to whether he was ever suspended from any hospital, the Respondent testified that his secretary filled out the application, checked the boxes (T.3518, 3524,5) and he did not read it (T. 3520); that the box was checked without his knowledge by some person outside his office (T. 3541, 3545, 3557,9); that he left the answer blank (T. 3554) because leaving Lenox Hill Hospital was a complicated act (T. 3552); and that he answered that he left Lenox Hill at the "Patients Requests" because the patients wanted to start a class action suit. (T. 3574, 3577)

Respondent, in his letter of February 6, 1999 to Godfrey Burns, M.D., the Chairman of the Saint Vincent's Hospital Credentials Committee, characterized the summary suspension from Lenox Hill as "possible pending disciplinary proceedings". (P's Ex. 25 at 38)

When the Respondent was asked the question, "Did you think it would have been important for you to tell Dr. Neuwirth during this meeting that you had been suspended from Lenox Hill Hospital?"(T.3537) The Respondent answered, "I don't know, Mr. Stein. He was not interested in a long meeting. He wanted me to get an application to him and go through the processes."(T. 3537)

The Panel found Respondent's inability to understand the concept of summary suspension (T. 3488, 3489) when he was personally confronted by the Director of OB-GYN in the presence of head of security at Lenox Hill Hospital at his office instructing him that he is not permitted to treat patients at the hospital, including those patients that were presently in the hospital, incredible.

DEPARTMENT OF HEALTH PROCEEDINGS

The Respondent met with Thomas Hotz, Medical Conduct Investigator on April and May 1995. Repeatedly the Respondent answered "no" to questions of whether he was investigated by the Department of Health. (Ex.s. 22, 24, 25) The Respondent testified that he thought "...it is a meeting like all active doctors go through...."(T. 3473) yet he felt the necessity to bring two lawyers, Robert Deutsch and William Kuntsler. (T. 3460-3566) The Respondent testified that the now deceased William Kuntsler, was present at the investigation to "... see what this is about...."(T. 3460) The Respondent testified that he went to say hello to Mr. Kuntsler in his car while he was double parked outside his office, and Mr. Kuntsler told him that if you don't hear anything for three months, this case is dropped. (T. 3440, 3443)

Dr. Michael Tepedino, Medical Coordinator for the Office of Professional Medical Conduct, Department of Health testified that he interviewed the Respondent on July 26, 1998. (T. 230,1)

In September 1998, the Respondent was served with the first Statement of Charges. The Respondent appeared with his attorney for the hearing on that case on October 8, November 5th and November 15th, 1998. (T. 3547)

On December 21, 1998 Respondent answered "no" to the question of whether he had been the subject of a disciplinary proceeding in this state or any other state. (P's Ex. 25 at 31)

The Respondent testified that on the application dated December 10, 1998 to Roosevelt Hospital (Ex. 24 p. 9) he made an error by checking off "no" to the question regarding misconduct proceedings pending against him. (T. 3520, 3521) However, in the St. Vincent's application (Ex. 25 p. 31) dated December 21, 1998, the Respondent testified that he answered no to whether he was the subject of disciplinary proceedings in this state because "The way I read it is that that means a complete procedure."(T. 3561)

When the Respondent was asked the question "...did you read that affirmation as to the truth of what was above your signature?"(T. 3532) The Respondent answered, "I don't know what you mean."(T. 3532)

Respondent's history with the Office of Professional Medical Conduct consisted of two investigative interviews in 1995, a first hearing based on charges in 1998, a disciplinary decision in 2000, another investigative interview in 1999, the present hearing lasting 13 days, and when the Respondent was asked the question: "...knowing what you know today, its August 18th, in the year 2000, do you still think that you answered questions 8, 9 and 10 correctly in Exhibit 22, pages 133 and 134? Knowing what you know today?" The Respondent answer was "Yes, I do, because it was a meeting."(T.3473)

The Panel did not find the Respondent to be a credible witness.

PATIENTS A - G

The Panel found the Respondent's care of Patients A through G depending on the charge either negligent or grossly negligent. The Panel found the testimony of Respondent's expert, Dr. Reguero to be not credible. Dr. Reguero found the Respondent's treatment in all seven patients to be excellent (T. 3108) and the only problem was a recordkeeping one. (T. 2554, 2700, 2843,

2922, 3078, 3122) At times, Dr. Reguero testified to facts not in evidence. (T. 2638, 2656, 2657, 2906, 2933, 2982, 3008, 3058, 3077, 3078, 3082, 3093) The Panel found the testimony of Dr. Friedman to be credible, although the Panel recognized that some of his testimony regarding the charges did not rise to a level of negligence.

The Respondent repeatedly documented information in his operative reports that was either not confirmed or contradicted in the pathology report ([T. 1205 - T. 1206];[T 1570 - T 1577]; [T 1013 - T 1017, 1020]; [Ex. 17 p. 35 - Ex. 17 p. 44 T. 1032]; [Ex. 7 p. 8 - Ex. 7 p. 12, T 898, 899]; [Ex. 20 p. 29, T. 566 - Ex. 20 p. 37, T. 567]). The Panel found that the Respondent had a pattern of negligent behavior in his duty to properly diagnose the patient's condition, and then during surgery he repeatedly failed to correctly assess the size and nature of the tissue removed from the patient. Dr. Friedman testified that often these structures were normal physiologic structures and should not have been removed. (T. 568, 627, 632, 897, 1206, 1215, 1577,) The Panel recognized that although removing these structures caused minimal harm to the patient, what was most disturbing was that these patients were placed at unnecessary risks related to unnecessary surgery.

The Respondent's testimony as to the number of laparoscopies performed on Patient B is disturbing. Patient B testified that the Respondent performed approximately 13 laparoscopies on her. (T. 43) Dr. Tepedino, Medical Coordinator of the Office of Professional Medical Conduct testified that the Respondent told him on July 26, 1999, that he performed two laparoscopies and possibly a third ten years later. (T. 239) Patient's B's insurance claims document six laparoscopies performed by the Respondent. (Ex. 21A) The Respondent testified that he did not recall how many laparoscopies he had performed on Patient B (T. 3205) and while reviewing the insurance claims (Ex. 21A) at the hearing he was unable to count the number of claims.(T. 3213-

3214) The Panel found Patient B to be a credible witness and the Respondent to be evasive and not credible.

The Panel found the Respondent's care of Patient C to be negligent. The Respondent failed to utilize the most rudimentary medical care such as performing a pregnancy test prior to continuing the drug Danocrine (Ex. 5, T. 1081), failed to properly screen the patient for gestational diabetes (Ex. 5 p. 33, T. 1097,8), and inappropriately used fundal pressure in the presence of shoulder dystocia. (Ex. 14 p. 26, T. 1155). The Respondent's use of excessive force resulted in the baby's injury of Erb's palsy. (T. 1106,7,8, 1149) When the Respondent was asked what was the source of the force that caused the pressure, the Respondent replied "The patient's pushing." (T. 3187) The Respondent's testimony was not credible.

The Panel found the case of Patient A, and the Respondent's testimony regarding that patient most troubling. The Panel found Nurse LHHDRN, who was present at the delivery to be most credible. Her testimony regarding the Respondent's pulling after applying the forceps (T. 349, 350) and moving the bed (T. 355, 425) was grossly negligent. (T. 1659) The Respondent's testimony that the bed moved from side to side was implausible and improbable. (T. 3340) The Respondent's expert, Dr. Reguero testified that the baby's injuries were caused by an intrauterine disaster, which is not supported by any evidence. (T. 2709, 2710, 2724, 2725) Both the Lenox Hill Hospital CT scan (Ex. 11 p. 130) and Dr. Kalina's testimony confirmed skull fractures, subcutaneous hemorrhages and edema, and hemorrhagic contusions consistent with the use of forceps. (T. 843) The panel found this persuasive evidence supporting the events as described by Nurse LHHDRN. The Respondent testified that the skull fractures and hematomas within the skull and within the brain are "... normal in many many cases." (T.3432)

The Panel placed minimal importance on the testimony of Respondent's character witnesses, Dr. Victor Reyniak and Dr. Edmund Funai, who were not aware of the pending charges against the Respondent or the summary suspension by Lenox Hill Hospital. (T. 1957, 1969) The Panel regarded the testimony of Dr. Reginald Puckett as biased in light of his financial/employment relationship with the Respondent. (T. 2131) Although the testimony of the Patients (D,E,F) was insightful as to their experience with the Respondent, but was minimally relevant as to the issues of fraud and negligence. The most difficult testimony for this Panel was that of Nurse Bock who testified that contrary to the note in the record that fundal pressure was applied on Patient C; Nurse Bock stated that she did not witness such application. (T. 2401) One Panel member requested a legible copy of her comments on Exhibit 14 p. 11 (T. 2420) but was never given that copy. After hearing Ms. Bock's testimony the Panel found the testimony to be suspect and not credible.

The Panel found Respondent's testimony to be not credible based on the foregoing reasons. In addition, the Respondent seemed to have a selective memory and was able to answer questions by his attorney regarding information relating to several years ago (T. 3147) but had no memory of more recent facts when asked by the Department's attorney and the Panel. (T. 3223, 3407, 3491, 3505, 3529) Additionally, the Respondent's testimony was selectively non-responsive, (T. 3153, 3154, 3158, 3162, 3269, 3270) disjointed and confused (T. 3162, 3175, 3198, 3273, 3315) and incoherent. (T. 3127, 3160, 3175, 3197, 3199, 3214, 3221, 3230, 3275, 3342, 3350, 3353) The Panel was very concerned about the Respondent's lack of insight regarding his wrongdoing in fraud and negligence and his failure to take responsibility for his actions.

THE FOLLOWING CHARGES AS LISTED IN THE STATEMENT OF CHARGES ARE SUSTAINED (charges not listed are not sustained)

Paragraphs A 9; A 10; A 11; A 12

Paragraphs B1; B2; B3; B6; B7; B9

Paragraphs C1; C3; C7; C8

Paragraphs D2; D4; D6; D7; D8

Paragraphs E1; E4; E5; E8; E10

Paragraphs F1; F4; F5; F7; F8

SPECIFICATION OF CHARGES

PRACTICING WITH GROSS NEGLIGENCE

Paragraph A 9, A 10,

Paragraph B 2, B 6

Paragraphs C1; C7

Paragraph D2, D 7

Paragraph E 4; E 5; E 6

Paragraphs F5; F7

Paragraphs G 2; G 3; G 4

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Paragraph B7

Paragraphs C3; C8

Paragraphs D4, D6; D8

Paragraphs E1; E5; E 8; E 10

Paragraphs F1; F 8

Paragraph G 5

EXCESSIVE TREATMENT

Paragraph B6;

Paragraph E4

Paragraph F5

Paragraph G2

FRAUDULENT PRACTICE

Paragraph A 12

Paragraphs B 1, B 9

Paragraphs H 1; H 2

Paragraph I 2

Paragraphs J 1, J 2

Paragraphs K 1; K 2

Paragraphs L 1; L2; L3

Paragraph M 1

Paragraph N 1;

MORAL UNFITNESS

Paragraph A 12

Paragraphs B 1, B 9

Paragraphs H 1; H 2

Paragraph I 2

Paragraphs J 1, J 2

Paragraphs K 1; K 2

Paragraphs L 1; L2; L3

Paragraph M 1

Paragraph N 1

FAILURE TO MAINTAIN A RECORD

Paragraphs A11

Paragraphs B 7

Paragraph C 8

Paragraph D 8

Paragraph E 10

Paragraph F 8

Paragraph G 5

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The hearing Committee, unanimously, after giving due consideration to all the penalties available, have determined that the Respondent's license to practice medicine in the state of New York should be **REVOKED.**

The Panel members based their penalty determination on the repeated aggregious acts committed by the Respondent.

DATED: **New York, New York**
October 20 , 2000

REDACTED

MICHAEL R. GOLDING, M.D. (Chair)

REVERAND THOMAS KORNMEYER

FRED LEVINSON, M.D

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

IN THE MATTER

OF

NIELS HELTH LAUERSEN, M.D.

STATEMENT

OF

CHARGES

NIELS HELTH LAUERSEN, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 16, 1969 by the issuance of license number 104954 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From on or about April 1, 1998 through on or about December 2, 1998, Respondent provided obstetrical care for Patient A (Patient A and all other patients are identified in Appendix A), in his New York City offices and at Lenox Hill Hospital, New York City. Patient A's prenatal course was essentially uneventful. On or about November 28, 1998, Respondent admitted Patient A to Lenox Hill Hospital. She was managed with analgesics and epidural anesthesia for pain relief, and given oxytocin to augment her labor. The fetus developed signs of distress late in the course of the labor. Respondent attempted forceps delivery twice, but failed, and the infant was delivered on November 28, 1998 by emergency cesarean section. The infant required aggressive cardiopulmonary resuscitation and was treated in the neonatal intensive care

unit, where he was found to have suffered severe brain damage. He recovered sufficiently to be discharged home.

1. On November 27, 1998, Respondent scheduled Patient A for induction of labor on November 29, 1998 without adequate medical indication.

2. Respondent failed to timely recognize and respond to the development of a nonreassuring electronic fetal heart rate monitoring tracing pattern of Patient A's fetus, indicative of compression of the fetal umbilical cord.

3. Respondent failed to timely effect delivery of Patient A's baby upon recognizing signs of fetal compromise.

4. Respondent failed to timely recognize the signs of cephalopelvic disproportion in Patient A.

5. Respondent failed to timely evaluate Patient A for the presence of cephalopelvic disproportion.

6. Respondent inappropriately applied fundal pressure to Patient A in the presence of cephalopelvic disproportion.

7. Respondent inappropriately attempted a vaginal delivery with midforceps on Patient A.

8. Respondent failed to timely perform a cesarean section on Patient A.

9. Respondent improperly positioned the forceps on Patient A's fetus.

10. Respondent employed excessive force to deliver Patient A's fetus with forceps.

11. Respondent failed to keep an adequate record for Patient A, including but not limited to, failing to periodically record fetal station, not identifying the type of forceps used, not identifying the fetal position at application of forceps, not identifying fetal station at time of application of forceps, not describing the degree of molding, and not characterizing the pelvic architecture and capacity.

12. Respondent, intentionally, with intent to deceive, asked the delivery room nurse (identified in Appendix A) to falsify the times listed in Patient A's record for Respondent's application of forceps.

B. From in or about 1984 through on or about May 22, 1998, Respondent treated Patient B, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of

pelvic pain. During the course of this treatment, before May 9, 1997, Respondent performed approximately 11 laparoscopies on Patient B for pain, all without more than temporary relief. On or about May 9, 1997, Respondent performed a laparoscopy and other procedures on Patient B, in his New York City offices. On or about May 11, 1998, Respondent performed a laparoscopy and other procedures on Patient B, at Lenox Hill Hospital.

1. Respondent incorrectly recorded in the operative reports for the May 9, 1997 and May 11, 1998 procedures that Patient B suffered from menometrorrhagia and from heavy menstrual and intermenstrual bleeding.

2. Respondent incorrectly recorded in the operative report for Patient B's May 9, 1997 laparoscopy a 5 by 5 cm. ovarian cyst with a large endometrioma.

3. Respondent incorrectly recorded in the operative report for Patient B's May 11, 1998 procedures an approximately 5 cm. cyst.

4. Respondent failed to refer Patient B for a psychiatric consultation.

5. Respondent failed to refer Patient B for a pain management consultation.

6. Respondent performed surgery on Patient B on May 11, 1998 without adequate medical indication.

7. Respondent failed to keep an adequate record for Patient B.

8. On several occasions in or about 1999, Respondent, by telephone, intentionally, with intent to deceive, attempted to discourage Patient B's husband (identified in Appendix A) from cooperating with any New York State Department of Health investigation of Respondent.

9. In or about April of 1999, Respondent, intentionally, with intent to deceive, instructed Patient B to write an inaccurate and misleading patient history of herself for his inclusion in his office medical record for Patient B.

C. From on or about March 10, 1987 through on or about October 22, 1992, Respondent provided obstetrical and gynecological care for Patient C, in his New York City offices and at Lenox Hill Hospital, New York City. On or about January 18, 1989, Respondent operated on Patient C for worsening pelvic pain, in his New York City offices. Patient C was admitted to Lenox Hill Hospital on or about March 22, 1992 in labor at 37-38 weeks' gestational age. The

delivery, on March 22, 1992, was complicated by shoulder dystocia. The infant, who weighed 4717 grams at birth, was diagnosed with Erb's palsy of the left arm.

1. Respondent failed to determine whether or not Patient C was pregnant before initiating treatment for endometriosis on or about ~~January 18, 1989~~ March 10, 1987 in what was at least the seventh week of her pregnancy.

2. Respondent performed surgery on Patient C on January 18, 1989 without adequate medical indication.

3. Respondent failed to properly screen Patient C for gestational diabetes during the pregnancy that culminated in the March 22, 1992 birth.

4. Respondent failed to appropriately manage Patient C's gestational diabetes during the pregnancy that culminated in the March 22, 1992 birth.

5. Respondent failed to timely anticipate and prepare for the complicated delivery of Patient C of March 22, 1992.

6. Respondent failed to timely diagnose Patient C's fetus' developing fetal macrosomia.

7. Respondent failed to properly employ appropriate procedures to deliver the Patient C's baby once the diagnosis of shoulder dystocia was made at delivery, including, but not limited to a use of excessive force when pulling on the fetal head, and the inappropriate use of fundal pressure.

8. Respondent failed to keep an adequate record for Patient C, including but not limited to, failing to accurately record Patient C's symptoms, response to therapy, and surgical findings for the procedure of January 18, 1989, and failing to adequately record estimated fetal weight for the pregnancy that culminated in the March 22, 1992 birth.

D. From on or about May 1, 1997 through on or about March 25, 1999, Respondent treated Patient D, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of endometriosis with chronic pelvic pain and heavy periods. On or about October 8, 1997, in his New York City offices, Respondent performed laparoscopic surgery on Patient D, which included an ovarian cystectomy. On or about January 26, 1998, Respondent performed a hysterectomy, right ovarian cyst resection, and other procedures on Patient D, at Lenox Hill Hospital.

1. Respondent failed to take an appropriate history of Patient D.

2. Respondent incorrectly recorded in his operative report for the laparoscopy of October 8, 1997 that Patient D had extensive endometriosis, an ovarian cyst, and a large uterus.

3. Respondent inconsistently recorded in his office records the size of Patient D's uterine fibroid.

4. Respondent incorrectly recorded Patient D's anatomical condition at the time of the January 26, 1998 surgery on Patient D.

5. Respondent performed a hysterectomy on Patient D without adequate medical indication.

6. Respondent incorrectly recorded that he performed a total abdominal hysterectomy on Patient D on January 26, 1998.

7. Respondent failed to appropriately diagnose and treat Patient D.

8. Respondent failed to keep an adequate record for Patient D.

E. From on or about February 25, 1997 through on or about February 27, 1998, Respondent treated Patient E, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of increasingly severe pelvic pain and menometrorrhagia. On or about March 12, 1997, Respondent performed a laparoscopy on Patient E, in his New York City offices. On or about February 2, 1998, Respondent performed a total abdominal hysterectomy and removal of left ovarian cyst on Patient E, at Lenox Hill Hospital.

1. Respondent failed to objectively corroborate Patient E's complaints of heavy menstrual and intermenstrual bleeding.

2. Respondent failed to refer Patient E for a psychiatric consultation.

3. Respondent failed to refer Patient E for a pain management consultation.

4. On or about February 2, 1998, Respondent performed a total abdominal hysterectomy on Patient E without adequate medical indication.

5. On or about March 12, 1997, Respondent performed a removal of a normal follicular cyst on Patient E without adequate medical indication.

6. On or about March 12, 1997, Respondent incorrectly recorded a normal follicular cyst removed from Patient E as an ovarian cyst and misdescribed its size.

7. Respondent incorrectly recorded Patient E's symptoms in the hospital record for her admission of February 2-6, 1998.

8. Respondent incorrectly recorded Patient E's anatomical condition in his preoperative office record notes and in the operative record of February 2, 1998.

9. Respondent incorrectly recorded having performed a pelvic floor reconstruction on Patient E on February 2, 1998.

10. Respondent failed to keep an adequate record for Patient E.

F. From on or about January 30, 1998 through on or about May 7, 1999 Respondent treated Patient F, in his New York City offices and at Lenox Hill Hospital, New York City, for a long history of pelvic pain. On or about March 9, 1998, Respondent

performed a dilatation and curettage, examination under anesthesia, exploratory laparotomy, lysis of adhesions, removal of a right ovarian cyst, vaporization of endometriosis, removal of staples from the bowel, a uterine suspension procedure, and a repair of the left incisional hernia on Patient F, at Lenox Hill Hospital.

1. Respondent inappropriately attributed Patient F's pain to endometriosis and adhesions.

2. Respondent failed to refer Patient F for psychiatric consultation.

3. Respondent failed to refer Patient F for pain treatment consultation.

4. Respondent failed to include irritable bowel syndrome in Patient F's differential diagnosis.

5. Respondent undertook surgery on Patient F without adequate medical indication.

6. Respondent inappropriately attributed Patient F's urinary and fecal incontinence, loss of colonic motility, and loss of feeling below the waist to her previous presacral neurectomy.

7. Respondent removed a normal 2.4 cm. hemorrhagic corpus luteum cyst from Patient F without adequate medical indication.

8. Respondent failed to keep an adequate record for Patient F.

G. From on or about March 10, 1998 through on or about May 13, 1998, Respondent treated Patient G, in his New York City offices and at Lenox Hill Hospital, New York City, for symptoms of progressively heavy bleeding and pain due to fibroids. On or about March 30, 1998, Respondent performed a multiple myomectomy, uterine suspension and other procedures on Patient G, at Lenox Hill Hospital.

1. Respondent incorrectly recorded Patient G as suffering from a history of menometrorrhagia.

2. Respondent incorrectly recorded the tissue he removed from Patient G in surgery as a 4 cm. ovarian cyst.

3. Respondent removed a normal corpus luteum cyst from Patient G without adequate medical indication.

4. Respondent incorrectly recorded the size of Patient G's uterus in the operative record and in his office record.

5. Respondent failed to keep an adequate record for Patient G.

H. On or about October 21, 1996, Respondent executed, certified the truth of, and submitted a Confidential Information form for recertification to Aetna/US Healthcare, P.O. Box 150428, Hartford, Connecticut 06115.

1. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "8. Are you presently under investigation by any state licensing board or federal agency?", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. Have you been investigated by any state licensing board or federal agency during the past five years?", although Respondent knew this statement to be false.

3. In this application, Respondent, intentionally, with intent to deceive, answered "No" and provided no further information to question, "11. Are you presently a defendant in a malpractice, discrimination or professional liability lawsuit or proceeding or have you been placed on notice of such a potential lawsuit or

proceeding yet to be filed which has not been reported to US Healthcare? If yes, provide full details (including the plaintiff and court caption of any pending lawsuit.", although Respondent knew this statement to be false.

I. On or about April 24, 1998, Respondent executed, affirmed the truth of, and submitted a Recredentialing Addendum to Oxford Health Plans, Westchester One, 44 South Broadway, White Plains, New York 10601.

1. In this application, Respondent, intentionally, with intent to deceive, initialed the statement, "There are no professional medical misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or any other state or country.", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, initialed the statement, "I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payer, Medicare, or Medicaid, or governmental licensing or other authority.", although Respondent knew this statement to be false.

J. On or about December 10, 1998, Respondent executed, affirmed

the truth of, and submitted an Application for Medical Staff Appointments of Continuum Health Partners, Inc. for appointment to Beth Israel Medical Center and to St. Luke's-Roosevelt Hospital Center, both in New York City.

1. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. 3. Are any professional misconduct proceedings pending against you in any state or other jurisdiction?", although Respondent knew this statement to be false.

2. In this application, Respondent, intentionally, with intent to deceive, answered "No" to question, "9. 7. Have your medical/dental staff appointment/employment status or clinical privileges in any hospital or health care facility every been denied, revoked, suspended, restricted, reduced, limited, placed on probation, not renewed, voluntarily relinquished, discontinued or otherwise changed, including any leaves of absence?", although Respondent knew this statement to be false.

K. On or about December 21, 1998, Respondent executed, verified the truth of, and submitted an Application for Appointment to the Medical/ Dental/Ancillary Staff at Saint Vincent's Hospital and Medical Center, 153 West 11th Street, New York, NY 10011.

1. In this application, Respondent, after listing Lenox Hill Hospital under the section "ALL HOSPITAL APPOINTMENTS", intentionally, with intent to deceive, answered "No" to question, "V. Was any employment, privilege or practice related to *ANY* Hospital and Faculty Appointments discontinued, *or have your clinical privileges at any listed facilities been limited, reduced or lost*?" [italics and underlining in original], although Respondent knew this statement to be false.

2. In this application, under "Professional Conduct History", Respondent, intentionally, with intent to deceive, answered "No" to question, "IX. A. Have you ever, during your professional career, been the subject of a disciplinary proceeding in this state or any other state?", although Respondent knew this statement to be false.

L. On or about March 16, 1999, Respondent executed and submitted a Membership Application for participation in Saint Vincent's PHO, 130 West 12th Street, New York, NY 10011. On or about April 13, 1999, the Assistant Director of the PHO (identified in Appendix A) had a telephone conversation with Respondent regarding his Membership Application. On or about April 14, 1999 Respondent signed a letter that was sent to the Saint Vincent's PHO.

1. On page "9" of this application, Respondent, after listing Lenox Hill Hospital under the section "Discontinued Hospital Affiliations", intentionally, with intent to deceive, wrote under the heading "Reason for Terminating Privileges" the words "Patients Requests", although Respondent knew this statement to be false and/or misleading.

2. In the telephone conversation with the Assistant Director of the PHO, on or about April 13, 1999, Respondent, intentionally, with intent to deceive, told the Assistant Director of the PHO that by "Patients Requests" he meant that patients had requested that he affiliate himself with St. Vincent's Medical Center. Respondent further stated that he "left" Lenox Hill Hospital, and the Assistant Director of the PHO requested that Respondent provide a letter clarifying why he left Lenox Hill Hospital.

3. In the letter signed by Respondent on or about April 14, 1999 and sent to the Saint Vincent's PHO, Respondent, intentionally, with intent to deceive, stated

> This is to state that I, Niels H. Lauersen, MD as well as other physicians, have left Lenox Hill Hospital because of disagreements with the direction the department was taking after a new Chairman was appointed.

although Respondent knew this statement to be false and/or misleading.

M. On or about April 7, 1999, a nurse reviewer (identified in Appendix A) for Oxford Health Plans, Westchester One, 44 South Broadway, White Plains, New York 10601, spoke with Respondent by telephone as part of her investigation of Respondent's care and treatment of Patient A.

1. During this telephone call, Respondent, intentionally, with intent to deceive, stated that as far as his privileges at Lenox Hill Hospital, he resigned from the hospital, although Respondent knew this statement to be false and/or misleading.

N. On or about July 26, 1999, Respondent was interviewed by Office of Professional Medical Conduct (OPMC) Medical Coordinator Michael Tepedino, M.D. and OPMC Senior Medical Conduct Investigator Thomas Hotz at the OPMC offices at 5 Penn Plaza, 6th floor, New York, New York.

1. During this July 26, 1999 interview, Respondent, intentionally, with intent deceive, stated that Patient B had been a patient of his since January of 1997, he had seen Patient B once before then more than 10 years earlier, he did not maintain Patient B's early records as he did not believe she would return as a private patient, and of the 10 to 12 prior laparoscopies performed on Patient B before 1998, he had performed one, although he knew these statements to be false and/or misleading.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraphs A and A1-11.
2. Paragraphs B and B1-7.
3. Paragraphs C and C1-8.
4. Paragraphs D and D1-8.
5. Paragraphs E and E1-10.

SIXTH THROUGH TENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. Paragraphs A and A1-11.
7. Paragraphs B and B1-7.

8. Paragraphs C and C1-8.

9. Paragraphs D and D1-8.

10. Paragraphs E and E1-10.

ELEVENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

11. Paragraphs A and A1-11; B and B1-7; C and C1-8; D and D1-8; E and E1-10; F and F1-8; and/or G and G1-5.

TWELFTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

12. Paragraphs A and A1-11; B and B1-7; C and C1-8; D and D1-8; E and E1-10; F and F1-8; and/or G and G1-5.

THIRTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(35)(McKinney Supp. 2000) by the ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient as alleged in the facts of the following:

13. Paragraphs B and B6.
14. Paragraphs C and C2.
15. Paragraphs D and D5.
16. Paragraphs E and E4-5.
17. Paragraphs F and F5, 7.
18. Paragraphs G and G3.

NINETEENTH THROUGH TWENTY-SEVENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession fraudulently as alleged in the facts of the following:

19. Paragraphs A and A12.
20. Paragraphs B and B8-9.
21. Paragraphs H and H1-3.

22. Paragraphs I and I1-2.

23. Paragraphs J and J1-2.

24. Paragraphs K and K1-2.

25. Paragraphs L and L1-3.

26. Paragraphs M and M1.

27. Paragraphs N and N1.

TWENTY-EIGHTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6630(20)(McKinney Supp. 2000) by conduct in the practice of medicine which evidences moral unfitness to practice medicine as alleged in the facts of the following:

28. Paragraphs A and A12; B and B8-9; H and H1-3; I and I1-2; J and J1-2; K and K1-2; L and L1-3; M and M1; and/or N and N1.

TWENTY-NINTH THROUGH THIRTY-FIFTH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the facts of the following:

29. Paragraphs A and 11.

30. Paragraphs B and B1-3, 7.

31. Paragraphs C and C8.

32. Paragraphs D and D2-4, 6, 8.

33. Paragraphs E and E6-10.

34. Paragraphs F and F8.

35. Paragraphs G and G1-2, 4-5.

DATED: New York, New York
April 24, 2000

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct