



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.  
Commissioner

Dennis P. Whalen  
Executive Deputy Commissioner

**PUBLIC**

February 25, 2000

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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

Niels Helth Lauersen, M.D.

REDACTED

Lawrence D. Bloomstein, Esq.  
Aaronson, Rappaport, Feinstein & Deutsch, LLP  
757 Third Avenue  
New York, New York 10017

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

Dear Parties:

Enclosed please find the Determination and Order (No. 99-269) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

REDACTED

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:nm

Enclosure

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

**In the Matter of**

**Niels Helth Lauersen, MD. (Respondent)**

**A proceeding to review a Determination by a  
Committee (Committee) from the Board for  
Professional Medical Conduct (BPMC)**

**COPY**

**Administrative Review Board (ARB)**

**Determination and Order No. 99-269**

**Before ARB Members Lynch, Shapiro, Price and Briber <sup>1</sup>  
Administrative Law Judge James F. Horan drafted the Determination**

**For the Department of Health (Petitioner):**

**Paul Stein, Esq.**

**For the Respondent:**

**Lawrence D. Bloomstein, Esq.**

Following a hearing below, a BPMC Committee placed the Respondent on probation for two years, upon determining that the Respondent practiced medicine with negligence on more than one occasion and failed to maintain accurate patient records. In this proceeding, pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 1999), the Petitioner asks the ARB to modify that Determination by requiring that the Respondent practice with a monitor during probation and by imposing a stayed suspension against the Respondent's License. After reviewing the record and the parties' submissions, the ARB modifies the Committee's Determination by requiring that the Respondent complete a course in medical record keeping and that the Respondent practice with a monitor during probation. We reject the request to impose a stayed suspension against the Respondent's License. We discuss the reasons for our Determination in greater detail, after we summarize the charges, the Committee's Determination and the issues that the parties raised for review.

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<sup>1</sup> ARB Member Stanley Grossman, M.D. recused himself from participating in this case. The ARB proceeded to review this case with a four member quorum, see Matter of Wolkoff v. Chassin, 89 N.Y.2d 250(1996).

### Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent, an obstetrician/gynecologist (OB/GYN) violated N. Y. Educ. Law §§ 6530(3-6), 6530(26), 6530(32) & 6530(35) (McKinney Supp. 1999-2000) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence,
- performing medical services unauthorized by the patient,
- ordering excessive or unwarranted tests or treatments, and,
- failing to maintain accurate records.

The charges concerned the care that the Respondent provided to eight patients, A through H. The record refers to patients by letters to protect patient privacy.

The Committee dismissed the specifications charging gross negligence or gross incompetence, incompetence on more than one occasion, ordering excessive tests or treatment and providing services without patient authorization. The Committee sustained charges that the Respondent practiced with negligence on more than one occasion, upon finding that the Respondent:

- failed to perform an appropriate pre-operative exam on Patient C,
- prepared inaccurate operative reports for Patient D,
- failed to obtain a pathological examination on tissue removed from Patient E, and,

- failed to monitor Patient G while prescribing medication for the Patient.

The Committee's Determination at page 33 created a question whether the Committee sustained a specification that charged the Respondent with failing to monitor Patient C post-operatively.

The Committee also sustained charges that the Respondent failed to maintain accurate records for Patients B through H. The Committee Determination at pages 28 and 44 created a question whether the Committee also sustained the charge that the Respondent failed to maintain appropriate records for Patient A.

The Committee voted to place the Respondent on probation for two years under probation terms that appear in eight paragraphs in Appendix II to the Committee's Determination. The Committee stated that they found the core issues in the proceeding revolved around the Respondent's poor quality medical records, which the Committee described as incomprehensible. The Committee indicated that although the Respondent's busy practice might explain the records, the busy practice failed to excuse the records. The Committee also noted that the Respondent displayed problems beyond record keeping, such as the failure to provide an appropriate pre-operative exam to Patient C, the failure to follow-up Patient E's pathology specimens and prescriptions for Patient G by mail, without appropriate follow-up. The Committee determined, however, that the Respondent's negligence fell below the egregious level that would warrant revocation. The Committee stated that probation with monitoring would convince the Respondent about the need for greater attention to medical records and dissuade the Respondent from cutting corners in his daily practice.

## Review History and Issues

The Committee rendered their Determination on November 4, 1999. This proceeding commenced on November 22, 1999 when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and response brief and the Petitioner's brief and response brief. The record closed when the ARB received the Petitioner's response brief on January 7, 2000.

The Petitioner's brief notes that although the Committee found that monitoring with probation would aid in correcting the problems in the Respondent's practice, the Committee failed to include a requirement for a practice monitor in the probation terms. The Petitioner asks the ARB to amend the Committee's Determination by adding a probation term requiring a practice monitor with board certification in the Respondent's specialty. The Petitioner also asked the ARB to impose a two-year stayed suspension, to impress upon the Respondent the need for significant improvement in his practice.

The Respondent argues the ARB should dismiss the Petitioner's review notice, because the Petitioner failed to serve the Respondent with a review notice within the time period set out in N. Y. Pub. Health Law § 230-c (4)(a)(McKinney Supp. 1999-2000). If the ARB refuses to dismiss the notice, the Respondent argues that the Committee imposed an appropriate penalty for the conduct at issue in this case.

In reply to the Respondent's motion to dismiss, the Petitioner's counsel argues he mailed the notice to the Respondent in a timely fashion, but later received the envelope back bearing a "RETURN TO SENDER" stamp.

### Determination

Prior to deliberations in this case, ARB Member Winston Price, M.D. informed the ARB that he knew the Respondent approximately twenty years ago, when Dr. Price received some OB/GYN training from the Respondent. Dr. Price indicated that his prior contact with the Respondent would in no way affect Dr. Price's ability to render a just and fair judgement in this case. Dr. Price took part in the case, with the other three members in the quorum. As noted before, ARB Member Stanley Grossman, M.D. recused himself from participating in the case.

The ARB has considered the record and the parties' briefs. We reject the motion to dismiss. We sustain the Committee's Determination that the Respondent practiced with negligence on more than one occasion and failed to maintain accurate records. We amend or clarify the Committee's findings, however, as to the record for Patient A and as to the post-operative monitoring for Patient C. We sustain the Committee's Determination to place the Respondent on probation for two years, but we amend the probation terms to include a requirement that the Respondent practice with a monitor. We amend the Committee's Determination further to require that the Respondent complete successfully a course on medical record keeping.

**Motion to Dismiss:** The question on the motion to dismiss involves 1.) whether the Petitioner complied with the law on serving the review notice by mailing the notice to the Respondent, event though the Respondent received the notice late, and 2.) whether the Respondent received sufficient notice concerning the review. Clearly, the Respondent received sufficient actual notice to prepare his brief and response brief. We hold that the determination on whether the Petitioner provided sufficient legal notice constitutes an issue for the courts to decide and we leave the Respondent to raise that issue in the courts.

**The Record for Patient A:** At page 28 in their Determination, the Committee stated that the Respondent maintained an adequate record for Patient A and the Committee stated that they dismissed the Eleventh Misconduct Specification, that had charged inaccurate record keeping for Patient A. On page 44, in the Order following the Committee's Determination, however, the Committee noted that they sustained the specifications charging inaccurate record keeping, including the Eleventh Specification. We hold that these inconsistent statements in the Committee's Determination constitute a clear error. The Committee conclusion at page 28 establishes that the Committee found the record for Patient A adequate and that the Committee dismissed the charge in the Eleventh Specification. We amend the provision in the Committee's Order, at page 44, to delete the statement indicating that the Committee sustained the Eleventh Specification. Further, we affirm the Committee's Determination to sustain the record keeping charges that appear in the Twelfth through the Eighteenth Specifications.

**Post Operative Monitoring for Patient C:** The Respondent performed a surgical procedure on Patient C. Factual Allegation C.5 charged that the Respondent failed to monitor appropriately Patient C's post operative recovery. At page 33 in their Determination, the Committee stated that no evidence in the medical record showed post-operative monitoring. The Committee then cited to testimony that established that the anesthesiologist rather than the surgeon bore the responsibility for post-operative monitoring. The Committee concluded that: "the Respondent did not fail to appropriately monitor the patient's post-operative recovery". Later in their Determination, however, the Committee stated that Factual Allegation C.5: "should be sustained".

The ARB concludes from the Committee's language that the Committee intended to dismiss Factual Allegation C.5 and that the statement otherwise amounted to an error. We amend the Determination to provide that the Committee dismissed Factual Allegation C.5. We also



affirm the Committee's Determination that the Respondent committed negligence on more than one occasion in treating Patients C, D, E and G.

**Penalty:** The Petitioner requested that the ARB modify the Committee's Determination and impose a stayed suspension against the Respondent's License. The ARB quorum voted 3-1 against a stayed suspension. The majority agreed with the Committee that the Respondent's misconduct failed to rise to an egregious level and the majority questioned what purpose a stayed suspension would serve. The dissenting member, Mr. Shapiro, favored a period on actual suspension or at least a stayed suspension, as a penalty for the non-record keeping conduct, that included prescribing for Patient G without monitoring the Patient.

We vote 4-0 to modify the Committee's Determination and to require that the Respondent practice with a monitor during the probation period. The Committee indicated in their Determination that they felt that probation and monitoring could aid in correcting the Respondent's practice deficiencies. The Committee failed to include monitoring provisions in the probation terms. Although we concluded that the Respondent's negligent conduct failed to rise to a level to warrant revocation or suspension, the ARB concludes that the Respondent would benefit from monitoring by another OB/GYN. The failure to perform a proper pre-operative exam, to obtain a pathological exam and to monitor a patient while prescribing medication all posed dangers for harm to patients. The ARB amends the Committee's probation terms to add a paragraph 9, to read:

*"9. Respondent shall practice medicine only when monitored by a licensed physician, board certified in the Respondent's specialty("practice monitor"), proposed by Respondent and subject to the written approval of the Director of OPMC.*

- a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least quarterly and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of*

*accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.*

- b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.*
- c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.*
- d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order."*

The ARB concludes that the practice monitor will assist the Respondent somewhat with the record keeping problems in addition to the Respondent's other deficiencies in practice. In addition, the ARB concludes that the Respondent's extensive record keeping problems would also benefit from a course in medical record keeping. The Petitioner made no request that we add retraining in record keeping to the penalty. The ARB may, on our own motion, substitute our judgement for the Committee's, in deciding upon an appropriate penalty, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). We elect to do so here. We direct the Respondent to take and complete successfully a course in medical records and that the Respondent complete arrangements for taking that course within one hundred twenty days from this Determination's effective date. We amend the Committee's probation terms further to add a Paragraph 10, to read:

*"10. The Respondent shall take and complete successfully a course in medical record keeping, that the Respondent shall propose, subject to the approval by the Director of OPMC. The Respondent shall complete arrangements for taking the course, exclusive from receiving the Director's approval, within one hundred twenty days from the effective date of the Administrative Review Board Determination in this case. In the event that the Respondent continues in the course at the time this probation would have ended, the probation shall continue until such time as the Respondent completes the course successfully".*

We had considered ordering the Respondent to complete the course within a specific time period, but we rejected that idea, because scheduling for such a course would be totally outside the Respondent's control.

**ORDER**

**NOW**, with this Determination as our basis, the ARB renders the following **ORDER**:

1. The ARB **AFFIRMS** the Committee's Determination that the Respondent practiced with negligence on more than one occasion and failed to maintain accurate records, but we **AMEND** certain portions in the Determination that pertain to Patients A and C.
  
2. The ARB the Committee's **AFFIRMS** the Committee's Determination to place the Respondent on probation for two years.
  
3. The ARB **AMENDS** the Committee's Determination to add probation terms requiring that the Respondent practice under a monitor during probation and complete a course successfully in medical record keeping.

**Robert M. Briber  
Sumner Shapiro  
Winston S. Price, M.D.  
Therese G. Lynch, M.D.**

In the Matter of Niels Helth Lauersen, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Lauersen.

Dated: February 17, 2000

REDACTED

~~Robert M. Briber~~

**In the Matter of Niels Heith Lauersen, M.D.**

**Sumner Shapiro**, an ARB Member concurs in part and dissents in part in the  
Determination and Order in the Matter of Dr. Lauersen.

Dated: FEB. 16, 2000

REDACTED

**Sumner Shapiro**

**In the Matter of Niels Helth Lauersen, M.D.**

**Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in  
the Matter of Dr. Lauersen.**

**Dated: Feb 14, 2000**

REDACTED

**Therese G. Lynch, M.D.**

**In the Matter of Niels Helth Lauersen, M.D.**

**Winston S. Price, M.D.**, an ARB Member concurs in the Determination and Order in the Matter of Dr. Lauersen.

Dated: 2/14, 2000

REDACTED

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**Winston S. Price, M.D.**