KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

February 9, 2022

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Won Yi, M.D.

Anthony Z. Scher, Esq.
800 Westchester Avenue
Suite N641
Rye Brook, New York 10573

Ian H. Silverman, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower Building
Room 2512
Empire State Plaza
Albany, New York 12237

**RE: In the Matter of Won Yi, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 22-026) 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 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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:

Jean T. Carney, Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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 Ms. Carney 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,

Dawn MacKillop-Soller
Acting Chief Administrative Law Judge
Bureau of Adjudication

DXM: cmg
Enclosure

COPY

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

| IN THE MATTER OF WON YI, M.D. | DETERMINATION AND ORDER |
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BPMC-22-026

A Notice of Hearing and Statement of Charges, both dated September 13, 2018, were served upon **WON YI, M.D.** ("Respondent"). Pursuant to § 230(10)(e) of the Public Health Law of the State of New York ("PHL"), **ELISA J. WU, M.D.**, Chairperson, **DEBORAH WHITFIELD** and **STEVEN M. LAPIDUS, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **MATTHEW C. HALL**, Administrative Law Judge, served as the administrative officer.

The Department of Health, Bureau of Professional Medical Conduct ("Department") appeared by **IAN H. SILVERMAN, Associate Counsel.** The Respondent was represented by **ANTHONY Z. SCHER, ESQ.** Evidence was received, witnesses were sworn and heard, and transcripts of the proceedings were made.

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

## PROCEDURAL HISTORY

| | |
|---|---|
| Pre-Hearing Conference: | October 11, 2018 |
| Hearing Dates: | October 15, 2018<br>January 18, 2019<br>February 26, 2019<br>April 12, 2019<br>June 14, 2019<br>August 15, 2019<br>August 23, 2019<br>March 13, 2020<br>August 19, 2020 |
| Witness for Petitioner: | Isamettin Aral, M.D. |
| Witness for Respondent: | Michael Kos, M.D. |
| Written Submissions Received: | December 21, 2020 |
| Deliberations Held: | August 12, 2021 |

## STATEMENT OF CASE

The Department charged the Respondent with seventeen specifications of professional misconduct, as defined in § 6530 of the Education Law of the State of New York ("Educ. Law"). The Respondent denied the Factual Allegations and Specification of Charges set forth in the Statement of Charges.

The Department recommends that the Respondent's license to practice medicine be revoked. The Respondent asks that the Hearing Committee to conclude that he did not commit professional misconduct and determine to impose no penalty.

**FINDINGS OF FACT**

The following Findings of Fact were made after a review of the entire record in this matter. All findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Numbers below in parentheses refer to exhibits (Ex.) or transcript page numbers (T.). The Hearing Committee hereby makes the following findings of fact:

1. The Respondent, Won Yi, M.D., was authorized to practice medicine in New York State on or about June 20, 2006, by the issuance of license number 240628 by the New York State Education Department. (Dept. Ex. 3.)

2. The Respondent graduated from Columbia University in 1994 with a degree in environmental engineering. While there, the Respondent also took premedical classes. (T. 486.)

3. After spending a year conducting medical research at University of California at Los Angeles, California (UCLA), the Respondent was accepted to medical school at the University of Rochester in Rochester, New York. (T. 487.)

4. The Respondent graduated from the University of Rochester with a medical degree in 1999. After graduation, he completed an internship at Rush Medical Center in Chicago, Illinois. From there, he began his residency in radiation oncology in 2001, again at the University of Rochester and completed his residency training in 2005. He then began

his private practice in Buffalo, New York as a radiation oncologist. (T. 489-490.)

5. Between February 2009 and June 2013, the Respondent evaluated and treated Patients A through G for a variety of complaints. (Dept. Ex. 1.)

**Patient A**

6. From on or about September 13, 2012, to on or about December 20, 2012, the Respondent provided medical care to Patient A. (T. 21.)

7. Patient A, a forty-three-year-old female patient, presented to the Respondent with a diagnosis of metastatic breast cancer. (T. 21.)

8. Eight months prior, Patient A received a course of whole brain radiation from another physician, totaling 5,000 Centigray (cGy). (Dept. Ex. 5; T. 25.)

9. Respondent prescribed and administered radiation treatment to Patient A from September 18, 2012, to November 2012. (T. 25.)

10. The total dosage administered to Patient A during this course of treatment was 6,000 cGy. (Dept. Ex. 4; T. 25.)

**Patient B**

11. Respondent treated Patient B at various times from on or about February 9, 2009, to on or about March 14, 2012, when Patient B expired.

12. Patient B was a 72-year-old-male, who presented with a Prostate Specific Antigen (PSA) greater than 80. (T. 134.)

13. Patient B presented with metastatic prostate cancer. (T. 135.)

14. Respondent recommended radiation treatment to the patient's thoracal lumbar spine as well as pelvic treatment for his primary prostate cancer. (T. 135.)

15. From February 2009 to May 2009, Patient B received radiation to the prostate area as well as to the spine. (T. 140.)

16. The dosage to the prostate area was 8,100 cGy. (T. 140.)

17. The dosage to the spinal area was 4,500 cGy. (T. 140.)

18. On August 19, 2009, Patient B's PSA decreased to a low value of 0.1, which was improved from the May value of 0.3. The May value was improved from the December 2008 value of 87.4. (T. 142.)

19. However, on February 2, 2010, Patient B's PSA had increased to 2.6. (T. 142, 143.)

20. On March 2, 2011, Respondent prescribed further radiation to Patient B. At this time, Respondent's PSA had elevated to 21.4 from a prior value of 2.6, and a prior value of 7.3. (T. 145.)

21. Respondent prescribed radiation treatment to Patient B's lumbosacral spine. (T. 148.)

22. Respondent administered radiation treatment to Respondent's right shoulder, totaling 5,000 cGy in twenty treatments. (T. 150-152.)

23. After Patient B complained of bilateral shoulder pain, Respondent administered further radiation treatment to Patient B's left shoulder, totaling 4,200 cGy in fourteen treatments. (T. 150-152.)

24. On August 16, 2011, Patient B complained of right jaw pain. Respondent ordered an x-ray of Patient B's jaw. The report per the Respondent was "unremarkable." The term "unremarkable" signifies that the radiologist made no findings consistent with metastasis. (T. 153, 154.)

25. Respondent treated Patient B from August to September of 2011, with 5,000 cGy in twenty fractions. (T. 155.)

26. On November 29, 2011, Patient B presented with lower back pain with radiating symptoms down both legs. He also described pain involving his right temporal skull. (T. 156.)

27. Respondent acknowledged that Patient B's metastatic disease was progressing "aggressively" at that point and recommended further treatment. (T. 157.)

28. Patient B received 4,200 cGy to his skull and 5,000 cGy to his pelvis. (T. 158.)

29. On January 31, 2012, Patient B presented with complaints of right hip and femur pain. Respondent concluded that his pain was due to progressive metastatic prostate cancer, and he proposed additional radiation. (T. 161.)

30. For a patient presenting with metastatic prostate disease, radiation treatment should not be the primary or sole method of treatment. (T. 135-137.)

31. On February 14, 2012, Patient B was sent to hospice care. (T. 166.)

32. Patient B then opted out of hospice care on a temporary basis to complete a course of right hip palliative radiation treatment. (T. 168.)

33. Respondent recommended giving Patient B five more radiation treatments after Patient B had signed out of hospice care. (T. 170)

**Patient C**

34. Patient C presented with aggressive prostate disease. (T. 236.)

35. Respondent recommended treating the patient's prostate and pelvic lymph node in conjunction with hormonal therapy. (T. 237.)

36. Patient C received 8,100 cGy over two months. This was a standard dosage for prostate cancer. (T. 239.)

37. On October 18, 2012, Patient C's PSA was then up to 10, from a pre-radiation treatment of 8. (T. 246.)

38. A Computed Tomography (CAT) Scan from October 22, 2012, did not show obvious metastatic disease. However, the bone scan suggested metastatic disease in the thoracic spine, lumbar spine, sternum, and a portion of the left skull. (T. 248.)

39. From November 1, 2012, through November 30, 2012, Patient C received 3,500 cGy in fourteen fractions to the lumbar spine. (T. 252.)

40. After completing the course of radiation to the lumbar spine, Patient C complained of pain in his mid to upper back. Based upon bone scan findings, Respondent considered radiation to those areas. (T. 254.)

41. From December 7 to December 28, 2012, Patient C received 3,750 cGy to the thoracic spine in fifteen fractions. (T. 257.)

42. A Positron Emission Tomography (PET)/CAT scan from January 30, showed pulmonary or lung metastasis. (T. 258.)

**Patient D**

43. Patient D was first seen by Respondent on January 20, 2012. (T. 275.)

44. Patient D was initially diagnosed with Chronic Lymphocytic Leukemia (CLL) in June 2007. (T. 275.)

45. Patient D received radiation treatment to his neck in November of 2007. (T. 275.)

46. Patient D first presented to Respondent complaining of mild swallowing difficulty and neck pain. (T. 277.)

47. Patient D received 2,250 cGy to the left and right neck. (T. 283.)

**Patient E**

48. Patient E was a 43-year-old woman who self-referred to Respondent. She had recently been diagnosed with primary rectal carcinoma as well as metastasis to her liver. (T. 300,301.)

49. The standard course of treatment for metastatic disease is to administer chemotherapy. Radiation is administered solely for palliative purposes. (T. 302-303.)

50. Respondent recommended palliative radiation to the rectum and to "possibly treat the liver disease." (T. 301.)

51. The rectal tumor received 3,750 cGy in fifteen fractions and her dominant liver tumor received 4,050 cGy in nineteen fractions. (T. 306.)

52. Patient E had a PET/CAT scan performed after this initial round of radiation. The imaging showed the primary rectal disease decreased in size while the liver disease progressed. (T. 309.)

53. On November 9, 2012, Patient E was diagnosed with metastatic disease by Dr. Krabak. At this point it is noted by Dr. Krabak that therapy should be palliative in nature. (T. 309.)

54. Respondent prescribed additional liver treatment. (T. 311.)

55. Patient E received 1,500 cGy in ten fractions before passing away. (T. 313.) (Ex. 11, p. 64.)

**Patient F**

56. Respondent first saw Patient F on February 16, 2012. (T. 349.)

57. Patient F presented with metastatic Stage 4 small cell carcinoma. (T. 345,346.)

58. Respondent recommended that Patient F undergo radiation. (T. 352.)

59. Standard treatment for metastatic small cell carcinoma of the lung is chemotherapy. Radiation therapy is indicated only for palliative purposes. (T. 347.)

60. Patient F received 7,180 cGy to the right lung and lymph node areas in forty-two fractions. (T. 353.)

61. Treatment of metastatic disease with local therapies is not indicated for metastatic small cell diseases. (T. 373.)

62. Following the first course of treatment, Respondent recommended another course of radiation to Patient F from May 13, 2012, to June 21, 2012. (T. 362.)

63. Patient F received radiation to the right adrenal tumor totaling 7,000 cGy in thirty-five fractions. (T. 363.)

64. Patient F received whole brain radiation treatment beginning August 8, 2012, and received 3,750 cGy. (T. 370.)

65. On August 9, 2012, Respondent cited multiple brain metastasis, which indicated that the patient's disease was progressing. (T. 368.)

66. A CAT scan from October 4, 2012, showed a progression of the patient's left hilar and evidence of a left inguinal adenopathy. (T. 372.)

67. Respondent recommended further radiation treatment to Patient F's left lung. (T. 373.)

68. Patient F received 6,600 cGy to the left lung and hilar disease. He also received 4,180 cGy to the left pelvis. (T. 376.)

69. Patient F received radiation treatment from March 14, 2013, to March 21, 2013, to the left and right neck totaling 2,500 cGy in five fractions. (T. 380.)

70. Respondent administered doses of radiation therapy that exceeded normal lung tolerance. (T. 383.)

**Patient G**

71. Patient G received radiation therapy at Roswell Park from July 8, 2010, until August 13, 2010. A total dose of 5,400 cGy was delivered. (T. 426.)

72. Patient G's tumor progressed after this first course of radiotherapy. (T. 426.)

73. Respondent became involved with treatment of Patient G, then twenty-seven-years-old, on May 11, 2011. (T. 426.)

74. Patient G had responded poorly to all prior treatment and the disease had progressed. Since the patient's tumor had not responded to the first dose of radiation therapy, further radiation therapy should

be considered for palliative purposes only, in smaller doses than would be administered for treatment. (T. 433, 438.)

75. Respondent planned additional radiation treatment for Patient G due to the patient's complaints of pain to the left gluteal region. (T. 434.)

76. Respondent administered a dose of 4,500 cGy. (T. 435.)

77. Patient G again presented to Respondent on July 27, 2011, complaining of more pain. Respondent recommended radiation again at a higher dose. (T. 444.)

78. Respondent treated Patient G's sacral region from August 4, 2011, to September 30, 2011, with 6,480 cGy in thirty-six fractions. (T. 446.)

79. On November 21, 2011, after Patient G complained of further pain, Respondent recommended a subsequent course of radiation treatment. (T. 447.)

80. Patient G received 4,500 cGy from December 6, 2011, to February 13, 2012, to the recurrent sacral tumor. (T. 450.)

81. The doses of radiation therapy administered exceeded the standard to be given for palliative purposes. (T. 438.)

## CONCLUSIONS OF LAW

Respondent is charged with professional misconduct as defined in § 6530 of the Educ. Law, as follows:

- § 6530(3) - Practicing the profession of medicine with negligence on more than one occasion.
- § 6530(4) - Practicing the profession of medicine with gross negligence.
- § 6530(5) - Practicing medicine with incompetence on more than one occasion or with a lack of knowledge necessary to practice the profession.
- § 6530(6) - Practicing the profession of medicine with gross incompetence.
- § 6530(32) - Failing to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient.

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department. (*See* Prince, Richardson on Evidence § 3-206). The Hearing Committee made these conclusions of law pursuant to the factual findings and definitions listed above, and all conclusions resulted from a unanimous vote.

The Department called Isamettin Aral, M.D. as an expert witness. Dr. Aral is licensed to practice medicine in New York. He is a well-

trained and experienced practitioner in radiation oncology. He received his medical education at the State University of New York Downstate and has been a physician for over thirty years. At the time of the hearing, he was employed as the Chief of radiation oncology by ProHealth Care. He is board certified in radiation oncology by the American Board of Radiology.

The committee finds that Dr. Aral's testimony was thoughtful, clear and comprehensive. He readily acknowledged instances when care rendered by the Respondent was within the appropriate standard of care and when the Respondent's actions did not pose a risk to a patient. The committee further found Dr. Aral to be well-credentialed, his testimony to be very credible, and his opinions on deviations in standards of care to be persuasive.

The Respondent called Michael Kos, M.D. Dr. Kos received his medical training at the University of Saskatchewan Medical School. After receiving his degree, Dr. Kos completed his internship in internal medicine. Then, he continued his residency in radiation oncology at Hamilton Regional Cancer Treatment Center. After his residency was completed, Dr. Kos moved to the United States and practiced in Reno, Nevada. He is Board Certified. (T. 1219.)

Specifications One through Seven

The Department's First through Seventh Specifications charged the Respondent with committing professional misconduct as defined in N.Y.

Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence in his care of Patients A through G. Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates a risk of potentially grave consequences. Post v. State of New York Department of Health, 245 A.D.2d 985 (3d Dept. 1997). There is no need to prove that a physician was conscious of the impending dangerous consequences of his conduct. Minielly v. Commissioner of Health, 222 A.D.2d 750 (3d Dept. 1995).

The Respondent provided medical care to Patient A, then a forty-three-year-old female, who had been diagnosed with metastatic breast cancer, at the Respondent's offices. He treated Patient A at various times between September 13, 2012, until about December 20, 2012, when Patient A expired. From December 29, 2011, to January 27, 2012, prior to her initial visit with the Respondent, Patient A received a course of whole brain radiotherapy totaling 5, 000 cGy over twenty treatments from Dr. Panahon of the Radiation Oncology Group.

Dr. Aral testified that when a radiation oncologist evaluates a patient on an initial visit, the first goal of the oncologist is to determine what it is that the oncologist is trying to accomplish with the patient. Dr. Aral further testified that there are two types of patients in these situations. First, there are patients within whom the oncologist believes the disease can be eradicated. These patients should be treated with "curative" intent. Such a patient should typically receive higher radiation doses, a more complicated treatment,

and may possibly involve other modalities. (T. 21-22.) If a patient has metastatic disease, such as Patient A, the approach should be different, according to Dr. Aral. In such a case, the patient cannot be cured, so he or she should be treated with "palliative" intent. Here, the patient would be treated with limited doses of radiation with a goal towards lessening the symptoms of the patient and relieving the patient's pain so that the patient can be more comfortable in the final stages of his or her life. Regarding the previous treatment received by Patient A, Dr. Aral stated, "not only didn't it work, it didn't work when they probably gave more radiation than they should have." (T. 30.) There was no likelihood that further treatment would affect the course of the patient's disease. (T. 41.)

When a radiation oncologist decides to administer additional radiation to a patient who has already undergone a course of radiation therapy, this implies that the oncologist is accepting more risk of side effect. (T. 31.) It is believed that the whole brain can safely tolerate between 4,500 and 5,000 cGy. Since Patient A had previously received 5,000 cGy in prior treatment, there was a limited amount of radiation that Patient A could receive without significantly increasing the likelihood of permanent brain injury. (T. 45.) After the Respondent administered a second dose of radiation totaling 5,000 cGy, the patient had received a total dose of 10,000 cGy, which significantly exceeds the central nervous system or brain tolerance levels. (T. 48.)

The hearing committee found that the Respondent's use of a "curative" dose of radiation on a clearly "palliative" patient departs from the accepted standards of care in this situation. Not only did she receive excessive radiation, but she was denied the appropriate dose of radiation that would have eased her suffering in the latter days of her life.

Respondent's care of Patient A seriously departed from the accepted standards of care in treating the patient with a "curative" dose of radiation when a "palliative" dose was clearly called for. The Department's charge of gross negligence regarding Patient A is sustained.

The Respondent also provided medical care to Patient B, then a seventy-two-year-old male, at the Respondent's offices. He treated Patient B at various times between February 9, 2009, until about March 14, 2012, when Patient B expired.

Dr. Aral testified that the standard treatment in 2009 for a patient presenting with a diagnosis of metastatic prostate carcinoma is total androgen suppression. (T. 137.) Respondent's own expert witness, Dr. Kos, acknowledged that hormone therapy is the standard course of treatment. (T. 1306.) Respondent administered radiation therapy to multiple body sites, including the patient's prostate, spine, shoulders, mandible, skull, pelvis, hip, and femur. Dr. Aral testified that spot-welding is "missing the overall story.. This PSA is going up because the disease is growing." (T. 151.) Dr. Aral also testified

that the dosage prescribed by Dr. Yi to Patient B was in excess of what was considered standard for palliative radiation treatment, and that it was a deviation from the standard of care. (T. 152-153.) Additionally, the Respondent either did not take into account the prior doses of radiation with each subsequent course of treatment to an adjacent or potentially overlapping site, or he failed to document it. (T. 159-160.) Dr. Aral testified that acceptable tolerance levels were exceeded. (T. 161.) There was a lack of documentation with regards to the calculation of cumulative radiation doses to all of the important critical organs in the submitted medical records, and the Respondent himself was unable to answer questions regarding which specific body sites he had treated, despite review of his own medical records. (T. 827-829, T. 832-838.) Dr. Kos, the Respondent's own witness, testified that this was the radiation oncologist's responsibility. (T. 1362 - 1363.)

The Hearing Committee found that the Respondent's treatment of Patient B with numerous courses of radiotherapy was not indicated, and it was particularly excessive during Patient B's final year of life. This constitutes a serious deviation from the accepted standards of care in this situation. The Hearing Committee also agreed with the Department's expert witness that the Respondent's repeated use of high doses of radiation in a patient with widely metastatic disease was not appropriate in the palliative setting, and that the medical records did not demonstrate he had properly accounted for prior radiotherapy. The

Department's charge of gross negligence regarding Patient B is sustained.

The Respondent also provided medical care to Patient C, a sixty-four-year-old male patient, at the Respondent's offices. He treated Patient C at various times from on or about April 6, 2012, until about June 6, 2013, when Patient C expired.

Dr. Aral testified that, for a patient presenting with metastatic prostate cancer, it must be demonstrated that hormonal therapy is effective before any radiation treatment is administered. (T. 261.) However, Dr. Kos testified that radiotherapy may be started shortly after hormone therapy or wait two or three months, but that neither is absolutely wrong. (T. 1369.) The Hearing Committee found that, while a period of waiting and reassessment may have been optimal, Respondent's delivery of radiation concurrently with hormone therapy did not depart significantly from the accepted standard of care in this situation.

However, Respondent did not refer Patient C to a medical oncologist upon noticing that his PSA was rising. After the bone scan showed that the patient's disease had metastasized to the bones, Respondent still did not refer him to a medical oncologist immediately. Rather, he continued to treat Patient C with radiation therapy. (T. 248.) Dr. Aral testified that this was a deviation from the minimum accepted standard of care. (T. 250.) Dr. Kos concurred that the Respondent did not refer the patient to the oncologist or urologist until later "down the road." (T. 1391.) Records show that Patient C finally saw the oncologist after

completion of two additional courses of radiotherapy, one to the lumbar spine and another to the thoracic spine. This occurred after the disease had further spread. The Hearing Committee found that the failure to refer a patient in a timely fashion to the medical oncologist may have resulted in the delay of other treatment options and further negative outcome for a patient with disease that was clearly progressing aggressively, and that this was a significant deviation from the standard of care.

During his treatments of Patient C, Respondent failed to document doses of radiation delivered to the specific anatomical sites, stating only "lumbar spine" or "thoracic spine" without delineation of vertebral bodies. Further, he did not appear to account for whether there was overlap between treated areas, in which determining the cumulative doses of radiation to adjacent critical normal tissues would be needed. For example, there was no documentation of a dose volume histogram for the small bowel, which is a critical organ whose dose tolerance limits likely was exceeded in this case. Dr. Aral testified that there was potential for dose overlap between the prior pelvic radiation treatment and the subsequent lumbar spine radiation. (T. 253.) Despite detailed review of the submitted records, as well as the testimonies of the Respondent and both expert witnesses, it remained unclear which specific anatomical sites were irradiated in Patient C. The Respondent's testimony was confusing and contradictory to his own medical records. He testified repeatedly that he did not irradiate the highly suspicious

external iliac lymph node in this case. (T. 953-954.) However, his Consultation Note stated that he did conclude that the lymph node was likely involved, his initial clinical staging of the Patient's disease was N1, and he had planned to irradiate the node. Respondent's expert witness, Dr. Kos, testified that Respondent's documentation showed that the involved lymph node had received 8,100 cGy. (T. 1403-1404.)

The Hearing Committee found that this was also a significant deviation from the standard of care. If the Respondent had indeed irradiated a portion of the pelvis which included the involved lymph node to 8,100 cGy, a dose that is significantly higher than the normal tissue tolerance of the small bowel, then the standard of care would be to clearly calculate and document the dose received by the small bowel in this case. Respondent's witness, Dr. Kos, also testified that it would be most appropriated to document the dose to the small bowel. (T. 1407.) Even if a lower dose, such as 5,040 cGy, was delivered to the lymph node, it still would be standard practice to generate a dose volume histogram for the small bowel. (T. 1421.) Additionally, when he treated Patient C with a subsequent course of radiation therapy to the "lumbar spine," the cumulative doses of the small bowel would be of critical importance, as there may be potential overlap with the prior pelvic radiation and the small bowel tolerance may have been exceeded. On the other hand, if Respondent did not irradiate the "highly suspicious" lymph node in a patient with N1 disease, then his inadequate treatment of this patient would have constituted a deviation from the

standard of care. The Department's charge of gross negligence regarding Patient C is sustained.

The Respondent also provided medical care to Patient D, a forty-six-year-old male, at the Respondent's offices. He treated Patient D at various times from on or about January 20, 2012, until about May 22, 2013.

As CLL is a very slowly progressing systemic disease, radiation oncology perspective treatment should only be offered when a patient is symptomatic, or the blood counts are suggesting that there is going to be some imminent danger or harm. (T. 276.) Typically, radiation oncologists have a limited role in the management of CLL and are usually only involved in palliation. (T. 278.) Patient D had previously received radiation treatment to his neck, wherein there are several sensitive structures including the salivary gland, nerve tissues and blood vessels. Any prior dose of radiation received by Patient D was not provided in the Respondent's dose volume histogram. (T. 282.) Salivary glands are at or near their maximum dose when administered with 3,000 to 4,000 cGy. Incremental addition of radiation would certainly cause permanent imperative salivary function. (T. 283.) When a patient presents indicating that he had a prior course of radiation, it is incumbent upon the radiation oncologist to approximate the course of therapy to find out what the course was, what the dosage was and the areas that were treated. (T. 298.)

Patient D originally received radiation treatment to his neck in 2007. In 2012, he presented to the Respondent with complaints of mild swallowing difficulty and neck pain. (T. 277.) The Respondent treated the patient with 2,250 cGy to the left and right neck. (T. 283.) According to Dr. Aral, CLL should be treated aggressively if it is causing problems to the patient, such as difficulty breathing. Here, Patient D complained of neck pain and difficulty breathing. The Respondent was aware that Patient D had previously received radiation as indicated in his notes. The Respondent referred Patient D to medical oncology, but also recommended another round of treatment. When asked about this, Dr. Aral responded, "this is not the standard, but I don't know if we can say it is wrong." (T. 281.) When it was determined that the Respondent had referred the patient to oncology, Dr. Aral was asked if this changed his opinion of the Respondent's treatment of Patient D. Dr. Aral responded, "the oncologist suggested (alternative treatment), but it wasn't done." When asked by the Hearing Committee, "As there are notes showing the patient still had pain, is it so wrong to offer the patient reradiation to palliate?" Dr. Aral responded, "If we feel comfortable that we have exhausted the medical management and all treatment plans have been considered." (T. 294.)

While Respondent deviated from accepted standards of care in his treatment of Patient D by treating him with radiation without a clear understanding of the patient's prior radiation history, the Hearing Committee found that he did not severely deviate from the standards of

care. The Hearing Committee finds that the Respondent was negligent in his care of Patient D, but not grossly negligent, and the Department's charge of Gross Negligence regarding Patient D is not sustained.

The Respondent also provided medical care to Patient E, a forty-three-year-old female, at the Respondent's offices. He treated Patient E at various times from on or about October 4, 2012, until about February 23, 2013, when Patient E expired.

Patient E was diagnosed with primary rectal carcinoma as well as metastasis to her liver. After being treated with 3,750 cGy to the tumor in her rectal tumor and 4,050 cGy to her dominant liver tumor. Subsequent to these treatments, it was determined that the liver disease had progressed, and Dr. Krabak determined that any further treatment should be palliative in nature. At that point, the Respondent treated Patient E's liver with an additional 1,500 cGy before she passed away. The standard course of treatment of a patient, such as Patient E, who presented with metastatic liver disease would be to start with chemotherapy. (T. 301.)

With respect to treatment of metastatic disease, radiation should be purely palliative in nature. When a tumor has metastasized, the primary tumor continues to feed the body with other metastatic foci. Therefore, the circulating tumor cells are not receiving any therapy with radiation alone. (T. 302.) Chemotherapy is the mainstay for all metastatic disease. It will target not only local tumors, but also distant tumors and potentially any circulating cells that may have

lodged themselves in the body. (T. 303.) Local radiation to the liver and simultaneous local radiation to the pelvis does not do anything for circulating tumor cells. (T. 302.) Dr. Aral testified that the initial treatment to the liver was not indicated or appropriate. (T. 303.) He further stated that irradiating the liver would not affect the overall course of Patient E's disease, may delay systemic therapy, and may result in normal tissue damage. (T. 304-305.) He also testified that the 4,750 cGy of radiation delivered to the liver by the Respondent was in excess of standard palliative regimens. With regards to the second course of radiation to the liver, Dr. Aral testified that there was no indication for offering additional radiotherapy. (T. 311.) He stated that, "Not only did the patient take unneeded palliative radiation treatment to the liver, but she further received unnecessary palliative treatment in the second course to the same organ without regard to summations of dose tolerances within that area, unindicated treatment being administered without concern for normal tissues toxicity." (T. 314.) The patient expired prior to finishing her second course of liver radiotherapy.

The Hearing Committee found that the Respondent's treatment of Patient E with two localized courses of radiotherapy to the liver in lieu of chemotherapy, especially considering that the disease had metastasized and that the patient should be receiving "palliative" treatments, departs significantly from the accepted standards of care in this situation. Although the opinion of the Respondent's expert

differs from the that of the Department's expert witness, the Hearing Committee found Dr. Aral's testimony to be credible and reasonable. The Department's charge of Gross Negligence regarding Patient E is sustained.

The Respondent also provided medical care to Patient F, a sixty-two-year-old male, at the Respondent's offices. He treated Patient F at various times from on or about February 16, 2012, until about May 20, 2013, when Patient F expired.

Patient F presented to the Respondent with Stage 4 small cell carcinoma and the Respondent recommended radiation therapy. Patient F received a first dose of radiation of 7,180 cGy to the right lung and lymph nodes. The standard radiation dose in this instance would be between 3,000 and 3,500 cGy for palliation. After the first course, the Respondent recommended a second treatment to the right adrenal tumor. Patient F was radiated with another 7,000 cGy. At this point, the Respondent then treated Patient F with 3,750 cGy to the whole brain and another 6,600 cGy to the left lung. Additionally, Patient F received 4,180 cGy to the left pelvis and 2,500 cGy to the right neck.

The standard treatment for a patient with metastatic small cell carcinoma of the lung is chemotherapy, which was recommended by the patient's medical oncologist, Dr. Zielinski. (T. 347.) By definition, a patient with Stage 4 disease will not be cured, so the role of radiation is purely palliative. (T. 347.) Treating metastatic disease with local therapies is not called for because the disease will continue

to emerge in areas that have not been treated. Chemotherapy addresses the disease in its entirety. (T. 373.) Respondent admitted that "Dr. Zielinski thought he could be treated with chemotherapy," and this was also indicated in Dr. Zielinski's note. (T. 1081.) Instead, the Respondent recommended to treat the patient with radiation therapy alone to the lung/mediastinum. (T. 1079.) Although the Respondent testified, "My understanding was that they were going to follow up with Dr. Zielinski in a couple of weeks or so after discharge from the hospital," he decided to prescribe a long and protracted course of radiation using a high dose of 7,180 cGy in forty-two fractions. (T. 353-354.) Dr. Aral testified that the choice of the dose and fractionation was not consistent with minimal standards of care. (T. 355.)

The Hearing Committee found that the Respondent's use of "curative" doses and fractionation schemes of radiation therapy in a patient who has stage IV small cell lung cancer with distant metastases constitutes a significant deviation from the accepted standards of care, especially when it prevented the patient from receiving systemic therapy which is the treatment of choice and the standard of care for patients like Patient F. The Respondent testified that it is not his job to convince the patient to go for chemotherapy. (T. 1145.) However, even the Respondent's own expert, Dr. Kos, stated that it is extremely rare for such patients to refuse chemotherapy right off the bat, and that they usually take the recommendation of their radiation oncologist and their medical oncologist. (T. 1496.) By offering Patient F suboptimal

treatments in lieu of the standard of care and treating the patient with radiation for more than a third of the days in his final year of life, the Hearing Committee found that the Respondent has failed to meet the minimum acceptable standard of care in his treatment of this patient.

Furthermore, Respondent continued to prescribe multiple additional courses of radiotherapy using "curative" doses to Patient F's many sites of metastatic disease. A high dose of 7,000 cGy to the adrenal tumor would likely affect the adjacent small bowel, but there was no documentation that the Respondent accounted for the dose to the small bowel in the treatment planning process. (T. 385.) Additionally, Respondent exceeded normal lung tolerance due to delivering two courses of radiotherapy to the lung, which is associated with an increased risk of severe side effects. (T. 383-384.) The Hearing Committee found that these factors are significant deviations from the accepted standards of care, and the Department's charge of gross negligence regarding Patient F is sustained.

The Respondent also provided medical care to Patient G, a twenty-seven-year-old male, who suffered from a chordoma, a tumor that grows slowly and is generally one of the least responsive to radiation therapy, in the sacral region. He treated Patient G at various times from on or about May 11, 2011, until about March 14, 2012, when Patient G expired.

Prior to presenting to the Respondent, Patient G received 5,400 cGy from a different provider. His disease progressed and he responded poorly to all prior treatment. After the Respondent administered 4,500 cGy, Patient G was still in pain. Respondent then treated Patient G's sacral region with another 6,480 cGy. Still unsuccessful, the Respondent added another 4,500 cGy to the recurrent sacral tumor. (T. 450.)

The preferred treatment for a chordoma is surgical resection. In the absence of surgical resection, radiation can be used to shrink the tumor. For patients who develop metastasis, however, surgery is necessarily ruled out. (T. 432.) Patient G did not respond well to the radiation he received from Roswell Park prior to presenting to the Respondent. This would indicate that the tumor was radio-resistant and applying a second dose to the same area would likely not be productive, especially from a lower dose than the one applied in Roswell Park. (T. 435.) Further, although it was a lower dose than the one administered previously, the dose of 4,500 cGy would not be considered a palliative dose, which would be more in the range of 3,000 cGy. (T. 438.) Considering that Patient G could not likely be cured at this point, an oncologist's objective would be to alleviate the patient's pain. Standard pain relief would include pain medications, including narcotics and nerve blocks. (T.438.) Without proper indication, the Respondent delivered multiple courses of radiation therapy to Patient G's sacral region, resulting in an extremely high cumulative dose in

excess of 20,000 cGy which can be associated with devastating complications for the patient.

The Hearing Committee found that the Respondent's treatment of Patient G using excessive and multiple doses of radiation to Patient G's sacral region, significantly departs from the accepted standards of care in this situation. The Department's charge of gross negligence regarding Patient G is sustained.

Specifications Eight through Fourteen

The Department's Eighth through Fourteenth Specifications charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence in his care of Patients A through G. Incompetence is defined as the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board of Professional Medical Conduct, 224 A.D.2d 609 (3rd Dept. 1996). Gross incompetence is a lack of requisite skill to practice medicine safely that can be characterized as serious or significant, carrying potentially grave consequences. Dhabuwala, 225 A.D.2d 609; Post; 245 A.D.2d 985.

As discussed above, the Respondent's use of a "curative" dose of radiation on a clearly "palliative" patient, departs from the accepted standards of care in this situation. Not only was Patient A denied the appropriate dose of radiation that would have eased her suffering in the latter days of her life, but she also received excessive radiation,

which could lead to potentially grave consequences. For these and the other reasons discussed above, the Hearing Committee found that the Department's charge of Gross Incompetence regarding Patient A is sustained.

Regarding Patient B, the Respondent's repeated use of radiation on a patient for whom it was not indicated, as well as his failure to account for prior radiation treatment with each subsequent course, demonstrates a lack of requisite skill that may have placed the patient at greater risk of serious injury. The Department's charge of gross incompetence regarding Patient B is sustained.

As for Patient C, the Respondent's failure to timely refer the patient to a medical oncologist for consideration of other treatment options upon noticing that his PSA had risen and his disease had metastasized, and the Respondent's failure to account for cumulative doses of radiation to critical normal tissues, both depart significantly from the accepted standards of care in this situation and demonstrate a lack of requisite skill that could lead to serious consequences for Patient C. The Department's charge of Gross Incompetence regarding Patient C is sustained.

As discussed above, while Respondent deviated from accepted standards of care in his treatment of Patient D by treating him with radiation without a clear understanding of the patient's prior radiation history, the Hearing Committee found that he did not severely deviate from the standards of care, in that the Respondent's actions did not

place the patient at risk of grave consequences. The Hearing Committee finds that the Respondent was incompetent in his care of Patient D, but not grossly incompetent, and the Department's charge of gross incompetence regarding Patient D is not sustained.

Similar to the Hearing Committee's determination that the Respondent was grossly negligent regarding Patient E, they also found that his care of Patient E showed gross incompetence. The Respondent's treatment of Patient E with two sequential courses of localized radiation to the liver, especially considering that the disease had metastasized and that the patient should be receiving palliative systemic treatments aimed at improving her quality of life, showed a lack of understanding required of a radiation oncologist and presents the risk of serious harm to the patient. The Department's charge of gross incompetence regarding Patient E is sustained.

As discussed above, the Respondent's treatment of Patient F by localized radiation in multiple locations in lieu of chemotherapy, in addition to over-radiating the bowel area, shows a lack of knowledge required of a radiation oncologist which could lead to serious harm or death to the patient. The Department's charge of gross incompetence regarding Patient F is sustained.

Finally, the treatment of Patient G using excessive and multiple doses of radiation to Patient G's sacral region shows a lack of skill and knowledge of a radiation oncologist and presents the risk serious

pain and harm to the patient. The Respondent's care of Patient E was grossly incompetent.

Specification Fifteen

The Department's Fifteenth Specification charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion in his care of Patients A through G. Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. Bogdan v. State Board for Professional Medical Conduct, 195 A.D.2d 86 (3d Dept. 1993).

As discussed above, the Hearing Committee has determined that Respondent was grossly negligent in his treatment of Patients A, B, C, E, F and G. In that the Respondent's care of Patients A, B, C, E, F and G was determined by the Hearing Committee to be grossly negligent, his treatment of these patients is necessarily deemed to be negligent. Although the Hearing Committee did not find that Respondent was grossly negligent regarding Patient D, they did find that his care of Patient D was negligent because he failed to properly consider the patient's prior radiation history before subjecting him to additional radiation

therapy. As such, the Department's charge of negligence on more than one occasion is sustained.

Specification Sixteen

The Department's Sixteenth Specification charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion in his care of Patient's A through E. Incompetence is defined as the lack of requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board of Professional Medical Conduct, 224 A.D.2d 609 (3rd Dept. 1996).

As discussed above, the Hearing Committee has determined that Respondent was grossly incompetent in his treatment of Patients A, B, C, E, F and G. Although they did not find that Respondent was grossly incompetent regarding Patient D, they did find that his care of Patient D was incompetent because he did not understand the significance of the patient's prior treatment history in devising a treatment plan. In that the Respondent's care of Patients A, B, C, E, F and G was deemed by the Hearing Committee to be grossly incompetent, his treatment of these patients is necessarily deemed to be incompetent. As such, the Department's charge of incompetence on more than one occasion is sustained.

Specification Seventeen

The Department's Seventeenth Specification charged the Respondent with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) in that the Respondent failed to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient. A medical record needs to convey objectively meaningful medical information concerning a patient treated to other physicians. Maglione v. New York State Dept. of Health, 9 A.D.2d 522 (3d Dept. 2004).

Throughout the hearing, very little was mentioned regarding the Respondent's failure to maintain adequate records. Indeed, the mention of his failure to keep appropriate records was more of an afterthought from both parties, both during the hearing and in the party's post-hearing briefs.

The Department has failed to establish that the Respondent failed to maintain records for patients A through G, as required by N.Y. Educ. Law § 6530(32). Accordingly, the Department's charge of failure to maintain a record for each patient which accurately reflected the evaluation and treatment of each patient, is not sustained.

**DETERMINATION AS TO PENALTY**

The Hearing Committee considered the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension, probation, censure, and the imposition of civil penalties.

The Hearing Committee is mindful that the Respondent held a very serious and stressful position and that he successfully treated many of his patients in his capacity as a radiation oncologist. The Hearing Committee also finds that the Respondent's care of Patient D, while not within the standard of care, did not rise to the level of a severe departure from the accepted standard of care for radiation oncologists. However, the Hearing Committee finds that the Respondent's treatment of Patients A, B, C, E, F and G severely departed from the standard of care for these patients.

The Hearing Committee has serious concerns about the Respondent's lack of insight as to the impact of his treatment decisions concerning patients A through G. Throughout the hearing, at no time did the Respondent accept responsibility for his actions and the dire consequences thereof. There was no sense of contrition from the Respondent, and the Hearing Committee believes that if his license is reinstated, the Respondent would continue with these same harmful practices.

Physicians must comply with among the highest of ethical standards, which become of utmost importance when treating patients who face life or death decisions. These patients need to make the appropriate choices that enable them to obtain pain relief and comfort when there is no available cure for their disease. It is the responsibility of the physician to properly guide such patients in order to offer them the most appropriate and optimal treatments available.

In addition to doubting the Respondent's insight regarding the impact of his treatment decisions, the Hearing Committee concludes that the Respondent's treatment of Patients A, B, C, E, F and G demonstrate that he is a danger to potential new patients should he be reinstated as a radiation oncologist. Accordingly, the Hearing Committee concurs with the Department's recommendation that the Respondent's license be revoked.

## ORDER

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

1. The First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, Eleventh, Twelfth, Thirteenth, Fourteenth, Fifteenth and Sixteenth Specifications of professional misconduct, as set forth in the Statement of Charges, are **SUSTAINED**; and

2. The Seventeenth Specification of professional misconduct, as set forth in the Statement of Charges, is **NOT SUSTAINED**; and

3. Pursuant to PHL § 230-a(4), the Respondent's license to practice medicine in the State of New York is **revoked**; and

4. This Determination and Order shall be effective upon service on the Respondent. Service shall be either by certified mail or upon the Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: **Albany, New York**
**February 04, 2022**

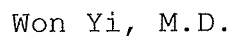
**ELISA J. WU, M.D. (CHAIR)**

**DEBORAH WHITFIELD**
**STEVEN M. LAPIDUS, M.D.**

TO: Ian H. Silverman, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower Building
Room 2512
Empire State Plaza
Albany, New York 12237-0032

Anthony Z. Scher, ESQ.
Attorney for Respondent
800 Westchester Avenue
Suite N641
Rye Brook, New York 10573

Won Yi, M.D.



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

| IN THE MATTER OF WON YI, M.D. | STATEMENT OF CHARGES |
|---|---|

WON YI, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 20, 2006 by the issuance of license number 240628 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (each patient is identified in the attached Appendix A), a forty-three-year-old female patient, at Respondent's offices at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about September 13, 2012, to on or about December 20, 2012, when Patient A expired. Respondent's medical care of Patient A deviated from accepted standards of care as follows:

1. Respondent, from September 18, 2012 to November 1, 2012, administered an excessive course of whole brain radiotherapy to Patient A's dominant right frontal lobe lesion, contrary to medical indications and/or without documenting such indication.
2. Respondent's treatment plan, despite the fact that Patient A previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy,

and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

3. Respondent, contrary to medical indication and/or without documenting such indication, failed to adequately account for available radiographic findings from the March 2012 and August 2012 MRIs in planning for radiotherapy.

B. Respondent provided medical care to Patient B, a seventy-two-year-old male patient, at Respondent's offices at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about February 9, 2009 to on or about March 14, 2012, when Patient B expired. Respondent's medical care of Patient B deviated from accepted standards of care as follows:

1. Respondent treated Patient B with prostate radiotherapy from February 12, 2009 to May 20, 2009, without adequate medical indication that he was symptomatic and or without documenting such adequate medical indication.

2. Respondent, contrary to medical indication and/or without documenting such indication, administered to Patient B multiple courses of radiotherapy that exceeded commonly prescribed palliative doses for metastatic disease and/or exceeded conventional daily fractionation schema.

3. Respondent, contrary to medical indication and/or without documenting such indication, failed to consider alternative treatment strategies, even as Patient B's condition declined throughout the series of treatment courses.

4. Respondent, without adequate medical indication and/or without documenting such adequate medical indication, treated Patient B's right jaw with radiotherapy, from August 26, 2011 to September 26, 2011, despite lacking clear radiographic evidence that Patient B was even experiencing metastatic disease at this site.

5. Respondent's treatment plan, despite the fact that Patient B previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy, and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

C. Respondent provided medical care to Patient C, a sixty-four-year-old male patient, at Respondent's offices at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about April 6, 2012 to on or about June 6, 2013, when Patient C expired. Respondent's medical care of Patient C deviated from accepted standards of care as follows:

1. Respondent, contrary to medical indication and/or without documenting such medical indication, introduced radiotherapy almost immediately after Patient C began therapy with androgen blockade.

2. Respondent, contrary to medical indication and/or without documenting such medical indication, failed to refer Patient C to a medical oncologist upon noticing Patient C's rising PSA.

3. Respondent, contrary to medical indication and/or without documenting such medical indication, failed to consider alternative treatment strategies, even as Patient C's condition declined throughout the series of treatment courses.

4. Respondent, contrary to medical indication and/or without documenting such indication, administered to Patient C multiple courses of radiotherapy that exceeded commonly prescribed palliative doses for metastatic disease and/or exceeded conventional daily fractionation schema.

5. Respondent's treatment plan, despite the fact that Patient C previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy, and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

6. Respondent, without adequate medical indication and/or without documenting such medical indication, delivered radiotherapy for metastatic disease to an asymptomatic site.

D. Respondent provided medical care to Patient D, a forty-six-year-old male patient, at Respondent's offices at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about January 20, 2012 to on or about May 22, 2013. Respondent's medical care of Patient D deviated from accepted standards of care as follows:

1. Respondent's treatment plan, despite the fact that Patient D previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy, and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

E. Respondent provided medical care to Patient E, a forty-three-year-old female patient, at Respondent's office at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about October 4, 2012 to on or about February 23, 2013, when Patient E expired. Respondent's medical care of Patient E deviated from accepted standards of care as follows:

1. Respondent, without adequate medical indication and/or without documenting such medical indication, treated Patient E's rectal primary and liver from October 9, 2012 to November 9, 2012, despite the fact that she was initially asymptomatic.

2. Respondent, without adequate medical indication and/or without documenting such medical indication, treated Patient E to a second course of radiotherapy to her liver from February 4, 2013 to February 15, 2013, despite the fact that Patient E presented with no clinical evidence of impaired liver function.

3. Respondent, contrary to medical indication and/or without documenting such indication, administered to Patient E multiple courses of radiotherapy that exceeded commonly prescribed palliative doses for metastatic disease and/or exceeded conventional daily fractionation schema.

4. Respondent, contrary to medical indication and/or without documenting such medical indication, failed to consider alternative treatment strategies, even as Patient E's condition declined throughout the series of treatment courses.

F. Respondent provided medical care to Patient F, a sixty-two-year-old male patient, at Respondent's office at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about February 16, 2012 to on or about May 20, 2013, when Patient F expired. Respondent's medical care of Patient F deviated from accepted standards of care as follows:

1. Respondent, contrary to medical indication and/or without documenting such indication, administered to Patient F multiple courses of radiotherapy that exceeded commonly prescribed palliative doses for metastatic disease and/or exceeded conventional daily fractionation schema.

2. Respondent's treatment plan, despite the fact that Patient F previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy, and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

3. Respondent, contrary to medical indication failed to comprehensively stage Patient F's disease and to determine what the goal of the therapy was and/or failed to document what the goal of the therapy was.

G. Respondent provided medical care to Patient G, a twenty-seven-year-old male patient, at Respondent's office at 45 Spindrift Drive, Williamsville, NY 14221; 2950 Elmwood Avenue, Kenmore, NY 14217; 810 Davison Road, Lockport, NY 14094; and/or 6932 Williams Road #1400, Niagara Falls, NY 14304 at various times from on or about May 11, 2011 to on or about March 14, 2012, when Patient G expired. Respondent's medical care of Patient G deviated from accepted standards of care as follows:

1. Respondent, contrary to medical indication failed to comprehensively stage Patient G's disease and to determine what the goal of the therapy was and/or failed to document what the goal of the therapy was.

2. Respondent's treatment plan, despite the fact that Patient previously was treated with radiotherapy, failed to account for such prior doses of radiotherapy, and thus exceeded appropriate tissue tolerances, contrary to medical indication and/or without documenting such indication.

3. Respondent, contrary to medical indication and/or without documenting such indication, administered to Patient G multiple courses of radiotherapy that exceeded commonly prescribed palliative doses for metastatic disease and/or exceeded conventional daily fractionation schema.

## SPECIFICATION OF CHARGES

## FIRST THROUGH SEVENTH SPECIFICATION

### GROSS NEGLIGENCE

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

1. A and A1, A and A2, and/or A and A3;
2. B and B1, B and B2, B and B3, B and B4, and/or B and B5;
3. C and C1, C and C2 and C and C3, C and C4, C and C5, and/or C and C6;
4. D and D1;
5. E and E1, E and E2, E and E3, and/or E and E4;
6. F and F1, F and F2, and/or F and F3; and/or
7. G and G1, G and G2 and/or G and G3.

## EIGHTH THROUGH FOURTEENTH SPECIFICATION

### GROSS INCOMPETENCE

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

8. A and A1, A and A2, and/or A and A3;
9. B and B1, B and B2, B and B3, B and B4, and/or B and B5;

10. C and C1, C and C2 and C and C3, C and C4, C and C5, and/or C and C6;

11. D and D1;

12. E and E1, E and E2, E and E3, and/or E and E4;

13. F and F1, F and F2, and/or F and F3; and/or

14. G and G1, G and G2 and/or G and G3.

## FIFTEENTH SPECIFICATION

## NEGLIGENCE ON MORE THAN ONE OCCASION

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

15. A and A1, A and A2, A and A3, B and B1, B and B2, B and B3, B and B4, and B and B5, C and C1, C and C2 and C and C3, C and C4, C and C5, C and C6, D and D1, E and E1, E and E2, E and E3, E and E4, F and F1, F and F2, F and F3, G and G1, G and G2 and/or G and G3.

## SIXTEENTH SPECIFICATION

## INCOMPETENCE ON MORE THAN ONE OCCASION

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

16. A and A1, A and A2, A and A3, B and B1, B and B2, B and B3, B and B4, and B and B5, C and C1, C and C2 and C and C3, C and C4, C and C5, C and C6,

D and D1, E and E1, E and E2, E and E3, E and E4, F and F1, F and F2, F and F3, G and G1, G and G2 and/or G and G3.

## SEVENTEENTH SPECIFICATION

## FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) 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:

17. A and A1, A and A2, A and A3, B and B1, B and B2, B and B3, B and B4, and B and B5, C and C1, C and C2 and C and C3, C and C4, C and C5, C and C6, D and D1, E and E1, E and E2, E and E3, E and E4, F and F1, F and F2, F and F3, G and G1, G and G2 and/or G and G3.

DATE: August 6, 2018
Albany, New York

Michael A. Hiser, Esq.
Deputy Counsel
Bureau of Professional Medical Conduct