DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

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

Dennis P. Whalen
Executive Deputy Commissioner

March 20, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin P. Donovan, Esq.
NYS Department of Health
Corning Tower - Room 2438
Empire State Plaza
Albany, New York 12237

Mark Albert Binder, M.D.
451 North Terrace Avenue
Mount Vernon, New York 10552

Mark Albert Binder, M.D.
PO Box 9009
Mount Vernon, New York 10552

RE: In the Matter of Mark Albert Binder, M.D.

Dear Mr. Donovan and Dr. Binder:

Enclosed please find the Determination and Order (No. BPMC 97-70) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

COPY

IN THE MATTER

OF

MARK ALBERT BINDER, M.D.

DETERMINATION

AND

ORDER

BPMC-97-70

ALBERT L. BARTOLETTI, M.D., Chairperson, **PAUL J. WEINBAUM, M.D.** and **NANCY J. MACINTYRE, R.N. Ph.D,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.,** served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **HENRY M. GREENBERG,** General Counsel, **KEVIN P. DONOVAN, ESQ.,** Associate Counsel. The Respondent did not appear and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged eighteen (18) specifications of professional misconduct, including allegations of gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, conduct evidencing moral unfitness, fraud, failure to make available medical records, permitting, aiding or abetting an unlicensed person to perform duties requiring a license and permitting an unauthorized person to share in fees.

The charges are more specifically set forth in the Statement of Charges dated September 11, 1996, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	September 11, 1996
Pre-Hearing Conference:	November 5, 1996
Hearing Dates:	November 8, 1996 December 5, 1996 December 9, 1996 December 16, 1996
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	January 9, 1997
Received Respondent's Proposed Findings of Fact, Conclusions of Law:	None submitted
Deliberation Date:	January 15, 1997
Places of Hearing:	Legislative Office Bldg., Rm. 104A Empire State Plaza Albany, New York; and Bureau of Adjudication NYS Department of Health Hedley Park Place- 5th Fl. Troy, New York

WITNESSES

For the Petitioner:	Patient A Husband of Patient A Sunhee Hill Robert O' Keefe Timothy J. Vinciguerra, M.D. Raymond D. Fish, Sr. Leilani Pieringer Melonie Rooker Michael A. Durant Patient C Louis P. Gagliardi, M.D. William K. Rashbaum, Sr., M.D.
For the Respondent:	None

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS

1. Mark Binder, M.D., the Respondent, was authorized to practice medicine in New York State on October 2, 1990, by the issuance of license number 184074 by the New York State Education Department (Ex. 2)[1]. He is not board certified (T. 202).

2. Respondent was personally served with the Notice of Hearing, Statement of Charges, and Summary of Department of Health Hearing Rules (Ex. 1).

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[1]Ex. ___ or T. ___ are references to exhibits in evidence or pages of the transcript of the proceeding.

3. A prehearing conference was held on November 5, 1996, at which Respondent was represented by counsel (see prehearing conference transcript).

4. Hearing dates were held on the following dates in 1996: November 8, December 5, December 9, and December 16.

5. Neither Respondent nor his counsel appeared at any of the hearing dates, nor did Respondent submit any evidence. (ALJ 3)

6. Respondent performed terminations of pregnancies for American Women's Services (AWS) (T. 181-182).

7. American Women's Services (AWS) opened up an office at 1522 Central Avenue, Albany (Town of Colonie), New York, in November, 1994 (T. 246-47, 280).

8. AWS was the name by which American Medical Management, Inc., and American Medical Services, did business (T. 182, Ex. 6). Employees were paid by checks out of the account of American Medical Management, Inc. (AMM) (T. 124, 281). Receipts to patients showed that the fees were paid to American Medical Services, Inc. (Ex. 6 at 5, Ex. 13, 14).

9. AWS advertised in the local paper for personnel in October 1994 (T. 117, 280). Applicants met with Elizabeth Navarra, who was introduced as the director and manager of AWS (T. 118, 280). She received fees from patients (T. 124).

10. Stephen Brigham was the owner, operator, and principal of AWS (T. 120, 242- 243, 246). He was introduced to staff in October 1994 as a physician and told employees that he was available to answer any medical questions about procedures (T. 120, 122).

11. The only signatories on all of the professional medical corporation accounts were Steven Brigham and Elizabeth Navarra (Ex. 30).

12. When difficulties arose, Navarra contacted Brigham for resolution, and Respondent asked her to contact him (T. 123, 246). Respondent would contact Brigham when there was a problem or a complaint from a patient (T. 246).

13. Beginning in January 1994, and continuing to this date, Stephen Brigham was no longer authorized to practice medicine in New York State (Stipulation of parties, see Prehearing Conference Transcript at 107; official notice of NYS Education Department physician licensure files).

14. Respondent was not an owner or principal of AWS. He was an independent contractor (T. 181-182, 189). He was paid by checks from the account of American Medical Management, Inc. for performing terminations at AWS in Albany and at their office in Nanuet (T. 182).

15. Patients paid AWS directly and Respondent was paid a fee based on the number of cases he did (T. 183-184). The only exception was that Respondent would bill directly to Medicaid for Medicaid patients. Amounts he received from Medicaid would be deducted from the fee he received from AMM (T. 184).

16. Respondent had no privileges at any hospital in the Albany area during the time he was performing terminations in Albany (T. 186,188). He told an investigator for the Office of Professional Medical Conduct (OPMC) that he had applied for privileges at Albany Memorial, but he had not done so (T. 186).

17. During his interview with OPMC, Respondent refused to identify the names of the physician principals of AWS or AMM (T. 191).

18. Respondent's schedule appeared to be as follows: He would arrive at AWS in Albany Wednesday afternoon and work there that afternoon and Thursday morning. He would then drive to AWS at Nanuet and work there Thursday afternoon and Friday morning, after which he would drive to Albany and work there Friday afternoon and Saturday morning, then return to Nanuet office (T. 127). Nanuet and Albany are about 150 miles apart (official notice of distance), Prince, Richardson on Evidence, §2-204 (11th ed).

19. Based on where Respondent was scheduled, patients would have to travel from one clinic to the other to have their case completed. (T. 266-267)

20. Respondent was the physician performing procedures at AWS in Albany (T. 180-181, 281).

21. Respondent had the gestational age of the fetuses estimated by ultrasound (T. 249, 253). The estimated gestational weeks would be displayed on the ultrasound machine (T. 255).

22. Respondent would use the Hobbins scale to convert from BPD measurement to weeks of gestation unless the gestational age read over 24 weeks. Then, Respondent would ask the technician to not print out that reading, but to switch to the Campbell scale to obtain a reading of 24 weeks or under (T. 255). The lower number of weeks gestation would then be printed (T. 255). For example, at 6.0 BPD, the gestational age, according to the Hobbins scale, would be 25.5 weeks (T. 254). In those cases, Respondent would tell the ultrasound technician to change the measurement scale to Campbell, which resulted in a gestational age of 22.4 weeks (T. 254). Respondent would then have the lower gestational age printed for the record (T. 255).

23. Respondent told the ultrasound technician that noting the weeks of gestation to be under 24 weeks on the report looked better (T. 271-272).

24. The ultrasound technician told Respondent that using the Campbell scale in the U.S. was not valid, and that she had been told this at a lecture given by Campbell himself (T. 256). Respondent did his own research on this and informed the technician that she was right, that the different power sources result in different measurements, and that a mathematical conversion is necessary to make the Campbell scale valid in the United States (T. 256-257). However, Respondent continued to use the Campbell scale without any mathematical conversion (T. 257).

25. Ultrasound is not accurate to the day of gestational age. In the second trimester, there is error of at least plus or minus ten days of the actual age of the fetus (T. 276). This means the fetus could be 10 days older than reported by ultrasound (T. 276). Respondent knew this (T. 276).

26. On April 26, 1996, Respondent was personally served with a letter requiring that he produce, within 30 days, original sonograms for Patients A and B. The letter stated that the records were relevant to an inquiry or complaint about his misconduct and that failure to produce the records may form the basis for charges of professional misconduct (T. 187, Ex. 3).

27. Respondent did not produce the sonograms (T. 188).

28. Respondent had custody and control of the medical records for Patients A and B. as established by a finding of the Supreme Court in a proceeding concerning Respondent (Ex. 26). In that proceeding, the Supreme Court ruled that Respondent was the owner or custodian of the patient records of AWS between March 30, 1993, and March 8, 1996 (Ex. 26 at 5-8, 14). Respondent treated Patient A at Nanuet and Albany in November 1994, and Patient B in August 1995 (Ex. 4, Ex. 8). As the records of both Patients A and B fall within that time frame, the Respondent was the custodian of the records of Patients A and B.

29. Patient A was pregnant in November 1994 (T. 25, 78, Ex. 4 at 12). She and her husband decided to terminate the pregnancy (T. 25, 78).

30. Patient A contacted American Women Services (AWS), located in Nanuet, New York after finding the AWS telephone number in the local phone book at their home in Maryland (T. 25-26). She made an appointment for the Friday after Thanksgiving, November 25, 1994 (T. 26-27, Ex. 4 at 12).

31. Upon arrival at AWS, she paid a fee for the termination of pregnancy (TOP) based on an estimated fetal gestational age of 15 weeks (Ex. 4 at 15, T.28, Ex. 6). Following two sonograms, she was charged an additional fee and was given a receipt stating that the pregnancy was 24 weeks (Ex. 4 at 15, Ex. 6, T. 28-29). The patient was told the fee was larger because the weeks were more (T. 57). Payment was to American Medical Services, P.C. (T. 30, Ex. 6).

32. Ultrasound is the most accurate measurement of the duration of the pregnancy (T. 367). Estimating fetal ages is important because morbidity and mortality increase with duration of pregnancy (T. 368). Furthermore, law regulates when terminations of pregnancy may be performed (T. 368, Ex. 11 - New York Penal Law §125.45).

33. Following payment, by Patient A, Respondent inserted laminaria into her to dilate the cervix so that the products of gestation may be removed with special instruments (T. 33, 366, Ex. 4 at 21).

34. After insertion of the laminaria, she rejoined her husband in the waiting area. She and her husband were informed that they would need to travel to Albany, where Dr. Binder would be, to have a second set of laminaria inserted (T. 33-34, 82). They were given a xerox copy of directions to Albany (T. 34)

35. The patient and her husband drove to Albany that day and went to the Albany AWS office located at 1522 Central Avenue at 6:00 p.m. Respondent inserted another set of laminaria and the patient was told of a nearby hotel to spend the evening, and to report the next morning again at the AWS office (T. 35-36, 83, 129, Ex. 4 at 17).

36. The next morning, November 26, 1994, Patient A presented at the Albany AWS office at 1522 Central Avenue (T. 37, 85, Ex. 4 at 4, 19). Patient A's husband stayed in the waiting area and the patient was taken for the procedure (T. 86).

37. Following insertion of an IV and removal of her underpants and lifting her skirt up, some anesthesia was given and the procedure was started (T. 38, Ex. 4 at 4). Respondent was the only physician at AWS (T. 65).

38. During an approximately 15 minute attempt to complete the procedure, Respondent ruptured the patient's membrane and cut the umbilical cord (T. 41, 134-35, Ex. 4 at 4).

39. Respondent reported to staff that he was unable to complete the procedure because a fibroid was blocking his access to the uterus (T. 87, 136, Ex. 4 at 4).

40. He asked the patient if she had insurance (T. 137). Respondent left the room with Navarra and they contacted Brigham about how to handle the case (T. 261).

41. During the procedure the patient lost a significant amount of blood, more than the usual amount for a termination (T. 135-136, 286).

42. The patient moved a lot during the procedure due to pain (T. 37, 39, 135).

43. At the time Respondent began to perform the termination of pregnancy on Patients A, B, and C, he did not have privileges at a hospital in the Albany area (T. 186, 287). Staff at AWS had been told that there was backup with Dr. Gagliardi (T. 139, 160), but there was no such arrangement (T. 348-349). On interview with OPMC Respondent stated that the had a backup arrangement with a local physician, but did not identify the person (T. 186).

44. Respondent had privileges at Beth Israel Medical Center in New York City and Saint Agnes in White Plains (T. 188).

45. Terminations performed later in the second trimester carry greater risks due to the thinness of the uterus as pregnancy progresses, its greater vascularity, and greater calcium in the fetus (T. 368-369). The thinness of the uterus can result in more easily perforating that organ. The uterus's greater vascularity can result in greater bleeding or hemorrhage and greater calcium in the fetal bone can result in those bones having a greater likelihood of perforating the uterus (T. 368-369). There is a greater risk of damage to intraperitoneal organs (T. 368).

46. Failure to promptly respond to the occurrence of the risks can result in severe hemorrhage, infection, and even death of a patient (T. 369).

47. The patient was dressed and moved to a waiting area with the IV kept in (T. 39). Her husband was brought back to where she was (T. 86-87, 138, 286). She sat on pads for her bleeding (T. 287).

48. When Respondent decided that he could not complete the procedure, he began discussing this with the patient and her husband. He stated that the cord was cut and the fetus was dead (T. 87). He discussed the option of transporting the patient to a hospital in New York City for completion of the procedure (T. 40-41). Respondent referred to this transport as "across town." (T. 40, 42, 61-62, 89).

49. Respondent was asked by staff and the patient why the patient could not be transported to a hospital in the Albany area for completion of the procedure (T. 40, 42, 88-89). The patient wanted to go to a local hospital (T. 91, 143). Respondent replied that hospitals in the Albany area could not or did not perform the procedure she required (T. 42, 88-89).

50. Respondent contacted Dr. Gagliardi to see if he would handle the case of Patient A (T. 345). Dr. Gagliardi refused (T. 345). Respondent reported to Dr. Gagliardi that he had started a termination on a woman and found her to be farther along than he had expected, and the case could not be handled on an ambulatory basis (T. 345).

51. Before the case of Patient A, Respondent had called Dr. Gagliardi when he had a problem with a case that required hospitalization of the patient (T. 343). Respondent told Dr. Gagliardi that he had no privileges at a local hospital or any backup (T. 343). Dr. Gagliardi told Respondent he should obtain hospital privileges before performing terminations (T. 346-348).

52. Following Respondent's cutting the umbilical cord, the fetus would have died within ten to fifteen minutes (T. 223). Treatment of such a case would include inducing labor and delivering the dead fetus (T. 223).

53. Respondent treated the patient at Beth Israel Medical Center in New York City, New York, by induction of labor after fetal demise (T. 224, Ex. 5 at 5).

54. Albany Medical Center, located in the City of Albany, had the capability and open beds on November 26, 1994, to treat Patient A for her condition or for any complication that could have arisen (T. 223).

55. Furthermore, there were several other hospitals in the Albany metropolitan area with the capability of handling Patient A's condition (T. 226).

56. Albany Medical Center would have treated Patient A even if Respondent did not have privileges (T. 224). A member of the obstetrics gynecology department or the emergency department would have made the arrangements for admission even if there were no advance notice (T. 225).

57. Respondent reported in the patient's medical record that he was unable to locate an ambulance service that would transport the patient to New York City, that ambulances were not available or in the case of Mohawk Ambulance "refused due to liability" (Ex. 4 at 5). Respondent's signature is at the bottom of that note, meaning he agrees with its contents even if he did not write it himself (T. 396-397).

58. Contrary to Respondent's note, Doctors Ambulance had two crews available on November 26, 1994, between the hours of 10:00 a.m. and 10:45 (T. 231). The owner of Doctors Ambulance did not remember any phone call concerning a request for transport to New York City of a patient who had a partial termination of pregnancy performed (T. 237).

59. Even with the two available crews, Doctors Ambulance would have refused to perform the transport to New York City because they lacked the capability for transport of a patient who had a termination started, such as Patient A (T. 232), and because there was no medical necessity for the transport (T. 233-234). Medical necessity for transport out of an area only exists when no facility in the area could handle the case (T. 234). There was no medical necessity here as Albany Medical Center could have handled this patient 's care (T. 233-234).

60. Respondent's note also states that both Medicab Ambulance and Care-A-Vans Ambulette were not available (Ex. 4 at 5). There is no Medicab Ambulance; the correct name is Medicab Ambulette (T. 234-235). Neither Medicab nor Care-A-Vans have the capability to handle the transport of this patient (T. 235).

61. An AWS employee who was also employed by Mohawk Ambulance called her Mohawk supervisor and asked if Mohawk would do the transport. He told the AWS employee that they would only transport a patient to New York City if a local hospital could not handle the case (T. 141-142). Mohawk was willing to transport the patient to Albany Medical Center (T. 142-143). The AWS employee told all of this information to Respondent (T. 143).

62. Respondent suggested air transport, but the patient refused due to the cost (T. 42, 88).

63. After Respondent told her that no ambulance was available, the patient stated that she could be driven by her husband to the hospital (T. 43-44). Respondent agreed, and it was decided that the patient would be driven in her family vehicle by her husband, with the patient and an employee of AWS in the back seat (T. 43, 91-92). Respondent would lead in a car to be followed by the patient's husband driving the patient in their own vehicle (T. 43).

64. Respondent never discussed with Patient A the risks associated with being transported from Albany to New York City in her family vehicle (T. 43, 90).

65. The risks of the transport would include: delivery of fetus, internal bleeding from possible perforation (T. 385-386). These risks could result in patient death (T. 386).

66. Following the decision that the procedure could not be completed at just before 10:00 in the morning, the patient had to wait at AWS until approximately noon before transport began, while Respondent performed terminations on other patients (T. 44-45).

67. Complications can occur from delay in instituting appropriate care, such as occurrence of the complications and risks mentioned before (T. 392-393).

68. Before the transport of the patient in their own vehicle, Patient A's husband, who had a cellular phone, asked Dr. Binder, who also had a cellular phone, for his phone number. This was so that he could contact Dr. Binder while driving in the event of an emergency (T. 48, 92). Respondent refused to provide his cell phone number (T. 48, 92).

69. Between the time the patient was dressed and removed from the procedure room until the time the patient and Respondent left AWS, at approximately noon, Respondent did not perform an examination of the patient (T. 41, 90). In addition to the testimony of the patients on this point, Respondent did not note his performance of any physical in the patient's record (See Ex. 4).

70. After Respondent left AWS with Patient A, her husband, and an AWS employee, Respondent did not immediately proceed to the New York State Thruway to travel to New York City. Instead, he led Patient A's vehicle to a hotel in the Albany area to pick up a female (T. 46, 93), who was his girlfriend (T. 196). Respondent went into the hotel and left Patient A in the car (T. 46). He was in the hotel between 20 and 45 minutes and emerged with a female companion (T. 46, 49, 93).

71. At the hotel, Respondent went to Patient A's car and asked how she was doing. He did not examine her in any way (T. 47, 93-94, 147).

72. The patient left AWS with her IV in place (T. 73). The IV had no pump, it was just hanging and dripping (T. 75). Respondent provided no other medical equipment for the patient, nor did he provide any instruction to the AWS employee who was accompanying Patient A to New York City (T. 47, 92, 98, 145-146, 163). This employee was not trained in nursing, she was an emergency medical technician with training in basic first aid and cardiopulmonary resuscitation (T. 116). On her own initiative, the employee brought Chux pads for the patient to sit on because she was still bleeding, and an extra bag of fluid (T. 47-48, 164).

73. About an hour before reaching Beth Israel Medical Center in New York City, Respondent pulled over at a Thruway rest area (T. 50, 94, 98). Respondent went to the patient's car and asked how the patient was doing, but he did not examine her in any way (T. 50, 95, 148).

74. At the rest area, Respondent got into another vehicle, left Patient A, and went to the Nanuet office of AWS (T. 50-51, 149). He left instructions for the patient to follow Respondent's female companion, who was not a physician, for the rest of the journey to the hospital (T. 51, 150).

75. Respondent did not record in his office chart that the patient was transported from Albany County to New York City by private automobile (Ex. 4). Instead, the record indicates that the patient was to be transported to New York City by Air Response (Ex. 4 at 5, 16).

76. Respondent's record for the patient creates a fraudulent impression that the patient was transported by air.

77. When the patient arrived at Beth Israel Medical Center, she and her attendant were dropped off by her husband who parked the car; her clothes were soaked with blood and she felt faint (T. 51).

78. The patient's blood count at Beth Israel showed that she had significant blood loss (T. 401-402).

79. The patient proceeded to the labor/delivery area as instructed by Respondent's female companion (T. 401). The personnel in that department did not expect them (T. 151-152). The patient arrived at the labor and delivery at approximately 5:30 p.m., Respondent arrived at approximately 6:30 (Ex. 5 at 14, 12).

80. Following Pitocin induction of labor, the fetus was expelled at 2:05 in the morning of November 27 (Ex. 5 at 19).

81. When Navarra arrived back in Albany, she spoke with Respondent by telephone. Respondent asked Navarra to ask Brigham to obtain a particular medical instrument for him (T. 156).

82. Respondent completed a Certificate of Spontaneous Termination of Pregnancy for this patient (Ex. 7, p.2).

83. This was not a spontaneous termination of pregnancy, it was an elective induced termination (T. 397).

84. Patient B presented to the Nanuet office of American Women Services (AWS) on July 30, 1995 (Ex. 8 at 27). She was noted to be 23 weeks pregnant by dates (Ex. 8 at 10).

85. Actually, the patient would be just over 24 weeks based on her last menstrual period (T. 409-410).

86. A first set of laminaria were inserted on August 3, 1995, at Nanuet, and a second set was inserted in Albany (Ex. 8 at 2).

87. On August 4, 1995, Respondent performed a termination of pregnancy procedure on Patient B. Respondent noted that the preoperative estimated gestational age was 23 weeks (Ex. 8 at 6, 10,18,22).

88. As with Patient A, Respondent had no privileges at any local hospitals nor any hospital coverage backup agreement with either a local hospital or a physician who had privileges (T. 287).

89. Respondent requested the ultrasound technician to assist him during the procedure by operating the ultrasound equipment so that he could view the placement of his instruments internally (T. 263).

90. When the ultrasound technician entered the room, she immediately noticed that the patient seemed very large and she told Respondent that (T. 263). It seemed pretty apparent that the fetus would have been pretty far along (T. 265).

91. As soon as the ultrasound technician could visualize the fetus on her equipment, she said told Respondent that the lady was very large and was at least a 6.4 BPD, but she could not tell him the exact dates because she had not put in a conversion from size of BPD to weeks of pregnancy (T. 263). The ultrasound technician thought the fetus was 26-27 weeks by ultrasound and that if she had been the original ultrasound technician, the procedure would not have been done (T. 290).

92. Respondent had previously told the ultrasound technician that he would do a termination on a fetus up to 6.0 BPD because that would still be less than 24 weeks (T. 253).

93. Respondent replied that it was too late to stop because the patient was dilated and she had ruptured membranes (T. 263).

94. Respondent completed the procedure on Patient B and the fetus was taken to another room, the lab, for analysis (T. 264, 291).

95. The technician in the lab reported the fetal weight as 770 grams and the fetal foot length at 55 millimeters, but she did not write a final estimated gestational age (Ex. 8 at 7).

96. Respondent signed the operative and post-operative findings, leaving blank the estimated gestational age (Ex. 8 at 7).

97. A nurse who worked in the procedure room reported that when the fetus was removed she thought it looked a little smaller than 30 week old fetuses she had seen delivered at a local hospital (T. 291).

98. This nurse went to the room where the fetus was assessed after removal, measured its foot herself, and found that the fetal foot length correlated with a 26 to 28 week pregnancy (T. 289, 291).

99. The inaccuracy of one of the sonograms of Patient B can be seen even on the photocopy (Ex. 3 at 11), because the dotted line that measures BPD is at less than a 90 degree angle, making it too short (T. 410). The original sonogram print would permit certainty as to whether the BPD (thus fetal age) is grossly underestimated (T. 411). While review of the photocopies of the sonogram does not permit an opinion as to gestational age, the fetus is large and late, such as 26 or 27 weeks (T. 414). The sonogram was done four days before the termination (Ex. 8 at 10, 22).

100. It is the responsibility of Respondent to assure that the sonogram is accurate (T. 414).

101. While the margin of error for sonograms is plus or minus seven to ten days, all indications here are that the fetus is larger, not smaller (T. 414).

102. The funeral director who disposed of the fetal remains had over 26 years of experience (T. 309). He had seen many cases of fetal deaths and stillborns (T. 312). In those cases he would be provided with the age of fetus (T. 313).

103. The funeral director's assessment was that this was much larger than any 24 week old fetus he had ever seen (T. 313), and that this fetus was the equivalent in size to a fetus that was seven to eight months (T. 314).

104. When the funeral director first went to AWS, he met with Liz Navarra and Respondent. He was told by them that the reason the fetus needed to be disposed of by the funeral director was that its weight exceeded a certain amount (T. 310).

105. There is no requirement in New York law for disposition of a fetus based on its weight. The only requirement for disposition with a permit comes when a fetus is over twenty weeks [See Public Health Law § 4162(1)].

106. Payment for the funeral director's services was drawn on the account of American Medical Services, PC (Ex. 10).

107. It is the responsibility of the physician to properly assess fetal age before performing a TOP (T. 414). Assessment of fetal age is important to determine the type of procedure to be performed, which depends on fetal age, and to determine whether performing the procedure is within the fetal age limits permitted by law (T. 367-368).

108. The most accurate method for determining fetal age is by ultrasound (T. 367).

109. New York Penal Law prohibits performing a termination of pregnancy on a fetus that exceeds 24 weeks of pregnancy or 24 weeks after fertilization (New York Penal Law § 125.45) (Ex.11).

110. Gestational age is normally calculated from the first day of the last menstrual period (T. 374). Normally, fertilization occurs after the last menstrual period, so gestational age is considered to be actually two weeks greater than the age of the fetus as measured from time of conception (T. 374).

111. The ultrasound performed preoperatively was obviously inaccurate (T. 410). The inaccuracy resulted in the sonogram showing a lower biparietal diameter (BPD) of the fetal head (T. 411). This is obvious when a physician looks at the ultrasound, as the technician did not have the fetal skull positioned properly in the ultrasound to obtain a measurement of the maximum biparietal diameter (T. 410).

112. Failure to note and record the maximum biparietal diameter will result in a lower than true reading, and therefore underestimates the true fetal age (T. 411).

113. The measurement of the fetal foot at 55 millimeters (Ex. 8 at 7) means the fetus was over 26 weeks (T. 418).

114. It is clear that this fetus was well over 26 weeks from last menstrual period, or over 24 weeks of pregnancy (T. 418).

115. On the certificate of fetal death, Respondent noted the clinical estimate of gestation of the fetus to be 24 weeks (Ex. 9, item 22).

116. The clinical estimate of gestation reported postoperatively should be based on the examination of the fetus after removal from the patient, not the preoperative estimate (T. 421).

117 Respondent had a clear motive for noting the gestational age as being 24 weeks, because noting a higher number of weeks would raise questions as to whether the termination had been performed in violation of the criminal law (See Penal Law § 125.45) (Ex. 11).

118. Respondent was notified by the ultrasound technician that the fetus was over the legal limit (and Respondent's 6.0 BPD limit) for termination. (T. 415).

119. Patient C was pregnant on July 28, 1995, when she presented to American Women Services on Central Avenue in Albany for a TOP (Ex. 12 at 10).

120. Patient C, a Medicaid recipient, was noted as having her services covered by Medicaid on the two receipts she received, which showed the payments were made to American Medical Services, P.C. (Ex. 13).

121. After an ultrasound was performed, the patient was notified that she was carrying twins and that ultrasound guidance would be required during the procedure (T. 325). Navarra told her that there would be an additional fee for this ultrasound guidance which was not covered by Medicaid (T. 325).

122. Patient C asked how there could be an additional fee since Medicaid covered her medical bills. Navarra said that Medicaid did not cover this (T. 325).

123. Patient C asked if she could pay in installments and Navarra said that she could not, and that cash or credit card was required before the procedure could be done (T. 322).

124. Patient C called her boyfriend who came and also asked how there could be an additional charge for a Medicaid payment (T. 322). Her boyfriend did pay the demanded additional $160.00 for the patient's procedure (T. 324, Ex. 14).

125. Neither the Medicaid nor credit card receipts were included in the records Respondent provided to OPMC for Patient C (See Ex. 12).

126. There was no medical justification for use of ultrasound guidance to perform the terminations for Patient C (T. 435).

127. The ultrasound technician, from the beginning of her employment with AWS beginning around October 1994, questioned the additional fee for Medicaid patients (T. 259-260).

128. In a telephone conversation with Steven Brigham, the ultrasound technician questioned why these fees were charged, particularly since she was paid on an hourly rate and the performing of the ultrasound guidance during a procedure resulted in no additional cost to American Women Services (T. 243). In that telephone conversation, Brigham stated that the additional charges were dictated by Respondent, and that Respondent kept the money resulting from those charges (T. 245-246).

129. Respondent was told by the ultrasound technician that she thought the extra charge for ultrasound guidance was unfair because it did not cost more to provide ultrasound guidance, she told him it was a scam (T. 244-245). Respondent stated that they would stop charging that fee, but the ultrasound technician later found out that they had not stopped (T. 260).

130. It is a violation of Medicaid requirements to charge a fee in addition to billing Medicaid (T. 431).

131. The regulations of the New York State Department of Social Services (DSS) specify that a provider of Medicaid services agrees "to accept payment from the medical assistant program as payment in full for all care ..." [See Ex. 18 - 18 NYCRR 504.3(c)]. The DSS regulations also state that it is an unacceptable practice to seek or accept any money in addition to the amount paid or payable under the program [See Ex. 18 - 18 NYCRR 515.2(b)(8)].

132. The fact that Medicaid prohibits a practitioner from receiving any money in addition to that paid by the Medicaid program is not an obscure point, it is well known to practitioners (T. 431).

133. Respondent signed and filed a claim for payment for the termination he performed for Patient C (Ex. 17 at 5). Respondent was paid for procedure #59840 performed on July 28, 1995 (Ex. 17 at 2). Procedure #59840 is an induced abortion (Ex. 17 at 4). Respondent billed and was paid for code 76815, which is for an echo, or sonographic examination (Ex. 17 at 2, 4).

134. Patient C was also provided with a sheet entitled "Follow-up instructions" which states "You should have a follow-up appointment in two weeks. Please note: we charge a $95.00 fee for a follow-up appointment. We DO NOT ACCEPT Medicaid for the postoperative exam." (Ex. 15 at 2) (emphasis in original).

135. It is a violation of Medicaid requirements to charge a fee for follow up care two weeks after the Medicaid-covered termination procedure (T. 432).

136. The Medicaid system requires that such follow up be provided within the fee that Medicaid provides. Specifically, the DSS regulation require that follow up of a surgical patient take place for a certain number of days postoperatively [See Ex. 18 - 18 NYCRR 533.5(b)(2)]. The follow up for procedure an induced abortion is 45 days [See Ex.18 p. 10; 18 NYCRR 533.5(c)]

137. When interviewed by OPMC, Respondent was asked, but did not answer questions about his receiving fees from Patient C (T. 192).

138. Three days postoperatively, Patient C started experiencing abdominal pains (T. 329).

139. Patient C called the 800 number provided by American Women Services and spoke with a receptionist, who said that the patient should come into the clinic (T. 329). The receptionist wanted her to come to a clinic in New Jersey (T. 329).

140. The patient informed the receptionist that she had the procedure done in Albany and the receptionist then stated that the patient would be called back (T. 329-330).

141. The patient was called back by Respondent who asked her symptoms and then said she should go to a local hospital and ask for Dr. Gagliardi (T. 330). Respondent then asked the patient how she paid for the procedure. She told him that she paid "half Medicaid and half credit card" (T. 330).

142. At that point Respondent said the patient should just go to any local hospital because Dr. Gagliardi does not accept Medicaid (T. 330).

143. Patient D went to the American Women Services office in Nanuet on October 14, 1994, for a TOP (Ex. 19 at 2, 3). Patient D had a history of bleeding and transfusions which were required after her two previous births (Ex. 19 at 5, 8).

144. Respondent agreed to perform the termination of pregnancy procedure at Beth Israel Medical Center (Ex. 19 at 6). When Patient D arrived at Beth Israel on October 15, 1994, she went to the emergency department (Ex. 20 at 3-4). The physician's assistant (RPA) who did the triage assessment of Patient D contacted Respondent. Respondent stated that the patient was there for a termination, that the gestational age was the emergency, that the patient could not have a D&C (dilation and curettage) after 12 weeks, and that the patient was almost 12 weeks (Ex. 20 at 5).

145. There was no medical reason that would prohibit this patient having a termination after 12 weeks gestational age (T. 437-439).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(1, 26-28)
Paragraph B:	(18-20,30-53)
Paragraph B.1:	(34-39,43,51)
Paragraph B.2:	(49, 54-56)
Paragraph B.3	(53, 63)

Paragraph B.4:	(64-65)
Paragraph B.5:	(66-67)
Paragraph B.6:	(70)
Paragraph B.7:	(69,71-72)
Paragraph B.8:	(68)
Paragraph B.9:	(73-74)
Paragraph B.10:	(54-62,75-76)
Paragraph B.11:	(82-83)
Paragraph C:	(84,86-87)
Paragraph C.1:	(86-88)
Paragraph C.2:	(89-99)
Paragraph C.3:	(102-118
Paragraph D:	(119-120)
Paragraph D.1:	(120-133)
Paragraph D.2:	(134-137)
Paragraph D.3:	(138-142)
Paragraph E:	(143-144)
Paragraph E.1:	withdrawn
Paragraph E.2:	Not sustained
Paragraph E.3:	withdrawn
Paragraph F:	(10-15,17)
Paragraph G:	(10-17)

FAILURE TO MAKE AVAILABLE MEDICAL RECORDS

First Specification: (Paragraph A)

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Second Specification: (Paragraphs B - B.1 and B.3 - B.9)
(Paragraphs C - C.2)
(Paragraph D , D.1 and D.3)

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Third Specification: **NOT SUSTAINED**

GROSS NEGLIGENCE

Fourth Specification: (Paragraphs B -B.1 and B.3-B.9)

Fifth Specification: (Paragraph C. - C.2)

Sixth Specification: (Paragraphs D and D. 3)

GROSS INCOMPETENCE

Seventh Specification: **NOT SUSTAINED**

FRAUD

Eighth Specification:	(Paragraphs B -B.2, B.10-B.11)
Ninth Specification:	(Paragraph C and C.3)
Tenth Specification:	(Paragraph D and D.1)

PERMITTING, AIDING OR ABETTING AN UNLICENSED PERSON

Twelfth Specification:	(Paragraph F)

PERMITTING AN UNAUTHORIZED PERSON TO SHARE IN FEES

Thirteenth Specification:	(Paragraph G)

MORAL UNFITNESS

Fourteenth Specification:	(Paragraph A)
Fifteenth Specification:	(Paragraphs B and B.1 through B.11)
Sixteenth Specification:	(Paragraph C and C.1 through C.3)
Seventeenth Specification:	(Paragraph D and D.1 through D.3)

The Hearing Committee further concluded that the following specifications should not be sustained:

Third Specification

Seventh Specification

Eleventh Specification

Eighteenth Specification

DISCUSSION

Respondent is charged with eighteen (18) specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with he intention to mislead may properly be inferred from certain facts.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that fourteen (14) of the eighteen (18) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of the significant witnesses presented by the parties. In this instance, only the Department presented witnesses. The Department's significant witnesses included Patient A, her husband, Sunhee Hill, Robert O'Keefe, Leilani Pieringer, Patient C, Louis P. Gagliardi, M.D. and William K. Rashbaum, Sr., M.D.

The Hearing Committee found that while Patient A often had difficulty expressing herself, there was no reason not to believe her testimony. Her husband was also found to be a credible witness regarding his interaction with Respondent. The Hearing Committee was further impressed with the intelligent testimony of Sunhee Hill and her dedication to Patient A during the car ride from Albany to New York City. The Hearing Committee believes that as a young person, she needed the income provided by her job at AWS, but she quit after 2 months as a result of Respondent's treatment of Patient A and other things she observed at AWS. (T. 157-158) The Hearing Committee was

equally impressed with the testimony of another AWS employee, Leilani Pieringer, the ultrasound technician. When answering questions, Ms. Pieringer appeared to be not only very knowledgeable, but also very dedicated to her profession. The Hearing Committee found Patient C to be credible in her testimony regarding overcharges and follow-up care. The Hearing Committee further found Mr. O'Keefe, the OPMC investigator and Louis Gagliardi, M.D., a local physician to be both credible and straightforward in their answers.

William K. Rashbaum, Sr., M.D., testified as an expert for Department (T. 359). Dr. Rashbaum's credentials are stated in his curriculum vitae (exhibit 32). Dr. Rashbaum is an Associate Professor at the Cornell University School of Medicine (T. 360). His teaching program is the only formal program East of the Mississippi that teaches terminations (T. 362-363). The bulk of his teaching is in the area of terminations (T. 364). Dr. Rashbaum has performed over 18,000 second trimester pregnancy terminations. (T. 362) The Hearing Committee found Dr. Rashbaum to be the most knowledgeable physician on the subject of terminations in the country. There is no doubt about his clinical expertise and accordingly, the Hearing Committee gave his testimony great weight. Finally, the Hearing Committee found all other witnesses offered by the Department to be credible in their testimony.

CHARGE A

Respondent was charged with failure to provide the original sonograms for Patients A and B. Investigator O'Keefe testified that on June 14, 1996, Respondent told him that he could not turn over the sonograms to OPMC because he did not have custody or access to them. (T. 190) However, on May 4, 1996, the Supreme Court of the State of New York had already found that "it is well established and beyond a reasonable doubt that Mark Albert Binder, as the only licensed medical doctor at the two locations, who also performed the services and requested payments form the State of New York, is the person who has care, custody and control of the requested records." (Ex. 26, p.14)

The Hearing Committee finds that Respondent's refusal to turn over the original sonograms make it impossible for anyone to know what Respondent saw at the time. The Hearing Committee finds that Respondent's actions demonstrate contempt and arrogance for the law as well as the practice of medicine. Therefore, the First Specification is sustained.

CHARGE B through B.11

The charges involving Patient A allege gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, fraud and moral unfitness.

The Hearing Committee finds that Respondent was grossly negligent in his treatment of Patient A. The Hearing Committee finds that from the very onset, Respondent exhibited callous disregard for Patient A's welfare by scheduling her procedure between 2 clinics that were approximately 150 miles apart. The Hearing Committee concurs with Dr. Rashbaum that practicing terminations of pregnancy (TOP) without local hospital privileges or arrangements with a local physician does not meet minimum acceptable standards of care.(T. 376-377) Dr. Rashbaum found Respondent's arrangements with Beth Israel to be obviously "unsatisfactory,"" because if you have an emergency, you cannot transport a patient 150 miles with any degree of safety." (T. 378)

Dr. Rashbaum found Respondent's decision to transport Patient A to Beth Israel Hospital in her family vehicle was not acceptable medical practice because Patient A had incurred significant bleeding and the back seat of an automobile is not "the proper venue for measuring blood volume." (T. 383-384) Respondent should have called an ambulance and taken Patient A to the nearest hospital. (T. 388) When asked to discuss various aspects during the road trip to New York such as delays, lack of monitoring, departure by Respondent, Dr. Rashbaum indicated that the "the whole damn trip isn't acceptable standards" so it doesn't matter what was done or who was involved. (T. 395-396) The Hearing Committee concurs completely with Dr. Rashbaum's opinion that Respondent's actions were an "egregious deviation" from acceptable standards of care. (T. 398)

The Hearing Committee does not sustain the charges of gross incompetence or incompetence on more than one occasion because there is insufficient evidence in the record to assess Respondent's degree of medical knowledge and skill.

The Hearing Committee finds that Respondent acted fraudulently when he told Patient A that she needed to be transported from Albany to a hospital in New York City to complete the termination of pregnancy because hospitals in the Albany area could or would not perform the procedure. Dr. Rashbaum explained that once the umbilical cord is severed, the fetus will die within 8 minutes. "Once the fetus is dead, there is no prohibition of terminating that pregnancy anyplace by anybody." He continued, "It's no longer an abortional act, but an evacuation of the uterus, fetal demise." (T. 382) The Hearing Committee concurs with Dr. Rashbaum and believes that Patient A should have been transferred to a local hospital.

Dr. Rashbaum testified that when a physician signs a medical note it signifies that he agrees with its contents and that he is taking responsibility for it. (T. 396-397) The Hearing Committee finds that Respondent acted fraudulently when he wrote in Patient A's record that there was no backup available at any local hospitals and that no ambulances were available to transport Patient A. Respondent also failed to document that Patient A was transported from Albany to New York City by private automobile. The Hearing Committee concluded that the testimony at the hearing was to the contrary and that Respondent's note on page 5 of Exhibit 4 was fraudulent.

The Hearing Committee finally finds that Respondent acted fraudulently by completing a Certificate of Spontaneous Termination of Pregnancy. (Ex.7, p.2) The Hearing Committee concurs with Dr. Rashbaum that this was an elective induced termination, not a spontaneous one. (T. 397)

Therefore, the evidence in support of this charge sustains the Second, Fourth and Eighth Specifications.

CHARGE C

The Hearing Committee finds again that Respondent deviated from acceptable medical standards and placed Patient B at risk because he initiated a medical procedure upon her without having privileges or back-up at a local hospital. (T. 287, 410)

More importantly in this case, Respondent is charged with performing a TOP for Patient B when he knew or should have known that Patient B was pregnant for more than 24 weeks. In reviewing copies of the sonograms, (Ex. 8, pp.11 and 13) Dr. Rashbaum testified that the fetus was "large, late" with a possible gestational age of 26, 27 weeks. (T. 414) The Hearing Committee notes that the ultrasound technician thought the fetus was 26-27 weeks (T. 290) and its reported weight was 770 grams with fetal foot length of 5 millimeters. (Ex. 8, p.7) The nurse who worked on the procedure found that the fetal foot length correlated with a 26 to 28 week pregnancy. (T.289, 291) Even the funeral director assessed the fetus to be 7 to 8 months. (T. 314) The Hearing Committee further notes Respondent left the gestational age blank on the operative and post operative findings. (Ex. 8 at 7) Respondent noted the clinical estimate of gestation of the fetus to be 24 weeks on the certificate of fetal death. (Ex. 9, item 22) The Hearing Committee firmly believes that Respondent used the Campbell scale over the Hobbins to cover up the age of a fetus that was outside the legal limit of abortion to perpetrate a fraud to perform an abortion and be paid for it.

Therefore, the evidence supports the Second, Fifth and Ninth Specifications.

CHARGE D

It is alleged that Respondent fraudulently charged or permitted Patient C, a Medicaid beneficiary, to be charged $160 for an ultrasound in addition to fees allowed by Medicare for a TOP. Dr. Rashbaum testified that it is well known to practitioners that Medicaid prohibits a practitioner from receiving any money in addition to that paid by the Medicaid program. (T. 431) The Hearing Committee finds that there is ample proof in the record that the $160 fee was paid by Patient C's boyfriend (Ex. 14, T. 324) and that it was a fraudulent overcharge under the regulations of the Department of Social Services (DSS). (Ex. 18, p.7)

It is further alleged that Respondent permitted Patient C to be given a form which stated that she would have to pay $95 for a follow-up visit, when said follow-up is included in the allowed Medicaid fee. Dr. Rashbaum testified that an additional follow-up fee is not permitted under the Medicaid system. (T. 432) The Hearing Committee finds that Patient C was indeed provided with the follow-up instructions that stated a $95 fee would be charged for any follow-up visit (Ex.15). They find further that Respondent again violated DSS regulations requiring a 45 day follow-up visit for an induced abortion that should have been provided within the fee that Medicaid provides. (Ex. 18, p. 10)

Respondent was further charged with failure to have available appropriate post-operative follow-up for Patient C. Patient C testified that when she first called AWS with complaints of abdominal pains, she was told to go to the New Jersey clinic. (T. 329) Later Respondent called to tell her to go to a local hospital, because Dr. Gagliardi would not accept Medicaid. (T. 330) Dr. Rashbaum testified that Respondent's care for Patient C was completely inadequate because it was unlikely that "this lady had a jet handy that can take her down to New Jersey" (T. 433) The Hearing Committee concurs completely with Dr. Rashbaum. Therefore, the Hearing Committee sustains the Sixth, Tenth and Seventeenth Specifications with respect to Patient C.

CHARGE E

The Department withdrew charges E. 1 and E. 3 with respect to Patient D without prejudice. (T. 440) However, it was alleged that Respondent fraudulently told a physician's assistant at Beth Israel Medical Center that Patient D needed an abortion immediately and/or could not have one after 12 weeks due to her history of bleeding. The Hearing Committee finds that there was insufficient evidence presented at the hearing to sustain this charge. Therefore, no charges are sustained with respect to Patient D.

CHARGE F

This charge alleges that during the time period of the treatment of Patients A through D, Respondent permitted, aided or abetted an unlicensed person to perform duties requiring a license within the meaning of N.Y. Education Law § 6530(11).

The Hearing Committee finds that the evidence in the record clearly indicates that Respondent practiced as a physician for a corporation owned by Stephen Brigham. (Ex. 30; T 181-182) The Hearing Committee also notes that Stephen Brigham's license to practice medicine in New York was revoked in January 1994 to present, yet in October 1994, he told AWS employees that he was available to answer any medical questions. (Prehearing Conference Transcript, p. 107, T. 120, 122) The Hearing Committee further notes that the sonogram technician as well as the AWS employee who assisted Patient A, testified that both Respondent and Elizabeth Navarra would contact Stephen Brigham to resolve problems or complaint by patients. (T. 123, 246) Thus, the Hearing Committee finds that Respondent 's conduct violates the prohibition on permitting, aiding or abetting an unlicensed person to perform duties requiring a license in New York State. Although not part of the charge, the Hearing Committee further notes that Respondent also allowed the AWS employee assisting Patient A to be responsible for the patient's emergency care and to monitor her IV when she was not trained or qualified to do so. Therefore, the Twelfth Specification is sustained.

CHARGE G

The Respondent is charged with permitting an unauthorized person to share in fees for professional services within the meaning of New York Education Law § 6530 (19).

As discussed, in Charge F, the Hearing Committee finds that the evidence supports the charge that Respondent split fees with a non-physician in violation of Education Law §6530(19). Therefore, the Thirteenth Specification is sustained.

MORAL UNFITNESS

For reasons previously discussed, the Hearing Committee finds that Respondent's actions constitute moral unfitness for his contemptuous attitude in his failure to make his medical records available and for his often egregious treatment of Patients A, B and C. Therefore, the Fourteenth through Seventeenth Specifications of Moral Unfitness are sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York state should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee sustained the charge of gross negligence against three patients, and they note that his professional misconduct was particularly egregious towards Patients A and C. They believe that Patient A's life was placed at grave risk of harm and they fully concur with Dr. Rashbaum's comment that it is "very, very difficult to make a judgment as to how bad horrible is." (T. 388) Respondent's motivation by greed was exhibited not only in the overcharges to Medicaid, but by the fact that he continued to see patients at AWS, once Patient A's condition demanded immediate attention.

The Hearing Committee believes that each charge against Respondent in and of itself would warrant revocation. The Hearing Committee finds Respondent's behavior to be reprehensible and they strongly believe that he should never be allowed to practice in New York State again. In this particular instance, the Hearing Committee believes that a civil penalty of $50,000 is appropriate because Respondent has "thumbed his nose" at the legal and disciplinary process in this state. He was held in contempt by the Supreme Court and yet failed to turned over the original sonograms for this proceeding. In requesting an adjournment from this Committee last November, he misrepresented

that a pyloric stenosis performed upon his son in August, continued as a serious illness. Although surgery upon a newborn is certainly stressful to the parents, the Hearing Committee did not believe this was appropriate to delay the start of the hearing in November. Respondent further alleged that his wife was suffering from psychiatric problems, but no documentation was offered in support. (Pre-hearing Conference Transcript, pp. 21-23) Therefore, under the totality of the circumstances, revocation of Respondent's license and a civil penalty of $50,000 are the only appropriate sanctions in this instance.

ORDER

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

1. The First, Second, Fourth, Fifth, Sixth, Eighth, Ninth, Tenth, Twelfth, Thirteenth, Fourteenth, Fifteenth , Sixteenth and Seventeenth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. The Third, Seventh, Eleventh and Eighteenth Specifications are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in New York State be and hereby is **REVOKED.**

4. A fine in the amount of Fifty Thousand Dollars ($50,000.00) is imposed upon the respondent. Payment of the fine shall be made within thirty (30) days of the effective date of this **ORDER** to the New York State Department of Health, Bureau of Accounts Management, Revenue and Cash Unit, Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237.

5. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes, but is not limited to, the imposition of interest late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses (Tax Law 171(27); State Finance Law 18; CPLR 5001; Executive Law 32).

6. This **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York
19 MAR **1997**

Albert L. Bartoletti M.D.
ALBERT L. BARTOLETTI, M.D.

PAUL J. WEINBAUM, M.D.
NANCY J. MACINTYRE, R.N. Ph.D

TO: Kevin P. Donovan, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, N Y 12237

Mark Albert Binder, M.D.
451 North Terrace Avenue
Mount Vernon, NY 10552 and

Mark Albert Binder, M.D.
P.O. Box 9009
Mount Vernon, NY 10552

APPENDIX I

EXHIBIT
Pet. #1

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	NOTICE
OF	:	OF
MARK ALBERT BINDER, M.D.	:	HEARING

TO: MARK ALBERT BINDER, M.D.
451 North Terrace Avenue
Mount Vernon, New York 10552

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 8th day of November, 1996, at 10:00 in the forenoon of that day at Room 104A, the Legislative Office Building, Empire State Plaza, Albany, New York and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and

you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or

dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1996). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
September 25, 1996

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Kevin P. Donovan
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	: STATEMENT
OF	: OF
MARK ALBERT BINDER, M.D.	: CHARGES

----------X

MARK ALBERT BINDER, M.D., the Respondent, was authorized to practice medicine in New York State on October 2, 1990, by the issuance of license number 184074 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. A letter delivered personally to Respondent on April 26, 1996, stated that Respondent was to provide, within thirty days, original or copies certified to be true and complete of medical records for Patients A, B, C, and D (patients are identified in Appendix A), and also to provide original sonograms for Patients A and B, to the Office of Professional Medical Conduct. The letter stated that the records were relevant to an inquiry or complaint about his misconduct, and that failure to provide the records may form the basis for charges of professional misconduct. Respondent did not produce the requested sonograms.

B. Respondent provided medical care relating to a termination of pregnancy (TOP) for Patient A beginning November 25, 1994, at offices known as American Women's Services (AWS),

a/k/a American Medical Services, P.C., at locations at 259 South Middletown Road, Nanuet, New York and at 1522 Central Avenue, Albany (Town of Colonie), New York. Respondent began but did not complete the TOP begun at AWS, and had the patient driven by her husband to Beth Israel Medical Center in New York City for completion of the TOP by Respondent. Respondent's care of Patient A did not meet acceptable standards of care, in that:

1. Respondent undertook the procedure on Patient A at AWS, Albany, New York, without adequate provision for medical care in event of a complication.

2. When Respondent did not complete the TOP at the Albany office, he fraudulently told Patient A that she needed to be transported to a hospital in New York City to complete her procedure because hospitals in the Albany area could or would not perform the procedure she required.

3. Respondent had Patient A transported by her husband in her family vehicle from AWS, Albany, to Beth Israel Medical Center, New York City, for completion of the TOP.

4. Respondent failed to appropriately notify Patient A of the risks associated with being transported from Albany to New York City in her family vehicle to complete the procedure.

5. Respondent inappropriately delayed transporting Patient A to a hospital while he performed procedures on other patients.

6. Respondent inappropriately delayed transporting Patient A to a hospital while he went to a hotel in the Albany area.

7. Respondent had Patient A transported to New York City without ordering or arranging for adequate monitoring of her vital signs, without adequate precautions in the event Patient A's condition deteriorated en route, and/or without an adequate examination of Patient A en route.

8. Respondent inappropriately refused to provide his portable telephone number to Patient A's husband, who stated he wanted the number so that he could call Respondent en route if there were a problem.

9. Respondent accompanied Patient A, in another vehicle, during part of the journey to Beth Israel in New York City, then inappropriately left Patient A in the care of non-physicians for the rest of the journey while Respondent went elsewhere.

10. Respondent fraudulently wrote or permitted to be written entries in Patient A's record which were not accurate, namely, that there was no backup available at any local hospitals, that no ambulances were available to transport Patient A, and/or that did not indicate that Patient A was transported from Albany County to New York City by private automobile.

11. Respondent fraudulently completed a Certificate of Spontaneous Termination of Pregnancy when the TOP was not spontaneous.

C. Respondent provided medical care relating to a TOP for Patient B in or around August, 1994, at AWS. Respondent's care of Patient B did not meet acceptable standards of care, in that:

1. Respondent undertook the procedure on Patient B at AWS, Albany, New York, without adequate provision for medical care in event of a complication.

2. Respondent performed a TOP for Patient B when he knew or should have known that Patient B was pregnant for more than 24 weeks.

3. Respondent fraudulently noted on the Certificate of Fetal Death that the clinical estimate of gestation was 24 weeks when he knew or should have known that it was later.

D. Respondent provided medical care relating to a TOP for Patient C on or about July 25, 1995, at AWS. Respondent's care of Patient C did not meet acceptable standards of care, in that:

1. Respondent fraudulently charged or permitted the charging of Patient C, a Medicaid beneficiary, a fee for ultrasound in addition to those allowed by Medicare for the TOP.

2. Respondent permitted Patient C to be given a form which stated that she would have to pay $95 for a follow-up

visit, despite such follow-up being included in the allowed Medicaid fee.

3. Respondent failed to have available appropriate post-operative follow-up for Patient C.

E. Respondent met Patient D at an office of American Medical Services, P.C., 259 South Middletown Road, Nanuet, New York, on or about October 14, 1994, and told her that he would perform a TOP for her the next day at Beth Israel Hospital in New York City. Respondent's care of Patient D did not meet acceptable standards of care, in that:

withdrawn 1. Respondent fraudulently instructed Patient D to go to the emergency department at Beth Israel and tell personnel there that she had vaginal bleeding, when that was not true.

2. Respondent fraudulently told a physician's assistant at Beth Israel Medical Center that Patient D needed an abortion immediately and/or could not have one after twelve weeks due to her history of bleeding.

withdrawn 3. Respondent fraudulently wrote a note dated 10/14 in Patient D's record, stating that he agreed to perform the procedure regardless of the patient having inadequate payment, but that the patient stated she would see someone else.

F. Beginning in about 1994, and specifically at the times he was involved in the cases of Patient A through D, Respondent conspired with Steven Brigham and Elizabeth Navarra to engage in the practice of medicine, and/or did engage in the practice of medicine, at a medical practice not operated by a person authorized to practice medicine. The practice was operated by Steven Brigham, whose New York license to practice medicine was summarily suspended in January 1994, and was revoked in November, 1994, and/or the practice was operated by other persons

unauthorized to practice medicine in New York State whose identity has not been disclosed to Petitioner by Respondent.

G. Beginning in about 1994, and specifically at the times he was involved in the cases of Patients A through D, Respondent conspired with Steven Brigham and Elizabeth Navarra to perform, and/or did perform medical services as a contractor at an entity held out to be "American Women's Services." The fees for Respondent's non-Medicaid payments were paid to an entity known as "American Medical Services, P.C.", which was operated by Steven Brigham, or by other persons unauthorized to practice medicine in New York State whose identity has not been disclosed to Petitioner by Respondent. Steven Brigham's license to practice medicine in New York was summarily suspended in its entirety in January 1994, and never reinstated in part or in whole before it was revoked in November 1994.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

FAILURE TO MAKE AVAILABLE MEDICAL RECORDS

The Respondent is charged with failing to make relevant records available to the Department of Health with respect to an inquiry about the licensee's professional misconduct, within the meaning of N.Y. Educ. Law §6530(28) (McKinney Supp. 1996), in that Petitioner charges:

1. The facts of paragraph A.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law § 6530(3) (McKinney Supp. 1996), in that Petitioner charges two or more of the following:

2. The facts of paragraphs B and B.1, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, C and C.2, D and D.1 and/or D and D.3.

THIRD SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

The Respondent is charged with practicing the profession with incompetence on more than one occasion within the meaning of N.Y. Educ. Law § 6530(5) (McKinney Supp. 1996), in that Petitioner charges two or more of the following:

3. The facts of paragraphs B and B.1, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, C and C.2, D and D.1 and/or D and D.3.

FOURTH THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

The Respondent is charged with practicing the profession with gross negligence within the meaning of N.Y. Educ. Law § 6530(4) (McKinney Supp. 1996), in that Petitioner charges:

4. The facts of paragraphs B and B.1, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8 and/or B and B.9.

5. The facts of paragraphs C and C.1 and/or C and C.2.

6. The facts of paragraphs D and D.3.

SEVENTH SPECIFICATION

GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Educ. Law § 6530(6) (McKinney Supp. 1996), in that Petitioner charges:

7. The facts of paragraphs B and B.1, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, C and C.1, C and C.2 and/or D and D.3.

EIGHTH THROUGH ELEVENTH SPECIFICATIONS

FRAUD

The Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law § 6530(2) (McKinney Supp. 1996), in that Petitioner charges:

8. The facts of paragraphs B and B.2, B and B.10 and/or B and B.11.

9. The facts of paragraphs C and C.3.

10. The facts of paragraphs D and D.1.

11. The facts of paragraphs E and E.1, E and E.2, and/or E and E.3.

TWELFTH SPECIFICATION

PERMITTING, AIDING OR ABETTING AN UNLICENSED PERSON

The Respondent is charged with permitting, aiding or abetting an unlicensed person to perform duties requiring a license within the meaning of N.Y. Educ. Law § 6530(11) (McKinney Supp. 1996), in that Petitioner charges:

12. The facts of paragraph F.

THIRTEENTH SPECIFICATION

PERMITTING AN UNAUTHORIZED PERSON TO SHARE IN FEES

The Respondent is charged with permitting an unauthorized person to share in fees for professional services within the meaning of N.Y. Educ. Law § 6530(19) (McKinney Supp. 1996), in that Petitioner charges:

13. The facts of paragraph G.

FOURTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

MORAL UNFITNESS

The Respondent is charged with conduct in the practice of medicine which evidences moral unfitness to practice medicine within the meaning of N.Y. Educ. Law § 6530(20) (McKinney Supp. 1996), in that Petitioner charges:

14. The facts of paragraph A.

15. The facts of paragraphs B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10 and/or B and B.11.

16. The facts of paragraphs C and C.1, C and C.2 and/or C and C.3.

17. The facts of paragraphs D and D.1, D and D.2 and/or D and D.3.

18. The facts of paragraphs E and E.1, E and E.2, and/or E and E.3.

DATED: September 11, 1996
Albany, New York

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct