STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

November 23, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Steven Brigham, M.D.
1 Alpha Avenue
Voorhees, New Jersey

Nathan L. Dembin, Esq.
225 Broadway
New York, New York 10007

Marcia Kaplan, Esq.
NYS Dept. of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Steven Brigham, M.D.

Dear Dr. Brigham, Mr. Dembin & Ms. Kaplan :

Enclosed please find the Determination and Order (No.94-146) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

STEVEN BRIGHAM, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-98

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., SUMNER SHAPIRO** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on October 28, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) August 12, 1994 Determination finding Dr. Steven Brigham (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on August 29 ,1994. James F. Horan served as Administrative Officer to the Review Board. Nathan L. Dembin, Esq. filed a brief for the Respondent, which the Review Board received on October 12 , 1994, and a reply brief, which the Board received on October 18, 1994. Marcia Kaplan, Esq. filed a brief for the Office of Professional Medical Conduct (Petitioner), which the Board received on October 12, 1994, and a reply brief, which the Board received on October 20, 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

[1] Dr. Edward Sinnott recused himself from participating in this case. Dr. Stewart participated by telephone conference.

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with gross negligence and negligence on more than one occasion. The Charges involved the Respondent's care for two patients, whom the record refers to by the initials A and B. The Petitioner commenced this proceeding through a January 3, 1994 Summary Order by the Commissioner of Health, which suspended the Respondent's license to practice medicine. Following an initial Determination by the Hearing Committee on the issue of imminent danger, the Commissioner issued an Interim Order on April 29, 1994 continuing the summary suspension.

The Hearing Committee determined that the Respondent was guilty of gross negligence in the treatment of Patient A and Negligence on more than one occasion in the treatment of Patients A and B. In both cases, the Respondent performed abortions on the Patients through a dilation and evacuation (D&E), on an out-patient basis. The Committee found that the Respondent had failed to appropriately counsel Patient A concerning a second trimester pregnancy and failed to maintain adequate records of the counselling. The Committee found that Patient A had not been a proper candidate for the D&E because of her physical condition and the late stage of the pregnancy, which made the surgery too difficult to perform in an outpatient basis. The Committee found that the Respondent did not have appropriate transfer arrangements for high risk operations. The Committee found that the Respondent had failed to recognize the existence of a laceration of the uterus, did not grasp the gravity of the injury, continued in attempting to repair the laceration when he should have transferred the Patient and delayed in transferring the Patient. In the case of Patient B, the Committee found that the Respondent had persisted in performing the

D&E after the laceration of Patient B's uterus and after the Respondent should have transferred the Patient. The Committee also found that the Respondent had caused unnecessary injuries to the Patient's bowel and ureters because the Respondent failed to follow the accepted standards of medicine with regard to the management of complications.

The Committee voted to revoke the Respondent's license to practice medicine in New York State. The Committee found that the Respondent was guilty of deviations and in some instances gross deviations from accepted medical practice, that the Respondent had used inexcusably bad judgement and that his negligence was life threatening and caused injuries to the Patients. The Committee found that the Respondent showed no hint that he understood the gravity of his errors in judgement. The Committee found that the Respondent was not qualified to continue in his chosen area of practice and could find no basis on which to recommend any sort of remediation.

REQUESTS FOR REVIEW

The Respondent challenges all of the Hearing Committee's Findings and Conclusions on the Charges. The Respondent alleges that the Hearing Committee did not evaluate the evidence fairly, reached unsupported conclusions and created facts that can not be substantiated. The Respondent argues that the Hearing Committee, because of bias and personal attitudes, prejudged the Respondent, disregarded facts adduced and improperly and without any basis in the record created new allegations to suit its purposes. The Respondent also argues that the Hearing Committee's Penalty is excessive and harsh. The Respondent asks that the Review Board reverse the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State.

The Petitioner urges the Review Board to sustain the Hearing Committee's Determination. The Petitioner argues that the Respondent's brief raises issues which are beyond the scope of the Review Board's jurisdiction and that the Respondent is seeking a relitigation of the entire case.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence in the treatment of Patient A and negligence on more than one occasion in the treatment of Patient's A and B. The Committee's Determination is consistent with the Committee's detailed and extensive findings and conclusions concerning the two cases. The Respondent performed dangerous procedures in an out-patient setting, without appropriate transfer arrangements, injured both patients, continued with the procedures when he should have transferred the Patients and delayed transferring the Patients. The Hearing Committee's findings support the Determination that the Respondent deviated from the accepted standards of medicine and that in some instances the deviations were gross in nature.

The Review Board has considered the record in light of the Respondent's contention that the Hearing Committee's Determination was influenced by bias. The Review Board finds nothing in this record that in any way demonstrates bias on the part of the Hearing Committee.

The Review Board sustains the Hearing Committee's Determination to revoke the Respondent's license to practice medicine in New York. The Hearing Committee's Determination is consistent with the Hearing Committee's Findings and Conclusions and is appropriate considering the hazard which the Respondent poses to the public. The Respondent demonstrated bad judgement and caused injury to two patients. The Respondent failed to grasp the gravity of the situation in both cases, failed to obtain sufficient back up and delayed in transporting the injured patients. The evidence at the hearing indicated that the Respondent constitutes a danger to the public. The Review Board agrees with the Hearing Committee that there is no indication in the record that the Respondent is a candidate for remediation. In the absence of any possibility for remediation, to correct the dangerous pattern of the Respondent's practice, the Committee had no alternative to revoking the Respondent's license to practice.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board sustains the Hearing Committee on Professional Medical Conduct's August 12, 1994 Determination finding Dr. Steven Brigham guilty of gross negligence and negligence on more than one occasion in practicing medicine.

2. The Review Board sustains the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF STEVEN BRIGHAM, M. D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Brigham.

DATED: Albany, New York

11/16 **, 1994**

ROBERT M. BRIBER

IN THE MATTER OF STEVEN BRIGHAM, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Brigham.

DATED: Delmar, New York

11/18, **1994**

SUMNER SHAPIRO

IN THE MATTER OF STEVEN BRIGHAM, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Brigham.

DATED: Brooklyn, New York

_____, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF

IN THE MATTER OF STEVEN BRIGHAM, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Brigham.

DATED: Syracuse, New York
17 Nov. **, 1994**

William A Stewart

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

August 12, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Steven Brigham, M.D.
1 Alpha Avenue
Voorhees, New Jersey 08043

Marcia Kaplan, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Nathan L. Dembin, Esq.
225 Broadway Suite 1905
New York, New York 10007

RE: In the Matter of Steven Brigham, M.D.

Dear Dr. Brigham, Mr. Dembin and Ms. Kaplan :

Enclosed please find the Determination and Order (No. 94-146) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the

Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER
-OF-
STEVEN BRIGHAM, M.D.

DECISION
AND ORDER
OF THE
HEARING COMMITTEE
BPMC ORDER NO. 94-146

This matter was commenced by a Summary Order dated January 3, 1994. A hearing was held (after an adjournment at the request of Respondent) on February 3, March 2, 9, 10, 18, 23 and April 5, 6, 13, 14, and 21, 1994 before **ANN SHAMBERGER, Chairperson, WILLIAM P. DILLON, M.D.,** and **LEMUEL A. ROGERS, M.D.,** duly designated members of the State Board for Professional Medical Conduct, who served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JONATHAN M. BRANDES, ESQ.**, Administrative Law Judge, served as the Administrative Officer.

The State Board For Professional Medical Conduct (hereinafter referred to as "the State") appeared by **PETER J. MILLOCK,** General Counsel, **MARCIA E. KAPLAN, Esq.**, Associate Counsel, of counsel. **STEVEN BRIGHAM, M.D.,** (hereinafter referred to as "Respondent") appeared in person and by Nathan L. Dembin & Associates, **NATHAN L. DEMBIN, Esq.**, of counsel. Evidence was received and witnesses sworn and heard. A transcript of these proceedings was made.

After consideration of the entire record, the Hearing Committee issued their determination with regard to imminent danger, on the record. On April 29, 1994, the Commissioner of Health of the State of New York issued an interim order which continued the summary suspension of Respondent's license. Now, upon consideration of the original record as well as the submissions and arguments of the parties, the Hearing Committee hereby issues its final determination with regard to all matters before it in this proceeding.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges:	May 19, 1993
Notice of Hearing returnable:	June 23, 1993
Place of Hearing:	New York, New York
Respondent's answer served:	None
The State Board for Professional Medical Conduct appeared by:	Marcia E. Kaplan, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, New York
Respondent appeared in person and was represented by:	Nathan L. Dembin & Associates 225 Broadway, Suite 1905 New York, N.Y. 10007 Nathan L. Dembin, Esq. of Counsel
Respondent's present address	1 Alpha Avenue Voorhees, N.J. 08043
Hearings held on:	February 3, 1994 March 2, 9, 10, 18, and 23, 1994 April 5, 6, 13, 14, and 21
Conferences held on:	March, 1994
Closing briefs received State Respondent	 June 13, 1994 June 14, 1994
Record closed:	June 14, 1994
Deliberations held:	June 16, 1994

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges[1] Respondent has committed gross negligence and

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[1]The statement of charges originally included 11 patients. On April 21,1994, The State withdrew the charges relating to patients C through K. This left the Committee with only patients A and B to consider. The Committee has been instructed to disregard the former charges. All

negligence on more than one occasion. Respondent is also charged with a failure to maintain accurate records. The allegations arise from the treatment of two patients, one in 1992 and the other in 1993. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Lynn Borgatta, M.D.	Expert Witness
Patient A	Fact Witness
Husband of Patient A	Fact Witness

Respondent testified in his own behalf and called these witnesses:

Michael Policar, M. D.	Expert Witness
Anthony Mustalish, M.D.	Expert Witness
Gary Mucciolo, M.D.	Expert Witness
Elizabeth Navarra	Fact Witness
Laura Ann Petras	Fact Witness
Linda Ball	Fact/Expert Witness
Wendy Jacquet	Fact Witness

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. By letter of May 17, 1994, Respondent submitted proposed instructions for the Committee. The Administrative Law Judge accepted proposed and issued proposed instructions 1, 2, 5, and the first sentence of proposed instruction 9. The other proposed instructions were rejected on the grounds that they either did not accurately state the applicable standards or the standards were better stated in the instructions , which are set forth below. The letter of May 17 will be a part of the record herein.

The Administrative Law Judge instructed the Committee that negligence is the failure to use that level of care and diligence expected of a prudent physician under the circumstances. The

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findings and conclusions herein are based upon the allegations in the Statement of Charges as attached hereto (Appendix I).

standard to be applied is consistency with accepted standards of medical practice in this state. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any. Under any circumstances, the Committee was instructed that patient harm need never be shown to establish negligence in a proceeding before the Board For Professional Medical Conduct.

The following findings of fact were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The State was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

GENERAL FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York state on September 24, 1987 by the issuance of license number 172457 by the New York State Education Department.

2. Respondent's license was summarily suspended by Order of the Commissioner of Health dated January 3, 1994 upon the Commissioner's determination that Respondent's continued practice of medicine in New York State constitute an imminent danger to the health of the people of New York State.

3. On April 21, 1994, this Committee recommended that the Commissioner of Health continue the summary suspension pending the final disposition of the charges.

4. On April 29, 1994, the Commissioner of Health issued an Interim Order continuing the summary suspension in full force and effect. (Pet. 1; T. 2058-2068)

5. Until the summary suspension of his license to practice medicine in New York, Respondent was registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 1 Alpha Avenue, Apt. 27, Voorhees, N.J. 08043. (Pet. 1)

FINDINGS OF FACT WITH REGARD TO PATIENT A

A.1 At all relevant times, Patient A was 20 years old. Her partner, who was at the time of the incidents herein her fiance, is now her husband. He was 18 at all times herein. Patient A and her husband have one child, born in December 9, 1992.

A.2. Patient A's last menstrual period (LMP) prior to November 1993 was noted as May 13, 1993. (Pet. 3, pp. 21, 23, 25; T. 548-549, 575-576)

A.3. On November 7 or 8, 1993, Patient A called Respondent's office at American Medical Services, P.C., 2 Perlman Drive, Spring Valley, N.Y., (hereafter referred to as

Respondent's "office"). (T. 551- 552, 590-591)

A.4. Respondent treated Patient A at his office from November 10, 1993 through November 11, 1993. (Pet. 3)

A.5. One of Respondent's employees was Wendy Jacquet. At the time of this incident, Ms. Jacquet was recently employed by Respondent. She conducted the counseling session with Patient A. Patient A was one of the first patients to be counseled by Ms. Jacquet. In addition to counseling Patient A, Ms. Jacquet provided Patient A with the laminaria and abortion consents. Patient A signed the consent forms. (Pet. 3, pp. 14-16, 19, 29; T. 553-562, 599-602)

A.6 Respondent performed an ultrasound on Patient A and told her that she was 26 weeks pregnant. He told her there was a risk of perforation or cervical laceration. He also stated that there are risks with any medical procedure. Respondent told Patient A he had never had a problem in this type of procedure. (Pet. 3, pp. 21-22; T. 553-555, 602-604)

A.7. Accepted standards of care establish that the physician is responsible for counseling the patient and noting that counseling has taken place and describing it in the chart. Ensuring that appropriate notations regarding counseling are recorded is the responsibility of the physician even if he delegates counseling functions to someone else. (Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.8. Counseling of a prospective abortion patient must include a discussion of the following issues:

a. Alternative procedures for terminating the pregnancy;[2]

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[2]at 26 weeks the alternative abortion procedures are dilation and evacuation (hereinafter "D&E"), labor induction, or hybrid procedures.

b. The relative advantages and risks of the alternatives

c. an explanation of the selected procedure;

d. the possible outcomes of the selected procedure

e. postoperative care, and complications that might reasonably be expected. (Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.9. No procedures other than D&E were discussed with Patient A. (Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.10. Patient A was told that laminaria would be inserted and would remain in overnight. Patient A was told she might not be dilated sufficiently to perform the procedure the following day. However, the possibility of insertion of more laminaria was not discussed. (Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.11. Patient A was given a fact sheet. The fact sheet she was given explained first trimester abortions. Abortion at 26 weeks is not a first trimester procedure. Hence, the contemplated procedure is not covered by the fact sheet Patient A was given.(Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.12. The frequency and severity of complications, as well as the overall risk of hospitalization, is significantly higher in late abortions. The complications of D&E increase with gestational age.(Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.13 Some of the known risks of D&E include perforation or laceration of the cervix Respondent failed to explain these risks to Patient A.(Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.14. Established procedures and protocols at this office for the treatment of complications were not explained to Patient A. (Pet. 3, pp. 17-19; T. 156-161, 172-192, 439, 553-556, 608-609, 1807-1808, 1823-1824)

A.15. Respondent interviewed and examined patient A on November 10. From this interview and examination a practitioner would have been able to observe that Patient A was 26 weeks pregnant, obese, smoked cigarettes and had unspecified allergies. A practitioner would also have been able to observe that this patient ,had a very long vagina, a very long cervical canal, and a very small external cervix. Obesity and smoking increase the risks associated with anesthesia or sedation. Patient A's obesity and her particular anatomy make a D&E procedure technically difficult and significantly compromise visualization of the operative field. Visualization of the cervix is also made more difficult. (Pet. 3, pp. 3-4, 9-10, 21, 23, 25-26, 28; T. 152-156, 207-208)

A.16. Respondent placed twelve 8 mm. laminaria and injected 6 cc digoxin in preparation for a termination of pregnancy procedure. (Pet. 3, p. 28; T. 57, 125)

A.17. During the laminaria insertion, Respondent told Patient A that she probably had the longest birth canal he had ever seen. (T. 563)

A.18. Patient A and her fiance returned the next morning, (November 11, 1993), at 9 a.m. At this point, the laminaria had been in place for approximately 14 hours. Respondent removed them. Before doing so, he performed another sonogram. (Pet. 3, pp. 3-4, 20; T. 60-61, 116, 125)

A.19. The sonogram which Respondent performed, displayed a fetal biparietal diameter of 61 millimeters (6.1 cm.). (T. 152-156, 207-208)

A.20. The standard of care for a D&E procedure requires a physician to dilate the patient's cervix until sufficient dilatation, for the particular treatment contemplated, is achieved. The amount

of dilatation is dependant upon the particular anatomy of the patient, the procedure contemplated and the technical skill of the practitioner. After considering the amount of dilatation required under the particular facts presented to the physician, if sufficient dilatation cannot be achieved, a labor induction procedure is an available alternative to D & E. (T. 152-156, 207-208)

A.21. At approximately 10 a.m., Patient A was brought to the procedure room, examined and prepared for surgery. The procedure was begun at 10:40 a.m. Respondent performed a D&E procedure to terminate Patient A's pregnancy. During the procedure, Patient A was under twilight anesthesia. The procedure ended at approximately 11:05 a.m. (Pet. 3, pp. 3-4, 23; T. 61-65, 223, 606, 611)

A.22. Respondent's notes were not written contemporaneously with the procedure or the events thereafter. The notes in the patient record were composed by Respondent while Patient A was at the hospital and the following day. Respondent took the vital signs set forth at 12:20 and 12:30 p.m. The remainder were taken by Ms. Jacquet and recorded on scraps of the rolled paper used to cover examination and procedure tables (referred to by the witness as "table paper"). The notes which were recorded by Ms. Jacquet on table paper were reviewed by Respondent the day after the incidents herein, and incorporated into Respondent's medical notes. The original notations of the vital signs, as recorded by Ms. Jacquet, are not a part of Patient A's record and were not available to the Committee. (Pet. 3, pp. 3-13; T. 224, 364, 1640, 1738-1740, 1771-1772, 1868-71)

A.23. During the D&E procedure, Respondent caused a cervical laceration on Patient A's right side which extended up into the lower uterine segment and then lacerated the uterine artery. He also caused another separate laceration on the posterior side of the uterus. The most likely causes of the major laceration was the rupture of the lower uterine segment followed by the pulling out a large fetus against an inadequately dilated cervix. In the alternative, after the rupture of the lower uterine segment, the uterine wall was then grasped with forceps and the laceration extended by pulling on the initial laceration. The posterior laceration was probably a separate injury, done with the forceps during the dismembering of the fetus. (Pet. 3, p. 6; Pet. 4, pp. 21-22; T. 225-230)

A.24. Respondent did not recognize the existence of the cervical laceration at any time during the procedure. Inspection of the cervix at the close of the procedure is part of the standard of care for any abortion procedure. (Pet. 3, pp. 4 and 6, 23-24; T. 195, 224-225, 229-232, 279, 370, 1633)

A.25. The cervical laceration in this instance was in such a position that it was visible under direct vision by the practitioner. Respondent's record reflects that he did not discover the cervical laceration until 12:30 p.m. (Pet. 3, pp. 4 and 6, 23-24; T. 195, 224-225, 229-232, 279, 370, 1633)

A.26. After the laceration was discovered, Respondent was able to see that it extended beyond his field of vision. (Pet. 3, pp. 3-13; Pet. 4, pp. 21-22; T. 226, 230-232, 279-280, 325-326, 441-442, 445-447)

A.27. Accepted standards of practice require that the physician be able to visualize the entire extent of a cervical laceration in order to be able to conclude whether or not the patient will be stable. Where a physician cannot determine the extent of a cervical laceration, the patient must be transferred to a hospital immediately. (Pet. 3, pp. 3-13; Pet. 4, pp. 21-22; T. 226, 230-232, 279-280, 325-326, 441-442, 445-447)

A.28 An immediate transfer is required by accepted standards of care, because the cervical laceration may extend upward into the lower uterine segment. The vascular supply to the lower uterine segment consists of large blood vessels which, when cut or lacerated, will not stop bleeding without surgical intervention and can bleed profusely. (Pet. 3, pp. 3-13; Pet. 4, pp. 21-22; T. 226, 230-232, 279-280, 325-326, 441-442, 445-447)

A.29. At approximately 11 a.m., Patient A was transferred into the recovery room, where she remained for approximately one hour. Patient A lay on the couch. While in the recovery room,

Patient A continued to bleed. At about noon, Patient A was brought back to the operating room. (Pet. 3, p. 2; T. 65-72, 92-97, 100, 102-103, 108, 110, 116-118, 121, 566, 606-607, 610-612, 1735, 1889-1892)

A.30. From approximately noon until approximately 3:00 p.m., Respondent continued to treat Patient A in his operating room. (Pet. 3, pp. 3-13)

A.30. Respondent was aware that internal bleeding remained a risk. Respondent did not know, at this time, whether Patient A was bleeding internally or not. (1635-1636, 1744)

A.31. Respondent noted that at 12:20 p.m., Patient A was confused and disoriented, that she had active bleeding , and that she had a pulse of 100. The notes also show that the IV which had been inserted earlier, was opened wide. (Pet. 3, p. 6; T. 234-235, 429)

A.32. At 12:30 p.m., Respondent noted that Patient A's BP was 90/45 with a pulse of 90 lying and 90/50 with a pulse of 90 sitting up. Respondent noted the cervical laceration at 10 o'clock on the right side of the patient extending into the cervical canal. Blood was trickling. (Pet. 3, p. 6; T. 235-238, 325)

A.33. At 12:40 p.m., Respondent noted that Patient A's blood pressure was 85/60, and that her pulse was 90. Respondent inserted an 18 gauge angiocatheter into Patient A's right arm to provide a second IV site. (Pet. 3, p. 7; T. 238-239)

A.34. At 12:50 p.m., Respondent noted that Patient A's blood pressure was 100/65, her pulse was 85, and her hematocrit was 32%. Respondent noted that Patient A was trickling dark blood from her cervix. Respondent gave the patient intracervical injections of .2 mg. Methergine, 10 units Pitressin, 10 units Pitocin and 20 cc's 1% lidocaine.

A.35. Throughout this time the temporary improvements in the patient's vital signs were attributable to the large boluses of IV fluids she was given. (Pet. 3, p.7; T. 240-241)

A.36. At 1:00 p.m., Respondent noted that Patient A's blood pressure was 100/50, and her pulse was 93. Respondent performed a procedure in which he explored the intrauterine cavity with an 8 mm. curette, avoiding the cervical canal, and applied repeat vacuum aspiration. Respondent did not find the defect which existed in the uterine wall and stated in his record that no defect existed. (Pet. 3, p. 7; T. 241-242)

A.37. At 1:10 p.m., Respondent noted that Patient A's blood pressure was 110/60, and that her pulse was 90. He noted that she was still bleeding. He performed transabdominal ultrasonography. (Pet. 3, p. 8; T. 244-247, 1837-1838)

A.38. At 1:20 p.m., Respondent noted that Patient A's blood pressure was 100/60 and her pulse was 95. Respondent applied silver nitrate to the cervix, and then attempted to suture the cervix. The bleeding continued. (Pet. 3, p. 9; T. 247-249)

A.39. At 1:30 p.m., Respondent noted that Patient A's blood pressure was 70/50 and her pulse was 90. (Pet. 3, p. 9; T. 249-250)

A.40. At 1:35 p.m., Respondent noted that Patient A's blood pressure was 80/50 and her pulse was 90. At 1:40 p.m., Respondent pushed the patient's fundus. (Pet. 3, p. 9; T. 250-252)

A.41. At 1:50 p.m., Respondent noted that Patient A's blood pressure was 90/60 and her pulse was 93. Respondent noted that he abandoned an attempt to suture. The attempt was abandoned after one only one suture was accomplished. Only one suture was accomplished due to difficulties arising as a result Patient A's particular anatomy. Respondent ordered a repeat

hematocrit. He applied silver nitrate and Monsel's solution to the cervical laceration. (Pet. 3, pp. 9-10, Pet. 4, p. 23 ; T. 252-253, 1761-1762)

A.42. At 1:58 p.m., Respondent noted that Patient A was still not orthostatic, with blood pressure of 90/50 and a pulse of 92. Respondent further noted that the patient was not bleeding per vagina. (Pet. 3, p. 10; T. 257-259)

A.43. It is possible for a patient to stop bleeding externally and still bleed significantly internally. Respondent had not ruled out a serious laceration. (Pet. 3, p. 10; T. 257-259)

A.44. At 2:05 p.m., Respondent noted that Patient A's blood pressure was 90/50, her pulse was 95 and that she was not bleeding per vagina. Patient A's oxygen saturation was noted at 92 per cent. Respondent applied oxygen via face mask. Patient A's hematocrit had dropped to 29 per cent from a preoperative level of 35. This was a significant drop in hematocrit not attributable solely to hydration. (Pet. 3, pp. 10, 23; T. 259-261, 1652-1653, 1763-1764, 1783-1788, 1801, 1886)

A.45. At 2:10 p.m., Respondent noted that Patient A's blood pressure was 80/50, that her pulse was 95, and that her oxygen saturation was 100 percent on oxygen mask. Respondent performed a repeat ultrasound abdominal examination, which he reported as normal. Respondent packed the vagina although he noted that she was not bleeding per vagina. Respondent noted that there was no evidence of internal bleeding, but he had not ruled out internal bleeding at this point. (Pet. 3, p. 10; T. 261-262)

A.46. At 2:15 p.m., Respondent noted that Patient A's blood pressure was 90/60, her pulse was 90, and that she had removed the oxygen mask, and was breathing room air. (Pet. 3, p. 10; T. 262-263)

A.47. At 2:20 p.m., Patient A's blood pressure was 80/50, her pulse is recorded as 90.

(Pet. 3, p. 10)

A.48. At 2:25 p.m., Patient A's blood pressure was noted as 90/50, and her pulse was 95. She was not bleeding per vagina. Respondent noted that she appeared tired but relieved that the bleeding had stopped, and that her companion was informed. (Pet. 3, p. 11; T. 1658)

A.49. At 2:30 p.m., Respondent noted that Patient A's blood pressure was 90/50, her pulse was 95, her oxygen saturation was 95, and that she was not bleeding. She was cool, pale, tired and dry. Respondent noted that she was talking and laughing, and had urinated on him. These findings are consistent with a change in sensorium. (Pet. 3, p. 11; T. 264-265)

A.50. At 2:35 p.m., Respondent noted that Patient A's blood pressure was 70/50, and that her pulse was 104. She complained of uterine cramping. (Pet. 3, p. 11; T. 265-268)

A.51. At 2:40 p.m., Respondent noted that Patient A's blood pressure was 80/50, her pulse was 112, there was no bleeding per vagina through gauze, and Patient A was woozy, pale and complaining of leg cramps. (Pet. 3, p. 11; T. 268-269)

A.52 At 2:45 p.m., Respondent noted that her blood pressure was 80/50 and her pulse was 115. Respondent noted that Patient A's heart rate was tachycardiac and he opened both IV's to about 250 cc's an hour each. The patient complained of cramping in the uterus. Respondent's plan was to remove the gauze and evaluate the bleeding. (Pet. 3, p. 12; T. 269-270)

A.53. At 2:50 p.m., Respondent noted that Patient A's blood pressure was 90/50, and her pulse was 120, and that she looked paler. Respondent ordered a repeat hematocrit. Respondent removed the gauze packing from Patient A's vagina and found that there was almost no blood on the gauze. (Pet. 3, p. 12; T. 270)

A.54. At 2:55 p.m. Patient A had a hematocrit of 18. Respondent noted Patient A's blood pressure as 90/50 and her pulse as 120. Respondent noted that she wanted to sit up. This request is consistent with confusion or agitation. After the request, Respondent sat her up. Patient A immediately felt dizzy, and expelled a gush of 200-300 cc. of blood. Respondent noted that he did a pelvic examination and uterine massage. After recording the hematocrit of 18 percent, Respondent noted that Patient A must be bleeding intra-abdominally, needed transfusion and admission to a hospital, and that he opened both IVs wide open. (Pet. 3, p. 12; T. 270-272)

A.55. At 3:00 p.m., Respondent noted that Patient A's blood pressure was 90/50 and her pulse was 115. Respondent called the Nyack Hospital emergency room and spoke to an emergency physician. (Pet. 3, p. 13; T. 273)

A.56. At 3:10 p.m., Patient A was transferred to the hospital. (Pet. 3, p. 13; Pet. 4, pp 11-13; T. 76-77, 120-121, 274-276, 567-568)

A.57. Patient A arrived at Nyack Hospital at 3:30 p.m. (Pet. 4, pp. 11-12; T. 120)

A.58. The admitting diagnosis was hypovolemic shock. The history reported in the discharge summary included "admitted in shock secondary to severe bleeding." The emergency service record includes a hematocrit of 9%, blood pressure of 80/50 in reverse Trendelenburg, and a diagnosis of "hypovolemic shock (hemorrhagic) r/o uterine perforation."

A.59. The emergency department triage nurse categorized the case as "emergent", recorded under "chief complaint" that the patient was considered unstable after an abortion at the clinic and was then sent to the emergency room. At 3:35 p.m., the patient was extremely pale, had a pulse of 113, respiration of 86, and a blood pressure of 88/52. The anesthesia record states that patient "arrived to OR in profound hypovolemic shock secondary to vaginal bleeding, laceration." A circulating nurse recorded the patient's preoperative color as ashen (Pet. 4, p. 17-18)

A.60. The hematologic consultation note gives as history "brought to ER and found to be in shock, hypotensive with increased bleeding. "It recites that the complete blood count in the emergency room showed a hemoglobin of 3.3, a hematocrit of 9.2. A consultation was called from the operating room. The patient received 4 units of packed cells, two units of fresh frozen plasma, and 10 units of platelets while in the operating room. She ultimately received seven units within the first 36 hours. (Pet. 4 pp. 2, 5, 7, 9, 11-13, 17-18, 25, 27; T. 120, 276, 303)

A.61. At 4:30 p.m., Patient A was in the OR. Dr. Jakus, the surgeon, examined the patient under general anesthesia. Dr. Jakus found that Patient A had a small cervix which was hard to visualize. Dr. Jakus found a cervical laceration on the left side of the cervix (the patient's right side), which extended past visibility. He attempted to suture the cervical laceration through the vagina and found it ineffective. As soon as the patient's blood pressure returned to a normal range, heavy hemorrhage continued from the uterus.

A.62. Dr. Jakus decided to do a laparotomy. He found the uterus enlarged, very mushy and doughy in consistency. He found a hematoma of approximately 300 cc. within the mesosalpinx. He also found the right uterine artery had been severed and was retracted and thrombosed. He noted two separate injuries: A cervical laceration coming from the vagina, approximately 4 1/2 - 5 cm in length, whose top was at the level of the low uterine segment on the right side very close to the level of the arrival of the uterine artery. This laceration was identified as the probable reason the uterine artery was severed. Dr. Jakus found a separate perforation in the lower uterine segment, approximately 1 cm posteriorly from the cervical laceration. Active bleeding continued from the uterine side of the myometrium. (Pet. 4, pp. 21-22, 55)

A.63. The standard of care for a physician who performs late D&E procedures in an office setting requires that the practitioner must have prior arrangements with appropriate medical facilities which would enable him to transfer a patient to that facility where any complications can be managed appropriately This is particularly important if the physician performing the D&E lacks hospital

privileges Such arrangements for contingencies must be made in advance with the individual facility. The availability of local ambulance services and hospital emergency rooms will not fulfill the standard of care. The standard of care would also remain unfulfilled by formal or informal arrangements with local physicians. (Pet. 3, pp. 12-13; T. 219-222, 273, 1684, 1691, 1694, 1703, 1843-1844)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS CONCERNING PATIENT A

The Committee now turns its attention to the factual allegations in the Statement of Charges. Allegation A.1 charges Respondent failed to counsel Patient A appropriately prior to performing the procedure. The charge also asserts that Respondent failed to appropriately note the counseling. At the outset, the Committee recognizes that Respondent's employee, Ms. Jacquet, did much of the initial counseling. Nevertheless, Respondent is responsible to see that all aspects of appropriate counseling were covered and recorded, whether he actually performed the counseling and recording or delegated it.

With regard to the counseling by Ms. Jacquet, the Committee finds this witness to have been devoid of credibility. The Committee does not believe that any individual could remember events from months prior in time with the kind of self-serving detail exhibited by this witness. This witness' answers sounded rehearsed to give an overwhelming picture of regularity in the process at the facility. Such absolute adherence to each and every conceivable standard, not once, but in the words of the witness, over and over again, is simply not consistent with reality and was credibly contradicted by Patient A and circumstantial evidence. While the Committee believes some counseling took place, the fact that the witness was so disingenuous makes her testimony of little worth.

The Committee finds Respondent's testimony regarding his counseling of Patient A to be

somewhat more credible. The Committee also finds the testimony by Patient A to have been credible. Synthesizing the testimony of the two witnesses, the Committee concludes that important aspects of requisite counseling were not addressed by Respondent and his staff. The Committee believes that Patient A was not counseled with regard alternative procedures for termination of the pregnancy. When Patient A arrived at the facility, as far as Respondent and his staff were concerned, a D&E was going to be performed. With regard to the fact sheet given to Patient A, the Committee does not believe Respondent or his staff discussed the difference between the first trimester fact sheet given to the patient and the actual second trimester procedures to be undertaken. The Committee also does not believe that Respondent or his staff presented Patient A with the total constellation of alternatives open to her: Accepted standards of practice require that an abortion patient be appraised of the various abortion procedures available, even if the physician does not offer each of those procedures; the patient must also be informed of the various options other than the voluntary termination of the pregnancy. While the State stipulated that informed consent was not an issue in this proceeding, appropriate counseling for an abortion procedure must include the various risks associated with abortion itself, including but not limited to the possible psychological impact of a voluntary termination of pregnancy and the possible compromise of future reproductive capability. The Committee does not believe that these important issues or any similar issues were discussed with the patient.

In addition to the inadequacy of the content of the counseling given, the Committee finds that Respondent's notes regarding the counseling were also inadequate. The patient record contains a checklist showing various issues allegedly discussed with the patient. However, the Committee finds that even if the checklist accurately reflected the actual counseling in this case, the checklist would have been inadequate as an overall counseling note. Given the lateness of this abortion, it is essential that the practitioner or his designee carefully discuss the issues set forth above and record the patient's responses, be they verbal or visual on the part of the practitioner. Only by a detailed record of the discussion can there be assurance that all necessary elements were covered and there were no misunderstandings. Respondent's notes, as presented, were

entirely inadequate for this purpose.

Therefore, based upon the above:
Factual Allegation A.1 is **SUSTAINED**

In Allegation A.2, Respondent is charged with failing to adequately prepare the patient's cervix prior to beginning the procedure. The presentation to the Committee resulted in the understanding that the essence of this charge was addressed to the use of laminaria. The State was alleging that the laminaria used for the time they were in place could not have produced the appropriate amount of dilation or cervical softening required for the safe conduct of the D&E. The Committee finds the evidence in this proceeding was inconclusive with regard to the effectiveness of the laminaria used by Respondent. The State endeavored to prove that the laminaria must not have sufficiently dilated the cervix based upon the fact that the injury occurred and the nature of the injury. Furthermore, the State based its proof on an extrapolation employing the number of laminaria, their anticipated rate of expansion and the duration of their insertion. Such circumstantial evidence is not sufficient to establish this charge. The fact is that no one other than Respondent knows the amount of dilation that resulted that day. Furthermore, the Committee disagrees with the expert offered by the State to the extent that the said expert offered a rule with regard to the extent of dilation. As stated previously, the amount of dilation is dependant upon the procedure to be undertaken, the anatomy of the patient and the technical expertise of the practitioner. Hence the question of sufficiency is a clinical judgment. In the absence of a preponderance of evidence showing the cervix was inadequately prepared, the State's case must fail.

Therefore:
Allegation A.2 is **NOT SUSTAINED**

In Allegation A.3, the State charges Respondent "continued to perform a D&E procedure on Patient A, which was inappropriate under the circumstances." Based upon the evidence presented, it is the understanding of the Committee that this charge is directed to the choice of Respondent to perform a D&E under the circumstances and his continuation of the procedure after it was begun. The State is alleging that the decision to perform the D&E followed by its performance, were inappropriate under the circumstances. The Committee agrees with this

proposition.

In so finding, it is the conclusion of this Committee that Patient A was not a good candidate for surgery in general and a D&E procedure in particular. It was undisputed that Patient A was obese, a smoker and had peculiarities of anatomy which made appropriate visualization of the operative site as well as performance of the procedure very difficult. In addition to the anatomical challenges posed by the patient, the fetus was 26 weeks old. Consequently it was large and contained calcified parts which would be hard and sharp upon removal. Hence, one is faced with a fetus which is difficult to visualize and expose, in a patient providing small physical dimensions for access plus the added concern of a large fetus with well calcified parts that would be sharp upon removal. Certainly, by the time of the surgery, if not sooner, Respondent should have realized that the procedure would be too difficult to perform safely on an out patient basis, and probably too difficult to perform at all. Respondent had a duty to stop the procedure and transfer the patient to an appropriate facility for induction of labor. The choice to perform this procedure on an out patient basis, given the information readily available to Respondent on minimal examination, is indefensible.

Therefore:

Allegation A.3 **IS SUSTAINED**

In Allegation A.4, the State alleges Respondent did not have appropriate transfer arrangements prior to beginning the D&E procedure. The Committee sustains this charge. In defense to this charge, Respondent cited formalized agreements with physicians in the region, agreements with local ambulance groups and "handshake" agreements with other physicians as his transfer arrangements. The Committee finds these undertakings to be essentially worthless. The evidence shows that Respondent was engaged in high risk procedures in an office setting. He had no hospital privileges. It was therefore incumbent upon him to have a formal agreement with a nearby hospital that was ready, willing and able to provide the specific care that would be warranted for all reasonably anticipated complications of abortions. At the minimum, the agreement would have to be with a facility which could perform surgery on an emergency basis. In comparison, an agreement with a specific physician, or even several physicians, would be useless if the

complication arose at a time when none of the physicians were available. That is why the standard of care requires a clear and unequivocal relationship with a local institution, rather than a doctor. By undertaking an arrangement with an appropriate hospital a practitioner can ensure that appropriate response to patient emergencies will be available on a 24 hour 365 day a year basis.

Therefore:
Allegation A.4 **IS SUSTAINED**

In Allegation A.5, Respondent is cited for his failure to recognize the existence of the laceration prior to Patient A leaving the procedure room. There can be no doubt that the standard of care requires that a practitioner inspect the uterus for injury upon completion of an abortion. There is also no dispute that Respondent did not see the injury when he examined the patient after the procedure in this case. While the defense suggested that the laceration may have been exacerbated after the transfer to the hospital, this proposition is not established by the evidence and is ultimately irrelevant. Clearly, upon her return to the procedure room, Respondent realized that a laceration existed. The fact that Respondent did not see the laceration during his routine post-procedure examination confirms the earlier conclusions expressed by the Committee that this procedure should not have been performed on this patient under these circumstances. The fact is that the challenges posed by the specifics of this patient's anatomy made it very difficult for Respondent to visualize where he was working. This compromise of vision led to the injury itself and the failure of Respondent to discover the injury. Had Respondent used appropriate judgment, he would have understood that one does not perform this kind of surgery on this kind of patient because one is more likely to injure a uterus which is poorly visible and less likely to discover the injury if it occurs.

Therefore:
Allegation A.5 **IS SUSTAINED**

With regard to Allegation A.6, the State alleges that upon his recognition of the injury, Respondent did not appreciate its gravity. The Committee sustains this charge as well. It is the conclusion of the Committee that Respondent knew his ability to visualize and examine the uterus appropriately, was significantly compromised. It therefore follows that Respondent should have

known that he had no appropriate choice but to transfer this patient to a facility where the injury could be properly assessed and treated. Since Respondent could not see the full extent of the injury, his only appropriate conclusion was to assume that it was serious and transfer the patient immediately. In other words, Respondent knew he had caused an injury which resulted in bleeding. He further knew that his ability to examine the injury was compromised. He therefore should have assumed, for the safety of his patient, that he was unable to fully gauge the gravity of the injury. Only by transferring the patient could he actually learn how serious the injury was. He chose to assume that the injury was not serious and could be treated in his office. Such an assumption resulted in his failure to recognize the gravity of the injury and under the circumstances is inexcusable.

Therefore:
Allegation A.6 **IS SUSTAINED**

Finally, in Allegation A.7, Respondent is cited for his continued attempts to repair the laceration rather than transfer the patient. Each of the major turning points in this procedure demonstrate unacceptable lapses in judgment by Respondent and this event is no exception. As stated earlier, this procedure should not have been undertaken. Upon recognition of an injury which, by definition, could not be fully assessed in an office environment, the practitioner had no appropriate choice but to transfer the patient. It follows then, that any attempt to repair the laceration in the office would, at best, be misguided. Even if each of the other errors in judgment could be excused, upon Respondent's unsuccessful attempt to suture, it should have been obvious to Respondent that he could not bring about a successful repair. Yet he still delayed in transferring the patient. Such a lapse in accepted standards of care cannot be overlooked.

Therefore:
Allegation A.7 **IS SUSTAINED**

In Allegation A.8, the State charges that Respondent failed to recognize that Patient A was in shock. Part of Respondent's defense was that this patient was never in shock. Such an assertion is belied by the facts. This patient was clearly in the early stages of shock while she was

in the care of Respondent. She exhibited tachycardia and changes in sensorium. Her Oxygen saturation was lowered. In so far as her blood pressure remained within acceptable limits or rose, it was a result of the massive amount of fluids administered by Respondent. The signs and symptoms of this patient were classic for the early stages of shock and the denial by Respondent is unfounded.

Therefore:
Allegation A.8 **IS SUSTAINED**

In Allegation A.9, Respondent is cited for his delay in transferring this patient to the hospital. The Committee makes reference to its earlier remarks with regard to the seriousness of the situation and Respondent's inappropriate delay in obtaining necessary care for this patient. In summary, this procedure should not have been conducted in the office; when the injury was discovered, the patient should have been transferred for evaluation; when suturing failed, the patient should have been transferred for surgical repair; as the patient's oxygen saturation moved lower and as tachycardia and changes in sensorium were noted, the patient should have been transferred for treatment of shock. Throughout this case, opportunities for Respondent to obtain the appropriate hospitalization arose. Respondent persisted in his fundamentally erroneous pathand delayed transfer of this patient beyond any reasonable time limit.

Therefore:
Allegation A.9 **IS SUSTAINED**

FINDINGS OF FACT WITH REGARD TO PATIENT B

B.1. Respondent treated Patient B at Flushing Gynecology Center, (aka Flushing Women's Center; hereafter "the Center") 36-09 Main Street, Flushing, New York 11354, from May 7, 1992 through May 9, 1992. (Pet. 8)

B.2. Patient B's LMP was November 20, 1991. On April 10, 1992, Patient B had an

ultrasound at the Hershey Medical Center in Pennsylvania. The results of the ultrasound suggested very serious structural abnormalities of the fetus. Fetal age was estimated at 19 weeks, plus or minus two weeks. The biparietal diameter was reported as 4.5 cm. The placenta was located posteriorly. (Pet. 6; T. 450-451)

B.3. Respondent noted that the pregnancy was 23.5 weeks and that the fetus had multiple anomalies. When Patient B was seen by Respondent, the gestational age was 24 weeks and two days, plus or minus 1.5 weeks. Based upon the patient's LMP, the gestational age of the fetus was approximately 24.5 weeks. (Pet. 8, p. 12; T. 454-455, 461, 464-465, 1973-1974)

B.4. Respondent's plan was to "begin laminaria tomorrow and continue dilation until reaching about 3 centimeters and performing D&E." (Pet. 8, pp. 12-13; T. 456)

B.6. On or about May 8, 1992, Respondent placed 6 laminaria of unrecorded size in preparation for a termination of pregnancy procedure. (Pet. 8, p.4; T. 456-457)

B.7. On May 9, 1992, Respondent began a D&E procedure to terminate Patient B's pregnancy. (Pet. 8, p.4)

B.9. Respondent performed the D&E under ultrasound, which provides visual feedback in addition to the tactile feedback the physician has during the procedure. Ultrasound provides an additional sense of the location of the instruments relative to the patient. (Pet. 8, p.4; T. 474)

B.10. Patient B had a posterior placenta, which means that the fetus and the rest of the uterine contents are anterior to the placenta. (Pet. 8; T. 492-494)

B.11. According to his record, Respondent used Hern forceps to remove an arm and part of the placenta. (Pet. 8, p.4)

B.12. After removing the placenta, Respondent inserted and moved the forceps on multiple occasions, posterior to where the placenta had been. (T. 493-494)

B.13. Respondent perforated the uterus.

B.14. After perforating the uterus, Respondent used his forceps at different times, in separate motions, to grasp tissue in several places.

B.15. Respondent caused an 8-10 cm. laceration of the posterior uterus running from the fundus of the uterus down the posterior midline almost to the posterior lower segment. He perforated the sigmoid colon through its mesentery, also perforating into the lumen of the colon. He cut the mesentery through the retroperitoneum to approximately the level of the inferior mesenteric artery. Patient B required a colostomy. Respondent also damaged both ureters, completely transecting the left ureter and partially lacerating the right ureter at a more distal portion of the ureter.

B.16. The injuries described, were at different levels relative to one another and therefore occurred at different times.

B.17. On pathology examination of a 16 cm segment of sigmoid colon, much of the mucosa were denuded. This finding is consistent with extensive contact by the instrument. (Pet. 8, p. 4; Pet. 10, p.50-51, 79-80, 87-90; T. 483-484, 489-492, 538)

B.18. Respondent admitted that he was unsure of what structures he had hold of with his forceps. He admitted the ultrasound picture was not consistent with what he felt. As he attempted to locate and grasp the fetal skull, he found soft tissue.

B.19 Although Respondent was not sure what was in the grasp of his instrument, he

grasped, opened his forceps wider and grasped again, with force. (T. 531, 1927-1941, 1946-1951, 1958-1959, 1961-1972)

B.20. Perforation of the uterus is a known risk of D&E procedures. (T. 525, 529-530, 534)

B.21. Continuation of this procedure in the face of a perforated uterus is outside accepted standards of care. (T. 525, 529-530, 534)

B.22. After removing an arm and part of the placenta, Respondent saw omentum. The discovery of omentum indicates that the peritoneal cavity had been entered. (Pet. 8, p. 4; T. 474-475)

B.23. Patient B was transferred by ambulance to Elmhurst Hospital Center, 79-01 Broadway, Elmhurst, N.Y. 11373. On arrival at the hospital, Patient B was in shock. Transfusion of 3-4 units of packed cells was given. (Pet. 10, p.4, 8-15, 81, 87; T. 481- 482, 485-489)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS CONCERNING PATIENT B

In Allegation B.1, Respondent is charged with a failure to adequately prepare this patient's cervix prior to commencement of the procedure. As stated with regard to Allegation A.2 above, the presentation to the Committee in this allegation resulted in the understanding that the essence of this charge was addressed to the use of laminaria. The State was alleging that the laminaria used for the time they were in place could not have produced the appropriate amount of dilation or cervical softening required for the safe conduct of the D&E. The Committee finds the evidence in this regard was inconclusive. The effectiveness of the laminaria used by Respondent was simply

not established. The State endeavored to prove that the laminaria must not have sufficiently dilated the cervix based upon the fact that the injury occurred and the nature of the injury. Furthermore, the State based its proof on an extrapolation employing the number of laminaria, their anticipated rate of expansion and the duration of their insertion. Such circumstantial evidence is not sufficient to establish this charge. The fact is that no one other than Respondent knows the amount of dilation that resulted that day. Furthermore, the Committee disagrees with the expert offered by the State to the extent that the said expert offered a rule with regard to the extent of dilation. As stated previously, the amount of dilation is dependant upon the procedure to be undertaken, the anatomy of the patient and the technical expertise of the practitioner. Hence the question of sufficiency is a clinical judgment. In the absence of a preponderance of evidence showing the cervix was inadequately prepared, the State's case with regard to this charge must fail.

Therefore:
Allegation B.1 is **NOT SUSTAINED**

In Allegation B.2, the State charges "*Respondent continued to perform a D&E procedure* in the face of an inadequately dilated cervix *which was inappropriate under the circumstances.(*emphasis supplied)." The Committee understood the essence of this charge to be that Respondent persisted in a D&E at a point when he should have ceased the procedure. As stated earlier, the Committee does not know if the patient's cervix was sufficiently dilated or not. They therefore must assume that there was sufficient dilation. However, the essence of the charge does not go to the extent of dilation, but rather to the continuation of a surgical procedure which should have been concluded due to injury. Respondent knew, or should have known that he had perforated the patient's uterus. At the point when a perforation is discovered or suspected, accepted standards of medicine require the practitioner to stop the abortion and transfer the patient to a hospital for surgical evaluation and repair. Respondent's continuation of the procedure violated accepted standards of medicine and injured the patient further.

Therefore:
Allegation B.2 is **SUSTAINED**

In Allegation B.3, Respondent is charged with performing the D&E inappropriately and

causing injury to the patient. While perforation of the uterus is a known risk of abortion and perhaps could be excused under some circumstances, the injuries caused by Respondent went far beyond perforation. Respondent knew he had perforated the uterus. He was using ultra-sound equipment to assist him in directing his instruments. There came a point when he could not reconcile what he saw on the ultra-sound screen and what he felt through his instruments. He did not know the location of his instrument yet he persisted in moving the forceps and closing them with some force. By this activity, Respondent violated fundamental tenets of accepted medical practice. It is unacceptable for a practitioner to move his instrument in the body cavity without a clear understanding of their location. It is a further violation of accepted standards of practice to close forceps without precise knowledge of what one is closing on. The resultant injuries, particularly those to the bowel and ureters illustrate the point. These injuries were entirely unnecessary and caused by compounded acts outside accepted standards of medicine. That is, while the perforation of the uterus is within the ambit of known complications from an abortion, the injuries to the bowel and ureters, could have been avoided by following accepted standards of medicine with regard to the management of complications.

Therefore:
Allegation B.3 is **SUSTAINED**

CONCLUSIONS WITH REGARD TO THE FIRST SPECIFICATION

In the First Specification, Respondent is charged with gross negligence based upon factual allegations A.7 (continued attempts to repair the laceration rather than transfer the patient), A.8 (failure to recognize that Patient A was in shock) and A.9 (delay in transferring the patient to the hospital). The Committee sustains this specification on all three grounds. As stated earlier, the Committee finds Respondent's decision to undertake the D&E procedure upon this patient to constitute a flagrant and dramatic deviation from accepted standards, and hence gross negligence. At several points in his treatment, Respondent had the opportunity to recognize his error and

correct it by transferring the patient. He persisted in treating the patient in his office and committed further flagrant and dramatic deviations from standards. As stated before, once Respondent realized that after his best attempt, he could obtain only one suture, it should have been manifest that his patient needed care he could not provide in his office. His persistence in attempting a repair was a glaring departure from standards. Likewise, when his patient began to exhibit tachycardia and signs of changes in sensorium, the conclusion that she was in shock or rapidly approaching that point should have been obvious. The appropriate conclusion was to transfer her immediately to a hospital. Respondent's failure to do so was a glaring departure from accepted standards. Finally, as stated throughout the discussion of Patient A, Respondent had every reasonable warning that this patient needed the services of a hospital. Sometime after noon and well prior to 3 P.M. a prudent physician would have transferred this patient to a hospital. Respondent's failure to do so for some three hours was an egregious departure from accepted standards of care.

Therefore:

The FIRST SPECIFICATION is **SUSTAINED**

CONCLUSIONS WITH REGARD TO THE SECOND SPECIFICATION

In the Second Specification, Respondent is charged with practicing negligence on more than one occasion. Allegations A.2 and B.1 were not sustained. Consequently, they will not form the basis for any finding of misconduct.

In reference to Allegations A.7, A.8, and A.9, the Committee makes these observations. Simple negligence (negligence other than gross negligence) is a lesser included offense in a finding of gross negligence. Therefore, Allegations A.7, A.8, and A.9, which formed the basis of findings of gross negligence, will also form part of the basis for sustaining the Second Specification.

It is the conclusion of this Committee that each of the other allegations which were sustained, support a separate finding of simple negligence. In Allegation A.1, the Committee has

found that Respondent failed to counsel Patient A appropriately prior to performing the D&E procedure. The Committee finds that appropriate patient counseling, prior to performing an abortion procedure is a necessary aspect of accepted standards of medicine. Therefore, a prudent physician acting within accepted standards of care and diligence, would have seen to it that this patient was appropriately counseled. The Committee discussed their conclusions delineating the parameters of appropriate counseling within the discussion of Allegation A.1, above. The Committee refers to their earlier discussion above as the basis for the finding that Respondent failed in this important responsibility. It is noted that Allegation A.1 also alleges that Respondent failed to note the counseling that did take place. The Committee has not sustained this portion of the charge. Consequently, it will not form the basis for a finding of misconduct.

Concerning Allegations A.3 and B.2, the Committee has found that Respondent continued to perform D&E procedures which were inappropriate under the circumstances. The Committee cites their earlier discussion under Allegations A.3 and B.2 for its basis in concluding that Respondent showed a serious failure of care and diligence. It is the finding of the Committee that Respondent ignored the clear signs that warranted abandonment of the D&E option for Patient A and concluding the procedure begun on Patient B. Respondent's failures demonstrated in these cases constitute two separate occasions of negligence.

In Allegation A.4, the Committee has found Respondent failed to have appropriate transfer arrangements in place prior to beginning the D&E procedure. The Committee finds that a prudent physician would have had appropriate arrangements in place prior to undertaking a late second trimester abortion. The Committee finds that the failure to prepare for complications which could reasonably be anticipated in a late second trimester D&E constitutes a clear violation of acceptable levels of care and diligence. The Committee refers to its earlier discussion within the factual allegation regarding what would have constituted appropriate preparations. Respondent's lapse in this regard constitutes an act of negligence.

Allegations A.5, A.6 and A.7 cite Respondent for failures in surgical care and diligence. The Committee finds that a physician exhibiting acceptable levels of care and diligence would have recognized the existence of the laceration at the end of the procedure or during the procedure. The

Committee has already discussed the anatomical considerations which contributed to Respondent's inability to recognize the injury earlier than he did. However, these anatomical considerations do not act to insulate Respondent, rather, the failure to recognize the injury affirms the reasoning for rejecting D&E for this patient. Rather than recognize that the procedure should not have been undertaken, or being ever more diligent in his performance and examination, Respondent went forward with the procedure and failed to discover the injury. From either point of view, Respondent demonstrated glaring failures in care and diligence, and hence, negligence. Similar comments are equally applicable to the issues raised by Allegation A.6 and A.7. Respondent did not recognize the gravity of the injury (A.6) and he continued to attempt to repair it in his office (A.7). The Committee concludes that as soon as the injury was discovered, a prudent physician exhibiting acceptable levels of care and diligence, would have transferred this patient to a hospital for appropriate evaluation and treatment. It follows that the attempts to repair the injury in the office were irresponsible and flagrant violations of accepted standards of medicine. Accordingly, separate findings of negligence are supported by each of the three allegations.

Allegations A.8 and A.9 are also related in that both charge Respondent with inappropriately delaying the transfer of this patient. The Committee finds that both charges support separate acts of negligence. The Committee finds that this patient was clearly exhibiting early signs of shock. Hence, even if Respondent could not conclude that the injury itself warranted transfer, certainly once the patient exhibited the various signs and symptoms of shock, a prudent physician would have sent the patient to the hospital. The Committee has discussed the signs and symptoms upon which their conclusions are based, under these factual allegations. Therefore, for the reasons set forth here and in the discussion under the factual allegations above, the Committee finds two separate acts of negligence.

Turning their attention to the allegations regarding Patient B, the Committee has discussed Allegations B.1 and B.2 above. This leaves only Allegation B.3. In Allegation B.3, Respondent is charged with performing the D&E inappropriately and causing injury to the patient. There is little left for the Committee to say beyond their discussion under the factual allegation itself. While perforation of the uterus is a known complication of abortion, the injuries caused by Respondent

here were aggravated. While it is known that physicians exhibiting care and diligence may cause injury, the prudent physician knows that when the uterus is perforated, the procedure must be terminated and the patient transferred. Assuming the physician does not know that perforation has taken place, surely a prudent physician will not close his instrument on unknown structures when he is not sure of his location in the patient. Respondent's acts in this case represented a flagrant and dramatic deviation from accepted standards of care and diligence and hence negligence.

Therefore, based upon Allegations A.1 and A.3 through A.9 and B.1 and B.3:

The SECOND SPECIFICATION is **SUSTAINED**

CONCLUSIONS WITH REGARD TO PENALTY

The Committee has sustained both Specifications, finding three acts of gross negligence and ten acts of negligence. Some of the acts which were charged as negligence were found to be flagrant deviations from accepted standards. Some of the allegations which were proven demonstrated gross deviations from accepted statndards of competence. Notwithstanding the nature of some of the deviations, the members of the Committee have limited themselves in their deliberative analysis solely to the charges as drafted.

In the analysis of the two cases before them, the Committee finds Respondent has shown inexcusably bad judgment. In both cases, Respondent's negligence was life threatening and caused serious injuries to the patients. In his testimony, Respondent showed no hint that he understood he had made errors in judgment of extraordinary gravity. The Committee concludes that under similar circumstances, Respondent would act today, precisely as he demonstrated in the cases of Patients A and B.

Respondent repeatedly exaggerated his medical training, experience and skill. Both in the acts established by the charges herein as well as in his testimony Respondent has demonstrated he lacks appropriate judgment and insight as to his own limitations. He routinely displayed a tendency to inflate and embellish the truth. For instance, Respondent regularly referred to himself

as an emergency room physician. However, upon further questioning, he admitted he had not had a residency in emergency medicine and had never had a full-time position in an emergency room. Ultimately, Respondent admitted that his experience and training in emergency medicine consisted of part-time positions in various emergency rooms. In like manner, Respondent testified that he had "extensive training" in OB/GYN and abortion. Respondent testified that his credentials in abortion procedures arose from taking a formal course of study in abortion as offered by Planned Parenthood of New York City. However, he eventually admitted that he has never done a residency in OB/GYN. Moreover, Respondent later admitted that he did not complete the course in first trimester abortion practice offered by Planned Parenthood, nor did he receive the course certificate. Eventually, Respondent testified that what he referred to as special training in preparation for his activities in the abortion field consisted of limited interludes of observation of other physicians.

The Committee was also concerned by Respondent's answer to one of the primary questions in this proceeding: When asked why he did not transfer Patient A to a hospital after she demonstrated significant bleeding in his recovery room, Respondent stated that there is nothing "magical" about a hospital; that he is an emergency room physician, and had he transferred Patient A, she would only have been seen by another emergency room physician. Furthermore, according to Respondent, he and his staff were giving Patient A more attention than she would get in an intensive care unit. Respondent's answer to this question and others evidences his inability to distinguish between mere attention and appropriate care.

In the final analysis, the Committee concludes that Respondent is under trained, has demonstrated grievous deviations from accepted standards or care and diligence, has shown submarginal abilities and has evidenced not the slightest recognition of any of his deficiencies. Hence, the Committee not only finds him unqualified to continue in his last chosen area of practice, but also can find no basis to recommend any sort of remediation within the practice medicine. Under all the facts and circumstances, the only appropriate penalty for this physician is revocation of his license.

ORDER

Wherefore it is hereby **ORDERED**;

That the license to practice medicine in the State of New York of **STEVEN BRIGHAM** be and is hereby **REVOKED**

Dated: Vestal, New York

August 03, **1994**

Mrs. Ann Shamberger
ANN SHAMBERGER, Chairperson

WILLIAM P. DILLON, M.D.
LEMUEL A. ROGERS, M.D.

APPENDIX I

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

----------X

IN THE MATTER : STATEMENT

OF : OF

STEVEN BRIGHAM, M.D. : CHARGES

----------X

STEVEN BRIGHAM, M.D., the Respondent, was authorized to practice medicine in New York State on September 24, 1987 by the issuance of license number 172457 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 1 Alpha Avenue, Apt. 27, Voorhees, N.J. 08043.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 20 year old female, at the American Medical ~~Pavilion~~ SERVICES P.C ~~and AB Services of New York~~, 2 Perlman Drive, Spring Valley, N.Y. (hereafter "office") from on or about November 10, 1993 through on or about November 11, 1993. (The identity of Patient A, and all other patients, is disclosed in the attached Appendix.) On or about November 10, 1993, at or after 5 p.m., Respondent performed an ultrasound on Patient A and told her that her pregnancy was 26 weeks. Patient A's LMP was ~~May 14, 1993.~~ NOTED AS MAY 13 1993

AMENDED 2/3/94 JB

AMENDED 2/3/94 JB

Respondent placed 12 laminaria and injected 6cc digoxin into the fetal heart in preparation for a termination of pregnancy procedure. Patient A was instructed to return the next morning at 9 a.m.

On or about November 11, 1993, at or about 9 a.m., Patient A returned to the office. Respondent performed a D&E procedure to terminate Patient A's pregnancy. At or about 11 a.m., Patient A was transferred into the recovery room, where she remained for approximately one hour. While in the recovery room, Patient A bled profusely, vomited and lost consciousness. From at or about noon until at or about 3:00 p.m., she was treated by Respondent at the office. At 2:55 p.m., Patient A's hematocrit was 18%. Respondent thereafter transferred Patient A by ambulance to Nyack Hospital. Patient A was in shock on arrival at the hospital. The cervical laceration extended up into the lower uterine segment; the uterine artery had been lacerated. An emergency hysterectomy was performed.

1. Respondent failed to counsel Patient A appropriately prior to the D&E procedure, or to note such counseling.

2. Respondent failed to prepare Patient A's cervix adequately prior to starting the evacuation procedure.

3. Respondent continued to perform a D&E procedure on Patient A, which was inappropriate under the circumstances.

4. Respondent failed to have appropriate transfer arrangements in place prior to starting the D&E procedure on Patient A.

5. Respondent failed to recognize the existence of the laceration at or before the end of the D&E procedure.

6. Respondent failed to recognize the gravity of the laceration in a timely manner.

7. Respondent continued to attempt to repair the laceration in the office after Patient A's condition required her transfer to a hospital.

8. From at or about 2:35 p.m. until he received the hematocrit results at or about 2:55 p.m., Respondent failed to recognize that Patient A was in shock.

9. Respondent delayed inappropriately in transferring Patient A to a hospital.

B. Respondent treated Patient B at Flushing Gynecology Center, (aka Flushing Women's Center; hereafter "Center") 36-09 Main Street, Flushing, New York 11354, from on or about May 7, 1992 through on or about May 9, 1992. On or about May 7, 1992, Respondent noted that by ultrasound the pregnancy was 23.5 weeks. The fetus had multiple anomalies. On or about May 8, 1992, Respondent placed 6 laminaria of unrecorded size in preparation for a termination of pregnancy procedure. On or about May 9, 1992, Respondent began a D&E procedure to terminate Patient B's pregnancy at the center. Hern forceps were used to remove an arm and part of the placenta when omentum was seen. Patient B was transferred by ambulance to Elmhurst Hospital Center, 79-01 Broadway, Elmhurst, N.Y. 11373. At laparotomy, there was an 8-10 cm. laceration of

AMENDED 2/3/94 JB

the posterior uterus. The sigmoid colon and mesentery were injured. Patient B required a colostomy. Both ureters were damaged: the right ureter had a partial laceration and the left ureter had a complete transection. Transfusion of 4 units of packed cells was done.

1. Respondent failed to prepare Patient B's cervix adequately prior to starting the evacuation procedure.

2. Respondent continued to perform a D&E procedure in the face of an inadequately dilated cervix, which was inappropriate under the circumstances.

3. Respondent performed the D&E procedure inappropriately, causing injury to Patient B's uterus, bowel and ureters.

C. Respondent treated Patient C, a 94 year old female, at her sister's home at 320 E. 42nd St., New York, N.Y. 10017 from on or about November 1, 1988 through on or about November 19, 1988.

1. Respondent failed to perform an appropriate social history in that he failed to ascertain or to note whether Patient C had any living next of kin other than Patient D, or any other relatives or support systems.

2. Respondent failed to order or perform appropriate blood tests.

3. Respondent prescribed Dilaudid inappropriately.

4. Respondent administered B12 30 micrograms IM inappropriately.

5. Respondent failed to evaluate Patient C's diarrhea appropriately on or about November 17, 1988.

6. Respondent failed to transfer Patient C to a hospital, as required by her condition, on or after November 17, 1988.

D. Respondent treated Patient D, a 91 year old female, at her home at 320 E. 42nd St, New York, N.Y. 10017 from on or about November 1, 1988 through November 20, 1988.

1. Respondent failed to perform an appropriate social history in that he failed to ascertain or to note whether Patient D had any living next of kin other than Patient C, or any other relatives or support systems.

2. Respondent failed to perform or note an adequate evaluation of Patient D's chief complaint of "a sore on the foot."

3. Respondent prescribed and/or administered morphine and/or penicillin IM for Patient D inappropriately.

4. On or about November 17, 1988, Respondent made and noted a possible diagnosis of "mitral stenosis/regurgitation" which was not substantiated by his findings, as noted.

E. Respondent treated Patient E, a 36 year old male, at the Smoke Stop Program, 905 Fifth Avenue, New York, N.Y. 10021 on or about June 20, 1988.

1. Respondent diagnosed chronic bronchitis, which was not supported by the findings.

2. Respondent failed to follow-up Patient E's blood pressure reading of 140/90 and/or failed to refer Patient E for such follow-up.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform.

F. Respondent treated Patient F, a 31 year old male, at the Smoke Stop Program, 205 East 64th Street, Suite 203, New York, N.Y. 10021, on or about October 10, 1989.

1. Respondent failed to perform or note an adequate history.

2. Respondent failed to perform or note an adequate physical examination.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient F.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform.

G. Respondent treated Patient G, a 32 year old female, at the Smoke Stop Program, 205 East 64th Street, Suite 203, New York, N.Y. 10021 on or about February 2, 1989.

1. Respondent made a diagnosis of COPD which was not supported by the findings.

2. Respondent ordered or performed an inadequate electrocardiogram and/or failed to recognize that the electrocardiogram was inadequate and have it repeated.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient G.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform and/or for an electrocardiogram which he knew was inadequately performed and/or reported a diagnosis of COPD which he knew was not supported by the findings.

H. Respondent treated Patient H, a 45 year old male, at the Smoke Stop Program, 905 Fifth Avenue, New York, N.Y. 10021 from on or about February 14, 1989 through February 22, 1989.

1. Respondent made a diagnosis of chronic bronchitis which was not supported by the findings.

2. Respondent ordered or performed an electrocardiogram without appropriate medical indication.

3. Respondent ordered or performed an electrocardiogram which was technically inadequate and/or failed to recognize that the electrocardiogram was technically inadequate and have it repeated.

4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient H.

5. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform and/or reported a diagnosis of chronic bronchitis which he knew was not supported by the findings.

I. Respondent treated Patient I, a 31 year old male, at the Smoke Stop Program, 505 Fifth Avenue, New York, N.Y. 10021, from on or about February 14, 1989 until on or about March 9, 1990.

1. Respondent made a diagnosis of asthma which was not supported by the findings and/or failed to treat appropriately the asthma he diagnosed.

2. Respondent ordered or performed an electrocardiogram which was technically inadequate and/or failed to recognize that the electrocardiogram was technically inadequate and have it repeated.

3. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient I.

4. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform and/or reported a diagnosis of asthma he knew was not supported by the findings.

J. Respondent treated Patient J, a 29 year old male, at the Smoke Stop Program, 905 Fifth Avenue, New York, N.Y. 10021, from on or about March 29, 1989 until on or about April 5, 1989.

1. Respondent made a diagnosis of chronic bronchitis which was not supported by the findings.

2. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient J.

3. Respondent intentionally billed for a comprehensive history and physical examination, and behavioral counseling, which he knew he did not perform and/or

reported a diagnosis of chronic bronchitis which was not supported by the findings.

K. Respondent treated Patient K, a 48 year old female, at the Smoke Stop Program, 205 East 64th St., New York, N.Y. 10021, on or about December 28, 1989.

1. Respondent made a diagnosis of bronchitis which was not supported by the findings.

2. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient K.

3. Respondent intentionally billed for a comprehensive history and physical examination which he knew he did not perform.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence on a particular occasion under N.Y. Educ. Law Sec. 6530(4) (McKinney Supp. 1993), in that Petitioner charges:

1. The facts in paragraphs A and A.7, A.8 and/or A.9.

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Sec. 6530(3) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

2. The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8 and/or A.9, B, B.1, B.2, B.3, C, C.1, C.2, C.3, C.4, C.5, C.6, D, D.1, D.2, D.3, D.4, E, E.1, E.2, E.3, F, F.1, F.2, F.3, G, G.1, G.2, G.3, H, H.1, H.2, H.3, H.4, I, I.1, I.2, I.3, J, J.1, J.2, K, K.1, and/or K.2.

THIRD THROUGH NINTH SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1993), in that Petitioner charges:

3. The facts in paragraphs E and E.4.

4. The facts in paragraphs F and F.4.

5. The facts in paragraphs G and G.4.

6. The facts in paragraphs H and H.5.

7. The facts in paragraphs I and I.4.

8. The facts in paragraphs J and J.3.

9. The facts in paragraphs K and K.3.

TENTH THROUGH NINETEENTH SPECIFICATION

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient under N.Y. Educ. Law Sec. 6530(32) (McKinney Supp. 1993), in that Petitioner charges:

10. The facts in paragraphs A and A.1.
11. The facts in paragraphs C and C.1.
12. The facts in paragraphs D, D.1 and/or D.2.
13. The facts in paragraphs E and E.3.
14. The facts in paragraphs F, F.1, F.2, and/or F.3.
15. The facts in paragraphs G and G.3
16. The facts in paragraphs H and H.4.
17. The facts in paragraphs I and I.3.
18. The facts in paragraphs J and J.2.
19. The facts in paragraphs K and K.2.

DATED: New York, New York
January 4, 1994

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct