STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

PUBLIC

July 24, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrance J. Sheehan, Esq.
NYS Department of Health
5 Penn Plaza-6th Floor
New York, New York 10001

Sherilyn Dandridge, Esq.
The Dandridge Law Firm
1633 Broadway, 23rd Floor
New York, New York 10019

Dr. Kildare Isaac Clarke, M.D.
REDACTED

RE: In the Matter of Kildare Isaac Clarke, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-224) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER

OF

KILDARE ISAAC CLARKE, M.D.
————————————X

ORDER # BPMC #02-224

COPY

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **JERRY WAISMAN, M.D.**, chairperson, **RALPH LEVY, D.O.**, and **LOIS VOYTICKY**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as the Administrative Law Judge. The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by KILDARE ISAAC CLARKE, M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

SUMMARY OF PROCEEDINGS

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, N.Y.

Pre-Hearing Conferences: April 4, 2002

Hearing dates:		April 23, 2002 May 1, 2002 May 21, 2002 May 28, 2002 June 4, 2002
Dates of Deliberation:		June 19, 2002 June 29, 2002
Petitioner appeared by:		NYS Department of Health
	by:	Terrance J. Sheehan, Esq. Associate Counsel
Respondent appeared:		The Dandridge Law Firm
		1633 Broadway, 23rd Floor New York, N.Y. 10019
	by:	Sherilyn Dandridge, Esq.

WITNESSES

For the Department:	Richard Birrer, M.D. Michelle Marsilio Mary Malone
For the Respondent:	Lee Chang Yang, M.D. Sammy Felton Clifford Schneiner, M.D. Kildare Isaac Clarke, M.D.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

FINDINGS OF FACT

PATIENT A

1. The Respondent was authorized to practice medicine in New York State on or about 11/04/77, by the issuance of license number 132990 by the New York State Education Department.

2. On or about April 28, 2000 and August 25, 2000, Respondent evaluated and treated Patient A for an unknown condition at his private office at 6 Hazelton Drive, White Plains New York. (Pet. Exh. 4)

3. Respondent did not obtain and document adequate medical, psychiatric, and substance abuse histories. (T. 29, 30)

4. Respondent did not formulate a diagnosis or differential diagnoses. (T. 28, 29)

5. On April 28, 2000, Respondent issued to Patient A, a prescription for Cannabis sativa, three grams maximum daily with three refills. (Pet. Ex.'s 4, 9; T. 17 - 19)

6. Cannabis is a Schedule 1 medication. Section 3330 of the Public Health Law prohibits the issuance of prescriptions for Schedule 1 drugs. Respondent's issuance of a prescription for Cannabis to Patient A is a violation of Section 3330 of the Public Health Law.

7. Respondent's chart for Patient A stated that the prescription is being issued pursuant to the "Controlled Substance Therapeutic Research Act." Respondent failed to abide by any of the terms of the Act. (Pet. Exh. 4; T. 21 - 24)

8. Patient A did not keep two scheduled appointments with the Respondent.

9. Patient A came to the Respondent's office on August 25, 2000 without an appointment, and the Respondent gave him another prescription for Cannabis. (Pet. Exh. 4)

10. At the time Respondent issued the prescriptions for Cannabis, Respondent was aware of Patient A's prior history of drug abuse. (T. 19, 20, 27, 41)

PATIENT B

The Committee found by a majority that the Respondent was not guilty of the State's allegations in relation to Patient B.

PATIENT C

11. On or about August 27, 1992, Patient C, a diabetic, was seen by Respondent, acting as triage officer, at the emergency room at Kings County Medical Center, with a complaint of lack of insulin for two days. (T. 714)

12. Respondent did not adequately evaluate the relative seriousness of Patient C's condition. (Pet. Exh. 6; T. 102 - 106)

13. Respondent did not obtain Patient C's significant medical history including insulin dependent diabetes for thirty-five years and an episode of diabetic ketoacidosis. (T. 734)

14. Respondent did not recognize the existence of an underlying diabetic ketoacidosis. (Pet. Exh 6 p. 11, Exh. 14A, B; T. 105 -107)

PATIENT D

15. On or about August 27, 1996, Patient D, who was pregnant, was brought to the emergency room at Kings County Hospital after two days of heavy vaginal bleeding and with lower abdominal cramps. (Pet. Ex. 7)

16. Respondent was the attending physician in the emergency room for Patient D. (T. 769)

17. Respondent did not start an intravenous infusion for Patient D. (Pet. Exh. 7, T. 123))

18. Respondent did not type and hold blood for crossmatch for Patient D for a possible transfusion. (Pet. Exh. 7, T. 123)

RESUME

19. Respondent submitted a resume to the New York State Department of Health containing false entries about his accomplishments and qualifications, although he knew they were false. (Pet. Exh. 12; T. 157, 160)

DISCUSSION

The Committee listened to the testimony of the witnesses and examined the exhibits entered into evidence. It was evident through the documents (Pet. Exh 13, 14, 15, 16) and testimony (T. 363, 652- 653, 676, 682) that Kings County Hospital emergency room was poorly equipped, overcrowded, and understaffed. However, physicians in the practice of medicine must be held to a minimally accepted standard of care of the physicians within the community, and the prudent, competent physician must consider all relevant medical issues in the care of their patients. The Respondent's care of Patients A, C, and D was below accepted standards of medical practice in this community.

Respondent's treatment of Patient A is most disturbing. The Respondent, having worked in Kings County Hospital is no stranger to drug addicts, who can be manipulative and can fabricate all sorts of stories. Patient A was a private patient of the Respondent and was seen in his White Plains office. Patient A came to the Respondent for a prescription for Cannabis only to deceive his probation officer and the judge. Respondent was aware of this situation yet wrote two illegal prescriptions on two separate occasions four months apart. There is no acceptable medical justification for such acts. The Respondent, who is both a physician and lawyer, intentionally wrote an illegal prescription that could serve no purpose but to convince a judge that Patient A should not go to jail. The aura of fraud in this action is obvious.

The Committee found by a majority that the Respondent was not guilty of the State's allegations in relation to Patient B.

Respondent's treatment of Patient C indicates poor medical skills. Respondent's failure to elicit from Patient C the most basic medical history regarding his diabetes placed this Patient in a mortal situation. Respondent's notes are void of his findings, general impressions, conclusions, or justifications for his actions.

Patient D came to Kings County Hospital via ambulance. The Respondent was the attending physician, and he failed to provide a minimal care to a patient, bleeding for two days. Standard emergency treatment of a bleeding patient is to stabilize first and then evaluate and treat. (T. 124) Such care for Patient D would have included starting an intravenous infusion for a patient who is bleeding to replace volume, (T. 123) and taking blood for the appropriate tests including type and cross-match (T. 123) for potential transfusion. The Respondent's failure to perform such medical care before sending the patient to the obstetrics department is not sound.

Finally, Respondent's *curriculum vitae* is replete with inaccuracies. The Respondent's witness, Sammy Felton, testified he was given a prior *curriculum vitae* to update. (T. 259) The information he was given was false. After the Respondent reviewed the *curriculum vitae*, he failed to assure that errors were corrected. (T. 260) The *curriculum vitae* was written on or about 1993, (T. 271) and the Respondent later presented this *curriculum vitae* as current and valid to the New York State Department of Health. Although the Respondent's actions regarding his *curriculum vitae* appear negligible, the Respondent's actions indicate both poor credibility and questionable judgment.

It is a credit to the Respondent that he has practiced in a New York City hospital that serves an under-privileged community; however, the Respondent's cited actions are unacceptable medical practice.

This committee has reviewed all possible penalties. The Respondent's serious violations of ethical standards cannot be corrected by probation. The Respondent was not credible and would evade answers or blame others for error perpetuated. The Respondent's behavior indicated that he had repeated patterns of poor judgment both in the areas of medicine and ethics and could not acknowledge that before this committee.

SPECIFICATION OF CHARGES

GROSS NEGLIGENCE

A and A(3), A (4), A (5) - guilty - unanimous

B and B (1), B (2), B (3) - not guilty - unanimous

C and C(1), C (2) - guilty - majority
C (3), C (4) - not guilty - unanimous

D and D (1) - guilty - majority

E and E (1), E (2) - not guilty - majority

GROSS INCOMPETENCE

A and A(3), A(4) and A(5) - not guilty - unanimous

B and B(1), B(2) and B(3) - not guilty - unanimous

C and C(1), C(2), C(3) and C(4) - not guilty - unanimous

NEGLIGENCE ON MORE THAN ONE OCCASION

A and A(1) - A(5) - guilty - unanimous

B and B(1) - B (3) - not guilty - unanimous

C and C(1) and C (2) - guilty - majority

C (3) and C (4) - not guilty - unanimous

D and D (1) - guilty - majority

E and E (1), E (2) - not guilty – majority

INCOMPETENCE ON MORE THAN ONE OCCASION

A and A(1) - A(5) - not guilty - unanimous

B and B (1) - B(3) - not guilty - unanimous

C and C(1) - C(4) - not guilty - unanimous

D and D(1) - not guilty - unanimous

E and E(1) - E(2) - not guilty - unanimous

FRAUDULENT PRACTICE

A and A (3) - guilty - unanimous

F - guilty - unanimous

FALSE REPORTING

F - guilty - unanimous

VIOLATION OF LAW

A and A (3) - guilty - unanimous

MORAL UNFITNESS

A and A (3) - guilty - unanimous

F - guilty - unanimous

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

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

ORDER

IT IS HEREBY ORDERED:

1) The Respondent's license to practice medicine in the State of New York is **REVOKED**.

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

DATED: Stockholm, Sweden
July 17, 2002

REDACTED

JERRY WAISMAN, M.D.

RALPH LEVY, D.O.
LOIS VOYTICKY

APPENDIX I

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

IN THE MATTER

OF

KILDARE ISAAC CLARKE, M.D.

STATEMENT

OF

CHARGES

KILDARE ISAAC CLARKE, M.D., the Respondent, was authorized to practice medicine in New York State on or about 11/04/77, by the issuance of license number 132990 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about April 28, 2000 and August 25, 2000, Respondent treated Patient A for an unknown condition at his private psychiatric office at 6 Hazelton Drive, White Plains, N.Y. (Patient names are listed in the attached Appendix.) Respondent's care and treatment of Patient A deviated from accepted standards of care in the following respects:

1. Respondent failed to obtain and document adequate medical, psychiatric and substance abuse and substance abuse treatment histories.

2. Respondent failed to formulate a diagnosis or differential diagnoses.

3. Not in good faith and not in the ordinary course of medical practice, Respondent issued to Patient A two prescriptions for Cannabis, one refillable three times and the other, two times.

4. The two prescriptions for Cannabis were issued without proper medical indication.

5. At the time Respondent issued the prescriptions for Cannabis Respondent was aware of Patient A's prior history of drug abuse. As a result, Respondent, by his actions, recklessly risked reigniting or perpetuating the Patient's pattern of drug abuse.

B. On or about May 10, 1998, Patient B was seen by Respondent in the emergency room at Kings County Hospital Medical Center, Brooklyn, New York, for a complaint of severe, crushing chest pain. Respondent's care and treatment of Patient B deviated from accepted standards of care in the following respects:

1. Respondent failed to adequately evaluate the relative seriousness of Patient B's condition.

2. Respondent failed to recognize or attempt to rule out the existence of a myocardial infarction.

3. Respondent failed to refer Patient B for thrombolytic therapy in a timely manner.

C. On or about August 27, 1992, Patient C, a known diabetic, was seen by Respondent in the emergency room at Kings County Hospital Medical Center, for a complaint of lack of insulin for two days. Respondent's care and treatment of Patient C deviated from accepted standards of care in the following respects:

1. Respondent failed to adequately evaluate the relative seriousness of Patient C's condition.

2. Respondent failed to recognize or attempt to rule out the existence of an underlying diabetic ketoacidosis.

3. Respondent failed to order a blood sugar test or the insertion of an IV line.

4. Respondent inappropriately delayed admitting Patient C.

D. On or about August 27, 1996, Patient D, who was pregnant, was brought to the emergency room at Kings County Hospital after two days of heavy vaginal bleeding and with lower abdominal cramps. Respondent's care and treatment of Patient D deviated from accepted standards of care in the following respects:

1. Respondent failed to start an intravenous infusion, check her vital signs or to order the Patient to be typed and crossmatched for a possible transfusion.

E. On or about August 11, 1992, Patient E was seen by Respondent in the emergency room at King's County Hospital complaining of shortness of breath and trouble swallowing.

1. Respondent failed to take Patient E's vital signs and order his oxygen saturation checked by pulse oximetry.

2. Respondent improperly allowed the Patient to go unaccompanied to the treatment area despite a working diagnosis of angioedema.

F. Respondent submitted a curiculum vitae to the Office of Professional Medical Conduct which knowingly, and with intent to deceive, contained numerous false statements including, inter alia, claimed membership in the American Psychiatric Association and the New York County Lawyers Association and PHD training at the University of London.

SPECIFICATION OF CHARGES

FIRST TO THIRD SPECIFICATIONS

GROSS NEGLIGENCE

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

1. A and A(3), A(4) and A(5)
2. B and B(1), B(2) and B(3)
3. C and C(1), C(2), C(3) and C(4).

FOURTH TO SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

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

4. A and A(3), A(4) and A(5)
5. B and B(1), B(2) and B(3)
6. C and C(1), C(2), C(3) and C(4).

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

7. A and A(1) - A(5); B and B(1) - B(3); C and C(1) - C(4); D and D(1); and or E and E(1), E(2).

EIGHT SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

8. A and A(1) - A(5); B and B(1) -B(3); C and C(1) - C(4); D and D(1); and or E and E(1), E(2).

NINTH AND TENTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

9. A and A(3)
10. F

ELEVENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of the following paragraph:

11. F

TWELFTH SPECIFICATION

VIOLATION OF LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(16) by his willful or grossly negligent failure to comply with substantial provisions of federal, state or local laws, rules, or regulations governing the practice of medicine, specifically Pub. Health Law § 3330, as alleged in the facts of the following paragraphs:

12. A and A(3)

THIRTEENTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following paragraphs:

13. A and A(3) and F.

DATED: March 5, 2002
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct