STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

January 11, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Department of Health
Empire State Plaza
Corning Tower – Room 2509
Albany, New York 12237

Mark Chalom, M.D.
3 Lyon Place
Ogdensburg, New York 13669

James D. Latier, Esq.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, New York 13202

RE: In the Matter of Mark Chalom, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-11) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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:

1355

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

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above. As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be

sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB: mla

Enclosure

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

COPY

IN THE MATTER OF

OF

MARK CHALOM, M.D.

DETERMINATION

AND

ORDER

ORDER #00-11

KENDRICK A. SEARS, M.D., Chairperson, **J. LaRUE WILEY, M.D.**, and **REV. EDWARD J. HAYES**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having committed conduct in the practice of medicine which evidences moral unfitness to practice medicine (two specifications), having practiced the profession of medicine with gross negligence on a particular occasion (five specifications) and gross incompetence (five specifications), and with negligence on more than one occasion (one specification) and incompetence on more than one occasion (one specification).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	March 29, 1999
Date of Service of Notice of Hearing and Statement of Charges:	March 31, 1999
Answer to Charges Dated:	June 30, 1999
Prehearing Conference Date:	July 2, 1999
Hearing Dates:	July 15, 1999[1] August 27, 1999 October 4, 1999
Deliberation Dates:	October 22, 1999 November 11, 1999
Place of Hearing for all of the above dates except August 27, 1999:	Holiday Inn – Carrier Circle 6555 Old Collamer Road South East Syracuse, New York
Place of Hearing for August 27, 1999:	Hampton Inn 417 7th North Street Liverpool, New York
Petitioner Appeared By:	Henry M. Greenberg, Esq. General Counsel NYS Department of Health By: Cindy M. Fascia, Esq.
Respondent Appeared By:	Smith, Sovik, Kendrick & Sugnet, P.C. 250 South Clinton Street, Suite 600 Syracuse, New York 13202 By: James D. Lantier, Esq.

[1] The first hearing date was originally scheduled for April 20, 1999. This date was adjourned at the Respondent's request. For a more detailed explanation of the circumstances surrounding this adjournment see pages 13 through 17 of the transcript of the Prehearing Conference conducted on July 2, 1999.

WITNESSES

For the Petitioner:	Nurse 1 Deborah Billings Nurse 2 David C. Brittain, M.D. Anita L. Harrison Joel Peter Amidon, II, D.O. Lori D. Hudzinski, M. D.
For the Respondent:	Mark Chalom, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Mark Chalom, M.D. ["the Respondent"] was authorized to practice medicine in New York State on July 1, 1977 by the issuance of license number 131355 by the New York State Education Department (Tr. 467).

2. The Respondent was Board Certified in Family Practice in 1977 and he was recertified in 1986. However, he subsequently allowed his certification to lapse. (Tr. 531-532, 536-538 and 568; Ex. B).

3. The Respondent has a solo family practice in Ogdensburg, New York. He currently maintains an office practice providing for the care of adults and children and a hospital practice limited to pediatrics and obstetrics. He also works at several nursing homes as well as the Ogdensburg Correctional Facility, the St. Lawrence Psychiatric Center and the St. Lawrence Alcohol Treatment Center. (Tr. 529-531; Ex. B).

4. In the late 1980s, the Respondent's hospital practice included the care of inpatient adults in addition to his pediatrics and obstetrics practice (Tr. 530).

FINDINGS AS TO NURSE 1[2]

5. During the months of March and April in 1996, the Respondent was the Medical Director of St. Joseph's Home ["SJH"], Ogdensburg, New York, an 82 bed nursing home facility with three wings – West Wing, Lawlor Wing and East Wing. (Tr. 20-24, 36 and 55).

6. During this period Nurse 1, a Registered Nurse, was employed as an R.N. Supervisor at SJH (Tr. 20 and 24).

7. In or about March or April 1996, Nurse 1 and the Respondent were sitting at the nursing desk in the Lawlor Wing of SJH working on residents' charts when Sister Theresa, an L.P.N. who was working on the West Wing, came up to them and told them that a resident and her family wanted to see the Respondent. Nurse 1 indicated to Sister Theresa that they would take care of it and Sister Theresa left. A few minutes later, Sister Theresa returned and stated that the resident's family was very upset and that if the Respondent did not see them right away, they were going to take action. The Respondent

[2] The findings appearing in paragraphs 7 through 12 were not unanimous. These paragraphs contain the findings of a majority of the Hearing Committee.

became upset and got up and walked very quickly to the West Wing, followed by Nurse 1. (Tr. 22-25).

8. When Nurse 1 reached the nurses' station in the West Wing, the Respondent was already there with the resident's chart. As Nurse 1 approached the nurses' station, the Respondent got up with the chart and started to walk out of the room and Nurse 1 followed after him. The Respondent suddenly stopped, turned around towards Nurse 1, said "And you", and then grabbed her with one hand around her neck. She then lifted herself up to her toes and moved backwards to relieve the pressure on her neck because the Respondent was hurting her. (Tr. 25-27 and 58-59). The actual placement of the Respondent's hand on Nurse 1's neck lasted for a very brief time – approximately ten to fifteen seconds (Tr. 39).

9. After the Respondent released Nurse 1, she told him that she considered it an assault and that he should never do it again (Tr. 27).

10. After Nurse 1 finished her rounds, she went to Myrna Sandburg, the Director of Nursing at SJH, and told Ms. Sandburg what the Respondent had done to her (Tr. 28 and 38).

11. Nurse 1 did not report this incident to any other authorities because she thought that by immediately confronting the Respondent about what he had done and telling him not to do it again, she had handled the situation, and she hoped that nothing like this would ever happen again. (Tr. 28 and 44-45).

12. Both Sister Theresa, the L.P.N. on the West Wing, and Deborah Billings, the Nursing Secretary at SJH, were present and witnessed the incident (Tr. 26, 37, 55 and 65).

FINDINGS AS TO NURSE 2

13. On September 21, 1996, the Respondent was still the Medical Director of SJH and Nurse 2, a Licensed Practical Nurse, was the Charge Nurse on the East Wing of SJH (Tr. 80, 82 and 85-86).

14. On Saturday, September 21, 1996, Nurse 2, while working on the East Wing of SJH, paged the Respondent twice on his pager within a period of approximately five to ten minutes because one of the residents on her wing had an elevated temperature. Nurse 2 used the same telephone to place both calls which paged the Respondent. (Tr. 85-89, 106-107 and 548).

15. As Nurse 2 replaced the receiver on the telephone after her second call, she turned around and saw the Respondent coming towards her. Suddenly, the Respondent put his hand on Nurse 2's neck, around her throat, causing her to elevate to the tips of her toes. She immediately told him to stop, that he was hurting her. The Respondent then let go of her and he turned around and left the unit. (Tr. 89- 91, 98 and 102).

16. This incident happened very quickly. It lasted under fifteen seconds (Tr. 98).

17. Later that day, before Nurse 2's shift ended, Nurse 2 reported the incident to Nurse 1, who was her immediate supervisor (Tr. 31-32 and 91).

18. On the morning of September 23, 1996, the following Monday, Nurse 2 reported the incident to Mr. O'Reilly, the Administrator of SJH (Tr. 93).

19. In April 1997, the Respondent was interviewed at the Syracuse Regional Office of the New York State Department of Health (Tr. 122-123). During the course of the interview, Dr. David Brittain, the Syracuse Medical Coordinator, asked the Respondent about his

actions regarding Nurse 2 at SJH. The Respondent stated that he had "lost it", and that he put his hands on Nurse 2's shoulders and shook her. (Tr. 124-125 and 554).

20. On October 4, 1999, the Respondent, while testifying at this hearing, stated that he became frustrated and he put his hands on Nurse 2's shoulders and shook her twice. However, he denied lifting her, exerting any upward motion, or squeezing or putting any pressure on her neck. He also acknowledged that his behavior towards Nurse 2 was inappropriate. (Tr. 548-550 and 551-552).

FINDINGS AS TO PATIENT A

21. Patient A, a 19 year old female in early labor who was pregnant with her first child, was admitted to A. Barton Hepburn Hospital ["ABHH"], Ogdensburg, New York, on November 1, 1995 (Tr. 490-491, 499-500 and 585; Ex. 3, pp. 4-5).

22. The Respondent treated Patient A at ABHH from on or about November 1, 1995 through November 3, 1995 and delivered Patient A's baby (Ex. 3).

23. Early labor of Patient A was uneventful, but in the later stages of her labor there were episodes of fetal bradycardia, which is frequently an indication of a distressed fetus (Tr. 491-493; Ex. 3, pp. 3 and 21; and Ex. 4).

24. The Respondent decided to perform an instrumented delivery using a vacuum extractor. After making this decision, the Respondent delivered the baby's head using a vacuum extractor (Tr. 496-497). Following the delivery of the baby's head, the Respondent encountered a shoulder dystocia. The Respondent then performed a McRobert's maneuver and an episiotomy to accomplish the delivery. (Tr. 502-503 and 573-575; Ex.

3, pp. 3, 19 and 27).

25. While performing the episiotomy the Respondent introduced two fingers into Patient A's vagina and he cut when he could not palpate what he was cutting, resulting in the amputation of part of the baby's left index finger (Tr. 503-504, 575, 582-584 and 587; Ex. 3, pp. 3, 19 and 27).

26. A reasonably prudent physician who chooses to perform an instrumented delivery would perform an episiotomy prior to the delivery of the infant's head (Tr. 510-513, 515, 523 and 525-527).

27. In performing an episiotomy, cutting beyond what can be palpated does not meet acceptable standards of medical care and exposes structures to injury which are not intended to be cut (Tr. 505-506).

FINDINGS AS TO PATIENT B

28. Patient B, a terminally ill 76 year old female, was admitted to ABHH on October 26, 1989. She had been diagnosed with colon cancer in 1987, for which she had undergone an abdominoperineal resection. She was subsequently found to have lung metastasis, for which she underwent a wedge resection, and metastasis to the vagina. She lived alone and was being followed medically at home by the Public Health Nurse and Hospice. She had poor oral fluid intake, had become weaker and was taken to ABHH when the Public Health Nurse noticed an acute onset of confusion (Tr. 198, 218 and 594-595; Ex. 6, pp. 1 and 7-9).

29. The Respondent was Patient B's attending physician from on or about October 26, 1989

through October 31, 1989 (Tr. 198; Ex. 6).

30. On October 19, 1989, Patient B had executed a Do Not Resuscitate Order requesting that she not be resuscitated if she suffered a cardiac or pulmonary arrest (Tr. 218-219 and 596; Ex. 6, p. 6).

31. On October 26, 1989, the Respondent saw Patient B and recorded a history, a past medical history, a review of systems and a physical examination (Ex. 6, pp. 8-9).

32. At the conclusion of the history and physical examination, the Respondent recorded his impression and plan of treatment (Ex. 6, p. 9).

FINDINGS AS TO PATIENT C

33. Patient C, a 73 year old female, was admitted to ABHH on February 26, 1989 with a diagnosis of having had an acute cerebral vascular accident ["CVA"]. She had a history of headaches, chest pain, palpitations and was status post CVA. She had good resolution of symptoms from these prior CVAs. (Tr. 247; Ex. 7, pp. 1 and 4-5).

34. The Respondent treated Patient C on numerous occasions at his office since 1983 (Tr. 246-247 and 610; Ex. 9) and from on or about February 26, 1989 through March 3, 1989 the Respondent attended to Patient C at ABHH (Tr. 248; Ex. 7). The Respondent also attended to Patient C on her readmission to ABHH from on or about March 30, 1989 through April 1, 1989 (Ex. 8).

35. During the course of Patient C's February 26th hospitalization, the Respondent placed Patient C on Coumadin, an anticoagulant (Tr. 249-250; Ex. 7, p. 4).

36. The standard of care for anticoagulating and monitoring a patient in 1989 was to

anticoagulate the patient with a dosage of Coumadin that a reasonably prudent physician would consider appropriate and to monitor the patient in the hospital for approximately two to five days. The patient's prothrombin time ["pro time"] levels would be monitored and the Coumadin dose adjusted until the patient was at a therapeutic level, then the dose would be adjusted down from the initial loading dose. The patient could then be discharged with instructions to have the pro times tested within one to three days, or, at most, within a week of the discharge from the hospital. (Tr. 250-252 and 257-258).

37. Patient C's condition improved during her hospitalization and she became stable to be discharged to home (Tr. 252-253; Ex 7, p. 4).

38. Patient C was discharged from ABHH on March 3, 1989 on 5 mg. Coumadin daily. She was advised to avoid aspirin and ibuprofen. However, the Respondent's discharge orders and instructions included no instructions whatsoever with regard to follow-up for testing of her pro times to monitor her anticoagulation. The Respondent did not order pro time testing and Patient C was never told that she should have such testing done. The Respondent's only follow-up care instructions for Patient C were that she should see the Respondent in his office in six weeks. (Tr. 253-255 and 617; Ex. 7, pp. 4 and 27).

39. The Respondent's failure to write anything about monitoring pro times in Patient C's discharge orders placed Patient C at risk of severe hemorrhagic complications (Tr. 255-256).

40. The Respondent did not monitor Patient C's pro times after her March 3rd discharge and his office records for Patient C do not reflect any pro times for the period between her March 3rd discharge and her hospital readmission on March 30, 1989 (Tr. 615; Ex. 9, pp. 4 and 5).

41. On March 30, 1989, Patient C was readmitted to ABHH with a hematoma in her neck as a result of hypoprothrombinemia from excessive Coumadin (Tr. 258-259 and 620-621; Ex. 8, pp. 1, 3, 5 and 10).

42. The Respondent, who was again Patient C's attending physician, treated the excessive anticoagulation appropriately during the March 30th hospitalization (Tr. 259-260; Ex. 8).

43. On April 1, 1989, Patient C was discharged from ABHH with a pro time of 14.3 seconds. She was discharged on a new, reduced dose of Coumadin (2.5 mg. per day; a dosage that she first received on the day of discharge) and the Respondent provided written instructions for Patient C to have a pro time repeated in one week. (Tr. 261-262 and 265-267; Ex. 8, pp. 17 and 37).

44. The applicable standard of care required that Patient C be closely monitored, with daily evaluation of her pro times for several days until her anticoagulation was stable in the therapeutic range. After this is achieved, she could then be tested on a weekly basis. The Respondent's deviation from this standard of care once again exposed Patient C to increased risk of harm from inadequately monitored anticoagulation. (Tr. 260-261 and 267-268).

FINDINGS AS TO PATIENT D

45. Patient D, a 42 year old male who was an inmate at Ogdensburg Correctional Facility, was treated by the Respondent at ABHH from July 18, 1989 through July 21, 1989 (Tr. 284 and 629; Ex. 11A).

46. On the day of this admission, Patient D was diagnosed as having status epilepticus by the

Emergency Room physician, the Respondent and a Neurology consultant who saw Patient D at the Respondent's request. This consultant documented a neurological and mental status assessment that was limited by the patient's thrashing in bed, which necessitated the use of four point restraints. (Tr. 629; Ex. 11A, see Admission Record, Discharge Summary, the Respondent's admitting progress note, Emergency Room Record and the Consultation Report).

47. The Neurology consultant formulated an adequate assessment and treatment plan which appears in his notes of July 18, 1989 and July 19, 1989. (Ex. 11A, see Consultation Report).

48. At the time of this admission, Patient D also had evidence of anemia, leukocytopenia, thrombocytopenia and metabolic acidosis. (Ex. 11A, see laboratory reports).

49. The Respondent documented a fairly detailed differential diagnosis (assessment) and plan for workup in his orders of July 18, 1989 and his progress note of July 19, 1989, which states in part "I doubt Pt has typical bacterial meningitis as mental status improved, and temp ↓ compared to yesterday. May still have HIV associated atypical meningitis – cryptococcus, toxo, or lymphoma. Low platelets may increase risk intracranial bleed". (Ex. 11A, see order sheet and the July 19, 1989 progress note).

50. Patient D was uncooperative and he was discharged from ABHH on July 21, 1989. (Ex. 11A, see Discharge Summary).

51. On July 25, 1989, Patient D was readmitted to ABHH to accomplish a lumbar puncture which could not be performed during the prior admission (Tr. 631-632; Ex. 11, pp. 8 and 9).

52. The Respondent treated Patient D at ABHH from on or about July 25, 1989 through July

26, 1989 (Ex. 11).

53. The admission history prepared by the Respondent in connection with the July 25th readmission includes a statement that the patient "** was in hospital just recently for status epilepticus. Detailed history can be obtained from that time." (Tr. 630-631; Ex. 11, p. 9).

54. Since the interval between the two admissions was only four days, the standard for history and physical on the second admission would be the same as the standard for an interim history and physical, provided that the earlier hospital records were readily available (Tr. 296-297, 313 and 638-639).

FINDINGS AS TO PATIENT E

55. Patient E, a 70 year old male who was a former smoker and had a 15 year history of shortness of breath, was admitted to ABHH on April 13, 1989 with complaints of shortness of breath, wheezing and a cough (Tr. 303 and 643-644; Ex. 12, pp. 1 and 6-9).

56. The Respondent treated Patient E at ABHH from on or about April 13, 1989 through April 16, 1989 (Tr. 655; Ex. 12).

57. The admission history prepared by the Respondent in connection with the April 13th admission was adequate. Although it did not include documentation of allergy, the Emergency Room Record for this admission documented "NKA" – a standard abbreviation for "no known allergies". (Tr. 305 and 643; Ex. 12, p. 9).

58. The hands-on physical examination performed by the Respondent in connection with the April 13th admission met accepted standards of medical care. While this physical

examination lacked documentation of a basic neurological assessment and a rectal and genitalia examination or reasons why they were not performed, neither a neurological assessment nor a rectal and genitalia examination was pertinent to the reasons for Patient E's admission to ABHH in the first place. (Tr. 305; Ex. 12, pp. 7-8).

59. During the April 13th admission, the Respondent also ordered an electrocardiogram ["EKG"] which was interpreted by a cardiologist. The cardiologist accepted the computer interpretation of the EKG dated August 13, 1989 as showing sinus arrhythmia. (Tr. 646-647; Ex. 13, p. 14).

60. On April 16, 1989, Patient E was discharged from ABHH (Tr. 647 and 651; Ex. 12).

61. On April 18, 1989, Patient E was readmitted to ABHH through the Emergency Room (Tr. 311 and 652; Ex. 13, pp. 1 and 4-6).

62. The Respondent was Patient E's attending physician from on or about April 18, 1989 through April 21, 1989 (Tr. 655; Ex. 13).

63. The physical examination performed and documented by the Respondent and the Emergency Room physician in connection with the April 18th admission was extremely brief and did not meet accepted standards of medical care (Tr. 312-315; Ex. 13, pp. 5 and 6).

64. In addition, during this admission the Respondent did not assess Patient E's renal function, electrolyte levels or cardiac function, which were assessed during the prior admission (Tr. 334-338; Ex. 12, pp. 8, 9, 12, 16 and 17).

65. On April 21, 1989, Patient E was discharged from ABHH (Tr. 649 and 652; Ex. 13).

66. On April 22, 1989, Patient E was readmitted to ABHH. However, during this third hospitalization, Patient E was under the care of another physician. (Tr. 649-650 and 652;

Ex. 14).

FINDINGS AS TO PATIENT F

67. Patient F, an 85 year old male with a history of syncope and who had recently undergone prostate surgery for an apparent benign prostatic hypertrophy, was admitted to ABHH on October 28, 1988. He was brought to the Emergency Room after a syncopal episode. (Tr. 666-668; Ex. 15, pp. 1 and 5-8).

68. The Respondent was Patient F's attending physician from on or about October 28, 1988 through November 17, 1988 (Tr. 356-357; Ex. 15).

69. The physical examination performed by the Respondent in connection with the October 28th admission lacked documentation of any neurological examination or any rectal and genitalia examination, which are pertinent to Patient F's history (Tr. 357-358; Ex. 15, p. 7).

70. The Respondent's treatment of Patient F during this admission failed to address the patient's elevated temperature, tachycardia, urosepsis, pneumonia and other possible complications of the recent surgery (Tr. 359-361; Ex. 15).

71. On November 17, 1988, Patient F was discharged from ABHH and transferred to Cedars Nursing Home (Tr. 670 and 681; Ex. 15, pp. 1, 5-6, 160, 161, 166 and 168).

72. On November 22, 1988, Patient F was readmitted to ABHH through the Emergency Room, after having had at the nursing home a syncopal episode followed by apparent dyspnea. He also had cyanosis and a fever of 104 degrees. On admission to the hospital, he was unconscious, cyanotic and tachypneic (Tr. 361-362 and 670; Ex. 16, pp. 1 and 6-

9).

73. The Respondent was Patient F's attending physician from on or about November 22, 1988 through December 5, 1988 (Tr. 670-671; Ex. 16).

74. The physical examination performed by the Respondent in connection with the November 22nd admission lacked documentation of a neurological evaluation, which was indicated in view of Patient F having a history of being found unconscious (Tr. 362). In addition, the Respondent failed to perform a rectal examination to evaluate Patient F's prostate, which was also indicated in view of the patient's history. (Ex. 16).

75. However, the pneumonia was treated during the course of this second admission and Patient F had stabilized sufficiently to return to the nursing home (Tr. 369-370).

76. On December 5, 1988, Patient F was discharged from ABHH and transferred back to Cedars Nursing Home (Ex. 16, pp. 1, 6-7, 108-110 and 115).

FINDINGS AS TO PATIENT G

77. Patient G, a 78 year old female resident of United Helpers Intermediate Care Facility ["the ICF"], was admitted to ABHH on July 13, 1989 with a diagnosis of profound mental retardation and a history of seizures, breast cancer and mastectomy, rectal prolapse and previous CVAs. At the time of admission she had been found unresponsive to touch and speech and her admitting diagnosis was a probable CVA. (Tr. 376-377 and 702; Ex. 17, pp. 1 and 6-8).

78. The Respondent treated Patient G at ABHH from on or about July 13, 1989 through July 17, 1989 (Ex. 17).

79. The physical examination of Patient G performed by the Respondent in connection with her July 13th admission was inadequate since it lacked a comprehensive neurological examination, an assessment of her extremities or an evaluation of her carotid arteries, which were all indicated in view of her history. The Respondent did not order a CAT scan or an echocardiogram, made no apparent effort to find a reason for Patient G's recurrent strokes, and there is no reference to any such studies conducted in the past. The Respondent, in his assessment of Patient G, also failed to indicate consideration of anti-coagulation therapy or provide reasons for not using such therapy, which should have been considered after an acute neurologic event in a patient with a history of CVAs. (Tr. 377-380 and 714-715; Ex. 17).

80. On July 17, 1989, Patient G was discharged from ABHH and transferred back to the ICF (Tr. 383; Ex. 17, pp. 1, 42 and 50).

81. On August 10, 1989, Patient G was readmitted to ABHH with an admitting diagnosis of "unresponsiveness possibly secondary to CVA". Patient G was unresponsive, except to painful stimuli. (Tr. 387 and 706-707; Ex. 19, pp. 1, 16 and 17).

82. The Respondent treated Patient G at ABHH from on or about August 10, 1989 through August 13, 1989 (Ex. 19).

83. The physical examination of Patient G performed by the Respondent in connection with her August 10th readmission was inadequate since it lacked an adequate HEENT, an adequate assessment of her extremities and an adequate neurologic examination, which were all indicated in view of her condition on readmission. (Tr. 390-391 and 714; Ex. 19, p. 16).

84. The Respondent's assessment of Patient G on her August 10th readmission was also

inadequate since the Respondent failed to consider a differential diagnosis for unresponsiveness, especially in light of Patient G having multiple underlying medical problems. There was not even the most basic work-up that should have been done for an acutely unresponsive patient, nor was there any documentation explaining why such a work-up, including a CAT scan, was not done. (Tr. 390-391; Ex. 19).

85. The Respondent's treatment plan, which was to admit Patient G, start her on IV fluids and observe her, was also substandard. It was not based on an adequate work-up, differential diagnosis or a determination that Patient G was or was not a salvageable patient. (Tr. 396-397; Ex. 19, p. 16).

86. During the August 10th readmission, the Respondent failed to have Patient G's isoenzymes evaluated in a timely manner, and such failure constituted a deviation from accepted standards of care. Patient G had an elevated creatine phosphokinase ["CPK"] on her readmission. The CPK can direct a physician towards a specific organ system as the cause of a patient's problem. While one type of isoenzyme may be elevated in a patient who presents with a stroke, another type of isoenzyme may be elevated in a patient with a cardiac event. Evaluation of isoenzymes may therefore direct a physician towards the appropriate further work-up and care for a patient who presents with unresponsiveness. Prompt evaluation of Patient G's isoenzymes was warranted. (Tr. 390-395, 410-411, 412-414, 416 and 720-722; Ex. 19, pp. 29, 30 and 43).

87. On August 13, 1989, Patient G died of a massive cerebral infarction (Ex. 19, p. 10).

FINDINGS AS TO PATIENT H

88. On October 28, 1991, Patient H, a 35 year old male who had been the Respondent's patient since 1980, called the Respondent by telephone complaining of waking up at night with episodes of sweating, dyspnea and left arm pain (Tr. 422, 724-725 and 729; Ex. 20, pp. 1, 2 and 11). The Respondent advised Patient H to come to his office (Tr. 725 and 733; Ex. 20, p. 11). The Respondent also started Patient H on nitroglycerin and ordered an EKG, which was performed that same day (Tr. 422, 426 and 725-727; Ex. 20, pp. 11 and 13).

89. The Respondent saw Patient H in his office on November 12, 1991. During this visit Patient H complained that he had experienced 15 episodes of chest pain in the past two months and that the pain started in his arm and traveled to his chest, woke him up at night and was accompanied by dyspnea. He also stated that the duration of these chest pain episodes was approximately three minutes when he did not take nitroglycerin and about 30 seconds when he did take nitroglycerin. The Respondent listened to Patient H's heart and then ordered laboratory work and made arrangements for a stress test. (Tr. 421-422, 425 and 726-728; Ex. 20, p. 4).

90. The laboratory work was performed on November 15, 1991 and the results were essentially normal (Tr. 727-728; Ex. 20, p. 14).

91. The stress test was performed by Dr. A. Islam at ABHH on November 20, 1991. Although Dr. Islam interpreted the patient's stress test as normal, he recommended an evaluation of the patient for gastroesophageal reflux and an echocardiogram to check the patient's diastolic ventricular function. (Tr. 425-426 and 728-729; Ex. 20, p. 5).

92. On December 2, 1991, the Respondent noted in his office records for Patient H that the "chest pain continues daily" and that the patient should try antacids for possible reflux

(Tr. 427 and 735; Ex. 20, p. 4). However, during a telephone conversation on December 9, 1991, Patient H informed the Respondent that the antacids were not working. The Respondent, who was still considering esophageal reflux and directing therapy towards a gastrointestinal origin for the patient's chest pain complaints, then prescribed Axid. (Tr. 428 and 736-737; Ex. 20, p. 4). On December 11, 1991, Patient H notified the Respondent by telephone that the Axid was not helping, but the nitroglycerin continued to provide relief (Tr. 730-731 and 736-737; Ex. 20, p. 4).

93. Although at the time of the December 11th telephone conversation the Respondent was considering a differential diagnosis of "mild ASHD vs. esophageal spasm", the Respondent at that time did not send the patient for any gastrointestinal studies or any further cardiac studies, despite the recommendations of Dr. Islam and the fact that the trial of medication, the antacids and the Axid, did not work (Tr. 737-738; Ex. 20, p. 4).

94. On January 13, 1992, Patient H once again contacted the Respondent by telephone, complaining of chest pain and informing the Respondent that the Axid provided no relief. However, Patient H did inform the Respondent that he still got relief from the nitroglycerin. The Respondent then put Patient H on a nitroglycerin patch, but the Respondent did not send him for any further testing or even have him come to the office to be seen. (Tr. 434-435; Ex. 20, p. 4).

95. Patient H contacted the Respondent again by telephone on January 17, 1992, complaining of nighttime chest pain. Patient H was not only using the nitroglycerin patch, but he was also taking a large amount of sublingual nitroglycerin. The Respondent still did not refer Patient H for any further testing or evaluation. (Tr. 435-436; Ex. 20, p. 4).

96. On February 4, 1992, the Respondent finally saw Patient H in his office. Patient H still

complained of chest pain. The Respondent noted in his office records for Patient H that he was referring Patient H for an esophagram and an upper gastrointestinal ["GI"] series. (Tr. 436-437 and 738; Ex 20, p. 4).

97. On February 10, 1992, a barium esophagram and a double contrast upper GI series were performed on Patient H. The results were normal. (Tr. 437-438, 730 and 738; Ex. 20, p. 15).

98. The Respondent referred Patient H to a cardiology clinic in Burlington, Vermont. The Respondent's secretary made an appointment for Patient H to be seen at the clinic on March 4, 1992. In addition, a thallium stress test to be performed on Patient H at the clinic was tentatively scheduled for March 16, 1992. No efforts were made by the Respondent to try to obtain an earlier appointment for Patient H. (Tr. 440-441, 731 and 739-740; Ex. 20, p. 12).

99. On February 22, 1992, Patient H was brought to the Emergency Room of ABHH where he died. The autopsy indicates that Patient H died of coronary artery occlusion. (Tr. 441, 479-480 and 731; Ex 21; and Ex. 22, pp. 5 and 6).

100. The Respondent's medical care of Patient H did not meet accepted standards of medical care because the Respondent failed to adequately assess Patient H's chest pain and he failed to timely refer Patient H for an adequate cardiologic evaluation (Tr. 428-433 and 439-443).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing

Committee unless otherwise specified.

The Respondent did engage in conduct in the practice of medicine which evidences moral unfitness to practice medicine. The Petitioner has proved by a preponderance of the evidence the following: 1) that the Respondent's conduct towards Nurse 1 was in the practice of medicine and did evidence moral unfitness to practice medicine; 2) that the Respondent's conduct towards Nurse 2 was in the practice of medicine and did evidence moral unfitness to practice medicine; and 3) that in each instance the Respondent's conduct violated the moral standards of the medical community which were in effect at the time of the specific conduct.[3]

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients C, D, E, F and/or G, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did not practice medicine with gross incompetence. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients C, D, E, F and/or G.

The Respondent did practice medicine with negligence on more than one occasion. The Petitioner has proved by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's treatment of

[3] The conclusion relating to the incident involving Nurse 1 was not unanimous. This conclusion represents the view of a majority of the Hearing Committee.

Patients A, C, E, F, G and H, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E, F, G and/or H.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

At the outset, the Hearing Committee wishes to point out that the moral unfitness issue required a thorough assessment of the credibility of each of the various "fact" witnesses who testified about the events concerning Nurses 1 and 2. On the other hand, the negligence and incompetence issues required a thorough evaluation of the medical testimony regarding the

Respondent's care and treatment of the eight patients.

The Petitioner relies solely upon the factual testimony of Nurse 1 and Deborah Billings to establish its case against the Respondent regarding the Nurse 1 incident. A majority of the Hearing Committee found Nurse 1 and Ms. Billings to be honest, sincere, straightforward, non-evasive and without a motive to lie. The majority believes both witnesses and finds their testimony credible.

While two members of the Hearing Committee find Nurse 1 and Deborah Billings to be credible witnesses, the dissenting member has strong reservations about the credibility of these two witnesses. His reservations are based on the failure of Nurse 1 to promptly report the incident, the lack of documentation relating to the incident within a reasonable period of time following the incident, and the equivocal nature of Nurse 2's testimony concerning a conversation she had with Nurse 1 in September 1996, during which Nurse 1 first mentioned the previous assault by the Respondent.

The Petitioner's case against the Respondent regarding the Nurse 2 incident is based primarily on the testimony of Nurse 2 and various admissions made by the Respondent. After considering all the evidence, the Hearing Committee unanimously finds Nurse 2 to be a credible witness. She is honest, sincere, straightforward, non-evasive and also lacks a motive to lie. Furthermore, she promptly reported the incident. In addition, her testimony is not only supported by statements made by the Respondent to Dr. David Brittain, but it is also supported by the Respondent's testimony before this Hearing Committee.

The Petitioner relies upon the medical testimony of Lori D. Hudzinski, M. D., in its efforts to establish its case against the Respondent with respect to the care and treatment of Patient A. Dr. Hudzinski is Board Certified in Family Practice and has an extended background

in obstetrics (Tr. 484-488; Ex 24).

The Hearing Committee found Dr. Hudzinski to be a convincing and highly credible witness. She was organized and concise and her testimony was balanced. Furthermore, her testimony was straightforward and non-evasive.

The Petitioner's case against the Respondent with respect to the care and treatment of Patients B, C, D, E, F, G and H, is based primarily upon the medical testimony of Joel Peter Amidon, II, D.O.. Dr. Amidon is Board Certified in Family Practice and his credentials are quite impressive (Tr. 186-195; Ex. 23).

The Hearing Committee found Dr. Amidon to be a knowledgable and credible witness. However, there were occasions when the Hearing Committee did not accept Dr. Amidon's statements at face value. Some of these occasions will be included in the discussion relating to specific patients which appears below.

The only witness to testify in support of the Respondent's case, was the Respondent himself. Specifically, he testified about the Nurse 2 incident and about the care and treatment that he provided to Patients A, B, C, D, E, F, G and H. He also denied knowing anything about the Nurse 1 incident. Although at one time the Respondent had been Board Certified in Family Practice and he allowed his certification to lapse, the Hearing Committee found that the Respondent has a sufficient background for a family physician in a rural area (Tr. 528-532, 536-540 and 568; Ex. B).

The Hearing Committee had various concerns about the Respondent's credibility. He did not maintain a consistent level of believability throughout his testimony. For example, at different times during his testimony, he willingly admitted mistakes that he had made. However, at other times during his testimony, he made clumsy attempts to justify or minimize obvious

mistakes. Consequently, while certain portions of his testimony appeared forthright and truthful, other portions of his testimony appeared self-serving and questionable.

Discussion of Moral Unfitness

The resolution of the moral unfitness issue initially required a painstaking evaluation of the credibility of the "fact" witnesses in order to determine what, if anything, actually happened between the Respondent and Nurse 1 at the time of the first incident and between the Respondent and Nurse 2 at the time of the second incident. Once a determination was made as to what actually occurred during each separate incident, the Hearing Committee had to then determine what were the applicable moral standards of the medical community at the time of each incident. Finally, the Hearing Committee had to apply the Respondent's conduct in each instance to the applicable moral standards of the medical community and determine whether the Respondent's conduct violated those standards.

A majority of the Hearing Committee believed the testimony of Nurse 1 and Deborah Billings. The majority found both witnesses credible and their testimony reliable. The majority was convinced by a preponderance of the evidence that the Respondent physically assaulted Nurse 1 in an unwarranted and aggressive manner.

The Hearing Committee unanimously believed the testimony of Nurse 2. She was a credible witness and her testimony was found to be reliable. Furthermore, her testimony was essentially supported by the Respondent's testimony. Although there is a difference between her testimony and the Respondent's testimony as to the precise details of the actual incident, the difference is inconsequential. Ultimately, the issue is not whether the Respondent put his hands on her shoulders and shook her or placed his hands on her neck and choked her. Rather, it is the inappropriate behavior of physically assaulting a professional co-worker, however momentary,

however slight the assault might be, whatever might be the provocation.

The Hearing Committee unanimously believes that a physician placing his hands on a professional co-worker in an aggressive or hostile manner is inappropriate, unprofessional and unacceptable behavior. Such behavior violates the moral standards of the medical community and the public trust which is bestowed upon a physician by virtue of his professional status.

Discussion of Negligence and Incompetence

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

Patient A

The resolution of the negligence and incompetence issues pertaining to Patient A required the evaluation of the medical testimony of Dr. Hudzinski and the Respondent as well as a thorough review of Exhibits 3, 4 and 5.

Whether the Respondent has performed vacuum extractions without episiotomies in the past (Tr. 573-574) or observed obstetricians do the same (Tr. 573) is not germane. Good fortune is not to be equated with good medical practice. The situation where the head is delivered, a shoulder dystocia encountered, and an episiotomy now required, was the creation of the Respondent. Although Dr. Hudzinski stated on cross-examination that an episiotomy would not be required in every single vacuum extraction, she did make it clear that it would be prudent to perform an episiotomy (Tr. 515). She also cited the advantages of an episiotomy in hastening the delivery when fetal bradycardia is a consideration (Tr. 526). In addition, she made clear her personal practice (Tr. 521).

The Respondent had a standard Family Medicine residency and no additional training in the area of obstetrics (Tr. 529). He should be held to the standard of what the prudent physician should do, not what someone with particular training and expertise brings to the encounter.

The Respondent testified that he cut beyond what he could palpate with his fingers (Tr. 583). The Respondent also testified that he cut half the baby's left index finger off while doing the episiotomy (Tr. 587). This would appear to be directly related to his failure to do an episiotomy at the appropriate time and the ensuing difficulty in doing an episiotomy.

It is the Hearing Committee's belief that the Respondent demonstrates both incompetence and negligence as to the facts sustained in Factual Allegation B1. He not only failed to appreciate the factors that should have led him to do an episiotomy at the proper time, but he also did it negligently when he finally performed it. It was that negligence in performing the episiotomy that led to the amputation of part of the baby's finger.

Patient B

The resolution of the negligence and incompetence issues pertaining to Patient B required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibit 6. In addition, it is important to take into account the circumstances of this patient's care in considering the specific charges relating to this patient

Patient B was a 76 year old woman, with metastatic, terminal colon cancer, who was under Hospice care (Tr. 594). The Hearing Committee certainly understands Dr. Amidon's testimony relating to the elements of a proper history and physical (Tr. 199-201). However, prior to this admission it was determined that this patient would be treated with palliative care, not treatment aimed at prolonging her survival. In that spirit, her confusion, mild fever and

deterioration would not spark extensive investigation and the Hearing Committee accepts the Respondent's explanation of his evaluation and treatment. (Tr. 594-608).

Patient C

The resolution of the negligence and incompetence issues pertaining to Patient C required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibits 7, 8 and 9.

The Hearing Committee notes that the Respondent clearly admitted that he did not order the post discharge pro times, that he did not instruct the patient that she should have regular pro times performed as an outpatient, and that he did not realize that he was not getting pro time results at his office (Tr. 611 and 615-620). Therefore, he did not follow the patient's pro times after her discharge from the hospital. In the Hearing Committee's view this was a mistake and the Respondent was clearly negligent. Nevertheless, the Respondent seems to appreciate the necessity for pro times and therefore his failure to order, instruct the patient about and/or monitor pro times is not incompetence. Furthermore, in viewing the entire situation the Hearing Committee believes that this failure does not rise to the level of gross negligence.

The Hearing Committee also notes that in the Admission History and Physical appearing in the hospital records for the second admission, the Respondent wrote that it was his impression "that the patient was given a slip to have serial Protimes done" (Ex. 8, p. 5). The Hearing Committee accepts this notation as evidence that this failure was due to an inadvertent oversight rather than gross negligence.

Patient D

The resolution of the negligence and incompetence issues pertaining to Patient D required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a

thorough review of Exhibits 10, 11 and 11A.

The Hearing Committee is troubled by the fact that the Petitioner had made no effort to obtain Exhibit 11A prior to the commencement of the hearing. This exhibit, which is a copy of the hospital records for Patient D's hospitalization at ABHH between July 18, 1989 and July 21, 1989, was admitted into evidence during the Respondent's direct testimony on October 4, 1999 (Tr. 625-629). It was first requested by the New York State Department of Health on August 31, 1999. Consequently, it was not available to Dr. Amidon for his review before testifying or on August 27, 1999 when he actually testified about Patient D (Tr. 274-301).

The Hearing Committee finds that the information appearing in Exhibit 11A has a direct bearing on the specific charges relating to Patient D's July 25th readmission (which was only four days after Patient D was discharged from ABHH). More specifically, this exhibit contains the detailed physical examination, mental status examination, neurological examination and treatment plan for this patient.

Patient E

The resolution of the negligence and incompetence issues pertaining to Patient E required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibits 12, 13 and 14.

The Hearing Committee found that the physical examination performed by the Respondent on the patient on April 18, 1989 was clearly inadequate, even for an interim admission. The inadequacy of this physical examination is undisputed. Therefore, the Respondent was negligent. However, the Hearing Committee finds that the inadequacy of this particular physical examination does not rise to the level of gross negligence.

Patient F

The resolution of the negligence and incompetence issues pertaining to Patient F required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibits 15 and 16.

The Hearing Committee found that the Petitioner had met its burden of proof with respect to each of the allegations relating to the Respondent's medical treatment of Patient F, except the allegation concerning the Respondent's treatment of the patient during the November 22, 1988 readmission. Accordingly, the Hearing Committee finds the Respondent negligent in connection with each of the proven allegations. However, the Hearing Committee does not believe that any of these proven allegations rises to the level of gross negligence.

Patient G

The resolution of the negligence and incompetence issues pertaining to Patient G required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibits 17, 18 and 19.

The Hearing Committee has difficulty with the term "assessment" as used in Factual Allegation H1. In Factual Allegations C3 (Patient B), E1 (Patient D), F2 and F4 (Patient E), the use of the word "assessment" follows specific means of assessment, such as the history, physical examination and particular elements of the initial assessment. In this instance, the use of the general term "assessment" precedes the specific physical examination. The Hearing Committee, in order to maintain the consistency of the prior usage of this word, interprets Factual Allegation H1 as referring to the general term for the assessment of the patient. However, the term "physical examination" which is used in Factual Allegation H2 is considered by the Hearing Committee as part of the general assessment, but it is being used as a separate and more specific charge.

It is unclear when or whether the history and physical for the July 13, 1989 admission were carried out, but it was dictated on September 3, 1989 (Ex. 17, p. 7), almost two months from the time of admission, and clearly not within the accepted standard of care (Tr. 377-378). Although rudimentary, the initial history is probably adequate given the patient's unresponsive state (Tr. 376-377). While the history might have been supplemented from the ICF, the patient's ICF record (Ex. 18) contains even less medical information than is available in the hospital record for the patient (Ex. 17). Patient G was apparently a resident of the ICF before the CVA of July 13, 1989, but the ICF's record only goes back to July 4, 1989. Therefore, we have no knowledge of what information was available to the Respondent. Relative to the patient's overall assessment, there was no CAT scan, no echocardiogram (Tr. 379) and no apparent effort to find out a reason for recurrent strokes, nor any reference to such studies in the past.

The physical examination for the July 13th admission is described by Dr. Amidon as not meeting the accepted standards of care. The Respondent claims that doing breast, pelvic and rectal examinations on a 78 year old woman with the patient's particular history would have done nothing to further her care. While we might agree, in a patient with a CVA the lack of documentation of a neurological examination, the status of the patient's extremities or carotid pulses, is clearly inappropriate. (Tr. 377-380; Ex. 17, p. 7).

There is basically no adequate treatment plan for the July 13th admission. Additionally, there is no documentation as to why fluid and nutrition alone should be considered adequate. Consequently, the Respondent had failed to meet accepted standards of medical care. (Tr. 381-383; Ex. 17). The Hearing Committee notes the DNR for Patient G (Ex. 18, pp. 20-22) and wishes to point out that "do not resuscitate" is different from "do not treat", particularly

where there is no determination that the patient is terminal. Although the DNR form requires a surrogate to make decisions on behalf of the patient who lacks capacity, none is named or notified in the DNR for Patient G. Furthermore, Patient G did recover to the point of being responsive and taking nutrition, and was transferred back to the ICF (Tr. 384).

On August 10, 1989, Patient G was readmitted to ABHH. She was unresponsive, except to painful stimuli. (Ex. 19, p. 16). Again the Hearing Committee notes that the admission history and physical examination was dictated six weeks after admission, which does not meet the accepted standards of care as previously testified to by Dr. Amidon (Tr. 377-378). Dr. Amidon also testified that the assessment for the August 10th readmission did not meet the accepted standards of care (Tr. 390-391). Had this been done during the prior admission, the information would be known and could be referred to. Since this was never done, the assessment remains inadequate.

The physical examination performed in connection with the August 10th readmission was less complete than the one performed in connection with the prior admission. Dr. Amidon testified that this second physical examination did not meet the accepted standards of medical care (Tr. 390-391; Ex. 19, p. 16). The Respondent testified that a comprehensive physical examination would require the cooperation of the patient (Tr. 708). While that may be true, much of what Dr. Amidon cites in his testimony does not require the cooperation of the patient (Tr. 390). Had an adequate physical examination been performed the first time, an interim note might have been sufficient. However, it was not done the first time, so this physical examination was inadequate.

During the August 10th readmission, the Respondent once again failed to formulate an adequate treatment plan. There was no documentation that the patient had

sustained a non-survivable event. Therefore, the Respondent's treatment plan, which only provided for IV fluids and observation, was inadequate and did not meet the accepted standards of medical care. (Tr. 390-391 and 396-397).

Finally, Dr. Amidon testified about Patient G's CPK levels. He testified as to the use of CPK in diagnosis and the implications for treatment. He also testified that failure to secure the CPK at the time of the patient's readmission was a deviation from the accepted standards of care. (Tr. 391-395). The Respondent testified that he ordered the isoenzymes for the following day because he did not believe the etiology of the patient's difficulty was anything other than a CVA (Tr. 717-719). The Hearing Committee accepts Dr. Amidon's testimony and fails to discern a purpose to the isoenzymes as described by the Respondent. Clearly, if they were to be used to determine treatment, the use would be at admission.

The patient was a 78 year old woman with a history of profound mental retardation, seizures, rectal prolapse and multiple CVAs. She also previously had breast cancer and was apparently free of the disease. The Hearing Committee knows nothing of her quality of life as there is no documentation and there has been no testimony regarding this issue. In certain circumstances it would have been humane to let her disease (the multiple CVAs) run its course without intervention. However, lacking any determination of this issue, the Hearing Committee believes that Patient G, at the very least, was entitled to a work-up that would determine whether her life was salvageable, and if so, the implications of salvage in someone with her disease history. This situation stands in contrast to the situation regarding Patient B, where the diagnosis was known, the extent of the disease was known, and an affirmative decision was made to seek Hospice care, recognizing that the patient suffered from a terminal disease.

It is the Hearing Committee's determination that each of the factual allegations

relating to the Respondent's medical treatment of Patient G constitutes negligence. However, the Hearing Committee does not believe that any of these proven factual allegations rises to the level of gross negligence.

Patient H

The resolution of the negligence and incompetence issues pertaining to Patient H required the evaluation of the medical testimony of Dr. Amidon and the Respondent as well as a thorough review of Exhibits 20, 21 and 22.

The Respondent failed to consider the possibility of false negative stress tests and he failed to pursue either a cardiac or GI work-up in a timely manner. The Respondent also failed to consider that the consequences of not pursuing a cardiac work-up could be severe. (Tr. 426-433). In early February 1992, arrangements were made for a GI series and an esophagram. On February 10, 1992, more than three months after the patient first contacted the Respondent complaining of chest pain, these procedures were performed and the results were normal (Tr. 437 and 730; Ex. 20, p. 15). Arrangements were then made in a routine fashion for a cardiac evaluation and thallium stress test. Unfortunately, the patient expired before either of these evaluations could be carried out. (Tr.731). The Hearing Committee finds that the patient's chest pain was not evaluated in an adequate or timely fashion.

The Hearing Committee also finds that the referral for a cardiac evaluation was not accomplished in a timely manner. There is no note in the patient's chart indicating when the referral for the thallium stress test was actually made. However, the Respondent testified that this referral was made after the GI series, which was performed on February 10, 1992. He also testified that his secretary made the appointment and that he did not make any attempt to obtain an earlier appointment for the patient. The patient was to be seen at the cardiac clinic on March

4, 1992 and a thallium stress test was tentatively scheduled for March 16, 1992. (Tr. 440-441, 731 and 739-740; Ex. 20, p. 12). However, the patient died on February 22, 1992.

The Respondent attempted to justify the delay by stating that he thought that if the patient "had cardiac disease, it was mild disease" (Tr. 739-740). Nevertheless, the whole process was delayed. If a definitive diagnosis had been promptly pursued, even with performing the GI series first, the cardiac evaluation had the potential to save this patient's life. Obviously, the Respondent did not take into account the potential risk of not pursing a cardiac work-up as noted above.

Therefore, the Hearing Committee finds that each of the factual allegations relating to the Respondent's medical treatment of Patient H constitutes negligence.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to Nurse 1 and Nurse 2

A Sustained

A1 Sustained (2-1 vote)

A2 Sustained

Factual Allegations relating to the treatment of Patient A

B Sustained

B1 Sustained

B2 Sustained

Factual Allegations relating to the treatment of Patient B

C Sustained

C1 Not Sustained

C2 Not Sustained

C3 Not Sustained[4]

C4 Not Sustained

Factual Allegations relating to the treatment of Patient C

D Sustained

D1 Sustained

D2 Sustained

D3 Sustained

Factual Allegations relating to the treatment of Patient D

E Sustained

E1 Not Sustained

E2 Not Sustained

E3 Not Sustained

Factual Allegations relating to the treatment of Patient E

F Sustained

F1 Not Sustained

F2 Not Sustained[5]

F3 Sustained

F4 Not Sustained[6]

[4] The Hearing Committee's interpretation of the term "assessment" is the general term for overall assessment that includes specific modalities, such as history, physical, laboratory and x-ray evaluations, etc..

F5 Not Sustained

F6 Not Sustained

Factual Allegations relating to the treatment of Patient F

G Sustained

G1 Sustained

G2 Sustained

G3 Sustained

G4 Not Sustained

Factual Allegations relating to the treatment of Patient G

H Sustained

H1 Sustained[7]

H2 Sustained

H3 Sustained

H4 Sustained[8]

H5 Sustained

H6 Sustained

H7 Sustained[9]

Factual Allegations relating to the treatment of Patient H

I Sustained

---

[5] See note 4, supra.
[6] See note 4, supra.
[7] See note 4, supra.

[8] See note 4, supra.

[9] The Hearing Committee's interpretation of this allegation is that the Respondent failed to timely order CPK isoenzymes.

I1 Sustained

I2 Sustained

Specifications

Moral Unfitness

First Specification	(Nurse 1)	Sustained	(2-1 vote)
Second Specification	(Nurse 2)	Sustained	

Gross Negligence

Third Specification	(Treatment of Patient C)	Not Sustained
Fourth Specification	(Treatment of Patient D)	Not Sustained
Fifth Specification	(Treatment of Patient E)	Not Sustained
Sixth Specification	(Treatment of Patient F)	Not Sustained
Seventh Specification	(Treatment of Patient G)	Not Sustained

Gross Incompetence

Eighth Specification	(Treatment of Patient C)	Not Sustained
Ninth Specification	(Treatment of Patient D)	Not Sustained
Tenth Specification	(Treatment of Patient E)	Not Sustained
Eleventh Specification	(Treatment of Patient F)	Not Sustained
Twelfth Specification	(Treatment of Patient G)	Not Sustained

Negligence on More than One Occasion

Thirteenth Specification	(Treatment of Patients A, B, C, D, E, F, G and/or H)	Sustained

Sustained Factual Allegations in Support of the Thirteenth Specification

Treatment of Patient A: B, B1 and B2

Treatment of Patient C: D, D1, D2 and D3

Treatment of Patient E: F and F3

Treatment of Patient F: G, G1, G2 and G3

Treatment of Patient G: H, H1, H2, H3, H4, H5, H6 and H7

Treatment of Patient H: I, I1 and I2

Incompetence on More than One Occasion

Fourteenth Specification (Treatment of Patients A, B, C, D, E, F, G and/or H) Not Sustained

Sustained Factual Allegations in Support of the Fourteenth Specification

Treatment of Patient A: B and B1

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent's license to practice medicine in the State of New York should be suspended ["the suspension"] for a period of two years, the suspension is to remain uninterrupted for a period of sixty days following its commencement, and on the sixty-first day after its commencement the suspension is to be stayed and the Respondent shall be placed on probation for the remainder of the two year period of the suspension. In addition, the terms of probation shall include requirements for a Practice Monitor and for the completion of at least 50 hours per year of Continuing Medical Education in the area of Adult Medicine and Obstetrics, over and above the minimum standards required to maintain New York State license. The complete terms of probation are attached to this Determination and Order as Appendix II. Finally, the Respondent shall be evaluated, during the uninterrupted sixty

day period of the suspension, by a Board Certified psychiatrist, approved in writing by the Director of the Office of Professional Medical Conduct, for control of frustration, anger and impulsive behavior, and the Respondent shall undergo and complete any therapy recommended by the psychiatrist as a result of the evaluation.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent.

The Hearing Committee finds that the incident concerning Nurse 1 had nothing to do with the incident concerning Nurse 2. These incidents were not only separate and distinct from each other, but they were isolated incidents. They do not appear to be part of a continuing pattern. However, the Respondent's conduct was unacceptable and cannot be ignored. It is obvious that the Respondent has a problem in dealing with frustration, anger and impulsive behavior. He may need professional help, but that determination should be made by a professional. Therefore, the Hearing Committee believes that a psychiatric evaluation is appropriate and that the Respondent should be required to undergo and complete any recommended therapy.

The Hearing Committee notes that of all the incidents involving the Respondent's care and treatment of the eight patients (Patients A, B, C, D, E, F, G and H) which were the subject of this hearing, six of these incidents (Patients B, C, D, E, F and G) occurred over ten years ago, during a one year period. The other two (Patients A and H) occurred four and seven

years ago, respectively. The common thread running through most of these matters seems to be a lack of attention to detail. Although the Respondent no longer has adult admitting privileges, he does care for adult patients in his office, in nursing homes, and in several other facilities. Therefore, it is important to protect the Respondent's patients from the kinds of inattentiveness to detail which got the Respondent in trouble in the first place.

The Hearing Committee believes that the most effective way to address this problem – inattentiveness to detail – is to require some oversight of the Respondent's medical practice and additional education. A Practice Monitor would provide the necessary oversight, insuring the safety of the public. The additional Continuing Medical Education would further sharpen the Respondent's medical skills, thereby making the Respondent a better doctor.

Furthermore, the Hearing Committee wishes to point out that there was no recent charges questioning the Respondent's current ability to practice medicine. Given the totality of the circumstances regarding this matter, the fact that the gross negligence and the ordinary and gross incompetence charges were not proven, and that none of the proven acts of negligence were recent, the Hearing Committee believes that revocation of the Respondent's license to practice medicine is not warranted.

The Hearing Committee does not wish to be misunderstood as to in any way condoning the Respondent's conduct. The penalty imposed herein is designed to affirm the Hearing Committee's disapproval of the Respondent's conduct while imposing a fair punishment and offering sufficient protection to the public.

The Hearing Committee believes that by allowing the Respondent to practice medicine under the strict conditions it is imposing, the public is sufficiently protected and the Respondent can continue to fulfill an important role in the community where he lives.

ORDER

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

1. The First, Second and Thirteenth Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, Eleventh, Twelfth and Fourteenth Specifications of professional misconduct contained within the Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED** ["the suspension"] for a period of two years, the suspension is to remain **UINTERRUPTED** for a period of sixty days following its commencement, and on the sixty-first day after its commencement the suspension is to be **STAYED** and the Respondent shall be placed on **PROBATION** for the remainder of the two year period of the suspension; and

4. The **TERMS OF PROBATION** shall include requirements for a **PRACTICE MONITOR** and for the completion of at least 50 hours per year of **CONTINUING MEDICAL EDUCATION** in the area of Adult Medicine and Obstetrics, over and above the minimum standards required to maintain New York State license; and

5. The Respondent shall comply with all **TERMS OF PROBATION** as set forth in Appendix II, which is attached hereto and made a part of this Order; and

6. The Respondent shall be **EVALUATED**, during the uninterrupted sixty day period of the suspension, by a Board Certified psychiatrist, approved in writing by the Director of the Office of Professional Medical Conduct, for control of frustration, anger and impulsive behavior, and the Respondent shall undergo and complete any therapy recommended

by the psychiatrist as a result of the evaluation; and

7. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: **Syracuse, New York**
January 10, 2000

KENDRICK A. SEARS, M.D.
Chairperson

J. LARUE WILEY, M.D.
REV. EDWARD J. HAYES

TO: **CINDY M. FASCIA, ESQ.**
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
Room 2509 Corning Tower
Empire State Plaza
Albany, New York 12237

JAMES D. LANTIER, ESQ.
Smith, Sovik, Kendrick & Sugnet, P.C.
250 South Clinton Street, Suite 600
Syracuse, New York 13202

MARK CHALOM, M.D.
3 Lyon Place
Ogdensburg, New York 13669

APPENDIX I

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

----------X

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

----------X

MARK CHALOM, M.D., the Respondent, was authorized to practice medicine in New York State on July 1, 1977 by the issuance of license number 131355 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine through June 30, 2000, with a registration address of 3 Lyon Place, Ogdensburg, New York 13669-2518.

FACTUAL ALLEGATIONS

A. Respondent, while employed as the Medical Director of St. Joseph's Home, 420 Lafayette Street, Ogdensburg, New York, engaged in the following conduct at St. Joseph's Home:

1. Respondent, in approximately March 1996, when angered by a request that he interrupt his rounds to see another nursing home resident, grabbed Nurse 1 by the neck with his hand and squeezed her neck and/or pulled her upward by her neck.

2. Respondent, on or about September 23, 1996, after he was paged on his beeper by Nurse 2, went to Nurse 2's work station and put his hand around her neck and squeezed her neck and/or pulled her upward by her neck and/or shook her by her shoulders and/or neck.

B. Respondent provided medical care to Patient A [patients are identified in Appendix] at the A. Barton Hepburn Maternal Care Clinic and Hospital in Ogdensburg, New York from approximately November 1, 1995 through November 3, 1995. Respondent, on November 1, 1995, delivered Patient A's baby at A. Barton Hepburn Hospital.

1. Respondent failed to perform an episiotomy in a timely and/or appropriate manner.

2. Respondent, in performing an episiotomy on Patient A, amputated part of her baby's index finger.

C. Respondent provided medical treatment to Patient B from approximately October 26, 1989 through October 31, 1989 at A. Barton Hepburn Hospital in Ogdensburg, New York.

1. Respondent failed to obtain and/or document an adequate history.

2. Respondent failed to perform and/or document an adequate physical examination.

3. Respondent failed to perform and/or document an adequate assessment.

4. Respondent failed to make and/or document an adequate treatment plan.

D. Respondent provided medical treatment to Patient C on numerous occasions at his office and from approximately February 26, 1989 through March 3, 1989 at A. Barton Hepburn Hospital. Respondent also provided medical treatment to Patient C on her readmission to A. Barton Hepburn Hospital from approximately March 30, 1989 through April 1, 1989.

1. Respondent failed to order and/or document prior to Patient C's discharge from the hospital on March 3, 1989 that Patient C should have regular prothrombin times performed as an outpatient prior to her six week follow-up visit with Respondent.

2. Respondent failed to instruct Patient C prior to her discharge from the hospital on March 3, 1989 that she should have regular prothrombin times performed as an outpatient and/or to insure that the patient received such instruction.

3. Respondent failed to adequately monitor Patient C's prothrombin time following her April 1, 1989 discharge from the hospital.

E. Respondent provided medical treatment to Patient D from approximately July 25, 1989 through July 26, 1989 at A. Barton Hepburn Hospital.

1. Respondent failed to perform and/or document an adequate physical and/or mental status assessment.

2. Respondent failed to perform and/or document an adequate neurologic evaluation.

3. Respondent failed to make and/or document an adequate treatment plan.

F. Respondent provided medical treatment to Patient E from approximately April 13, 1989 through April 16, 1989; from approximately April 18, 1989 through April 21, 1989; and from approximately April 22, 1989 through April 30, 1989, at A. Barton Hepburn Hospital.

1. Respondent failed to perform and/or document an adequate physical examination on the patient's April 13, 1989 admission.

2. Respondent failed to perform and/or document an adequate assessment and/or evaluation for the patient's April 13, 1989 admission.

3. Respondent failed to perform and/or document an adequate physical examination for the patient's April 18, 1989 admission.

4. Respondent failed to perform and/or document an adequate assessment and/or evaluation for the patient's April 18, 1989 admission.

5. Respondent failed to adequately assess and/or document assessment of the patient's renal function, and/or electrolyte levels and/or during the course of the patient's April 18, 1989 admission.

6. Respondent failed to order and/or perform an adequate cardiac workup during the course of the patient's April 18, 1989 admission.

G. Respondent provided medical treatment to Patient F from approximately October 28, 1988 through November 17, 1988, and from approximately November 22, 1988 through December 5, 1988 at A. Barton Hepburn Hospital.

1. Respondent failed to perform and/or document an adequate initial physical assessment for the patient's October 28, 1988 admission.

2. Respondent failed to adequately assess and/or treat the patient's condition during the course of his October 28, 1988 admission.

3. Respondent failed to perform and/or document an adequate initial physical assessment for the patient's November 22, 1988 admission.

4. Respondent failed to adequately assess and/or treat the patient during the November 22, 1988 admission.

H. Respondent provided medical treatment to Patient G from approximately July 13, 1989 through July 17, 1989, and from approximately August 10, 1989 through August 13, 1989, at A. Barton Hepburn Hospital.

1. Respondent failed to perform and/or document an adequate initial assessment for the patient's July 13, 1989 admission.

2. Respondent failed to perform and/or document an adequate physical examination for the patient's July 13, 1989 admission.

3. Respondent failed to make and/or document an adequate treatment plan during the patient's July 13, 1989 admission.

4. Respondent failed to perform and/or document an adequate assessment for the patient's August 10, 1989 admission.

5. Respondent failed to perform and/or document an adequate physical examination for the patient's August 10, 1989 admission.

6. Respondent failed to make and/or document an adequate treatment plan during the patient's August 10, 1989 admission.

7. Respondent failed to timely order evaluation of isoenzymes, and/or to document his rationale for the delay.

I. Respondent provided medical treatment to Patient H on various occasions at Respondent's office through approximately February 1992, and at A. Barton Hepburn Hospital on approximately February 22, 1992.

1. Respondent failed to adequately assess and/or adequately document assessment of the patient's complaints of chest pain.

2. Respondent failed to timely refer the patient for adequate cardiologic evaluation.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Education Law § 6530(20) (McKinney's Supp. 1998), by reason of his committing conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges:

1. The facts in Paragraphs A and A.1.
2. The facts in Paragraphs A and A.2.

THIRD THROUGH SEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing medicine with gross negligence on a particular occasion in violation of New York Education Law § 6530(4) (McKinney Supp. 1998), in that Petitioner charges:

3. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3.
4. The facts in Paragraphs E and E.1 and/or E.2 and E.3.
5. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6

6. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.

7. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5 and/or H.6 and/or H.7.

EIGHTH THROUGH TWELFTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing medicine with gross incompetence in violation of New York Education Law § 6530(6) (McKinney Supp. 1998), in that Petitioner charges:

8. The facts in Paragraphs D and D.1 and/or D.2 and/or D.3.

9. The facts in Paragraphs E and E.1 and/or E.2 and E.3.

10. The facts in Paragraphs F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6

11. The facts in Paragraphs G and G.1 and/or G.2 and/or G.3 and/or G.4.

12. The facts in Paragraphs H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5 and/or H.6 and/or H.7.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion in violation of New York Education Law § 6530(3) (McKinney Supp. 1998), in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in Paragraphs B and B.1 and/or B.2 and/or C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or D and D.1 and/or D.2 and/or D.3 and/or E and E.1 and/or E.2 and/or E.3 and/or F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or G and G.1 and/or G.2 and/or G.3 and/or G.4 and/or H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5 and/or H.6 and/or H.7 and/or I and I.1 and/or I.2.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with incompetence on more than one occasion in violation of New York Education Law § 6530(5) (McKinney Supp. 1998), in that Petitioner charges that Respondent committed two or more of the following:

14. The facts in Paragraphs B and B.1 and/or B.2 and/or C and C.1 and/or C.2 and/or C.3 and/or C.4 and/or D and D.1 and/or D.2 and/or D.3 and/or E and E.1 and/or E.2 and/or E.3 and/or F and F.1 and/or F.2 and/or F.3 and/or F.4 and/or F.5 and/or F.6 and/or G and G.1 and/or G.2 and/or G.3 and/or G.4 and/or H and H.1 and/or H.2 and/or H.3 and/or H.4 and/or H.5 and/or H.6 and/or H.7 and/or I and I.1 and/or I.2.

DATED: March 29, 1999
Albany, New York

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

APPENDIX II

TERMS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Hedley Park Place, 433 River Street, Fourth Floor, Troy, New York 12180; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

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

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty ("the Practice Monitor"), proposed by Respondent and subject to the written approval of the Director of OPMC.

    a. Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the Practice Monitor, including on-site observation. The Practice Monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the Practice Monitor shall be reported within 24 hours to OPMC.

    b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    c. Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9. Respondent shall enroll in and complete a continuing education program in the area of Adult Medicine and Obstetrics to be equivalent to at least 50 credit hours per year of Continuing Medical Education, over and above the minimum standards required to maintain New York State license. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the period of probation or as otherwise specified in the Order.

10. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.